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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0850)

[*English*]

The Vice-Chair (Mr. Len Webber (Calgary Confederation, CPC)): Hello, everyone, colleagues and witnesses. We are going to start the meeting, even though we have a few members missing. They'll come trickling in here eventually.

I would like to thank you all for joining us here today for this very important meeting. On September 22, 2016, just about a week and a half ago, the House of Commons Standing Committee on Health adopted the following motion from MP Don Davies:

> That, pursuant to Standing Order 108(2), the Committee undertake an emergency study of the opioid crisis in Canada.

Today, we will begin that study. We will continue on this study for several meetings. It is my hope that the witnesses, in their testimony, focus on solutions, specifically solutions the federal government can participate in. There is a problem here in Canada, and it is well known. There is one fentanyl overdose death every 14 hours in Canada, and the problem is getting worse. We need to act very urgently.

We have a variety of witnesses lined up who will offer their own unique perspectives and suggestions. We know that there is no silver bullet solution, so this study will be important in providing us with a tool box of solutions that we can consider. I appreciate that we are all concerned about this issue.

With that, let's hear from our witnesses. To start, I'd like to introduce some witnesses from Health Canada.

We have Hilary Geller, who is the assistant deputy minister for the healthy environments and consumer safety branch at Health Canada. She holds a degree in business administration from York in Toronto, and she has been with Health Canada since 2007. Welcome, Hilary.

We have Supriya Sharma, who is a senior medical adviser to Ms. Geller. She is a medical doctor and has a master's in public health from Harvard University. She has been with Health Canada for almost 12 years in various roles.

We also have Rita Notarandrea, CEO of the Canadian Centre on Substance Abuse, and she has been with the CCSA for 10 years. Previously, she spent 21 years with the Royal Ottawa hospital, a large psychiatric institution, including 13 years as a CEO there. Welcome, Rita.

Also from the Canadian Centre on Substance Abuse, we have Matthew Young. Sorry, I don't have any biography for you, Matthew. Maybe you could tell us all about yourself when you're up.

From the Royal Canadian Mounted Police, we have Todd Shean, assistant commissioner for federal policing special services. This division has responsibility for border integrity and national intelligence coordination, among other things. Mr. Shean has been a police officer for 30 years. While in the rank of chief superintendent, he was responsible for drug and organized crime national operations.

We also have Luc Chicoine. Luc, I just have your business card here, so I'll just read that. Luc is a national drug program coordinator with the RCMP, at the federal coordination centre here in Ottawa.

We also have Caroline Xavier, vice-president of operations at Canada Border Services Agency. Caroline has a master's degree from Dalhousie, and an executive diploma from Harvard. She has been with the CBSA for about six years. As we all know, CBSA has responsibility for securing Canada's land and maritime borders.

We also have Mr. Brent Diverty, vice-president of programs at the Canadian Institute for Health Information. He has a master's degree in economics and has previously worked for Stats Canada. He recently spent two years working with the equivalent agency in Australia.

Welcome, everyone.

I would like to just quickly go around our table here to introduce my colleagues to you. We can start with Darshan.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): I'm Darshan Kang, member of Parliament for Calgary Skyview.

Good morning, everybody.

Mr. John Oliver (Oakville, Lib.): I'm John Oliver, member of Parliament for Oakville.

Good morning.

Mr. Randeep Sarai (Surrey Centre, Lib.): I'm Randeep Sarai, member of Parliament for Surrey Centre.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): I'm Doug Eyolfson, member of Parliament for Charleswood—St. James—Assiniboia—Headingley in Winnipeg.

Ms. Sonia Sidhu (Brampton South, Lib.): Good morning.

I'm Sonia Sidhu, member of Parliament for Brampton South.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Good morning.

I'm Ron McKinnon, member of Parliament for Coquitlam—Port Coquitlam.

Mr. Colin Carrie (Oshawa, CPC): I'm Colin Carrie, MP for Oshawa.

Mr. Don Davies (Vancouver Kingsway, NDP): I'm Don Davies, member of Parliament for Vancouver Kingsway.

Thank you for being with us.

The Vice-Chair (Mr. Len Webber): Rachael, do you want to quickly introduce yourself?

Ms. Rachael Harder (Lethbridge, CPC): I'm Rachael Harder, member of Parliament for Lethbridge in Alberta.

The Vice-Chair (Mr. Len Webber): All right. We'll get started with the presentations now. We have round one. We will start with the Department of Health, Hilary and Supriya.

Ms. Hilary Geller (Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Department of Health): Thank you, Mr. Chair.

Good morning. On behalf of Dr. Sharma and Brent Diverty, I'd like to thank you very much for the opportunity to appear today.

As you know, British Columbia is at the epicentre of the current crisis of drug overdose and deaths, with the B.C. Coroners Service reporting that there was a 62% increase in illicit drug overdoses from January to August of this year compared to the same period of last year. According to the B.C. Centre for Disease Control, if this trend continues, B.C. could see 800 illicit drug overdose deaths by the end of the year, with nearly half of those expected to involve fentanyl. Yet, the most recently available national data from the Canadian tobacco, alcohol and drugs survey did not show increases in the use of the most common illicit drugs.

What has changed?

What seems to be accounting for the unprecedented rise in deaths is the increased presence of fentanyl on the illicit market, an opioid that is significantly stronger than morphine. According to the B.C. coroner, there were 264 illicit drug overdose deaths where fentanyl was detected from January through July, a 222% increase from the same period in 2015. lnsite, one of two supervised consumption sites in Canada, recently began providing test strips as a pilot project at their site so that users of their services could test their drugs. They report that 86% of those samples tested positive for fentanyl.

As you'll no doubt hear from the CEO of the Canadian Centre on Substance Abuse, the Canadian Community Epidemiology Network on Drug Use flagged that deaths linked to fentanyl have increased markedly across the country. As you will no doubt hear from our colleagues from the RCMP, this also reflects what law enforcement is seeing.

While illicit drug use has always been a high-risk behaviour, with the exact composition and strength of the substance being unknown, fentanyl has increased those risks immeasurably. As British Columbia's provincial health officer, Dr. Perry Kendall, has said, no one is immune. People with long histories of drug use are overdosing, as are people trying drugs for the very first time.

In terms of critical actions to deal with the immediate crisis of overdose and deaths, many experts are calling for three things: increased availability of naloxone, increased availability of supervised consumption sites, and increased availability of treatment, including medication-assisted therapies.

Health Canada is responding to each of these three calls to action. We have made naloxone more widely available by removing the requirement to have a prescription. This was the first time that Health Canada initiated the removal of the prescription requirement for a drug to respond to a public health need. In addition, the Minister of Health issued an emergency order on July 5 to allow immediate access to the more user-friendly nasal spray form of this medication. I'm pleased to note that yesterday it was announced that the department has completed its expedited review of this nasal spray form of naloxone, thereby regularizing its availability in Canada.

In the case of supervised consumption sites, evidence has shown that, when properly established and maintained, they can save lives, all without increasing drug use and crime in the surrounding area. These supervised consumption sites decrease the number of deaths by overdose, and they can redirect injection drug users to health and social services. In addition, they reduce public drug use, rates of infection, and unsafe syringe disposal.

I would like to note that Health Canada has heard concerns with regard to the legislative requirements contained in the Controlled Drugs and Substances Act related to the establishment of supervised consumption sites. Further to direction from our minister, we are working closely with potential applicants to explain the legislative requirements in order to ensure there are no unnecessary barriers for communities that wish to open such a site. In addition, we are looking at the legislation to assess whether amendments may be advisable.

In this context, it is important to recognize that the application review and authorization process seeks to ensure that supervised consumption sites are established based on evidence and with sufficient support so that these sites will be properly maintained. These rigorous criteria protect the health and safety of both the clients and staff and give confidence to the community that there is a process in place to ensure that these facilities are operating responsibly.

● (0855)

Health Canada is also supporting access to medication-assisted treatment options. For example, a regulatory amendment was recently published to allow for the consideration of applications for medical-grade diacetylmorphine under Health Canada's special access program, as scientific evidence supports the use of heroin in select cases for the treatment of chronic relapsing opioid dependence. This same type of medical treatment with heroin has also been used in several European countries under very specific circumstances and provides a treatment option for the very small percentage of patients who have not responded to other treatments.

[*Translation*]

This winter, we also intend to consult stakeholders on the regulatory requirements for physicians to obtain an exemption to prescribe methadone in order to determine whether that requirement is an unnecessary barrier to treatment.

[*English*]

Health Canada also recognizes the importance of research to assist us in making evidence-based decisions, including as it relates to medication-assisted treatment.

Through the Canadian Institutes of Health Research, we are making important investments in research to help build the evidence on which key policy decisions are made. The OPTIMA study is just one project the CIHR is supporting. It will compare and evaluate the effectiveness of two treatments for prescription opioid dependence—methadone and the combination of buprenorphine and naloxone—with the goal of generating practice-based evidence that will inform patient care and improve health outcomes in Canada.

Beyond the harm reduction measures described above, I anticipate that others, including the RCMP, will highlight the importance of addressing the supply side of the opioid crisis.

Within the purview of Health Canada, the intention to put forward regulatory amendments to control six chemicals that are used in the illicit production of fentanyl was announced last month. The comment period for this regulatory proposal closed yesterday, and we will be moving forward expeditiously to control these precursor chemicals. The Minister of Health has also stated that she intends to bring forward legislative options for consideration on the issue of pill presses.

Stepping back from the immediate crisis of overdose and death, it's important that the numerous individuals and organizations with a role to play in addressing various aspects related to the root cause of the opioid crisis come together. It's only by taking a collaborative, comprehensive, evidence-based, and sustained approach that we can make a difference in the long term.

Important foundational work is well under way. Following the 2014 HESA report on the government's role in addressing prescription drug abuse, the report of the Canadian Centre on Substance Abuse, “First Do No Harm”, and the input of many stakeholders, budget 2014 funding of $44 million over five years has allowed many of the initiatives identified in these studies to move forward.

I will give just a few examples. Updated opioid prescribing guidelines will be available early in the new year. Nineteen new inspectors have been hired and are on track for over 1,000 inspections of community pharmacies. Public awareness campaigns have been run. The Canadian Institute for Health Information is using $4 million in funding to strengthen surveillance and data collection. The first nations and Inuit health branch of Health Canada is investing $13 million over five years to increase support for improved training for community-based addictions workers and to establish crisis response teams.

