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INTERIM REPORT AND RECOMMENDATIONS ON THE OPIOID CRISIS IN CANADA

Report of the Standing Committee on Health

Bill Casey
Chair

NOVEMBER 2016

42nd PARLIAMENT, 1st SESSION

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THE STANDING COMMITTEE ON HEALTH

has the honour to present its

FOURTH REPORT

Pursuant to its mandate under Standing Order 108(2), the Committee has studied the Opioid Crisis in Canada and has agreed to report the following:

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INTERIM REPORT AND RECOMMENDATIONS ON THE OPIOID CRISIS IN CANADA

INTRODUCTION

The emergence of fentanyl and its analogues, an opioid at least 100 times more potent than morphine[1], has given rise to a public health crisis in Canada requiring urgent action. British Columbia alone is expected to experience 800 illicit drug overdose deaths by the end of 2016, half of which are expected to involve fentanyl.[2] According to the Canadian Centre on Substance Abuse (CCSA), there were at least 655 fentanyl-implicated deaths in Canada between 2009 and 2014, representing an average of one fentanyl-implicated death every three days.[3] The unknown potency of fentanyl and other synthetic opioids means that all individuals that engage in illicit drug use are at risk of experiencing overdose and death, from recreational users to habitual users to those trying these drugs for the first time.[4] As these trends show no sign of abating, this crisis will continue to affect individuals and families in communities all across the country.

Seized with the life-threatening nature of this public health crisis, the House of Commons Standing Committee on Health ("the Committee") passed a motion on 22 September 2016 agreeing "to undertake an emergency study of the opioid crisis in Canada."[5] During the course of its study, the Committee held five meetings, where it heard from a range of stakeholders, including federal and provincial government representatives, health care professionals, addiction experts, emergency frontline responders, representatives of First Nations communities and individuals with lived experience in substance abuse and addiction. These witnesses outlined specific ways to address this opioid crisis and implored the Committee to make recommendations that would lead to concrete action. Through their stories, the Committee also heard first-hand the extent and depth of suffering of those most directly affected by the opioid crisis. In the words of Sean LeBlanc, Founder and Chairperson, Drug Users Advocacy League (DUAL)[6]:

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

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1 House of Commons Standing Committee on Health (HESA), *Evidence*, 1st Session, 42nd Parliament 4 October 2016, 0900 (Todd G. Shean, Assistant Commissioner, Federal Policing Special Services, Royal Canadian Mounted Police).

2 HESA, *Evidence*, 4 October 2016, 0850 (Hillary Geller, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Department of Health).

3 Canadian Centre on Substance Abuse (CCSA), "CCENDU Bulletin: Deaths Involving Fentanyl in Canada, 2009-2014," August 2015.

4 HESA, *Evidence*, 4 October 2016, 0850 (Geller).

5 HESA, Minutes of Proceedings, 1st Session, 42nd Parliament, 22 September 2016.

6 HESA, *Evidence*, 6 October 2016, 0925 (Sean LeBlanc, Founder and Chairperson, Drug Users Advocacy League).

This interim report summarizes the testimony from these witnesses and outlines actions that the federal government could take in collaboration with provincial and territorial governments and stakeholders to address the opioid crisis in Canada. While the Committee recognizes that this report only grazes the surface of this complex and multi-faceted issue, Members agree that urgent action needs to be taken to address the unprecedented levels of opioid-related overdoses occurring across the country. The recommendations in this report further aim to inform the outcomes of the Ministerial Summit on the opioid crisis taking place on 18 November 2016.[7]

BACKGROUND INFORMATION ON OPIOID MISUSE

Prescription opioids are drugs that are primarily used to treat acute and chronic pain and include drugs such as codeine, fentanyl, oxycodone, hydrocodone and morphine.[8] Other prescription opioids, such as methadone and buprenorphine-naloxone (Suboxone®) are used in the treatment of opioid addiction. Prescription opioids are classified as Schedule I drugs under the *Controlled Drugs and Substances Act* (CDSA). Under the CDSA, the use of these drugs is legal when they are prescribed by licensed practitioners and used by the person for whom they are prescribed.[9] Naloxone hydrochloride (naloxone) is a non-prescription drug that is used in emergency situations to counter the effects of opioid overdose.[10]

According to the CCSA, the misuse or non-medical use of prescription opioids refers to the use of prescription opioids for a purpose that is contrary to what is intended, or refers to the use of a prescription opioid by an individual who has not been prescribed the medication.[11] Prescription opioid misuse, like all substance-use disorders, falls on a continuum ranging from mild to severe depending upon the number of harms experienced by an individual.[12] Long-term regular use of these drugs can result in addiction[13], which is defined by the Canadian Society of Addiction Medicine as "a primary, chronic disease of brain reward, motivation, memory and related circuitry."[14]

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7 HESA, *Evidence*, 4 October 2016, 0850 (Geller).

