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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0845)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call our meeting to order. I want to welcome our guests.

I want to welcome Ms. Kwan as the replacement for Don Davies. I want to thank our vice-chair for chairing the last couple of meetings. I appreciate your co-operation there. I also want to thank you for tabling that petition yesterday in the interest of seniors.

Now, we're going to continue our study on opioids and the opioid crisis. We have some guests this morning. They're going to make presentations. Each party has 10 minutes for an opening statement, then we'll switch to questions.

First of all, I'm going to introduce the Canadian Medical Association and Dr. Jeff Blackmer, vice-president of medical professionalism. We also have the Canadian Pharmacists Association with Alistair Bursey, chair of the board. We have Réjean Leclerc, the president of the Montreal-Laval paramedics' association. I want to thank you all for coming.

We have the Vancouver Fire Fighters' Union Local 18. Chris Coleman's a firefighter, and Lee Lax is a firefighter. Thank you very much for coming.

We'll start with the Canadian Medical Association. You have 10 minutes.

Dr. Jeff Blackmer (Vice-President, Medical Professionalism, Canadian Medical Association): Thank you, Mr. Chair.

I'm Dr. Jeff Blackmer, the vice-president of medical professionalism for the Canadian Medical Association. On behalf of the CMA, I would first like to commend the committee for initiating this emergency study of the public health crisis in Canada. As the national organization representing over 83,000 Canadian doctors, the CMA has an instrumental role in collaborating with other health care stakeholders, governments, and patient organizations in addressing the opioid crisis in our country.

On behalf of Canada's doctors, the CMA is deeply concerned with the escalating public health crisis related to problematic opioid and fentanyl use. Physicians are on the front lines of this epidemic in many respects. We are responsible for supporting patients with the management of acute and chronic pain. Policy-makers must also recognize that prescription opioids are an essential tool in the alleviation of this pain and suffering, especially in palliative and cancer care.

The CMA has, for a long time, been concerned with the harms associated with opioid use. We appeared before this committee as part of its 2013 study on the government's role in addressing prescription drug abuse. At the time, we made a number of recommendations on the potential role of government, some of which I will reiterate for the committee today.

Since then, the CMA has also taken a number of actions to contribute to Canada's response to the opioid crisis. These actions have included advancing the physician perspective in all active government consultations.

In addition to the 2013 study by the health committee, we have also participated in the 2014 ministerial round table and recent regulatory consultations led by Health Canada. Specifically, we have contributed input on tamper-resistant technology for drugs and the delisting of naloxone for the prevention of overdose deaths in the community.

Other actions that we've undertaken have included undertaking physician polling to better understand their experiences with prescribing opioids, developing and disseminating a new policy on addressing the harms associated with opioids and other prescription medications, supporting the development of continuing medical education resources and tools for physicians, supporting the national prescription drug drop-off days, and hosting a physician education session as part of our annual meeting in 2015.

I'm also pleased to report that the CMA has recently joined the executive council of the First Do No Harm strategy, which, as you know, is coordinated by the Canadian Centre on Substance Abuse. In addition, we have joined seven leading stakeholders as part of a consortium formed this year to collaborate on addressing the issue from a medical and clinical standpoint.

It's important for the committee to recognize that inappropriate prescribing of opioids is not the sole contributing factor to our current crisis and that targeting this issue alone will not lead to a resolution of the problem. However, physicians must accept our share of the responsibility, and we are prepared to play our part in doing what is necessary to move forward in addressing this very complex and multi-faceted problem.

I'll now turn briefly to the CMA's recommendations for the committee's consideration. These are grouped into four major theme areas, the first of which is harm reduction.

Addiction needs to be recognized and treated as a serious, chronic, and relapsing medical condition for which there are effective current treatments. Despite the fact that there is broad recognition that we are in a public health crisis, the focus of the federal national anti-drug strategy is still heavily skewed towards a criminal justice approach rather than a public health approach. In its current form, the strategy does not adequately address the determinants of drug use, treat addictions, or reduce the harms associated with drug use. The CMA strongly recommends that the federal government review the national anti-drug strategy and reinstate harm reduction as a core pillar of the strategy.

Supervised consumption sites are an important part of a harm reduction program that must be considered as part of an overall strategy to address the harms associated with opioid use. The availability of supervised consumption sites, as you know, is still highly limited in Canada. The CMA maintains its concerns that the new criteria established by the Respect for Communities Act are overly burdensome and deter the establishment of new sites. We continue to recommend that the act be repealed or, at the least, significantly amended to address this issue.

The second theme I will raise is the need to expand treatment options and services. Treatment options and services for both addiction as well as pain management are very under-resourced in Canada.

● (0850)

This includes substitution treatments such as suboxone and methadone, as well as services that help patients taper off opioids or counsel them with intervention such as cognitive behavioural therapy. Availability and access of these resources vary significantly by jurisdiction and region. The federal government has a role to play in prioritizing the expansion of these services across the country. The CMA recommends that the federal government deliver additional funding on an emergency basis to significantly expand the availability and access to addiction treatment as well as pain management programs.

The third theme I will raise for the committee's consideration is the need for greater investment in both prescriber as well as patient education resources. For prescribers, this includes continuing education modules as well as training curricula at all levels of the medical continuum. We need to ensure the availability of unbiased and evidence-based educational programs in opioid-prescribing, pain management, and the management of addictions. Furthermore, support for the development of educational tools and resources, based on the new clinical guidelines that will be released early next year, will play a very important role in the overall approach.

Patient and public education on the harms associated with opioid usage is critical. As such, the CMA recommends that the federal government deliver new funding to support the availability and provision of education and training resources, not just for prescribers but for patients and the public as well.

Finally, to support optimal prescribing, it's critical that prescribers be provided with access to a real-time prescription-monitoring program. Such a program would allow physicians to review a patient's prescription history for multiple health services at the point of care, prior to prescribing medications. Real-time prescription-monitoring is currently only available in two jurisdictions in Canada.

Before closing, I should emphasize that the negative impacts associated with prescription opioids represent a complex issue that will require a multi-faceted, multi-stakeholder response. A key challenge for public policy-makers and prescribers is to mitigate the harms associated with prescription opioid use without negatively affecting patient access to the appropriate treatment for their clinical conditions. As one CMA past president said, the unfortunate reality is that there is no silver bullet solution, and no one group or government can address this issue alone.

The physicians of Canada are committed to being part of the solution.

Thank you very much.

The Chair: Thank you.

Now we'll go to the Canadian Pharmacists Association. I missed Dr. Emberley in my introductions, so I apologize for that.

Go ahead, please.

Mr. Alistair Bursey (Chair, Canadian Pharmacists Association): Good morning, everyone. Thank you for the opportunity to be here today.

[*Translation*]

My name is Alistair Bursey. I am a pharmacist in Fredericton, New Brunswick.

[*English*]

I'm here to speak with you about the growing problem of opioid addiction in our communities from the perspective of a practitioner at the front line of an urgent public health crisis. I'm also the chair of the Canadian Pharmacists Association, the CPhA, which is the national voice of Canada's 40,000 pharmacists. I'm joined today by my colleague Phil Emberley who serves as CPhA's director of professional affairs and also works as a community pharmacist here in Ottawa.

I want to begin by thanking the members of this committee for convening this emergency study. There is no question that opioid abuse is fast becoming a Canadian epidemic, and we need strong leadership in this country to stem the tide. Phil and I can tell you that not only are pharmacists the experts when it comes to medication but that we serve on the front line in our communities. Every day in our practices we come face to face with the tragedy of opioid abuse. As a pharmacist my mission is to treat all patients in my community. Over the years the number of patients receiving addiction therapy in my practice has grown at an unsettling pace. Generation after generation are caught in the grips of addiction and often we see them years after the damage has already been done. We know this problem can't be solved overnight. But there are many things we can do to treat those affected, prevent inappropriate prescribing and dispensing, and protect youth from the grips of addiction.

Prevention is where I would like to begin my remarks today. In addition to tackling the existing crisis, we really have to look at some of the underlying causes that have led us to this point. All levels of government need to work together to take a proactive approach to help prevent opioid misuse early on before it becomes a problem. This must be done through a mix of policies and public awareness of the consequences of opioid misuse and inappropriate use of pain medications. A particular focus should be on educating Canadian youth as the evidence demonstrates that many young people are exposed to illegal narcotics before they graduate from high school.

A key to success lies in building effective partnerships with health care providers. Community pharmacists play an important role in educating patients about the harms associated with prescription opioids and other potentially harmful medications. For example, medication reviews allow pharmacists to review the patient's response to the medications. This service provides an opportunity to educate patients on how to take their pain medications safely. It can also flag drug-seeking behaviour. Medication reviews can also reveal patient misconceptions about how and when to take medication, flag medications that are not adequately controlling pain, and confer with their prescribed optimized pain therapy. This valuable interaction between pharmacists and the patient is vital to ensuring safe and optimal use of medications. That fact that we see each Canadian on average 14 times per year provides us a great opportunity to intervene with our expertise and to consult with family physicians to improve patient's pain control.