Building on this, Minister Philpott called on the department in April to look at all possible options to take action in addressing this crisis. That work led to Minister Philpott's announcement in June of a five-point action plan that aims to influence the root causes and reduce the potential for harm, both in its most extreme manifestations as an overdose death but also for so many other Canadians who experience harm from problematic opioid use.

Given the challenges and complexities of this public health emergency, it's clear that our response to the crisis requires leadership among many different players, as well as a coordinated approach. To quote the Canadian Medical Association in a statement they made last year, “The unfortunate reality is that no single level of government, no single health provider group and no single sector of our society can resolve this complex crisis on its own.”

For this reason, the Minister of Health and the Honourable Eric Hoskins, Ontario's Minister of Health, as co-chairs of the conference of federal, provincial and territorial ministers of health, will be co-hosting a conference and summit in the middle of next month to discuss the current problem of opioid misuse in Canada and to identify further potential ways forward. The smaller summit following the conference will bring together individuals and organizations who have both the authorities and the commitment to take concrete action in combatting the opioid crisis.

I'd like to thank the committee for the opportunity to speak to you today.

● (0900)

[*Translation*]

My colleagues and I will be pleased to answer all your questions

Thank you.

[*English*]

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

We'll move to our next presenter, Brent Diverty, from the Canadian Institute for Health Information.

Brent, go ahead with your presentation.

Mr. Brent Diverty (Vice-President, Programs, Canadian Institute for Health Information): I'm actually not here with a planned presentation. I'm here supporting Hilary and to answer any questions you have about some of the data we have available to look at this issue.

The Vice-Chair (Mr. Len Webber): Thanks, Brent.

Then we'll move to the Royal Canadian Mounted Police, and we'll start with Todd Shean.

A/Commr Todd G. Shean (Assistant Commissioner, Federal Policing Special Services, Royal Canadian Mounted Police): Good morning, Mr. Chair, and thank you for the opportunity to speak to the committee this morning.

As we are well aware, there has been a staggering increase in opioid overdoses in Canada, both lethal and non-lethal, which is the reason that this issue must be treated as a crisis. Canada and the U.S. have been facing a similar crisis related to the abuse of opioids causing a large incidence of overdoses. As such, the U.S. has had the most fatal overdoses from opioids in the world while Canada follows in second place.

● (0905)

[*Translation*]

The increase in overdoses and fatalities linked to opioid abuse can be associated with the diversion of licit pharmaceutical opioids as well as with the increased availability and access to illicit opioids such as the fentanyls. The highly potent nature of synthetic opioids is well documented; in particular, fentanyl is estimated to be up to 100 times more potent than morphine. The mere exposure to it, whether it is via inhalation of air-borne powder or absorption through the skin, can result in serious and life-threatening consequences.

[*English*]

Since 2010, seizures of illicit fentanyl have been made all across the country, and this continues to increase. Important seizures continue to be made on a regular basis in areas of the country, such as British Columbia, Alberta, Saskatchewan, and Ontario, where high numbers of overdoses are also being reported regularly.

The current upsurge in illicit fentanyl is expanding geographically, facilitated by known organized crime groups and local drug trafficking networks. The constant demand has promoted the illicit importation of several analogues to fentanyl. For decades, Canada-based organized crime networks and drug traffickers have produced illicit synthetic drugs in both powder and tablet forms. Illicit fentanyl has been accessed as a replacement to conventional drugs of abuse, as well as used as an additive to other drugs, often without the user's knowledge.

Fentanyl is a significant concern, but the illicit opioid market is evolving at an alarming rate. As a primary example, in December 2015, a substance known as W-18 emerged in Canada, in what was thought to be a fentanyl seizure. Also imported from abroad, it was reported that W-18 is 100 times stronger than fentanyl and known to be fatal in very small doses.

[*Translation*]

Investigations and intelligence reports indicate that British Columbia is the main distribution point for fentanyl tablets and is the most affected province. This may be due to its geographical situation in relation to the main producer of fentanyl in the world, China.

Domestic production of fentanyl has also been identified, but in low numbers.Our federal investigators are currently working on a variety of investigations involving fentanyl importations. Shipments are coming into Canada disguised or labelled in a variety of ways such as printer ink, toys and DVDs.

[*English*]

Once in Canada, pure fentanyl is diluted using cutting agents. It is then manufactured in the final product, which can be in tablet form or powder form, in clandestine labs before being distributed throughout Canada and to a lesser extent the U.S. Illicit fentanyl trafficking offers a significant profit margin. By way of example, it is reported that the raw material cost to produce one million fentanyl pills is under $100,000, but once sold, these tablets can yield profits of upwards to $20 million. These profits, coupled with easy access to supply markets and a growing demand, are likely to mean that the situation will not abate any time soon.

Recognizing the potency of synthetic opioids has highlighted the immediate urgency to ensure the protection and safety of front-line police officers, border officers, postal workers, and the public writ large. As a result, the RCMP has engaged in a number of safety awareness initiatives for front-line officers and the general public.

[*Translation*]

In the past year and more recently, officer safety bulletins were distributed throughout the RCMP, addressing the safe handling of unknown substances, including fentanyl, and outlining the risks, hazards, and necessary precautions that must be taken.

We have made presentations to the provincial law enforcement community and other government departments as well as publicly releasing a video via social media which highlights some of the dangers that synthetic opioids pose to first responders and the public, and steps to protect themselves if there is a suspicion of possible exposure.

The RCMP has purchased 13,700 naloxone nasal spray kits which were distributed across the Force. Naloxone is an antidote to fentanyl that quickly reverses the symptoms of exposure to fentanyl and other opioids.

[*English*]

The kits are being carried by on-duty operational police officers and employees who are at risk of accidental exposure and who may be required to provide first-aid treatment to citizens in an emergency situation if an opiate overdose is suspected.

The RCMP has developed mandatory training for officers, as well as operational policies that address fentanyl and other opiate overdoses. With respect to collaborative efforts, the RCMP continues to consult with various stakeholders on outreach materials, and we are currently working to produce additional awareness of products to help police, youth, and parents to understand the impact of fentanyl.

● (0910)

[*Translation*]

Where are these illicit synthetic opioids coming from? According to RCMP criminal intelligence reports and investigations, it is apparent that China is the main source country for these drugs entering Canada, particularly fentanyl.

The growing threat from fentanyl, related precursors, and other novel synthetic opioids is directly correlated with a huge industry producing these substances within China.

[*English*]

Anchored between domestic criminal entities and those based in China is the Internet. The surface web and the dark web enable criminals to anonymously create global supply chains for a range of illegal goods and services, and acts as a platform for criminal expert forums. The RCMP has been building relations with our law enforcement counterparts in China in an effort to strengthen collaboration wherever possible to combat criminal activities with the goal of disrupting international drug trafficking networks.

In October 2015, the Chinese government completed regulatory amendments controlling 116 new substances, including some fentanyl analogues, but the drugs that made it to Canada are not controlled in China. In addition, there's a disparity between what Canada and China consider a public health crisis simply based on population numbers. Fentanyl abuse has not been identified in China. The Chinese government's focus is on other synthetic drugs of abuse like methamphetamine and ketamine.

[*Translation*]

As mentioned earlier, our U.S. counterparts have also been faced with the illicit synthetic opioid epidemic and have identified Mexico as their main source of distribution. However, it must be noted that the drugs that are entering Canada from China are also evident in the U.S.

The RCMP is working at home here in Canada with other government departments to raise awareness about the challenge, gather data on the scope of the problem, and collaborate with communities to stem the flow of illicit synthetic opioids that are having such a destructive impact. Alerts were put out as early as June 2013 by the Canadian Centre on Substance Abuse. Internationally, the RCMP has liaison officers and analysts who are deployed all around the world. They are tasked with providing direction, support and assistance to Canadian law enforcement agencies in the prevention and detection of offences relating to Canadian laws. As such, they liaise with foreign agencies and develop partnerships to address issues of concern to the RCMP and Canadian government.

[*English*]

The RCMP actively participates in the international narcotics control task force, which is a forum of countries that discuss both domestic issues as well as investigations with international dimensions. Over 30 countries, including China, participate in the task force. We have used this focus group to share information in relation to the Canadian opioid crisis. Discussions at these meetings can strengthen international co-operation by assisting respective countries in considering amendments to the regulatory framework.

In addition, initiatives are being proposed in international forums, such as the G7 law enforcement project groups, to address issues around equipment and new technologies that facilitate the ability to manufacture pills made from bulk active ingredients. Criminals are profiting from new psychoactive substances that haven't yet been regulated by importing these powdered bulk ingredients. As such, law enforcement must think of novel ways to mitigate the presence of these threatening substances within our country.

[*Translation*]

Let me be clear - as long as criminal entities in Canada maintain vested interests in the opioid market, its expansion will likely continue to accelerate. Continued collaboration and support from Canadian agencies, government departments and our international partners will be necessary to combat this issue.

[*English*]

With that said, I believe that measures taken, under way, or under consideration across Canada will significantly assist in the prevention of fatal overdoses, advancing deterrent strategies and developing early warning systems to rapidly identify and respond to high-threat opioid substances circulating on the illicit market.

Thank you for this opportunity to speak with you today. I look forward to your questions.

● (0915)

The Vice-Chair (Mr. Len Webber): Thank you very much, Todd.

I will move to Caroline Xavier from the Canada Border Services Agency.

Thanks, Caroline.

[*Translation*]

Ms. Caroline Xavier (Vice-President, Operations Branch, Canada Border Services Agency): Good morning, Mr. Chair and honourable members.

My name is Caroline Xavier. I appear today on behalf of the Canada Border Services Agency, the CBSA, in my capacity as Vice-President, Operations Branch. I would like to thank the committee for the invitation to speak today.

The opiate situation in Canada is a subject that is of immediate and ongoing concern to the CBSA. Our mandate to keep Canadians safe encompasses a wide range of enforcement and facilitative activities, not least of which is the seizure of harmful drugs at the border. Part of our job is to interrupt the flow of drugs through our borders. This is a job that requires a combination of partnership, technology, and constant vigilance.

Today, I will divide my remarks into three sections.

[*English*]

To begin, I will summarize the operational mandate and role of the CBSA in interdicting drugs at the border, including the importance of partnerships. Next, I will describe some of the technology we are using in identifying and seizing drugs. Finally, I will speak directly to how we are dealing with the fentanyl issue.