8 CCSA, *Prescription Opioids*, July 2015.

9 Ibid.

10 Towardtheheart.com, "Take Home Naloxone: Frequently Asked Questions," 30 March 2015.

11 CCSA, *Prescription Opioids*, July 2015.

12 Elizabeth Harney, "DSM 5 Criteria for Substance Use Disorders: The Symptoms Used for the Diagnosis of Substance Use Disorders," *Addictions*, 20 June 2013.

13 CCSA, *Prescription Opioids*, July 2015.

14 Canadian Society of Addiction Medicine, *Policy Statements*, 5 October 2011.

OVERVIEW OF THE OPIOID CRISIS IN CANADA: WHAT THE COMMITTEE HEARD

A. Origins and Emergence of the Opioid Crisis in Canada

The Committee heard from witnesses that the misuse of prescription opioids first emerged as a problem in Canada in the 1990s with the increased prescribing of opioids in the treatment of chronic pain.[15] In particular, according to Dr. David Juurlink, Head, Division of Clinical Pharmacology and Toxicology, Sunnybrook Health Sciences Centre, Oxycontin, a prescription opioid 1.5 to two times more potent than morphine, was being increasingly prescribed in response to manufacturers marketing the drug as an effective pain reliever with low potential for addiction.[16] According to Dr. Evan Wood, Professor of Medicine, University of British Columbia, this marketing was able to exploit gaps in physician knowledge and training relating to addiction medicine, which in turn led to unsafe prescribing practices and the failure to employ evidence-based treatments for addiction.[17]

Though witnesses explained to the Committee that the full scope of the problem is unknown, the Committee heard that Canadians are the 2nd highest consumers of prescription opioids in the world, with 15% of Canadians aged 15 years and older reporting using prescription opioids in the previous year in 2013.[18] Dr. Juurlink estimated that approximately 10% of patients prescribed opioids for chronic pain become addicted.[19] Furthermore, the increased availability of prescription opioids in households has also meant that youth have begun using them for recreational purposes.[20] Six per cent of (or 16,000) youth aged 15 to 19 years in 2013 and 3% of (or 55,000) students from grades 7 to 12 in 2014-2015 indicated that they abused opioid pain relievers in the past year.[21] Finally, the increased availability and potency of licit prescription opioids means that they are also being diverted to the illegal drug market, replacing conventional drugs among habitual users.[22]

These trends result in significant harms. In Ontario, one in eight deaths of individuals aged 25 to 34 years was found to be opiate-related in 2010.[23] Similarly, there

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15 HESA, *Evidence*, 6 October 2016, 0915 (Dr. David Juurlink, Head, Division of Clinical Pharmacology and Toxicology, Sunnybrook Health Sciences Centre).

16 Ibid.

17 HESA, *Evidence*, 20 October 2016, 0900 (Dr. Evan Wood, Professor of Medicine, University of British Columbia, Interim Director, British Columbia Centre for Excellence in HIV/AIDS, British Columbia Centre on Substance Use).

18 Government of Canada, Canadian Tobacco, Alcohol and Drugs Survey (CTADS), "Summary of results for 2013," 3 February 2015.

19 HESA, *Evidence*, 6 October 2016, 0915 (Juurlink).

20 HESA, *Evidence*, 4 October 2016, 0920 (Rita Notarandrea, Chief Executive Officer, Canadian Centre on Substance Abuse).

21 Government of Canada, CTADS, "Summary of results for 2013," 3 February 2015 and Government of Canada, Canadian Student Tobacco, Alcohol and Drugs Survey, "Summary of results for 2014-15," 9 September 2016.

22 HESA, *Evidence*, 4 October 2016, 0900 (Shean).

23 HESA, *Evidence*, 6 October 2016, 0915 (Juurlink).

has been a substantial increase in the number of opioid-related deaths in Quebec since the 2000s, reaching 2.97 deaths per 100,000 persons in 2012.[24]

The Committee heard from witnesses that this situation began reaching crisis proportions in July 2013, when fentanyl, a prescription opioid 100 times more potent than morphine, became increasingly available on the illicit drug market.[25] Todd G. Shean, Assistant Commissioner, Federal Policing Special Services, Royal Canadian Mounted Police (RCMP) explained to the Committee that because of the high demand for this drug, organized crime groups began importing illicit fentanyl and its analogues from China, which is then transformed into tablet or powder forms in clandestine labs in Canada and disguised as other opioids such as Oxycontin® or used as cutting agents for other illicit drugs.[26] He further explained that while fentanyl is a significant concern, the emergence of new even more powerful synthetic opioids, such as W-18 and carfentanil, is even more alarming as these drugs are considered to be 100 times stronger than fentanyl and are known to be fatal even in small doses.