CPhA supports the government's recent announcement that it will proceed with regulatory change requiring opioids to carry warning stickers and come with patient information sheets describing addiction and overdose risks. It's a good start. But pamphlets and warning labels are no substitute for pharmacists' care. That's why CPhA recommends that all jurisdictions, including the federal government as a provider of health services, expand funding for pharmacists' services to include pharmacist pain medication reviews. Funding pharmacists' consultation and follow-up would go a long way to improving the outcomes of these patients. Education goes hand in hand with better prescribing practices. The government has acknowledged more must be done to support better prescribing of opioids but Canada has fallen behind. We know that outdated Canadian prescribing guidelines simply do not reflect the best available evidence, yet our standards have not caught up. While new guidelines are expected next year, prescribers may feel pressured to prescribe opioids to patients experiencing acute or chronic pain without trying non-drug approaches. In the United States, the Centers for Disease Control encourages prescribers to start patients with low doses while providing a limited supply. We must immediately adopt comparable standards here in Canada to ensure patients receive the best possible care.

Prescribing guidelines are not the only thing that must change for our profession to be more effective and decrease the inappropriate use of opioid medications. A pharmacy is the safest, and most effective and efficient and accountable delivery model for dispensing prescription drugs. But pharmacists can only be as effective as the tools at their disposal. The existing patchwork of prescription monitoring programs, also known as PMP, across Canada is no match for the problems of polypharmacy and double doctoring. PMPs are a stopgap solution.

● (0855)

Moving beyond prescription monitoring to implementing a fully integrated drug information system, DIS, and functional electronic health records, EHRs, in every province and territory would ensure that pharmacists and physicians have access to the information they need to work collaboratively to monitor inappropriate prescribing and address drug-seeking behaviour.

Greater accountability will result when prescribers are unable to claim that they were unaware that a patient was being treated by another physician. The progress of deploying EHRs and a DIS across the country needs to be accelerated to give us the tools we need to reduce opioid addiction.

Public drug plans can also help limit the supply of prescription opioids by limiting the number of opioid doses that can be reimbursed within a specific time period. In my home province of New Brunswick, for over 20 years opioids and other controlled drugs have been limited to a maximum 35-day supply, yet similar controls are not in place across the country. Limiting the maximum supply provides pharmacists with more frequent opportunities for monitoring and intervention, and a much tighter turnaround time to engage the prescriber if required.

From a public safety perspective, limiting the maximum supply results in a decreased inventory of narcotics in our communities. I know from my own experience that pain and chemotherapy patients have been violently targeted by criminals for their prescription opioids. Dispensing fewer capsules at a time can help reduce the risk of diversion.

However, limiting diversion of prescription opioids from pharmacies is a drop in the bucket in fighting this public health crisis. Counterfeit pharmaceuticals manufactured illegally in clandestine labs are feeding the overdose epidemic, plain and simple. These drugs are highly dangerous, putting users at a high risk of overdose since it's impossible to know what or how much of a given substance these drugs contain. Illicit manufacturing of synthetic opioids like fentanyl is increasingly common, and law enforcement needs tools at its disposal to curb the growing supply.

The government has made good progress through the restriction of precursor chemicals, but more can be done to limit production of these dangerous drugs. The Canadian Association of Chiefs of Police reports that criminals are importing commercial pill presses into Canada, but that border agents don't have the authority to seize them. To put this in perspective, these machines can be purchased online for less than $10,000, and they can make between 10,000 and 18,000 pills per hour.

As a pharmacist I can tell you that there is simply no reason for an individual to possess of one of these machines. The CPhA strongly urges the government to impose penalties for the illegal importation of pill presses and tablet machines, and to limit possession to pharmacists and others who hold an appropriate licence.

Finally, we can't forget the human face of opioid abuse, and we can't turn our backs on people who have already succumbed to opioid abuse. We need more programs to help those who are currently addicted to opioids. Pharmacists play a front-line role in assisting recovering addicts by dispensing drugs to treat addiction, such as methadone, suboxone, and naloxone, and by providing regular support, monitoring, and follow-up, sometimes on a daily basis.

These programs and the health providers who deliver them need more support. There is no magic bullet that will put an end to a crisis decades in the making, but we also want to be careful of unintended consequences. As we start to restrict legal access to these drugs, front-line health care workers can be put at risk. Pharmacists will be the first to experience intimidation, threats, and robberies.

Recently I had a discussion with a colleague from Newfoundland, where oil workers in the throes of addiction returned from Alberta to their rural community, and robbed a pharmacy with the aid of gallons of gasoline and a lighter.

Pharmacists are very concerned with the challenges that they're going to face as the supply tightens.

Lawmakers, regulators, and health care professionals must work co-operatively to find solutions to stem the tide of addiction. Pharmacists are committed to being a major part of the solution, and we ask for this committee's support in combatting opioid abuse in Canada.

● (0900)

The Chair: Thank you very much.

Speaking of front-line workers, now we have Mr. Leclerc.

[*Translation*]

Mr. Réjean Leclerc (Chair, Syndicat du préhospitalier (FSSS - CSN)): Thank you, Mr. Chair. Good morning, everyone.

Mr. Chair, members of the committee, I would like to thank you for having me here before you today. I am aware of what a privilege it is to appear before you so that I can contribute, however little, to the work concerning the opioid crisis.

My name is Réjean Leclerc. I have been a paramedic for over 20 years and I am currently the president of the Syndicat du préhospitalier, or FSSS-CSN, the union that represents almost 1,000 paramedics who work for Urgences-santé and provide emergency medical services to the populations of Montreal and Laval. The corporation is the only government emergency medical services body in Quebec. It has an annual budget of about $130 million and reports directly to the ministère de la Santé et des Services sociaux.

During fiscal 2015-16, the paramedics we represent were sent on 315,575 assignments serving a population of about 2.4 million people living in 744 square kilometres. This makes Urgences-santé one of the largest emergency medical services providers in Canada.

While a lot of information has already been given out about the work of this committee, we note that so far, there have been no presentations about the situation in Quebec here. Although the crisis is not comparable, at present, to what some other regions of Canada are experiencing, we are seeing a marked increase in opioid overdoses in Quebec. The Institut national de santé publique du Québec has said that the mortality rate attributable to overdoses associated with drugs and narcotics has increased in the years since 2000.

That increase primarily reflects the rise in fatal overdoses after taking opioids. From 2000 to 2012, a total of 1,775 deaths attributable to an overdose after taking opioids were recorded in Quebec, representing a rate of 2.97 deaths per 100,000 people. In addition, we have the article recently published in *La Presse*. According to the article, in summer 2014, Montreal was at the centre of an epidemic of overdoses linked to the use of street drugs. In the space of a few weeks, 233 cases were recorded and nearly 30 people died.

It should be noted that, according to the statistics published by the Régie de l'assurance maladie du Québec, between 2011 and 2015, opioid prescriptions had increased by 29%, rising from 1.9 million to 2.4 million. The Régie also said that the number of people who received prescriptions had risen by 10%, to 377,365 people in 2015.

In light of that information, some people will say there is a crisis and others will say there is not. But in any event, it is recognized that we have to continue collecting data on this subject, and even improve the work being done on that, in order to get a better picture of the situation and react better in real time.

It has also been brought to our attention that initiatives have been or are being proposed. Whether these consist of training and distributing naloxone kits to friends and family of people at risk of overdosing, wanting to set up supervised injection centres, creating watch groups to do a better job of identifying cases, or the wish expressed by the Collège des médecins du Québec to extend its members' investigative powers, the objective is the same: to significantly reduce the number of deaths attributable to opioid overdoses.

Because we are dedicated to our mission of reducing mortality and morbidity among our fellow citizens, we, as paramedics, support these initiatives, as well as Bill C-224, which was introduced by the member for Coquitlam—Port Coquitlam. We believe that the chances of survival of a person who is the victim of an overdose will be better once this bill is enacted, as long as the public is informed about it. The best thing is therefore to do it as quickly as possible.

Everyone agrees that paramedics provide the public with essential care. In Quebec, the responsibility for evaluating and maintaining the quality of that care rests with the physicians designated by the minister of health and social services. There is thus no professional order that governs paramedics in Quebec.

Because the paramedic profession is not officially recognized, which will be the case for another several years, does this mean that, if Bill C-224 provides for an exemption from possession of substances charges for persons present on the scene when health professionals arrive, the Quebec public would not be able to benefit from that exemption when only paramedics attend to a person who has overdosed? That is the question we have on this point.