Mr. Chair, our operational mandate covers a range of pre, post, and at-border activities. We ensure public safety and national security through risk assessment and intelligence, and through coordinated responses to emergencies, threats, and emerging issues.

Clearly, fentanyl and similar opioids fall in this category. These are the newest and latest substances appearing in increasing volumes, most often found in our postal and courier stream. The most effective approach is to develop awareness of the threat and to mobilize a commanding response.

Our national targeting centre, which is a 24/7 facility, works to identify suspected high-risk people, goods, and conveyances through an integrated, comprehensive risk assessment program. Likewise, we deploy officers around the globe, pushing the border out to manage threats before they arrive at our doorstep. These measures demonstrate our capacity to look beyond the border, to the point of origin, for contraband and other threats.

In addition to our in-house capacities, we are deeply integrated with our law enforcement partners across the spectrum, including the local police services, provincial law enforcement, the RCMP, and our counterparts in the U.S. and other like-minded countries.

The border is an obvious nexus for cooperative enforcement against drug trafficking and major crime.

[*Translation*]

We are also constantly developing and researching innovative detection technology to assist our officers. There are a number of tools and systems in use at the moment. At the border, digital fingerprint machines allow us to quickly and securely transmit electronic fingerprint data to our partners in the RCMP.

[*English*]

Density meters at major border and marine ports can determine the density of a surface or an object. These meters can discover hidden walls and help us detect contraband.

We also use flexible video probes and X-rays to locate undeclared currency and contraband and fibre scopes to view areas of vehicles and cargo that are not visible to the naked eye. Various tools help us inspect the undercarriage of vehicles and other hard-to-reach areas.

Trace detection technology is used to detect trace amounts of narcotics and explosives on sampled goods and conveyances.

Finally, we are supported as well by a team of detector dogs that assist in the detection of illegal narcotics, firearms, and currency, which is further enhanced by the training we are giving our officers to identify threats and risks, and also supported by a world-recognized science and engineering laboratory.

Mr. Chair, with respect to fentanyl in particular, we've seen an increase in the number of seizures since 2014. Fentanyl powder and equivalent substances are most often smuggled into Canada mainly from China, as was stated by our RCMP colleague, through the postal stream in our case. From January 1, 2010, to September 22, 2016, the CBSA recorded over 115 fentanyl seizures.

Due to the increased volume of packages sent through the postal and courier streams, it can be a challenge for the CBSA to identify and intercept all shipments of concern. Postal and courier shipments are often accompanied by false declarations or are intentionally mislabelled.

[*Translation*]

The CBSA takes its employees' health and safety very seriously. To that end, safe handling procedures and adequate control measures are in place, including personal protective equipment, to prevent accidental exposures. Furthermore, given the pace of evolution with these products, the agency reviews their adequacy on an on-going basis.

● (0920)

[*English*]

Again, this is where partnerships and our intelligence are important. The CBSA's collaborative efforts to address the fentanyl threat to public safety are ongoing, at the regional, national, and international levels. We leverage our intelligence and work with partners to identify and risk assess subjects and businesses that may be involved in fentanyl trafficking.

We have a number of commercial risk assessment projects designed to intercept fentanyl and other controlled substances arriving via air and marine cargo shipments from China and Hong Kong. Our regional operations are participating in policy agency projects, and our international network has been engaged with customs authorities in China on the fentanyl issue.

[*Translation*]

The opiate crisis is a challenge that requires considerable resources and coordination. We have a responsibility to all Canadians to focus our efforts and strengthen our collaboration wherever possible.

[*English*]

This is a multi-dimensional challenge. There are significant social, public health, and criminal justice impacts, and part of the solution lies in keeping the substance out of Canada to the greatest extent possible. This is where the CBSA's responsibility lies, and we welcome the opportunity to discuss this further today.

[*Translation*]

Thank you.

[*English*]

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

Finally, we'll move to the Canadian Centre on Substance Abuse, Rita Notarandrea and Matthew Young.

Go ahead, Rita.

Ms. Rita Notarandrea (Chief Executive Officer, Canadian Centre on Substance Abuse): Good morning, Mr. Chair and members of the committee.

My name is Rita Notarandrea and I'm CEO of the Canadian Centre on Substance Abuse.

I am joined today by my colleague Matthew Young, a senior research and policy analyst at CCSA. Dr. Young leads our drug use epidemiology research, which includes the Canadian Community Epidemiology Network on Drug Use, or CCENDU; the student drug use surveys; and work on novel psychoactive substances.

I'd like to begin by thanking the committee members for inviting us here today.

For those of you unfamiliar with CCSA, it was created in 1988, and we are Canada's only agency with a legislated national mandate to reduce the harms of alcohol and other drugs on Canadian society.

Today I will touch briefly on the crisis, given that others have already spoken to the prevalence and the devastation that individuals and families are experiencing in Canada. I will also mention CCSA's contributions to the federal response. Then, based on our experience with this issue as well as with our partners, I will highlight a few areas for action.

In the past decade, the use of opioids and the harms associated with them have increased dramatically. In response, in 2012 CCSA brought together more than 40 dedicated experts and organizations to determine how best to tackle this national health problem. This diverse group, with ownership in both the problem and its solutions, included physicians, nurses, dentists, pharmacists, coroners, medical examiners, first nations, law enforcement, researchers, and governments.

We all recognized that this was a complex and multi-faceted issue that could not be addressed by one level of government or one organization. Everyone was tackling this in silos. In fact, there were at least 70 reports that were being looked at. We also knew that there was no one solution and that many of the intended benefits of these drugs in treating chronic pain also came with unintended harms, like addiction, overdose, and death.

In 2013, 12 months later, the group released an ambitious 10-year national road map entitled, “First Do No Harm”, responding to Canada's prescription drug crisis. This vision was reliant on efforts by everyone at the table and everyone sharing the responsibility of addressing this significant health crisis in our society. Designed to be comprehensive in its approach, the strategy included 58 recommendations for action in areas of prevention, education, treatment, enforcement, legislation, regulation, as well as monitoring and surveillance.

In the past three years, we have made progress, and by “we” I am referring to the collective “we”. My colleagues here today have highlighted some of this work. Other experts at that table also received funding related to recommendations in the report. Again, it's a shared responsibility. I'd be happy to share copies of the initial strategy, the progress report, and an update of current activities by many of those partners.

Under the direction of Dr. Young, CCSA leads the Canadian Community Epidemiology Network on Drug Use, or CCENDU. This nationwide network of community partners serves as an early warning system by investigating reported emerging issues, communicating alerts and bulletins on topics of immediate concern, and informing communities on lessons learned in responding to local drug use issues.

CCENDU first alerted its network to the sale of fentanyl in the illicit drug market in July 2013 and followed up with alerts on fentanyl being disguised as OxyContin pills in February 2014. I mention this as an example of the unintended consequences of addressing the supply of prescription opioids and diversion, where organized crime steps in to produce and sell powdered fentanyl pressed into counterfeit pills or added to powders and sold in the illicit market.

In fact, given increasing concerns about the harms associated with fentanyl, from both illicit and pharmaceutical sources, and the lack of national data on deaths involving fentanyl, in August 2015 the CCENDU network decided to collect and collate the number of deaths involving fentanyl in Canada, spanning 2009 to 2014, to better understand this evolving situation and to plan for appropriate interventions, as needed.

Although the use of any opioid can result in harm, such as overdose or other health complications, illicit fentanyl and other new synthetic opioids pose an even greater health threat for a number of reasons, including the lack of regulation and quality control as well as their potency relative to other opioids. People take these drugs believing them to be other less-toxic substances.

We knew when we released “First Do No Harm” that this is a complex health and social issue, one that is part of a broader issue of substance use in Canada. We knew the strategy would require some refinements to keep it relevant and responsive as new information became available. We knew that priorities might shift.

● (0925)

While the solution continues to be challenging, the positive news is that we don't have to start at square one. “First Do No Harm” provides a road map that speaks to prevention and professional education, treatment, monitoring and surveillance, but it's all based on the evidence. We, and again I mean the collective “we”, recognize the need for interventions aimed at reducing the supply of prescription and illicit opioids, as has been presented. These are important and should continue or be enhanced. We also recognize that we need to address demand and availability of appropriate interventions in a timely way. To that end, we recommend a few areas for attention. These relate to evidence-based interventions, monitoring and surveillance data, public education and awareness, stigma, and collective efforts.

First, the opioid crisis has shed light on the system of care for substance use disorders. We recommend increasing access to effective evidence-informed treatment services along the continuum of care. That includes primary care, treatment services, and supports. We need to ensure that treatment is available. We need to ensure that these services are based on the evidence so that people seeking help get the help they need and the support they need. We need to promote accreditation and licensing of facilities providing treatment and the required qualifications of the health professionals. Every door opened should lead to help in getting the needed treatment and supports from those with the competencies, the current knowledge and skills to provide those supports. Yet sadly, we have heard in the news of facilities, many privately funded, providing health services to those with an addiction problem, lacking in qualified staff, and in fact, giving wrong information to clients.

We have discovered through the opioid crisis what is needed to be added to the health system to properly respond to effectively treat those with an addiction to opioids. We learned that primary care professionals were not well-equipped with competencies in pain management and addiction, that the curricula did not effectively address these areas. Therefore, we need to provide education and resources to help primary care professionals, as an example, to prescribe according to guidelines, to identify and intervene early. As we deal with the crisis, we know that many are looking for evidence-informed services to meet the needs of those with an addiction to opioids. As has been mentioned, there are interventions such as naloxone, overdose education, opioid substitution therapy, supervised consumption sites. Effective medications like Vivitrol are unfortunately not yet available in Canada.

As I continue to refer to the evidence in addressing the opioid crisis and treating those who need support with effective interventions, I would like to draw your attention to a new report by the WHO, the World Health Organization, and the United Nations Office on Drugs and Crime, entitled “International Standards for the Treatment of Drug Use Disorders”. It speaks to the continuum of care, different interventions, along with the strength of the research supporting these interventions.

Mr. Chair, we would be pleased to send copies of this report to the committee clerk.