● (0905)

Subject to interpretation by the experts, should Bill C-224 be amended to reflect this situation?

In addition, Mr. Chair, I would like to take advantage of the forum I am offered today to draw the attention of MPs and the public to a situation that we believe to be a matter of concern. Given the challenges inherent in the rising numbers of opioid overdoses, we would like to express our concern today about the way that Urgences-santé handles the training of paramedics in the naloxone protocol.

In November 2014, when the corporation was offered an opportunity to train all paramedics in the space of a few months, we made a proposal, following the usual procedure, to promote the rapid and uniform deployment of this antidote in Montreal and Laval. To our great surprise, Urgences-santé did not act on our request, claiming budget issues. The corporation preferred to adhere to the austerity vision imposed by the minister of health and social services and chose, in the middle of the opioid crisis, to train only a few dozen managers and paramedics. With only about 50 paramedics authorized to give this invaluable drug, that number being plainly insufficient, in our view, to meet rising demand, it was foreseeable that there would be unfortunate incidents, like the one that occurred and was recently described in *La Presse* by Dr. Marie-Ève Morin. In the case in question, an ambulance arrived urgently to find that when the paramedics arrived, they were not trained and also did not have the antidote with them that would have enabled them to rapidly reverse the effect of the drug ingested by the person suffering from an overdose.

What message are we, as an emergency service, sending the public when a large majority of paramedics are unable to do what is needed when they are called out to provide care in an emergency in the hope that they will make the difference between life and death?

Amending legislation to encourage the public to call 911 more often and faster is a fine thing, but if the luck of the draw results in the team of paramedics that are prepared to provide care not being authorized to act in overdose situations, we are failing in our objective and losing all credibility the first time out.

Is the public better served in Montreal and Laval today? According to the figures obtained by the CBC from the ministère de la Santé et des Services sociaux in September, only 35% of the thousand paramedics we represent have been trained to administer naloxone. We have to admit that this statistic is disturbing and seems to be incompatible with the efforts and policies supported by this committee and a number of other interested parties. In our view, this regrettable situation must be publicly denounced, until this training for Urgences-santé paramedics has been completed so that they are authorized to administer naloxone in order to save more lives.

Thank you for your attention.

● (0910)

[*English*]

The Chair: Thanks very much.

Okay, we'll move on to the Vancouver Fire Fighters' Union.

Mr. Chris Coleman (Representative, International Association of Fire Fighters Local 18 and Vancouver Fire Fighters' Union - Local 18): Thank you, Mr. Chair.

I am a firefighter in Vancouver. I'm also chair of a political engagement committee for our union, Vancouver Fire Fighters, International Association of Fire Fighters - Local 18.

The Vancouver firefighters appreciate this opportunity to share our views with you as you study the opioid crisis in Canada. We appreciate the committee's recognition of our role in responding to the crisis and its interest in hearing directly from firefighters as we all work toward the mutual goal of mitigating the consequences of the human tragedy that is unfolding in our city.

Our union represents more than 760 full-time professional firefighters in the city of Vancouver, men and women who respond to virtually any emergency in minutes and who are the city's first line of defence.

We are an all-hazard public safety service that is 100% municipally funded. Our members respond not only to fires, where suppression and rescue of trapped citizens may be required, but also to medical emergencies, where we administer first aid until paramedics arrive, hazardous materials incidents, technical rescues, ice and water rescues, and any other kind of emergency.

As witnessed in the past, especially the past few months, Vancouver firefighters are on the front lines of the opioid crisis that is sweeping our city—especially the Downtown Eastside, which, for lack of a better expression, is ground zero for this epidemic—which largely results from abuse of fentanyl and even stronger opioids.

Only a few years ago, police and public health agencies were warning that fentanyl abuse was a growing problem in Canada. Today, they are warning that “bionic” opioids 100 times stronger than fentanyl are coursing through the streets, finding their way into the hands of everyone, from hardened addicts to teens who are just looking to party on the weekend.

Vancouver firefighters are seeing the devastating results of this first-hand. We are witnessing the tragic human toll of this crisis on a daily basis, dozens of times a day. The crisis is also taking a toll on the many agencies and workers on the front lines, including firefighters, and it's taking a toll on the resources that our department has available for the purpose of safely and effectively protecting the public from all emergencies.

To put this problem in perspective, here are some numbers. I'm sure you've heard them, but please let me repeat. According to the B. C. coroner's office, the percentage of illicit drug deaths in which fentanyl is involved rose from 5% in 2012 to 30% in 2015, to 60% so far in 2016. This is moving in the wrong direction.

In the first eight months of this year, Vancouver firefighters responded to 2,287 overdose incidents, an average of 286 per month, though that number spiked to 319 overdose incidents in July, and 341 in August. The vast majority of these overdoses were in the catchment of fire hall 2 in the Downtown Eastside, which earlier this month recorded over 1,000 emergency calls in a single month for the first time in our history, and it has remained at that extreme level ever since. In essence, our call volume has doubled since fentanyl entered the picture.

Emergency medical response is nothing new for Vancouver firefighters. We arrive quickly on the scene of medical emergencies and use existing personnel and vehicles to improve patient outcomes in a cost-effective manner. Adding the very effective opioid antidote naloxone and the appropriate training to firefighters' medical skills has made a huge difference in the current opioid crisis.

Our medical role is also a great example of a value-added service that has a major benefit at relatively little cost. Our capacity to respond to medical emergencies such as opiate overdoses adds capacity to the existing provincially funded ambulance service. Our ability to respond quickly using existing fire department personnel and vehicles puts a trained professional on scene in a timely and cost-effective manner while freeing ambulance resources for other emergencies.

But as our fire department's resources become increasingly focused on one type of emergency within a six-block area of the city, it can only be expected that there will be impacts in other areas. Responding to the opioid crisis can tie up resources, which means fire apparatus may have to come from a nearby district in order to respond to other emergencies. This, in turn, can affect response times at a time when every second counts.

● (0915)

Remarkably, despite booming construction and sharp population growth, there are fewer front-line firefighters in Vancouver than there were 20 years ago. Our association is working hard at the local level to advocate for increased front-line resources, which are a key element of public and firefighter safety. Our role in responding to the opioid crisis has also meant there are fewer resources available for fire prevention work in the communities we serve. There's less time for the training we normally undergo on a regular basis to ensure that we are skilled and prepared to do our jobs effectively.

Another consequence of the opioid crisis is the toll it takes on all those who are on the front lines and who see its results first-hand. Specifically, it takes a toll on an individual's mental health to see such helplessness and suffering up close on a daily basis; to work extremely hard but to feel that you are having little or no impact on a problem that is growing exponentially, like a tidal wave, on the streets of your city. There is mental strain in watching a population repeatedly harming itself and in ultimately witnessing death and deceased persons who have succumbed to this human tragedy. There's physical and mental strain in the sheer volume of responses, which ultimately affects a firefighter's ability to recuperate between shifts.

On this point I feel I must be clear. I must stress that our brothers and sisters who work in the Downtown Eastside are in trouble. They feel abandoned and they feel hopeless. In conversations with these firefighters, I hear a lot of “It's driving me nuts” and “I can't take it”. I'm told stories of their being in an alley with 20 or 30 drug users. They're unprepared and untrained for that. Part of their hopelessness comes from having to deal with the same particular overdose patient who has a needle in their neck, who's rolling around in urine and feces, more than once on the same shift. They feel abandoned and they feel hopeless.

It bears mentioning that while Vancouver may be ground zero for the fentanyl crisis, it is a national problem that's now taken root in cities across Canada. In Ontario 162 deaths were reported as fentanyl overdoses in 2015, and in Atlantic Canada at least 32 deaths, according to news reports. It is a national problem, with provincial and also federal implications, in that illicit opioids, such as the ones wreaking havoc on my Downtown Eastside, are typically shipped to Canada from destinations such as Asia, with Vancouver being an obvious port of entry.

As noted, our medical response eases the burden on the provincially funded ambulance system. In that context, the committee should note that Vancouver fire rescue's role in responding to this opioid crisis is an example of a municipal government shouldering a cost that isn't borne solely at the municipal level, and that municipal and provincial requests for funding should be viewed through that lens when appropriate. The Vancouver Fire Fighters' Union commends the work that various government and non-governmental agencies are doing in response to the opioid crisis. We support current social initiatives that are designed to reduce harm, ease suffering, and otherwise assist those who are struggling due to the opioid crisis.

I'd like to add that I offer a unique perspective, as not only am I a Vancouver fireman but I also live in the Downtown Eastside. The people who choose to come down there to work with the severely addicted mentally ill deserve our thanks, so that's what I'm doing. We, as Vancouver firefighters, are but one of the many groups of dedicated people who are doing what they can to alleviate this crisis.

Thank you again for undertaking this important study and for requesting the input of Vancouver firefighters. I welcome any questions the committee members may have.

Thank you.

● (0920)

The Chair: Thanks very much.

I find it interesting; I think you've all thanked us for inviting you to make a presentation, but on behalf of the committee, I want to say thank you for coming and for telling us your story, your experiences, in this crisis. Few of us have had any experiences at all like yours. We appreciate your input. It's not falling on deaf ears.

We'll start our seven-minute round of questions with Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Mr. Chair.

I would like to thank the witnesses for being with us today.

I am going to start by asking Mr. Leclerc a few questions.

The national situation is a matter of concern to me. After hearing your testimony and reading newspaper articles and reports, I have to admit that the situation in Quebec is of great concern to me.

How do you explain the fact that Quebec is not learning from experiments being done elsewhere in Canada? Vancouver is an example of that. How do you explain that in Quebec, the necessary training of the necessary number of people to do this is not getting done? You talked about that briefly, but I would like you to talk in a little more detail about the reasons that explain this situation. I am thinking about training for this in Montreal, particularly. When we look at Quebec as a whole, it seems to be disproportionate, in terms of the impact that this kind of training would have in Montreal. We agree that major centres are more affected by this problem initially.

Mr. Réjean Leclerc: To summarize, we are currently facing budget restrictions. Urgences-santé is a government body that is directly connected with the department. When the government changed, we had a series of cuts, including cuts relating to the opioid crisis. At the same time, there was also a crisis in 2014.

You will recall the apprehension relating to the Ebola virus. A lot of resources were devoted to that dreaded crisis. At the same time, there was also the opioid crisis and a choice had to be made.

Mr. Ramez Ayoub: Who made that choice?

Mr. Réjean Leclerc: It was Urgences-santé, together with the department.

It is important to understand that the plan was to provide training on naloxone later. It was planned, but for later.

Mr. Ramez Ayoub: What does "later" mean?

Mr. Réjean Leclerc: It might be by 2019-20.

When the crisis occurred, people wanted—maybe for appearances—to train some ambulance paramedics, thinking that these people would serve the entire area. Obviously, that did not work. Even today, we are concerned because there are cuts in training. The ambulance paramedics are still not completely trained, and ordinarily, that takes only a few months. For providing this type of care, we are talking about four hours' training. We are not talking about three weeks' training per person; it is about four hours.

Mr. Ramez Ayoub: I am looking at the statistics on training. I am wondering why, elsewhere in Quebec, nearly 70% of ambulance attendants have been trained. There are only three exceptions to that, three regions.

● (0925)

Mr. Réjean Leclerc: Even in the regions where there have been no cases recorded, as many as 90% of ambulance paramedics have been trained.

There was already a delay at Urgences-santé in terms of mandatory training. Because they had to make up for that delay, they chose, in doing the planning, to do that.

However, the opioid crisis broke out and they were not able to adapt, for budget reasons. It was purely a question of budget.

Mr. Ramez Ayoub: How much time do you think it will take to make up for this delay in Montreal and Laval? Are we talking about one year or two years?

Mr. Réjean Leclerc: It depends on what the authorities want to do.

If we were starting from zero today, it would take four to six months to train everybody, including the people who are absent on an irregular basis.

Mr. Ramez Ayoub: I know it is not your field of expertise, but you work with other first responders—firefighters and police.

Are you prepared to have those people trained as well?

Mr. Réjean Leclerc: The important thing is that the drug be available to victims as quickly as possible.

In addition, the drug can be given without a prescription today. So that would go without saying, but on the condition that training is given. We still cannot have it being given just any way. The people have to be trained, they have to be....

Mr. Ramez Ayoub: But you would be prepared to have other workers be....

Mr. Réjean Leclerc: Yes, I have no objection to that if it can save lives. You understand that time is important, to save a victim.

Mr. Ramez Ayoub: I do not like to presume, but can we say that the statistics show that people have died because this drug was not available in Montreal when help was called, or because it took too long for help to be given?

Mr. Réjean Leclerc: It is hard for me to say. There would have to be coroner's inquests to determine the full sequence of events.

Was it because the drug was not available? Was it because the ambulance was delayed? Was death pronounced once the person arrived at the hospital? I do not have that information at the moment. However, I can confirm that ambulance paramedics have attended at some places where they found a patient who had overdosed and have been unable to do anything. That is an objective fact. I cannot tell you what the consequence was, today, because I do not have precise information about that.

Mr. Ramez Ayoub: That's fine.

We are currently dealing with the action taken by the federal government concerning health care. Budget issues always come up. Yves Robert, who is the secretary of the Collège des médecins du Québec, says that we always end up with some kind of budget and action being taken.

Given the differences that exist between various regions in terms of preparation and planning, whether within Quebec or in Canada, what action is the federal government going to take this time, Canada-wide, to ensure that there is monitoring and some degree of uniformity across Canada when it comes to care?

Mr. Réjean Leclerc: Even though it is less current, I will take the example of the apprehension generated by the Ebola virus disease. Within the border services, everyone was involved. The directives and recommendations were clear. In addition, monitoring afterward was requested.

In this case, the unique factor is that the crisis did not break out in the same way from one region to another. It has become national, but in the beginning, for several months, it was happening only in the Vancouver area.

I think we have to go about it somewhat in the same way. The directives have to be clear and there has to be monitoring so that resources are allocated to the right places. People have to be able to adapt so that they can incorporate this kind of emergency into their plans. In any case, the directives have to be clear.

At present, we are talking about it, but I have the feeling that neither the employer nor the department believes that this crisis needs to be addressed the way the Ebola crisis was at the time.

Mr. Ramez Ayoub: So you support the government making regulations and giving directives to ensure uniformity in the action taken Canada-wide.

Mr. Réjean Leclerc: I would make a distinction between regulations and directives. I am talking here about giving directives and explaining clearly that it is important to tackle the situation, given that it is a public health problem. In terms of regulations, which I prefer not to address today, that is another matter. It is up to the government to decide how it is going to proceed. In any case, the directives have to be clear.

● (0930)

[*English*]

The Chair: Your time is up.

Go ahead, Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you, Mr. Chair, and it's good to see you back. I hope you're feeling much better.

I want to take this opportunity to thank all the panellists and witnesses here today. This is a huge issue and we really appreciate your input. I really like what the pharmacist said. Mr. Bursey, you said that we really have to take a big picture approach to this; it's about prevention. The solutions are about prevention and treatment.

It seems that governments of all levels want to focus on these short-term interventions, so I appreciate your input on that.

I did want to start with the firefighters though. I read an article recently about one of your members, Ryan McConnell, a Vancouver firefighter from fire hall 2, who recently said, “Welcome to Welfare Wednesday in Vancouver” . He was referring to the busiest day for firefighters because it's the day that people line up to get their monthly welfare cheques. Jason Lynch , another Vancouver firefighter said that he had to revive a 24-year-old girl twice in one month. I think all of us realize that each person has such great potential in this great country of ours, but to hear stories like this—reviving a 24-year-old twice in one month—I think we have to say that we need to do more.

I do understand the importance of naloxone on the ground. Is naloxone really the solution or as Mr. Lynch stated, is it just a small band-aid on a big cut?

Mr. Chris Coleman: Thank you for the question.

I'll introduce my colleague Lee Lax as well.

It's a great point. Naloxone doesn't prevent overdoses. It doesn't fix the problem. Tomorrow our chief could put a hundred more firefighters in the Downtown Eastside, but it doesn't change a thing.

Mr. Colin Carrie: That's the thing. We can make naloxone available and it may be a temporary solution, but in my opinion, it's not the solution. A concern out there too is now that addicts know that this is more available, do you think that they may start to feel invincible, especially for young people who might be out there trying this for the first time? Is that a problem we have to be aware of?

Mr. Chris Coleman: I feel that the problem is a health one.

With or without the naloxone, somebody is going to get high. They're addicts, and I think with or without naloxone....just living there and watching it and working there, no, I don't think so.

Addicts will continue to use because they have to use. I don't believe naloxone has made anyone more of a superman. There was enormous risk before the stronger drugs.

Mr. Colin Carrie: They seem to be getting stronger and stronger. My colleague just mentioned that there is a new one out there that is 100 times more potent, a super fentanyl. I think we really have to focus on prevention.

We had Dr. David Juurlink from the division of clinical pharmacology and toxicology at Sunnybrook Health Sciences Centre here last week or the week before, and he put a lot of blame on physicians. He was pretty hard on physicians, about lack of education with regard to prescribing, and more specifically the over-prescribing of opioids in Canada. As I see it, though, physicians can only do so much.