Second, in order to address what is happening across the country and the impact of our actions, we need a comprehensive national monitoring and surveillance system, the national picture. In many countries this work is undertaken by a national drug observatory, NDO. As was mentioned just yesterday, Health Canada, CCSA, and the Canadian Institutes of Health Research hosted a best brains exchange to examine possible models for establishing a Canadian observatory and to assess how these models could support general and targeted drug surveillance. But this also includes in each province prescription monitoring programs. CCSA will be meeting with Health Canada and other leaders in this area to explore how best to develop this Canadian drug observatory in Canada, and an early warning system. Given the enormous amount of work that is required to develop a Canadian national drug observatory as well as the strength of many national leaders who are working in this area, such as Health Canada, CCSA, CIHI, the key to successful establishment of a Canadian observatory will be a clear vision, an understanding of the roles and responsibilities of leaders in this area as well as the jurisdictions, and a delineation of what is needed over the short and medium terms to identify emerging issues, and respond quickly. We do this well when it comes to physical health and infectious diseases, as an example.

● (0930)

Third, Canadians need access to accurate information to make informed decisions about their health. We need to do a better job of informing and educating Canadians about opioid-related harms and how to share in the decision-making when seeing their health professionals. Canadians also need to know about evidence, form non-pharmacological treatments for pain, and learn about quality-accredited treatment services for their substance use disorders. And they need to know the symptoms of overdose. They need to understand the importance of the safe storage and disposal of their unused medication and the dangers of driving while impaired by opioids.

Finally, one of the biggest challenges we face in addressing this crisis is societal stigma. Many still believe that addiction is a moral weakness. This means that people have to pay to get timely access to treatment, and when they do, this does not guarantee that the facility will provide quality care and treatment. We need to elevate awareness about the science that surrounds these disorders.

Mr. Chair, I look forward to continuing to work with our partners to bring about the needed changes to help address the opioid crisis and the devastation of people's lives. We look forward to collaborating with Health Canada, particularly on the opioid conference and summit that is coming up in November. There will be opportunities to connect with the “First Do No Harm” partners in addressing this issue and in developing concrete actions.

CCSA will continue to coordinate collective efforts, connect partners, gather and share evidence, identify emerging issues, and address stakeholders' needs as per our mandate.

Dr. Young and I would be pleased to answer any questions you may have at this time.

Thank you very much.

The Vice-Chair (Mr. Len Webber): Thank you ver much, Rita.

Yes, if we could get copies of that report, it would be much appreciated. Please bring it to the clerk.

All right, let's move to round one of questioning.

Mr. Randeep Sarai, you have seven minutes.

Mr. Randeep Sarai: Thank you to all the panellists. I'm very delighted that all of you have a very comprehensive knowledge of fentanyl.

This question is for the RCMP.

The RCMP division headquarters are in my riding in Surrey Centre. Some of the country's best and brightest law enforcement professionals live right in Surrey and across the Lower Mainland.

I'd like to know what sort of strategy the RCMP has in place to address the crisis, given the negative impact it's had in our community.

A/Commr Todd G. Shean: Thank you for your question.

The RCMP has a number of strategies involved. A number of years ago, the RCMP instituted what we called a synthetic drug strategy, which focused on prevention, enforcement, and of course education. Also, within the ranks of the RCMP here in Ottawa, as I said in my opening remarks, we have liaison officers and analysts who are posted around the world, to build those relationships we need around the world because, as we shared with the committee, a lot of the fentanyl that we're looking at is coming into the country. So how do we build those relationships with those particular countries to be able to address it at source and prevent some of those products from entering the Canadian market?

Just last week I spoke at a Canada-U.S. border symposium. It was addressed by the administrator of the DEA, Mr. Rosenberg. The issue that he raised as well was the issue of fentanyl and the emergence of W-18 and carfentanil, which they're seeing in the U.S., and the significance that they're placing on the prevention and education efforts within the U.S. to reach the youth at risk. He stated that what he sees as significant is the partnership and the collaboration between the Royal Canadian Mounted Police and the American authorities in securing our borders as we work along with our border enforcement officers, our CBSA counterparts who are also there.

As I said, through our office with Mr. Chicoine here and our federal coordination centre, we've done a lot of work with our communities. This includes videos and printed products; our front-line officers; adjusted our policies; issuance of naloxone to our front-line officers; and collaboration throughout the spectrum of government departments and consultations to inform, from an enforcement perspective, what the RCMP can bring to the table. As we've heard today from all the counterparts here, it's a collaborative effort among a number of departments.

There's a number of things, from the international to the domestic, to our front-line officers, to being part of the team that's before you here to inform each other to advance a Canadian effort against this crisis.

● (0935)

Mr. Randeep Sarai: Along those same lines, is there any support in our Criminal Code or elsewhere that would help you prevent this or enforce this? Is there anything you think that our Criminal Code or perhaps our legal streams are lacking?

A/Commr Todd G. Shean: I think we can always look at other areas and say that they have this or that. My approach to this has always been that there are bodies within Canada that decide what the laws within Canada will be, and we are there to enforce those laws. If laws are being considered and our opinion is asked, we will certainly inform those discussions, but at present we work within what the Criminal Code of Canada provides us today.

Mr. Randeep Sarai: Thank you.

This question is for the Canadian Centre on Substance Abuse.

As you may well know, Surrey, along with other areas in British Columbia and Alberta, has been hit hard by the opioid crisis, particularly by fentanyl-laced recreational drugs. My colleague Sukh Dhaliwal held an emergency summit with health professionals who work with individuals on the street who have substance abuse issues.

Through these dialogues, I've heard conflicting conclusions as to whether or not opioid prescriptions should be reduced. I'm curious. Could you disclose what your research indicates on this matter? Some have stated that the prescriptions should not stop and that some of the opioid-based prescriptions are helpful in reducing addictions; otherwise, the alternative is fentanyl-laced drugs. Others have said that prescription-based opioid use is very high. What's your opinion on that?

Ms. Rita Notarandrea: I do want to stress one thing. When we first did our “First Do No Harm” report, there was an impression that there was one solution to the issue. As all of us have said, I think, there is no one magic bullet, no one solution.

I think we do need to address prescriber education. I think we need to look at ensuring that clinical practice guidelines are being utilized in the physicians' offices by primary care professionals. At the same time, we also need to look at diversion.

We need to ensure first of all that the physicians are complying with those guidelines, and we do have that evidence that indicates what those guidelines ought to be. We then need to look at what physicians are prescribing that is higher than those guidelines. When I mentioned prescription monitoring programs, I was referring to that.

As to the diversion, there is a lot of diversion right now. I think that was mentioned, and we're seeing that.

There isn't one answer to the problem. We have to look at both.

Mr. Randeep Sarai: Thank you.

I'll give the rest of my time to MP Sonia Sidhu.

The Vice-Chair (Mr. Len Webber): You have one minute, Ms. Sidhu.

Ms. Sonia Sidhu: Thanks to all the witnesses for sharing that valuable information with us.

I would like to start by discussing safe injection sites. Recently we have seen many media articles about municipalities that are thinking about having safe injection sites to help reduce overdoses and address addiction problems. What does the current evidence say about the positive impacts of safe injection sites?

● (0940)

Ms. Hilary Geller: Thank you very much for the question.

The evidence is overwhelmingly clear that when a supervised consumption site is properly established and properly maintained, it saves lives without increasing rates of crime in the surrounding area.

There have been numerous studies, both domestic and international, that point to that. There is a relatively long history of experience with supervised consumption sites in Europe upon which to draw, and over a decade now of experience with Insite in Vancouver. It all points to that fact.

The Vice-Chair (Mr. Len Webber): We'll have to move on. Your minute is up now. I'm sorry.

We're moving to Dr. Colin Carrie, for seven minutes.

Mr. Colin Carrie: I want to thank the witnesses for being here today because this is a serious crisis.

Dr. Sharma, I would like to start with you because you are a physician. I think we all realize that addiction is a treatable condition. That's why our government's approach was our anti-drug strategy, which put $500 million out there to keep drugs out of the hands of addicts and looked towards prevention and treatment. At that time, the mandate of Health Canada was that it really wanted to look after the health and safety of Canadians. I think that's still true, isn't it?

I think it's really important in this situation we're facing that Health Canada and the minister's office be open and transparent. There has been some worry about some of the minister's actions and judgments, some of the controversial decisions that she's made. I want to ask you about that.

Because of the seriousness of opioids on the street, if there are reports going back about contaminated or adulterated drugs on the street, I think it's very important. We heard from the media, unfortunately, that Tilray, a company in British Columbia, sent information to Health Canada that, in dispensaries, there is marijuana that was adulterated with carcinogens, fungicides, and pesticides. The minister chose not to let Canadians know about this.

As the senior medical adviser for the health products and food branch, if information came across your desk about an adulterated opioid that was on the street, do you think it would be important to get that information out to Canadians, through a press release or something along those lines, or through the media, so that Canadians who may be using these substances would know about it? Do you think that would help in protecting the health and safety of Canadians?

Dr. Supriya Sharma (Senior Medical Advisor, Health Products and Food Branch, Department of Health): In terms of the authorizations in Canada for opioids, they're a marketed product. So if there was a situation where there was an adulteration or contamination, we would embark upon an assessment to see what the risks associated with that would be. Then we would look at whether or not there were compliance and enforcement actions that we would need to take.

There is a whole suite of compliance and enforcement actions that we can take, such as recalling the product, changing labels, etc.

Mr. Colin Carrie: You could get it off the street and you could do something about it, let Canadians know about it, and not wait a year, right? You wouldn't do that would you?

Dr. Supriya Sharma: Once we know what the risk is and what the action is, we make a decision about what the most appropriate form of communication is. Again, that could be putting something out on the web. It could be a news release. It really depends, on a case-by-case basis, on what the risks are and on what the assessment is.

Mr. Colin Carrie: All I'm saying is that waiting a year to get that information out, having people find out through the media, is a poor judgment.

Madam Geller, you do know about the SALOME study.

Ms. Hilary Geller: Yes.

Mr. Colin Carrie: Did that study find that hydromorphone was a valid alternative to actual heroin and had less risk?

Dr. Supriya Sharma: Perhaps I could take that.

SALOME was a study to assess long-term medication opioid use. The aim of the study was to compare the use of injectable pharmaceutical grade heroin or diacetylmorphine with the use of hydromorphone, an injectable form of a pain medication that's approved in Canada but not approved for use in opioid addiction at this point in time. The results of that study did show that, in the study population, hydromorphone was equally as effective as pharmaceutical grade heroin, and it did show some advantages in terms of adverse events.

However, that's one study and, obviously, that has to be taken into the context of the body of scientific and medical literature that is there.