Dr. Emberley, you're aware that the U.S. FDA has now approved over seven abuse-deterrent, tamper-resistant opioid formulations of prescription opioids from four different manufacturers, while our current Canadian government has abandoned this regulatory pathway that was being pursued by the previous government. It was supported by our own provinces and territories and health ministers.

I was wondering, does the Canadian Pharmacists Association support the use of abuse-deterrent, tamper-resistant opioids as one tactic, part of a broader national opioid strategy? If so, why?

Second, would you support a regulatory move to convert the entire class of controlled-release or all opioids to the ADF or tamper-resistant formulations over a short transition period?

Dr. Philip Emberley (Director, Professional Affairs, Canadian Pharmacists Association): We spoke out in favour of tamper-resistant formulations a few years ago. One of the reasons was that we had a very problematic drug, namely OxyContin, that was introduced in Canada, which we all know created huge problems. As a result of that, there was a tamper-resistant formulation, OxyNEO, that was developed, and we saw this as a move forward. It was not the only solution, but it was one solution.

We got some signals from the U.S. that this was going to become a pattern for all new, long-acting opioids to be introduced in this format, and we saw it as a good thing. We are still positive about this technological innovation.

However, the other side is that we've seen an unintended consequence. People have seemingly turned to illegal sources of narcotics and opiates. They've gone to the illicit market. We spoke about the fentanyl prices, with illicit forms of fentanyl being introduced. It creates this whole concept of a balloon effect. If you reduce the attractiveness of one type of medication or formulation, and in fact make all narcotics tamper-resistant, it causes certain elements of our society to move to the illicit form. We have to be very careful.

The short answer is yes, we still see tamper-resistance as one solution, not the only solution, but as one solution; there are some numbers out of the U.S. that say it has had some effect. However, we have to be very cautious of the unintended consequences, which may end up being even worse than what we were trying to prevent in the first place.

● (0935)

Mr. Colin Carrie: Now it appears that there is a certain percentage of it which is prescribing, but a larger part of it seems to be this illegal fentanyl. You mentioned the pill presses and stuff like that.

I was going to ask Mr. Blackmer about it. Your organization has known about and has been working on this issue for the past decade. What have you done to work with colleges to educate and help improve the knowledge of physicians on the ground?

I see tamper-resistance as a tool. However, for a 24-year old who maybe gets a broken bone playing sports and before you know it in 30 days is an addict, what have you been doing to help educate physicians on proper prescribing, but also maybe on de-prescribing these substances?

Dr. Jeff Blackmer: Those are extremely important issues for a physician.

We've been working very closely with the regulatory colleges and with our educational colleges as well. As you know, there are a number of medical bodies in Canada that have different responsibilities for different areas. We work primarily on the production and dissemination of educational tools online and in person, across the continuum of medical education.

We need to do a better job of educating medical students when they take their pharmacology courses, at that foundational level, to understand the potential of opioid addiction, the different types of pain medications that can be used, and other approaches to pain management, as well as things like addiction management. However, right now there is a lot of focus on practising physicians, because of the new formulations of medications, the new types, and getting that information out to them to address exactly the types of issues you're talking about, which are alternatives to opioid medication in certain circumstances. They can be appropriate in some circumstances but not others, then also that de-escalation of dosage, as well, to get them off the medication.

We've been working hand in glove with these other partners to disseminate those educational products.

Mr. Colin Carrie: I've heard that prescriptions for opioids are still up by 29% this year. Is the message actually getting out there? Part of the strategy is on the criminal element, because it seems that most of it is coming from the criminal element. There need to be substantial resources there, but for on-the-ground prevention, is it getting out there if there's a 29% increase in opioids in the last year? What more can we do? What advice can you give us?

Dr. Jeff Blackmer: Clearly, there's more to be done, right? We as a profession have to own that, and we are owning that. We're saying that we need to do a better job.

As in all of these discussions, it's much more complex on the front lines if you have a health care practitioner or a primary care doctor who has only five or 10 minutes with a patient. It would be much better if they had a long time to sit down and talk through all the different alternatives for pain management. They often have a very compressed period of time and they feel very pressured to provide or renew a prescription instead of talking about the other types of alternatives that are available.

As well, these front-line physicians feel that they're under a lot of pressure to provide these prescriptions. You have people coming in demanding access to medication and saying they need it and that if they don't get it, they'll go into withdrawal. The physicians are feeling stuck between a rock and a hard place.

What we're seeing sometimes—and I see this in my practice—is that family doctors are saying that this takes too much of their time, it's too difficult, and they feel under pressure from the regulatory authorities on one hand and the patients and their families on the other hand, so they're just not going to prescribe narcotics anymore. That will be their solution. From their standpoint, they've handled things with their patient population, but those patients just go elsewhere. We need to do a better job of equipping that group of physicians with the tools they need to make the proper decisions, as well as the prescribers, who need more help and guidance in terms of the proper dosing and de-escalation.

There's no question that there's a lot more work to be done.

● (0940)

The Chair: Your time is up. I'm sorry.

Ms. Kwan, we have it on our list here that Ms. Malcolmson is the replacement. Are you going to ask questions?

Ms. Jenny Kwan (Vancouver East, NDP): Yes, I am. I will do the first set and Ms. Malcolmson will do the second set.

The Chair: Thank you.

Go ahead. You have seven minutes.

Ms. Jenny Kwan: Thank you very much.

First off, let me say thank you to all the witnesses for your presentations, and in particular, in recognition of the first responders and the hard work you do in our community.

By way of background, I'm the MP for Vancouver East, in which the Downtown Eastside is located. I have a special appreciation for the first responders there and for the community, which is hard at work in trying to deal with this ongoing crisis.

Back in the 1990s, there was a declaration of a health emergency. That's when we pushed for the first supervised injection facility. Since that time, we now have a second round with a health emergency, with fentanyl and the stats that you presented to us, Mr. Coleman. It is indeed shocking, even for someone who has known the community for a very long time. To that end, I want to say first off on the question around harm reduction that the work you do is extremely important because, as we know, dead people don't detox. That's what we need to get to, and it is a medical health crisis.

On that issue in terms of going forward, knowing the crisis that's before us and that is going through the entire country, what can the federal government do to address this issue? What action do we need to ensure that the federal government undertakes to work in collaboration with the provincial and municipal levels of government, the NGOs, and the community on the ground?

Mr. Lee Lax (Representative, International Association of Fire Fighters Local 18 and Vancouver Fire Fighters' Union - Local 18): I think, first off, we should encourage the federal government to really look at this crisis like they would any other national disaster, and they should support the municipalities.

The move to making naloxone available to first responders, and primarily to firefighters in B.C., has been a great first step. Our death rates from overdoses have stabilized in the short term in Vancouver. Unfortunately, those overdose numbers continue to increase.

It should be noted though that naloxone helps, but it's first responders on the ground who are saving lives. For a person who's addicted to an opioid, or has an overdose, to walk you through it, the person overdoses on the opioid, and respiration slows to a point where breathing stops. That then leads to cardiac arrest and then to eventually to death. It's all about the support of first responders on the ground. Without the boots on the ground dealing with these overdoses, we're not going to be able to save lives. Municipalities at this point are pretty well taxed on that issue.

I think we need to realize that this is as much a mental health emergency as it is a drug emergency. In the Downtown Eastside, almost all of the patients that our members see on a daily basis are dealing with mental health issues. They turn to opioids to relieve them from the stress of their mental illness. Opioids provide them that relief and that temporary reduction in pain. Many of these people don't have access to proper mental health assistance. Mental health is a very strong point to this.

We also have to look toward providing mental health strengthening for first responders. It's the first responders who day in, day out are dealing with these types of emergencies. As Chris alluded to, there's a lot of pain and suffering that our members feel from having to see this every day. We appreciate the work that the federal government has done so far in identifying occupational stress injuries. Post-traumatic stress disorder is certainly a hot topic issue for first responders that we need a national approach from the federal government to deal with.

● (0945)

Ms. Jenny Kwan: Thank you very much.

Would it be fair to say there's a need to move away from, for example, doing pilot projects, which has been a historical practice of federal governments? They come in to do a project on mental health supports with housing that has been developed in the community, but when the pilot ends, the program ends and there's no funding anywhere. Then you're closing the facility that's been proven to be effective. Do we need ongoing support to do these programs, so that we can have effective long-term results? When people talk about treatment and prevention, you need to have stabilized housing, and you need to have ongoing mental health support for individuals who are faced with those challenges in our community, for example.

Mr. Lee Lax: It's pretty evident, you know, just walking the streets of the Downtown Eastside that there are members of society crying out for help. They don't have the supports that they need, and they're just looking to survive on a day-to-day basis. Being able to provide them with long-term assistance with their addictions, or with their challenges with housing, or with their mental wellness will go a long way in helping their lives.

Ms. Jenny Kwan: I want to turn to you for a minute, Mr. Coleman. You mentioned the impact for first responders or firefighters on the ground. I think it's quite striking. I think the words you used were “hopeless” and “helpless” for the first responders and the impact for you when you deal with this crisis.

I wonder, on that question, what action can be taken to take care of the first responders and the people who are on the ground and in the front lines doing this incredible work to save the lives of others? What can we do to ensure that you have the tools you need to do your job effectively and to also support you in this incredibly challenging situation?

Mr. Chris Coleman: As Lee said, it would be recognizing that it's a national problem and helping with the limited municipal resources. As was noted, we're quite active on the local scene trying to work with the council and the chief for more staffing, which they get a lot of push-back about. Since this is a national problem, help from the federal government would certainly help.

In the short term, there's nothing this committee can do, but I have to say my men and women down there do feel hopeless and abandoned. They're abandoned by their own leadership. They're abandoned by their own management team. The brothers and sisters don't feel they're supported.

When our chief spoke at a fentanyl crisis meeting two weeks ago in Vancouver, he assured council that everything is okay as far as mental health goes and not to worry because we have a great critical incident stress management team. Well, everything's not okay. It would be nice if they had somebody from the management team come to the hall not to say “suck it up”, which is a quote from a deputy, but to be there and to help and listen to these brothers and sisters and to listen to their stories.

The Chair: I'm sorry, but time's up.

Go ahead, Dr. Eyolfson.

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

I'd like to thank the entire panel for showing up and for your service in all these different aspects.

I practised emergency medicine for almost 20 years, and as much as I agree that prevention is key, it doesn't change the fact that there's an ongoing crisis you have to deal with. Certainly in the emergency department when all the different problems roll in, you can't just stand there and say, “This should have been prevented.” I appreciate what first responders and paramedics have to deal with, because we see the looks on their faces when they bring these patients in. It's a horrific situation.

I support what my colleague Ms. Kwan said about harm reduction. I know from the data on it how important it is.

Dr. Blackmer, you talked about how burdensome the Respect for Communities Act is. What aspects of it, in particular, are causing problems in preventing more harm reduction strategies?

Dr. Jeff Blackmer: There are a number of aspects, particularly the number of hoops that communities need to jump through and the barriers that are put in place in terms of the letters of support and a number of the other procedures that people need to go through. I think we all recognize that input from the community is one aspect of that decision-making process. It's an important aspect, but obviously those letters of support from all of these layers and levels are burdensome in a way that outweighs the potential benefit to having input from that community. That's one example; there are others as well.

I would note that we recognize that harm reduction is one aspect of a full approach to this, but it's a very important one. We also know that in communities where these clinics have been established, whereas there may have been obstacles prior to the establishment, in fact, surveys done afterward showed that in many cases those communities came to see them as being very beneficial. There are a number of aspects to the bill that while important provide more obstacles than they need to.

● (0950)

Mr. Doug Eyolfson: Thank you.

Mr. Bursey, perhaps you can answer this from the pharmacy's point of view. We were talking about the availability of opioids. Manitoba had one of the problems, which was noticed by the pharmacy community and the medical community. It had to do with Tylenol 1s. For background, Tylenol 3s and Tylenol 2s are of course available by prescription only. Tylenol 3s have 30 milligrams of codeine each. Tylenol 1s with eight milligrams of codeine apiece are non-prescription. In Manitoba they were noticing a lot of addicts, because they could get them over the counter, were taking a lot of them. Due to the amount of Tylenol it took to get high off Tylenol 1s, people were presenting at the hospital with liver damage, sometimes needing liver transplants.

As well, it turns out that there's a four-minute YouTube video that shows you how to extract pure codeine from Tylenol 1s.

In response to that, Manitoba has made Tylenol 1s prescription only. Would that be a strategy that would be at least somewhat helpful in removing one more source of narcotics from the street?

Mr. Alistair Bursey: I think it's a good strategy. In my practice we saw a lot of patients seeking Tylenol 1s, and it got to the point where we required a patient assessment by the pharmacist to see if it was an appropriate therapy, for example, for a migraine or abscessed tooth infection. Then the pharmacist would write a prescription as appropriate, and we would put it on our pharmacy system and it would be fed into the electronic health records so it could be tracked. The idea was that the appropriate patients would be taken care of, and the patients who were drug-seeking would no longer be able to gain access to it, and we would inform them of alternative therapies such as addiction services.

I can certainly say what we've done in our pharmacy has made a big difference, and I think what Manitoba has done certainly would. I do have concerns with those patients who are getting Tylenol 1s, codeine products, for appropriate therapies. If you do up-schedule it and pharmacists can no longer prescribe it after doing a thorough assessment, I think that could be concerning, but I do think there's an opportunity there to find solutions that take care of both parties.

Mr. Doug Eyolfson: To clarify, Manitoba pharmacists can prescribe it.

Mr. Alistair Bursey: They can?

Mr. Doug Eyolfson: Yes, they can prescribe it, but they have to do an assessment. They have to prescribe it, and it goes on the same electronic medical record that all the prescriptions go on, so as you say it can be tracked.

Mr. Alistair Bursey: Yes, and that's a great solution. I'm hopeful that more provinces can work together to move toward that solution.

Mr. Doug Eyolfson: Thank you.

You made a reference to commercial pill pressers. Now, there's a very alarming development, again in Manitoba. Some carfentanil made it into Winnipeg. I'm familiar with it from my residency. It is elephant tranquillizer. In residency, when I was doing my toxicology, I read that you would only encounter it if your hospital was near a large-animal veterinary facility like a zoo, because 20 years ago that was the only place you'd see that if there was an accidental exposure there. Times have changed, and it's shown up.

The form it showed up in in Winnipeg, unfortunately, was on paper blotters of the same form that young people will take other drugs like ecstasy, particularly at raves. There was nothing on it saying what was in it, but they had carfentanil, and the police found a fairly large shipment. There have been at least two carfentanil overdoses in Winnipeg in the last couple of months.

That being said, given that it's such an easy way to package fentanyl for consumption, would banning commercial pill pressers make that much of a difference, or would it just simply divert more of this to another form that makes it onto the street?

● (0955)

Mr. Alistair Bursey: As we said earlier, I don't think there's a magic bullet that's going to solve all the problems, but I do think we're going to have to use multiple different ways to find solutions. I think regulating pill presses is one solution. I think obviously there is some work to be done with this particular elephant tranquillizer, and I think as long as we try to deal in a multipronged approach, then we'll be able to start to make some progress on improving the situation of addiction.

Mr. Doug Eyolfson: My last question is for the colleagues at the Vancouver Fire Fighters' Union. Again, I agree naloxone is a band-aid, but when someone's bleeding you need a band-aid. Some jurisdictions have started to use police services for different forms of first response. Some American jurisdictions have had police carrying external defibrillators in their cars, calling them on 911 calls to a collapsed person. There is also talk of training police in the use of inter-nasal naloxone. Would the participation of the police in this, particularly with our new law when police are not automatically giving possession sentences now, be helpful in dealing with this disaster until we can get it under control?

Mr. Chris Coleman: I think so, and that conversation was taking place at that meeting a couple of weeks ago where our chief said everything's okay. A police officer presented as well on that very subject, so that conversation is happening. If it's not implemented right now, I'm sure it will be.

Mr. Doug Eyolfson: Good to hear, thank you.

The Chair: Thank you very much.

Now we're going to go to five-minute rounds, and we're starting with Ms. Harder.

Ms. Rachael Harder (Lethbridge, CPC): First off, I will join my colleagues in saying a very respectful thank you for coming and giving us your time today and sharing your expertise with us. We certainly appreciate it.

I'm going to direct my first question towards Mr. Blackmer.

I recently had a conversation with an aboriginal teenager in my community who was boasting to me—he was unfamiliar with who I was—about the prescription drugs, opioids, that he would get from his doctor, which he would then sell. He told me that depending on the drug, he would get anywhere from $10 to $25 per capsule. Basically, this is how this young man lives. He's going to his doctor, he's having these drug prescribed, and then he's functioning within an illicit market.

Clearly, his doctor is doing this continuously, and it would appear that there's no accountability. This teenager doesn't take them, so it is questionable whether or not he even needs them. I guess I'm just looking for your thoughts as to whether this is happening across Canada. Is this a common occurrence? How would we go about bringing a stop to this type of conduct?

Dr. Jeff Blackmer: I can't speak to specific statistics around that, but clearly this is a concern across Canada. The issue of patients selling prescription drugs is not unique to one jurisdiction. We've seen this for years. It speaks to some of the challenges that I was alluding to before at the individual patient-practitioner level. In conversation with a patient, it's very difficult for the practitioner to say, “Oh, this seems like the kind of person who would go and sell these drugs.”