● (0945)

Mr. Colin Carrie: I think it's promising. Madam Geller mentioned that the special access program—developed for patients with serious or life-threatening conditions when conventional therapies have failed, are unsuitable, or are unavailable—is being used to get the pharmaceutical heroin out there. It was never really intended for that. If you have a legal alternative to it—even in the access statement here on your website—don't you think we should be trying to substitute a legal, safer alternative rather than get more heroin out on the streets?

Dr. Supriya Sharma: The special access program, as you've said, is intended for emergency and life-threatening conditions. An individual physician comes in and makes a request for an individual patient and it's assessed as such. When requests come in, we do look at the information that the physician has provided and there are assurances that the physician has spoken to the patient about the potential risks and benefits, and then they're assessed on a case-by-case basis.

Comparing the two products, hydromorphone is a marketed product, but it is not marketed for that use, and diacetylmorphine has also a body of evidence that supports its use in terms of chronic relapsing opioid dependence and it has been used in a number of different countries.

As with any request to the special access program, we would look at that individual's information and the request that's being made, to make sure that it fulfills the criteria of the special access program and that it's reasonable. In some cases, you're right, in that we have authorized the use of diacetylmorphine. It has to be when all other treatments that could be applied have unfortunately failed, so it's a very small percentage of patients.

Mr. Colin Carrie: Hopefully it stays small. I know that program. I've actually advocated and tried to help patients who have life-threatening cancers. I know that program has a limited amount of funds, and to see that those resources go towards access to heroin when there is a legal, safe alternative out there that may be available in another way, I just feel that maybe we need to keep a close eye on that.

Dr. Young, the CCENDU reports that you have are extremely valuable to us and I want to thank you for that. A few years ago in Ontario, Deb Matthews, who was the health minister, basically demanded and begged that the federal government move towards tamper-resistant opioids.

The Vice-Chair (Mr. Len Webber): Dr. Carrie, I'm sorry but your time is up. Perhaps next time around you can continue on with that. I have to move on now.

Mr. Davies, you have seven minutes.

Mr. Don Davies: Thank you all for being here today.

By the end of the year, 800 British Columbians are expected to die from opioid overdoses. That's one by noon today, and one by midnight. Dr. Perry Kendall, the provincial health officer for British Columbia, has declared a public health emergency in British Columbia. Hundreds more will die in Alberta, and about the same number are expected to die in Ontario as in British Columbia by the end of this year. Across our country this year, 2,000 Canadians are expected to die from overdoses. That's a Canadian dying about every four hours.

The RCMP reports that the fentanyl market is expected to grow in the next 18 months, which means that even more Canadians will die. Two grains of fentanyl the size of a salt crystal, or one grain in the case of carfentanil, are capable of killing drug users, including young people who don't even know they're ingesting it. This puts our first responders and our police at risk. These are our neighbours, our friends, our families dying; as Ms. Geller said, no one is immune.

Ms. Geller, my question for you is this: Is the national opioid overdose crisis a national public health emergency?

Ms. Hilary Geller: Certainly B.C. has declared it a public health emergency in B.C. If you look at the definition of an epidemic as set out by the World Health Organization, it has to do with levels of death or disease above an average level. By that definition, certainly in British Columbia, as declared by the government, it is indeed an emergency. If you go with that strict definition, I can honestly say, because of some of the data limitations unfortunately, it's impossible to tell you if that definition would be met in every other province, but certainly we see growth in Alberta as you said and signs that it is moving eastward. We've heard from police in Ontario indicating that.

I think from our point of view we are treating it as an emergency to help jurisdictions across the country have what they need in order to be able to respond. We as the federal health department are putting everything in place within our areas of authority and encouraging others to do the same, so that not only can we respond in B.C., but we're ready for when it emerges elsewhere.

● (0950)

Mr. Don Davies: Okay. I don't mean to interrupt, but I have limited time.

Doesn't the Public Health Agency of Canada have the ability to actually declare a national public health emergency?

Ms. Hilary Geller: I apologize. I'm not familiar with their legislation.

Mr. Don Davies: Okay, thank you.

We've talked about Bill C-2. Ms. Geller, you've crisply described the evidence. We know that safe consumption sites save lives. We also know, from every stakeholder in the country, that Bill C-2, which was passed by the previous government, establishes 26 separate, discrete requirements that every group I've talked to in the country says establishes unnecessary barriers to establishing safe consumption sites. It takes months. It takes hundreds of hours.

I've talked to Toronto's Board of Health. I've talked to the City of Montreal. I've talked to the City of Victoria. These are not fly-by-night operators that want to open safe consumption sites. These are municipalities and boards of health in our provinces telling us that safe consumption sites save lives and that this legislation puts up unnecessary barriers.

Ms. Geller, you said that your strategy is to explain the barriers to the groups, but these groups aren't telling me that they need the barriers explained to them. They're telling me that they need the barriers removed.

My question is actually for Ms. Notarandrea. Does your group support the repeal or the streamlining of Bill C-2 so we can get more safe consumption sites up and running and save lives?

Ms. Rita Notarandrea: Our group is really an organization that looks at the evidence. I think Ms. Geller has spoken to the evidence on consumption sites. We also look at ensuring that the public is protected. I think there is always a balance. Right now, in terms of the bill and what I have been told, it's being facilitated. People who are putting forth proposals are being given a lot of assistance in ensuring that those proposals are successful.

Mr. Don Davies: So you're happy with the state of affairs in Bill C-2. Is that the position of your organization?

Ms. Rita Notarandrea: Again, we don't have a position, per se. We ask what the evidence says about consumption sites. What does it say in terms of being part of a continuum of care? We support that it be part of the continuum of care. What we have been told is that every effort is being made to ensure that the public is protected and that those individuals who are suffering are protected.

Mr. Don Davies: Okay.

Mr. Shean, Dr. Jane Buxton, a professor at the University of British Columbia, recently told this committee that about 82% of people in Vancouver call 911 during overdose events, but that number falls to less than 60% in regions outside Vancouver, primarily where the RCMP is the police force. Dr. Buxton attributed this in large part to the VPD's policy of non-attendance at 911 calls for overdoses. Has the RCMP explored such a policy?

A/Commr Todd G. Shean: I'm not aware that the RCMP looked at such a policy.

Mr. Don Davies: Thank you.

Ms. Xavier, when B.C.'s premier started a task force on fentanyl in late July, she called on CBSA to search small packages for fentanyl, but Clayton Pecknold, B.C.'s director of police services and co-chair of the task force, has been clear that this policy has not been implemented. He says, “We're still waiting for the federal minister of public safety to get back to us. We've asked very explicitly for new strategies to interdict fentanyl at the borders and to give the CBSA the tools they need”.

On September 15, the CBSA said that it is looking at new ways to screen mail but so far hasn't changed its policy. In the case of suspicious packages under 30 grams, they currently “contact the importer to request permission to open the mail. If permission is denied, the mail is returned to the exporter”. In your view, why has the CBSA not responded to the task force's request to search small packages?

● (0955)

Ms. Caroline Xavier: With regard to the limitations—

The Vice-Chair (Mr. Len Webber): I will have to interrupt. I'm sorry.

Your time is up, and you'll have to wait until the next time around, Mr. Davies. I have to move on.

Dr. Eyolfson, you're next, for seven minutes.

Mr. Doug Eyolfson: Thank you all for coming. This is something that's been near and dear to my heart. I practised emergency medicine for 20 years, much of it in the inner city of Winnipeg. We've seen many of these problems first-hand.

Ms. Geller, Mr. Davies was talking about Bill C-2 and some restrictions it placed on safe consumption sites. In your view, has this bill impeded your ability to monitor the crisis by slowing down the development of safe consumption sites in cities?

Ms. Hilary Geller: Thank you for the question.

I think it's important to recall that before the amendments to the CDSA, the Controlled Drugs and Substances Act, known as Bill C-2 —and Bill C-2 was not a stand-alone piece of legislation; It was a series of amendments to an act—

Mr. Doug Eyolfson: Exactly.

Ms. Hilary Geller: —there were a set of published and rigorous criteria that potential applicants had to fulfill. With or without a piece of legislation, there would inevitably need to be some strict guidelines so that the decision-maker had all the information he or she needed in order to make an informed decision and to ensure that if it was to be established, it would be properly run and properly maintained.

I think it's also interesting to note that most of the criteria, the 26 application criteria that are in the CDSA, are very similar to guidance documents issued both by the British Columbia government and the Quebec government, which were designed to inform people in their provinces about the types of information that they should be prepared to provide if they were considering opening a supervised consumption site.

What I will say is there's certainly a tremendous amount of interest out there in opening new facilities. Staff in my department have regular, very detailed conversations with those potential applicants. What I am told is that after having had those levels of engagement, the general view is: “Thank you very much. You've really helped clarify what is needed. You've helped me understand how this sort of information was provided by others, in particular Insite, and we now know what we need to do in order to submit a proper application.”

Mr. Doug Eyolfson: There's been a bit of a change in philosophy over harm reduction, safe consumption sites. We do know that previously there was a lot of opposition to it. The one in Vancouver was the only site for a long time simply because its status was unknown. It was being appealed to the Supreme Court. We didn't know if it was going to exist anymore.

If there had been less objection or less resistance to harm reduction throughout the past few years, would that have made it easier for surveillance and treatment to get ahead of this problem earlier with the crisis?

Ms. Hilary Geller: Surveillance and treatment are two different things.

I will say on the surveillance side—and it's no secret that we and colleagues here refer to it—we don't have a terrific system of surveillance at the national level. The development of surveillance systems, I think, is variable across the country. In places like B.C. it's excellent, in other places, it's not quite there. That is something we're working on. That's what I would say on surveillance.

On treatment, I think it's always been recognized that treatment is incredibly important. There was a significant investment into treatment in the 2014 budget coming out of the work of this committee and the work that Rita had referred to earlier on in "First Do No Harm". There is certainly more that can be done both in terms of work on medication-assisted therapy but also treatment indicators, work on first nations. I'd say that is continuing to be a focus of ours.

Mr. Doug Eyolfson: Thank you.

My next question is for our colleagues from the RCMP. Thank you for coming. I particularly like seeing you here, being an RCMP brat myself.

There have been different philosophies on drugs, and from the legislative and law enforcement perspective there has sometimes been the tough-on-crime approach and the zero tolerance approach. There are others who have said this zero tolerance, tough-on-crime approach has sometimes made things worse in driving people underground to not seek treatment.