You have to understand that the patient is presenting.... Some of these people are very good. If this is their livelihood, they become quite good at this. They present with a lot of pain. They present with a very convincing story, and sometimes they do this to multiple practitioners on the same day. Sometimes it's a primary care provider, but more often it's a walk-in clinic or an emergency room where there's not an established relationship and it's one-off meeting between that doctor and patient.

There are huge challenges for those health care practitioners to really get to the root of some of these problems and to understand how these medications are being used.

There are a number of things that can be put in place to try to mitigate that like prescription monitoring programs, so that a doctor can call up the history in real time and say, “Oh, they were just at the emergency department yesterday and they were prescribed the exact same medications they're asking me for now.”

They need more time to have those conversations and to screen for addiction potential, but also to screen for risk factors in terms of patients who might turn around and sell those drugs. Again, there's no perfect solution to this. There are a number of things that need to be put in place.

It is very challenging for front-line physicians and other health care providers to determine in very rapid sequence what will happen to those medications after they're dispensed.

● (1000)

Ms. Rachael Harder: It would appear to me, then, that it would make a significant difference if we were to implement a national databasing system with regard to the use of prescription drugs to tell us what's being prescribed, why it's being prescribed, and how often it's being prescribed—all of those things. Would you agree with that?

Dr. Jeff Blackmer: Absolutely, that would be hugely helpful. I think that's one important role that the federal government can play in this area. We know people can cross borders in Canada quite easily, and we know that drug seeking happens across borders as well, so being able to access that data in real time....

It's not enough for a doctor to find out two weeks later that the patient that they saw had been doctor shopping and had multiple prescriptions. That's helpful for future knowledge and changing practice, but in terms of being able to address the issue of the patient in front of them, they need access to all of that information in real time. We don't have systems like that in place now.

Ms. Rachael Harder: I recently learned that in places in the United States it's common practice for doctors to have a preconsult before prescribing. They'll actually bring patients in, sit down, talk to them, have a conversation with regard to why the prescription is being requested, then have a separate meeting with that same patient on another occasion to do the prescribing.

It's my understanding that this basically creates a bit of a lag period, if you will, which then allows the doctor to make a good judgment, but also creates a bit of a loophole for the individuals seeking the opioid.

Could you comment on whether or not you feel that this would be helpful in Canada?

Dr. Jeff Blackmer: I know that there are Canadian physicians who are doing that, who are having multiple consultations and meetings at different points in time. That also has its challenges.

For someone with severe acute pain who genuinely needs pain medications, asking them to come in for an appointment now and then for another appointment in three weeks—speaking to the access to primary care and access to physicians—can be really difficult. For some situations that might be very appropriate and for others it might be more challenging.

The Chair: Your time is up.

Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair.

Thank you to all the presenters. My question is to the Vancouver Fire Fighters' Union.

Are there any particular communities affected? As you said, it's not a drug issue; it's a mental health issue. What kind of education would you recommend and what kind of resources? What are your views about that?

Mr. Chris Coleman: At the risk of over-simplifying, I think it's a matter of housing and mental health support.

I'm sure you're familiar with the housing crisis in the city of Vancouver, and it gets no easier in the Downtown Eastside when a single-storey affordable bakery for the local residents is rezoned to 13 stories of condominiums with Starbucks as the anchor tenant.

Ms. Sonia Sidhu: For mental health issues, do you have any education perspective or any other resources?

Mr. Chris Coleman: I can't speak to that.

Mr. Lee Lax: To follow up on Chris's point, what a lot of these members of society need starts with housing. Stability of housing leads to mental stability.

When you're travelling the street day to day, walking through the cold winter rains in Vancouver, you don't have the opportunity to find mental stability. You're just looking to survive. You're looking for the next place to lay your head in the evening. It's about survival. If you start with the basic needs of food and shelter, you can move your way up to dealing with mental wellness.

Ms. Sonia Sidhu: Thank you.

My other question has do to with naloxone. I know it's a temporary relief. Do you agree with it being available to remote, rural, northern, and urban communities, and being easily accessible?

● (1005)

Mr. Chris Coleman: Is it currently accessible?

Ms. Sonia Sidhu: Yes, to all the communities, if they want it, rural, urban....

Mr. Chris Coleman: I don't know absolutely, but I assumed it was, yes.

Ms. Sonia Sidhu: There are no barriers?

Mr. Chris Coleman: It's not a prescription drug.

Ms. Sonia Sidhu: There are no barriers. It's easily—

Mr. Chris Coleman: That's right, yes. There's a cost.

Ms. Sonia Sidhu: Okay.

This question is for the CPhA.

Do you think the over-prescribing of fentanyl contributes to the opiate crisis?

Mr. Alistair Bursey: I think the vast majority of the fentanyl that is causing this problem is not coming from traditional fentanyl patches that you would see for treating patients such as cancer patients. The majority of this is coming from outside of Canada in tablet form. It's slipping through, and unfortunately it doesn't take much fentanyl to be able to provide these people with euphoria. The majority of it is coming from sources external to this country.

Ms. Sonia Sidhu: We've heard that the number of fentanyl prescriptions has increased. Why is that?

Mr. Alistair Bursey: There was an increase in the opioid prescriptions. I'm not 100% sure if it's fentanyl, morphine, or hydromorphone. Personally, in my practice, I have not seen an increase of fentanyl being dispensed, but I can say from talking to law enforcement that we're seeing an increase in synthetic fentanyl from outside of the country. That's primarily where it's coming from.

Ms. Sonia Sidhu: We heard from previous witnesses that telling someone a drug is a strong drug makes people want it more. They want to look cool.

Can you elaborate on that? Is it a fact?

Mr. Alistair Bursey: Sorry, could you provide some more context for me on that please?

Ms. Sonia Sidhu: We had a witness here who said that telling someone that fentanyl is a strong drug makes them want to look cool. Is that a fact?

Mr. Alistair Bursey: I can certainly say that in my own practice I've never used the phrase “strong drug” to a patient. I would say this is going to provide significant pain relief or it's a medication that we have to be careful with. When we counsel our patients day in, day out, we want to make sure they're fully educated on the particular medication. If it does seem that it's an inappropriate medication, we consult with physicians and prescribers to make sure that we keep patients safe.

Ms. Sonia Sidhu: Thank you.

The Chair: Mr. Webber, you have four pages of questions there.

Mr. Len Webber (Calgary Confederation, CPC): To tell you the truth, all four pages of questions have already been asked.

I do want to focus right now on our first responders and get some more specifics on the administration of the drug naloxone. What exactly has to be done in order to administer it to a patient? Is it an injection into a vein? I hear there's a nasal spray out there now that you can use. Can you just describe how you administer it to your patient?

Mr. Chris Coleman: The first responder arriving on the scene would have to establish the patient's level of consciousness, and determine that there is an overdose. Usually there are good signs because there are needles close by in an alley to determine that. Then a little pain stimuli to see if you can arouse the person. You would next assess and assist the breathing and then we have a small vial that we load the needle with and it's an intramuscular injection. I'm not sure of the dose. Sometimes you'd have to do multiple injections, but when the naloxone does take effect, you have a patient coming out of their high in 20 seconds and often quite upset you've taken their high away.

Mr. Len Webber: That's very interesting. It's basically an EpiPen that you can just insert.

Mr. Chris Coleman: That's exactly right.

[*Translation*]

Mr. Réjean Leclerc: In Quebec, the situation is different. In cases like these, we use a vaporizer. The drug is drawn from a vial and put in a syringe, and a vaporizer is added to that to administer the drug through the nose. The patient then has to be monitored. Withdrawal is virtually instantaneous. The patient may be very agitated, and the sort of aggressiveness associated with that new state has to be controlled. An electrocardiogram is necessary as part of the monitoring. Depending on the quantity of drug absorbed, the antidote stops having effect after 30 to 40 minutes. If the person is still under the effects of opioids, they can relapse into an overdose. So every time, the patient has to be monitored for about 30 minutes and taken to hospital quickly.

● (1010)

[*English*]

Mr. Len Webber: Great, thank you for that. Mr. Leclerc, you had mentioned that in order to administer an EpiPen of naloxone that there's a four-hour training program that needs to be done in order to learn how to administer this drug. I find that surprising that it would take four hours to be able to work an EpiPen.

[*Translation*]

Mr. Réjean Leclerc: For this drug, the training takes about four hours.

[*English*]

Mr. Len Webber: Thank you.

I'm sorry for interrupting you, but I only have a little bit of time here.

I want to talk to Mr. Bursey. You mentioned a couple of times about the drugs coming from outside Canada. We've had other presenters here as well who have indicated they're coming mainly from China, which is the number one source of illicit drugs in this country. Mr. Chair, I know that we talked about my motion and bringing that to the table, and I will respectfully do that after our presenters are finished with this session here, but I would like to put forward that motion at that time regarding bringing the Chinese ambassador here as a witness, to appear before us to provide evidence as to the measures being taken by the Chinese government to address the manufacture, distribution, and sale of illicit opioids that are coming here to Canada. I will wait until after this session here.