What would your views on that be? Do you think that primarily criminalizing these activities is making things worse by driving them underground?

● (1000)

A/Commr Todd G. Shean: Thank you for your question.

Your being an RCMP brat, and my son just completed his second-year residency. He wanted to be an emergency room doctor, so I think we have something in common.

What I'd like to share from a law enforcement perspective is that when asked, we will inform discussions around any legislation, and our role is to enforce the legislation that our government puts forward. That's essentially where we stand with that. Often we're asked about it as new legislation comes forward, and we will certainly provide input if requested, and then our role is to enforce the laws that our parliamentarians have decided are the laws of the land.

Mr. Doug Eyolfson: We only have one safe injection site in Canada right now. From the law enforcement point of view, has law enforcement in the B.C. area seen any increase in crime due to a safe consumption site?

A/Commr Todd G. Shean: I'm not aware that we've done a specific study with regard to a crime increase around a supervised site, so I wouldn't be able to give you an answer other than that I'm not aware of any particular study being done in that regard from an RCMP perspective.

Mr. Doug Eyolfson: All right. Thank you.

I think I have about 15 seconds, is that right?

The Vice-Chair (Mr. Len Webber): Yes, 15 seconds.

Mr. Doug Eyolfson: That's probably not enough for another question, so thank you very much.

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

We'll go to our second round now with five-minute questioning.

We'll start with Rachael Harder.

Ms. Rachael Harder: This question is for the Canadian Centre on Substance Abuse.

You talked about needing to strike a balance between the safety of the public and wanting to pursue some sort of safe injection venue, let's say, for those who use drugs. With regard to finding that balance, what would you say are some of the challenges that are posed with regard to the general safety of the public?

Ms. Rita Notarandrea: When I talk about treatment, we've been focusing on safe injection sites and safe consumption sites. There is an array of treatment options and I do want to say that when I talked about those standards from the WHO and UNODC, there is a variety of treatment options for the treatment of substance use disorders.

I do want to say that we need to look at interventions that are based on the evidence. Those are all the options available for people who are suffering from substance use disorders. As part of the bigger bucket of substance abuse disorders, there are those who are suffering from an addiction to opioids. What I am saying is that we need to look at all options to effectively treat the individual when they present with all of the complications that come with addiction. We need to have a comprehensive approach. We have to help them in terms of their disorder and we have to meet them where they are and keep them safe as well.

Ms. Rachael Harder: As part of a comprehensive approach, then, it seems that it would be appropriate to have a prevention mechanism in place. That should be a part of that comprehensive approach. What about getting people off addictive behaviours, out of addiction? Is that part of this comprehensive approach and what would that look like?

Ms. Rita Notarandrea: Absolutely, it is. That comprehensive approach, when I referred to the "First Do No Harm" road map, did speak to all of that comprehensive approach. It did speak to prevention. It talked about consumer education and public awareness; how to have that conversation with your physician; how to speak about other options besides opioids in terms of pain management. That is one of them.

The other part of that is the physicians themselves, primary care. I did mention in my remarks about primary care not having the competencies, as they have reported, in terms of pain management, in treating and recognizing addiction, also the whole treatment continuum. I talked about prevention, education. In terms of that treatment continuum, what does that treatment continuum entail? Do we have all the evidence to support the treatment that is out there?

As I mentioned earlier, some residential treatment facilities.... I think in B.C., there was an interesting article that spoke to 150 residential facilities and some of the information they were providing to desperate families that were looking for care for their loved one. The evidence is there. I think we have to ensure that that evidence is applied all the way in that continuum, from prevention, from education, from treatment, and in recovery.

● (1005)

Ms. Rachael Harder: In your estimation, what are some of the best treatments? What would evidence show us? What should we be pursuing with regard to treatment?

Ms. Rita Notarandrea: It's very comprehensive. That's why I indicated I'd be more than happy to share that report. It speaks to the latest evidence and it speaks to the strength of the evidence along that continuum, including the prescribing of opioids.

Ms. Rachael Harder: At the end of the day, if you had to name the root cause of this opioid crisis we're seeing in Canada today, what would you estimate that to be?

Ms. Rita Notarandrea: I'm sorry to say that I don't think there is one cause, and I do think it's all the things that you touched on. It is about prevention. It is about prescriber education. It is the whole continuum. It is about enforcement and what more can be done there. It is about the public knowing that you don't have 40 opioids sitting in your cabinet, because three-quarters of the students said they were getting their opioids from home. I believe it is a comprehensive approach, as has been stated. There is no one solution.

Ms. Rachael Harder: Thank you.

The Vice-Chair (Mr. Len Webber): Thank you. Time is up, Ms. Harder.

I'm going to move to Mr. Kang.

Mr. Darshan Singh Kang: I thank all the witnesses for coming here before the committee to address this very, very serious issue. I know in Alberta we too are going through a tough time. It's very serious in Alberta, and I wish we could get some direction from the committee to come to some resolution on this issue, and the sooner, the better.

I will pass the rest of my time on to Ms. Sidhu so she can ask a question on this. Thank you.

Ms. Sonia Sidhu: Could you clarify something briefly? Under the previous government, was Bill C-2 regarding safe injections sites a stand-alone bill that can be amended?

Ms. Hilary Geller: No, Bill C-2 contained a series of amendments to the Controlled Drugs and Substances Act.

Ms. Sonia Sidhu: We have heard comments from some people that the current process for applying for safe injection sites is too difficult or obstructive. I recall most recently seeing the mayor of Vancouver talk about this. I know the minister has said that there should be a review of the legislation.

Can you tell me the status of that review? What areas of the legislation could be improved if there is a review?

Ms. Hilary Geller: That review is ongoing, so I think it's premature to say any conclusions have been drawn yet, but we are assessing the bill, the CDSA portions that relate to the specific provisions on applying for a supervised consumption site, against the experiences we're having now.

Over a period of many months, we've had numerous discussions with potential applicants. There is actually currently only one applicant that has submitted, which is well known, and that is Montreal. Obviously, we have the most experience with Montreal, because they are furthest along. We are trying to have very detailed conversations with them to understand whether there are any specific criteria that are problematic for them. If perhaps it's just more of an issue around not really understanding what's required, as I think I mentioned earlier, they are finding it very useful, particularly when we can very accurately describe for them in the context of Insite's application precisely the type of information they need to submit.

In that context of the real lived experience we have had over the last year along with analyzing that against the legislation, we will be able to make some recommendations to the minister in due course.

● (1010)

Ms. Sonia Sidhu: You said just one application is currently being processed.

I noticed in particular that the discussion was headed in the direction of CDSA, and the minister recently commented regarding it. I would like to understand the impact of overdose and addiction problems on addicts and whether there are any effects on the broader community that we should be aware of. Has there been any discussion?

The question is for Rita Notarandrea.

Ms. Rita Notarandrea: If I understand your question correctly, you're talking about different populations that have been affected. Matthew has some more recent information, but I would say that the population we are seeing is the older adults. As well, in some of the work on utilization, we are seeing increases among youth and first nations communities. When we look at the different prescription drugs, I know we're dealing with opioids, but certainly when it comes to women, it has to do more with benzos.

There are different populations and there are different issues, and utilization is certainly showing increases, as I mentioned, in two key areas, and those are the older adult and youth, as well as first nations.

Ms. Sonia Sidhu: I'll pass my time to Ron.

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

Mr. Ron McKinnon: Thank you.

It was nice to hear your testimony. I'd like to thank Don for his cue to me to mention that this committee was expeditious in its study of my good Samaritan drug overdose act, which will facilitate allowing people to be less concerned about calling the police.

Since I have no more time, I will leave it at that.

Thank you.

The Vice-Chair (Mr. Len Webber): Sorry about that, Mr. McKinnon.

We'll move back to the Conservatives. Mr. Carrie, you have five minutes.

Mr. Colin Carrie: I wanted to point out that the Liberals seem to be focusing on safe injection sites, and the truth is they are only putting resources into that. In the budget, there was no new money for treatment, prevention, or education. One of the frustrations I have is that in Oshawa, if an addict wants treatment, he has to wait. Sometimes he waits weeks and weeks. Then he relapses before he even gets the treatment. It would be easier for him to just go to a place and keep injecting and injecting.

I just don't think, unless you put the priority on treatment, that we're going in the right direction. It was interesting to see the minister's priorities. I think that treatment was number three. I liked it when the Canadian Centre on Substance Abuse said that treatment is number one, because this whole obsession with safe injection sites.... Bill C-2 doesn't stop safe injection sites. It lets people who have the right to know have some input. If the community doesn't support the injection site, then it's not going to be successful.

I want to get back to my question for Dr. Young.

Our government was moving in step with other people around the world. I know we received letters from United States governors and the White House asking us to look at this entire class of drugs and move them toward tamper-resistant or abuse-deterrent formulations. That was where we were going. This past June, Minister Philpott, at a Toronto drug policy conference, said there was strong anecdotal evidence that the introduction of a tamper-resistant form of OxyContin in Canada caused the current fentanyl crisis in Canada. I just wondered, is this true, or is this situation more nuanced and complex than that?

Dr. Matthew Young: One of the things we've seen for quite some time is that there are a lot of interventions that have been put into place that will ideally, if they are effective, decrease the demand for opioids in the long term, but one of the immediate impacts they've had is to decrease the supply. I think that probably these formulations fit into one of those. One of the things is that if you have a supply that is in excess of the demand, then you have what we see now, which is organized crime stepping in and filling a market.

I don't think that directly answers your question, but that's the landscape that we're in right now.

● (1015)

Mr. Colin Carrie: I know that we're in that landscape now, but it seems that—and it would make sense to me, and be the proof of the pudding—once OxyContin was made tamper resistant, people couldn't use it, or it would be much more difficult to use it. If you had a strategy to make the entire classification of drugs, if they are available, tamper resistant, then that should slow down the access of diverted OxyContin or a similar type of opioids. It doesn't make sense to me. Isn't it true that generic OxyContin is available in Canada even after 2012, and that provincial regulatory colleges started to advise of shorter prescription lengths and lower opioid dosages in 2012? For those who are suffering from addiction, don't they just chase the next drug that is around? By moving away from tamper resistance, doesn't it make sense to utilize the technologies that are out there when you're looking at an overall strategy toward opioid abuse?

Dr. Matthew Young: Around 2014, we became aware of organized crime taking fentanyl and putting it into counterfeit OxyContin tablets. I don't know a lot of the answers to your specific question about whether that intervention was the key one that should have been done. I do know that around that time, there was a market that was satisfied by organized crime using counterfeit OxyContin tablets, and presumably that was because there was a decreased supply of diverted pharmaceutical opioids into the illicit marketplace.

Mr. Colin Carrie: I think one of the challenges now, having generics out there so readily available.... I think the governors of northern states have written to the Minister of Health. I was wondering if we could ask Border Services if we are starting to see this generic OxyContin going back and forth. Is it causing problems at the border with the northern governors? Are they getting a little upset about this?

Ms. Caroline Xavier: I can't speak to whether it's specific to OxyContin. I'd have to get back to you on that specifically, if that's what you're looking for. What I can tell you, as I mentioned in my opening remarks, is that we are seeing increased contrabandists trying to make their way through, for example, a courier in our postal stream, specifically. As was mentioned by our RCMP colleagues, contraband management continues to be dealt with within the larger context of illegal contraband activities.

The Vice-Chair (Mr. Len Webber): Okay, thank you.

Your time is up, Dr. Carrie.

We'll move to Mr. John Oliver.

Mr. John Oliver: Thank you for your presentations.

I want to focus on changing the behaviours of the people who are illicitly seeking fentanyl and opioids. It seems to me there are three categories. There are the recreational experimental users, and I'm thinking young adults and teenagers; there are people with substance use disorders, mental health disorders, and addictions; and there's a third category of what I would call the unintended addictions from pain management.

Mr. Diverty or perhaps Dr. Sharma, have you done the analysis? I would think there are different strategies to deal with those three populations. Have you done the analysis? What's the percentage? How does that break down?

Mr. Brent Diverty: Thank you for your question.

We actually have a study coming out in about a month that looks at hospitalizations due to opioids, and one of the things we're seeing in that study is, in fact, that seniors and young people do have a different profile when it comes to the reason for the hospitalization. I'm talking about acute hospitalizations—

Mr. John Oliver: Could you just get to the punch of the answer?

Mr. Brent Diverty: Sure. In the senior population you do see more of the accidental and unintended opioid poisonings. In younger people, they're more intentional.

Mr. John Oliver: As a percentage, would it be 80%, or is it one-third, one-third, one-third? How would you see the distribution of this?

Mr. Brent Diverty: We're still finalizing the numbers for this study. That's why I can only give you the overall trend at this point.

Mr. John Oliver: Right now you don't know. Okay.

Dr. Sharma, would there be different strategies? If you knew the majority were people who had unintended addictions and were now seeking them, would you have different strategies for that?

I'll come back to big pharma. Purdue, I think, for instance, has moved over to hydromorphone content, and they're still wrestling with getting that into a tamper-proof form. All provinces are using it now except, I think, for B.C.

What's the role of big pharma in educating doctors on prescriptions? Are we monitoring doctors' prescription-writing habits?

● (1020)

Dr. Supriya Sharma: I'll take the first part of the question.

If we have clear information on what the risks are, then you can have appropriate strategies. You're correct that for different circumstances there would be different strategies. The situation in Canada is more complicated than that because people may enter into a situation around use of opioids from one channel, but then it may be fluid, so that you might be moving from one place to another and, over the course of a single patient, that might change as well. I think that's why we're talking about a multi-pronged, comprehensive strategy, so that we're actually able to address various different factors simultaneously.

In terms of the role of the pharmaceutical companies, certainly they're the ones manufacturing and marketing the products, and they are partly responsible for the way that those are used. But there's also, obviously, the role of the pharmacist, the role of the physicians and the practitioners. That's why you have to address it as, very much as I said, a comprehensive strategy.

Mr. John Oliver: Okay, great. So there are strategies under way to influence prescription writing. It seems that this is an increasing problem. Unintended addictions are still occurring. Have you seen any breakthrough strategies that will stop that particular group of people from falling into this behaviour?

Dr. Supriya Sharma: Well, from the Health Canada perspective, because we're the ones who actually authorize the medications, our goal is to make sure that people have accurate and adequate information to be able to make those decisions.

When I went through medical school, we were very trepidatious about the use of opioids. I think there was a change in terms of the use, and we're trying to re-centre the pendulum. One way is making sure that there is appropriate information that's available. As well, Health Canada is actually working with the DeGroote Pain Centre to provide guidance and guidance documents for practitioners to be able to use the medications appropriately.

Mr. John Oliver: Thank you.

My last question will be for Ms. Geller.

For young kids—I don't know what percentage they are—who are experimenting with overdoses and hospitalization is occurring, it will be good to see the outcome of the study from CIHI. What are we doing at the school level of public health to talk about the dangers of fentanyl and the dangers of using the stamped green drugs that could potentially kill an 18-year-old experimenting at a party?

Ms. Hilary Geller: The problem with the younger people, not exclusively but in general, tends to be more about using prescription medication recreationally that they find in their parents' medicine cabinets. Surveys show that somewhere between 2% and 4% of young people use prescription medication recreationally in that way.

There has been a campaign run by Health Canada over the last number of years that's designed to get at that problem. That work will continue and as part of the minister's five-point plan, she's also undertaken to ensure that international best practices on prevention are part of our plan. It has been proven that the scare tactics, the “just say no to drugs” approach doesn't work. The approaches that do work are much more about building resiliency in very young children.

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

We'll have to move on now to Mr. Don Davies, for three minutes.

Mr. Don Davies: Ms. Xavier, I'll give you a chance to answer that question I asked you. Why has the CBSA not responded to the B.C. task force's request to search small packages for fentanyl?

Ms. Caroline Xavier: The Customs Act, section 99, subsection 2, stipulates that the CBSA is not able to open packages under 30 grams. As a result, we wouldn't be able to open those packages or we'd be breaking the law.

Having said that, it is stated in the act to not open small packages without consent, so we ask for consent. If it's not received within 30 days, we work with Canada Post as well as our RCMP colleagues to determine what to do with the package. Although we can't open it, Canada Post may be able to and, working with police jurisdiction, have a different approach to deal with it. Our primary role is to ensure that it does not get into the domestic stream and that's what we do to prevent that.

Mr. Don Davies: Would you recommend that we change that legislation to permit CBSA to open packages under 30 grams?

● (1025)

Ms. Caroline Xavier: As part of the ongoing review of our own mandate and of the work we're doing with our partners, we review legislation to see whether or not this will be one of the options in the way forward against this crisis.

Mr. Don Davies: If I wanted to export fentanyl into Canada and I knew about this, I would be sending my fentanyl in packages under 30 grams, wouldn't I?

Ms. Caroline Xavier: We do use all the various detection technology tools that I talked about. My goal is to ensure that if there's something that I suspect is of that type of contraband or something that should not be entering, it does not enter the stream based on my mandate, whether I open it or not.

Mr. Don Davies: Right, but the fact is that CBSA has to sift through a package they might find suspicious and you can't open it. You have to contact the person sending it, right?

Ms. Caroline Xavier: Correct.

Mr. Don Davies: Leading up to this process, the best evidence that I've been able to locate is that 10% of opioid users are addicted and 30% have what's known as opioid use disorder. There's no question that physical dependence happens very quickly. Withdrawal is unpleasant and difficult. Clearly, we need a large injection of funding for treatment in our country.

Ms. Geller, are there any plans in your department to provide increased funding, so we can open up treatment facilities in this country to help people recover who are addicted to opioids?

Ms. Hilary Geller: Certainly, within our area of responsibility for first nations and Inuit health, there has been a significant influx of funds to improve approaches to treatment in areas where we are responsible. There's also been a significant influx of funds to organizations like the CIHR to do some extensive research on the best approaches to treatment.

Rita could speak more to that, but the CCSA is also doing work in that regard. At the provincial level, I'm aware that B.C. has been doing some innovative things. I'm sure you know more about that than I do, including the premier's announcement last week, I think, of $5 million. We are, within our area of jurisdiction, beyond the first nations and Inuit health, looking for ways to support the provinces and others in making sure that the treatment that is available is the most efficient and effective possible.

Mr. Don Davies: Is the federal government making any funds available to the provinces?

The Vice-Chair (Mr. Len Webber): Your three minutes are up, but you'll have another five-minute opportunity here to talk to the parties and we'll each have an additional five minutes.

I would like to ask one very quick question with respect to the opioid antidote naloxone. I don't know who to ask this question, Ms. Geller or Ms. Sharma, with regard to the availability.

I know our police force carry naloxone but I don't know if all our first responders do or not. Would it not be a good idea to have our safe injection sites stocked with that drug as well? Why can't it be distributed out there more than it is right now?

Dr. Supriya Sharma: In terms of naloxone, there are two forms. There's the injectable form and now there's the nasal spray form. We did take steps to make both forms available without a prescription, which significantly aided access. Naloxone was already being used in such areas as supervised injection sites, by first responders, and in emergency departments. That was already available. Now there are various strategies under way to be able to increase the access. Many provinces have undertaken to provide naloxone free of charge. They will put naloxone either in the injectable form or now in the nasal spray form in specific kits, with instructions on how to use it.

I think the steps that have already been taken have increased access already. I think we will see increased access to both forms as well as we move forward.

The Vice-Chair (Mr. Len Webber): That's great to hear. Thank you.

I'll pass it on now to Mr. Ron McKinnon, for five minutes.

Mr. Ron McKinnon: I'll go in a little bit of a different direction here. Historically our approach to drugs and drug addiction has been to control substances that we consider highly addictive, and dangerous in that sense. However, in recent years, research done by people like Dr. Bruce Alexander in Vancouver and Dr. Gabor Maté suggests that people get addicted not because of the substances but because they lack human connections. If you address the human connections in their lives, you improve their quality of life and they're no longer as susceptible to addiction.

This question is for the Canadian Centre on Substance Abuse and probably also to the health department. Are you aware of these studies, and do you have an opinion on them? If so, would you share that with me?

● (1030)

Ms. Rita Notarandrea: Certainly when we look at prevention, we look at risk and protective factors. For instance, we're looking at resiliency. When you look at the risk factors, some of the risk factors are genetic. Some of the risk factors are the environment. When you look at protective factors, it speaks to connectivity in the school. It speaks to connectivity and parental nurturance at home.

There is a listing that, yes, we do consider when we look at prevention practices. It looks at both the risk factors and the protective factors.

Mr. Ron McKinnon: Are you familiar with Dr. Alexander's work?