I do appreciate all of you and your comments here today. They've been very insightful, thank you. I assume my time is up.

The Chair: Mr. Kang.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Thank you, Mr. Chair.

First of all, I would like to thank the stakeholders for their presentations here and for bringing us up to speed on this crisis we are facing.

Dr. Blackmer, how many safe injection sites do you think we would need to contain this epidemic, and would they be helpful in future crises too?

Dr. Jeff Blackmer: I don't think we have information on the exact number that's needed. I know that different municipalities have looked at their own individual needs. Certainly here in Ottawa we've had a number of conversations that perhaps more than one would be appropriate for our population. They've done some analyses in cities like Toronto and Montreal, and in other urban locations as well.

I think the point to understand with this is that the harm reduction piece, which would include supervised injection sites, is one part of an overall strategy to combat opioid addiction. It's not a panacea for this entire issue, as we've heard before, but it's one aspect that deserves some further attention and I think support as well.

Mr. Darshan Singh Kang: What other avenues could we explore, in your opinion, to alleviate this crisis?

Dr. Jeff Blackmer: Other than harm reduction?

Mr. Darshan Singh Kang: Yes.

Dr. Jeff Blackmer: There are a number of pillars. There's the prevention piece, which we've heard about, and education for physicians and other care providers in looking at alternatives, with different types of pain management initiatives and interventions. There's the treatment for patients who are addicted, whether that's detox, which does not work very well for narcotic and opioid addictions, or whether that's substitution therapy with things like suboxone. Then there are the prescription monitoring programs, which are a very important aspect of this.

Again, addressing any one of these issues will lead to unintended consequences, as we've already heard. We need a national strategy—we've heard a little bit about what that could look like—that will address all of these types of issues. Whether it's the availability of naloxone at the front line, better education of care providers, or harm reduction strategies, it needs to be multi-faceted.

● (1015)

Mr. Darshan Singh Kang: Okay.

There was a pilot project carried out at a supervised site in Vancouver that provided drug users with the option of testing their drugs for fentanyl. They found that 86% of the drugs tested contained fentanyl. When Dr. Bonnie Henry, the deputy provincial health officer of British Columbia, appeared before this committee on October 6, she noted that legislative barriers prevent individuals from checking their drugs for fentanyl, and that exemptions would need to be made under the Controlled Drugs and Substances Act to allow this practice.

In your opinion, should legislative barriers be addressed to facilitate individuals to test their own drugs for fentanyl or possibly other substances? If yes, how should the drug test kits be made available to people who use drugs? Do you think this will help alleviate the overdose problem?

Dr. Jeff Blackmer: I think that would be one part of an overall strategy, to be able to identify those substances and act accordingly. I think many Canadians have been quite shocked to hear some of those statistics that fentanyl is making its way into other substances through this means. We've heard about importation from foreign countries. I think testing these substances makes a lot of sense, but as one part of an overall strategy.

Mr. Darshan Singh Kang: Thank you, sir.

Mr. Bursey, what role can pharmacists play in identifying and treating individuals with substance use disorders?

Mr. Alistair Bursey: Pharmacists often are the eyes and ears of physicians on the front lines. We see patients, especially addiction patients or patients who are receiving pain medications, many times throughout the year. In New Brunswick, the average number of visits by a New Brunswicker to a pharmacist is 16 times a year. It's a great opportunity for identifying and for collaborating with our physicians on our addiction programs to find solutions and make sure that these patients who are in the throes of addiction can get treatment. I think pharmacists play a key role in collaborating with other health professionals.

The Chair: Your time is up.

Ms. Malcolmson, thank you for coming.

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Thank you, Chair.

I'm Sheila Malcolmson, member of Parliament for Nanaimo—Ladysmith. We have the sad honour of having had more deaths per capita to drug overdose than anywhere else in British Columbia has, since 2008, so this has been happening for some time.

The B.C. coroner, just last month, said that Vancouver Island Health Authority—just think of this beautiful island paradise, this rural area—has had the largest increase in opioid deaths, a 135% increase from last year, and we have the highest rate of overdose deaths in British Columbia. So I appreciate the work that all of you men and women are doing on the front line and all of the advocacy that you're doing through all of your organizations.

Mr. Emberley, you were quoted last year as saying that this is really a disaster that's happening all across Canada. We're hearing that again and again here. In your view, is the opioid overdose crisis a national emergency?

Dr. Philip Emberley: I believe it is. At first we were hearing of it in pockets. We were hearing that it was a problem in Vancouver, and maybe in the Prairies as well, but every community has been affected by this. Working in a pharmacy, we see it.

I see in the west end of Ottawa, where I work, that there's a certain population that has been profoundly affected by this. We see people getting into trouble with medication. We see people coming in early for their opioid prescriptions, and there's a sense that they're getting out of control with their own personal use of these medications. It is definitely a national problem; no community is unaffected. For that reason, I believe we have to treat it as a national crisis.

● (1020)

Ms. Sheila Malcolmson: Thank you.

Mr. Blackmer, we really appreciate the advocacy that your group is doing. I note that the Government of Ontario recently appointed an overdose coordinator. This is the first province that has taken that position, to put someone in the role of developing surveillance and reporting systems, to gather data on overdose deaths and to make informed decisions about patient care.

Do you believe that the federal government should follow suit by tasking our chief public health officer with coordinating a national response to the opioid overdose crisis?

Dr. Jeff Blackmer: I do absolutely, and I think there's a lot that the federal government can learn from what's being done at the provincial level. You alluded to whether or not this is a national emergency. British Columbia has declared a provincial state of emergency, which it has done primarily to have access to some data that it would not otherwise have, not just on deaths by overdose, but on the actual number of overdoses. I think there's a lot the federal government can learn by looking at what some of the individual provinces have done and instituted, and then trying to roll that out at the national level.

The Chair: Time is up. I'm sorry.

That concludes our testimony today. I really want to thank the presenters for their contributions here. You've all been closely involved with this issue and you've helped us a lot. Your testimony will be reflected in our report. Thank you very much for coming

To the committee, we have some committee business to do, so we're going to take just a two-minute break and then we'll reconvene to deal with some motions.

● (1020)

(Pause)

● (1025)

The Chair: We will reconvene now.

We have some motions to deal with. When we started this study, we agreed that it would be public and broadcast, but this is committee business and we need to have the agreement of committee as to whether it's going to continue to be public and broadcast, or held in camera because it's committee business. I know that Mr. Webber, who is the mover, prefers that it be in public. This discussion is just on whether we're going to go in camera.

Mr. Webber.

Mr. Len Webber: Yes, but I would like it to be known publicly that I would like to put this motion on the table.

The fact is that we've had numerous presenters here indicating to us that these illicit drugs are a problem and mainly are coming from China. We've had the Canada Border Services here. We've had the RCMP here. They've all indicated that the problem is China and the illicit drugs coming from there. We're talking about the "super drugs" like super fentanyl and carfentanil. These are drugs that could wipe out the population of Canada with some of the shipments that are coming here.

I do want to put the motion on the table right now, Mr. Chair:

> That, pursuant to Standing Order 108(2), the Committee call upon His Excellency Mr. Zhaohui LUO, Ambassador for the People's Republic of China to appear before this Committee to provide evidence as to the measures being taken by his Government to address the manufacture, distribution and sale of illicit opioids into Canada.

The Chair: Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you, Mr. Chair.

Without discussing the merits of the motion, in fact, I think we should have stayed on the topic that you asked us to stay on: are we going in camera or not? Regardless of the merits of the motion, I believe it is the committee's practice that we discuss witnesses to our committee in camera, and I would request that we move in camera immediately.

● (1030)

The Chair: Mr. Kang.

Mr. Darshan Singh Kang: I echo Mr. Oliver's words.

The Chair: Dr. Carrie.

Mr. Colin Carrie: I disagree. I'm in favour...we can go in camera for discussing our witnesses and that part of business, and I think that's customary, but for the motion, I think we can do the motion and vote on it publicly. I think my colleague is going to put the question right away.

Mr. Len Webber: I did put the question right away.

The Chair: All right.

All in favour of going in camera? All opposed?

Okay. We're going in camera.

Mr. Colin Carrie: [*Inaudible—Editor*] count the hands. I think we were very—

The Chair: Well, let's do it again.

All in favour of going in camera? Five in favour. Opposed? Four. We're going in camera.

An hon. member: Could we have a recorded vote?

The Chair: A recorded vote? It's already been voted on. We're going in camera.

[*Proceedings continue in camera*]