Ms. Rita Notarandrea: I'm familiar with Gabor, the second individual you mentioned.

Mr. Ron McKinnon: Okay.

How about the health department?

Ms. Hilary Geller: To be honest, I don't think I have much to add to what Rita just said. Certainly we are aware of the literature around the root causes of substance abuse disorders. We keep on top of that. I think some of that thinking perhaps is behind the fact that different countries take different approaches on their drug policies.

Mr. Ron McKinnon: Yes. It seems to me that if we're wrong about what causes addiction, then we would likely go off in different directions, wrong directions perhaps, in how to treat it and how to prevent it. If we are, in fact, focusing wrongly on the substances when we should be focusing more on the people, that would affect our ability to educate people on the problem, to treat people, and to prevent the occurrence.

Can either organization offer any more insight into this?

Ms. Rita Notarandrea: To repeat what I said earlier, I think it's both. I think we need to look at the prevention opportunities that are there. We also need to look at current practices, whether those practices be in education and prescribing or whether those practices be in the delivery of treatment services.

Mr. Ron McKinnon: Okay. Those are my questions.

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

Go ahead, Ms. Sidhu.

Ms. Sonia Sidhu: I just want to let the committee know that I have given the clerk notice of the following motion with regard to a discussion on Thursday:

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): Thank you for that, Ms. Sidhu. It will be distributed to the entire committee for our next meeting.

Let's move on now to Dr. Carrie or Ms. Harder for five minutes.

Mr. Colin Carrie: We'll split our time.

Maybe you can see that the Liberals are really trying to focus on this one thing, safe injection sites, as far as the spectrum of treatment is concerned. That's what I wanted to ask a question on, because Ms. Geller was quite correct when she said there's no evidence of increased crime rates at these safe injection sites.

I'd like to ask the RCMP if you could get back to us with statistics. I don't think you'll have them. My understanding is that where Insite is in Vancouver, it's actually been suggested to the police that they don't charge. In other words, if they're not charging for all the crimes that they see, the crime rates will not go up.

I actually had the opportunity to go down there unannounced, and it is amazing how many ongoing crimes you're seeing, but they just don't charge people.

I was wondering if you could get some of those statistics back to us, because they say one of the reasons for putting these safe injection sites into communities is it won't increase the crime rate. But we do know that addicts usually are not people of means. My understanding is that to get their hit for the day, they have to commit between four and eight crimes. If this is petty crime, prostitution, break and enter, or whatever they need to do, wherever you locate that safe injection site, within the area around it, it will cause an increase in crime, and the police officers we had a chance to talk to down there said there were all kinds of petty crime down there.

I think it's really important when you're looking at Bill C-2, that you see that public safety in the communities, the neighbourhoods, with the moms and dads, the kids in the area is balanced with just the desire to put these through.

Is that information you could get back to us with?

● (1035)

A/Commr Todd G. Shean: The specific one we're discussing now is located in the Vancouver city police jurisdiction, which is not an RCMP jurisdiction, so we'd have to actually go to another police force's jurisdiction and ask them if they have the statistics on that. It's not something we would keep. It would be within the City of Vancouver's data banks.

Mr. Colin Carrie: I'd like to find it out just to confirm that, because that's a really important point to bring forward.

Madam Geller, we understand that a major source of fentanyl is from China. Can you confirm that fentanyl was not brought up during the recent visit of the Prime Minister to China? Do you have any knowledge of that?

Ms. Hilary Geller: I'm afraid I have no knowledge of that.

Mr. Colin Carrie: Would you be able to find out for us and get back to us?

Ms. Hilary Geller: I could certainly make an inquiry. How successful I will be, I don't know.

Mr. Colin Carrie: It never hurts to ask. Thank you very much.

Ms. Rachael Harder: I have a really quick point of clarification. I think it was you, Ms. Geller, who stated that 2% to 4% of young people misuse or abuse. Is that correct? Were you the one who gave that statistic?

Ms. Hilary Geller: Yes. I could pull up the statistics. This comes from the student drug survey, which is now just recently released.

Ms. Rachael Harder: Is there any chance of our getting that report sent to the committee?

Ms. Hilary Geller: Absolutely. It's actually posted online, but yes, we can send the report.

Ms. Rachael Harder: That's great. Thank you.

My last question then, to close it off, would come back to you, Rita.

Mr. Oliver summed this up really well in terms of the three different groups of users. I find that framework helpful. I'm just wondering with regard to young experimenters, what the recommendation would be in terms of helping to prevent the use and abuse of opioids. This is a group that I'm very passionate about.

Ms. Rita Notarandrea: I would look at it as preventing the use and abuse of any psychoactive substance, so I would put it as part of a bigger.... I think opioids are one of those that we're dealing with today. Meth was in the past. Heroin was in the past. I think we need to look at it as I had mentioned earlier: what are some of the prevention initiatives that are proven in the evidence that address both the risk and protective factors. We have done, with respect to different substances...you think about cannabis, for example. We need to address how we deliver those messages in a way that resonates with the youth. We're doing the same thing pertaining to alcohol, and then delivering messages that resonate with the youth pertaining to alcohol.

Your question is a good one in the sense that we need to look at different substances to tailor our messaging, but the general framework that we use is the same in terms of prevention initiatives. We need to look at risk and protective factors, but tailor our messaging based on the particular substance.

Ms. Rachael Harder: Thank you.

The Vice-Chair (Mr. Len Webber): We'll move now to Mr. Don Davies for five minutes.

Mr. Don Davies: Ms. Geller, I'll give you a chance to answer that question. Are there any federal funds planned to give to the provinces to help them open detox or treatment facilities that you're aware of?

Ms. Hilary Geller: I'm not aware of funds beyond all of the existing government programs.

Mr. Don Davies: Thank you.

Assistant Commissioner Shean, I think I read that the RCMP would like to see controls brought in on high-volume pill presses in this country. Can you confirm that for me and maybe elaborate on it?

A/Commr Todd G. Shean: I've been involved, as I said, when legislation comes forward to inform discussions on some of the things we're seeing. I've been involved in projects in the past through my involvement with the G7 when we looked at equipment. When we are asked we inform discussions on some of the equipment being used so that a determination can be made on whether it would be appropriate to include in future legislation.

Mr. Don Davies: I think there is broad agreement from all sources that we don't have a national data collection registry. We don't really know how many people are dying of opioid overdoses. We don't have clear information on prescription practices, etc.

Mr. Diverty or Ms. Geller, either of you, what steps would you suggest we take? Do we need to have national data on this issue, and if so, how do we go about getting that data?

● (1040)

Mr. Brent Diverty: I think it's critical that we have national data. You have the opportunity through national data to understand the problem in the whole of the country, to compare our situation with that of other countries and other jurisdictions.

There are challenges. On the harm side, you have death data. Detecting that a death is the result of opioid poisoning is challenging. We're working on some guidelines for coroners, with their participation, to help standardize this. You can have dramatically different results on a death certificate with respect to the cause of death, depending on who the coroner is. We really don't have comparable data nationally, and we need to work on that.

On the drug claims side, which is one part of the supply equation, we're working towards nationally comparable data for all drug claims. We don't have nationally comparable data in private prescription claims. We only have that for three provinces at the moment, but through some of the new electronic records, drug information systems, we ought to have more complete data soon.

These are priority areas that we're working on now, and part of the investment from Health Canada is directed toward those aims.

Mr. Don Davies: Thanks.

Ms. Notarandrea, if you could suggest one measure we could take quickly that might have an immediate effect on saving people's lives from opioid overdoses, what would that be?

Ms. Rita Notarandrea: After all the messages I've given about a comprehensive approach, you want me to zero in on one.

Mr. Don Davies: I'd just like you to prioritize.

Ms. Rita Notarandrea: I would say the most important thing would be a national drug observatory. Included in that would be prescription-monitoring programs in each jurisdiction together with an early warning system.

We need to have the data. We have it for physical health issues. If there is a flu across Canada, we can zero in on where the pockets of flu are. We need the same kind of data for substance use disorders and for what we're dealing with today, opioids and opioid deaths. If I had to really zero in, that would be it.

Mr. Don Davies: Thank you.

I want to talk about prescribing guidelines. In the U.S., new opioid prescribing guidelines were released by the CDC in March of this year that focused on rationalizing prescribing practices and patient education. The College of Physicians and Surgeons in British Columbia has released new professional standards and guidelines closely modelled on the CDC guidelines. I'm told that the B.C. standards are more strict than Canada's national guidelines, which have not been revised since 2010, and which may be out of date with current research on taking painkillers.

I know that the guidelines are expected to be updated in January, but given the severity of the overdose crisis, Ms. Geller, do you think that we should be speeding up that process so that we can update our national prescribing guidelines?

Ms. Hilary Geller: The updating of Canada's national prescribing guidelines, which I think date from 2010, was one of the initiatives funded out of the 2014 budget. It is very close to finalization. I think it's going through the final peer review process, which is an important last step.

There is also a lot of work being done to ensure that these guidelines end up in the hands of prescribers very quickly after the guidelines are in place. I think that's a very important step. The U.S. Surgeon General wrote to every single physician in the United States providing copies of the guidelines in an easy-to-use form. That's certainly something we would like to see here as well.

We are hopeful that other provincial physician regulators will copy British Columbia and perhaps adopt the new Canadian guidelines as a standard of practice, because that is one of the key ways to get at one of the root causes of this problem, which is physician prescribing.

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

We have one more minute. I'm going to ask Ms. Xavier a very quick question.

What percentage of the postal stream that comes in internationally is tested and traced for opioids?

Ms. Caroline Xavier: All mail, both postal and courier, must be presented to the CBSA. We use a risk assessment lens.

In terms of any mail coming in from Asia, we are looking at it 100%, as a result of knowing that's one of our high-risk areas.

● (1045)

The Vice-Chair (Mr. Len Webber): Once it's detected, you find the package, and obviously, it is then passed over to our law enforcement agencies. From there, do you continue on and perhaps try to make an arrest here in the country?

Ms. Caroline Xavier: Correct.

When we do seize a package and have determined that it has potential links to organized crime or it's breaking a particular contraband law, we work with our police of local jurisdiction or our RCMP colleagues and then share that information. From that, there are decisions that are made as to how to get to the source aspect of it.

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

I appreciate everyone coming today. That concludes our day. We will be back on Thursday to continue this study.

The meeting is adjourned.