The unknown potency of illicit fentanyl and other synthetic opioids coupled with the fact that users are often unaware that they are taking the drug has resulted in a dramatic increase in illicit drug deaths in Canada. British Columbia has become "the epicentre of the crisis" because of its maritime ports and relative proximity to China.[27] According to the Chief Coroner for British Columbia, the percentage of illicit drug deaths involving fentanyl increased from 5% in 2012 to 60% in 2016, with the involvement of fentanyl doubling the rates of illicit drug deaths in the province.[28] According to the Coroner, the province had experienced 488 illicit drug deaths at the end of August 2016, or approximately 61 deaths a month. While the deaths have been primarily among male habitual drug users between the ages of 19 and 39 years, overdoses and deaths among recreational users have been occurring as well. Meanwhile, 162 fentanyl-related deaths were reported in 2015 in Ontario and 32 fentanyl-related deaths in Atlantic Canada.[29] Finally, the Committee heard that the opioid crisis is also affecting the mental health of first responders and other community-based workers:

> Specifically, it takes a toll on an individual's mental health to see such helplessness and suffering up close on a daily basis, to work extremely hard but to feel that you are having little or no impact on a problem that is growing exponentially, like a tidal wave, on the streets of your city.[30]

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24 HESA, *Evidence*, 18 October 2016, 0900 (Réjean Leclerc, Chair, Syndicat du préhospitalier).

25 HESA, *Evidence*, 4 October 2016.

26 HESA, *Evidence*, 4 October 2016, 0900 (Shean).

27 HESA, *Evidence*, 4 October 2016, 0850 (Geller).

28 HESA, *Evidence*, 6 October 2016, 0850 (Lisa Lapointe, Chief Coroner, British Columbia Coroners Service).

29 HESA, *Evidence*, 18 October 2016, 0910 (Chris Coleman, International Association of Fire Fighters Local 18 Representative).

30 Ibid.

The Committee also heard from witnesses that First Nations communities are being hit hard by the growing crisis. Dr. Susan Christenson Tallow, a family physician and member of the Blood Band of Blackfeet/Kainai from Alberta, explained in a written submission that the growing number of fentanyl-related overdoses and deaths led to her community declaring a state of emergency in 2014.[31] In addition, Carol Hopkins, Executive Director of the National Native Addictions Partnership Foundation, Assembly of First Nations (AFN) also reported to the Committee that a community-based opioid misuse study found that 28% of the members of the community aged 20 to 30 years old were engaged in opioid substitution therapy. By comparison, that was double the rate of diabetes in the same community.[32]

Witnesses explained to the Committee that the opioid crisis in First Nations communities has among its root causes the high rates of illness, injury and disability among First Nations peoples, who are frequently treated with opioids because of a lack of access to effective non-opioid therapies for physical pain.[33] Another contributing cause includes the lack of access to health care services more generally in First Nations communities.[34] Finally, the Committee heard that post-colonial trauma, and child maltreatment and trauma that occurred in the residential school system have also contributed to the initiation of drug and alcohol abuse among First Nations peoples.[35]

B. Federal/Provincial/Territorial Responses to the Public Health Crisis to Date

In response to the dramatic increase in the number of drug-related overdoses and deaths in British Columbia, the Committee heard that the Chief Public Health Officer for British Columbia declared a public state of emergency on 14 April 2016 under the *Public Health Act*, the first province to take this kind of action in response to the drug crisis.[36] Emergency powers under the Act allow the province to collect timely data and information that would support their response to the crisis.[37] The Committee heard that the province has also established a Joint Task Force on Overdose Response, which is undertaking key actions to address the crisis, including:[38]

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31 Dr. Susan Christenson and Dr. Cheryl Currie, "Briefing Note: Opioid Crisis-Perspective From First Nations Communities," written submission, 25 October 2016.

32 HESA, *Evidence*, 25 October 2016, 0855 (Carol Hopkins, Executive Director of the National Native Addictions Partnership Foundation, Assembly of First Nations).

33 HESA, *Evidence*, 25 October 2016 and Dr. Susan Christenson and Dr. Cheryl Currie, "Briefing Note: Opioid Crisis-Perspective From First Nations Communities," written submission, 25 October 2016.

34 HESA, *Evidence*, 25 October 2016, 0915 (Chief Isadore Day, Ontario Regional Chief, Assembly of First Nations).

35 HESA, *Evidence*, 25 October 2016 and Dr. Susan Christenson and Dr. Cheryl Currie, "Briefing Note: Opioid Crisis-Perspective From First Nations Communities," written submission, 25 October 2016.

36 HESA, *Evidence*, 6 October 2016, 0900 (Dr. Bonnie Henry, Deputy Provincial Health Officer, British Columbia, Office of the Provincial Health Officer).

37 Ibid.

38 Ibid.

- developing new guidelines for prescribing opioids;
- preventing overdoses by improving access to naloxone, expanding the number of supervised consumption sites and piloting drug checking, which allows individuals to check whether their drugs contain fentanyl;
- raising public awareness of the issue; and
- improving access to opioid substitution treatment by providing education and training to physicians on the use of Suboxone® in addiction treatment.

At the federal level, the Committee heard that Health Canada is addressing the immediate crisis by improving access to naloxone through the removal of the prescription requirement for the drug and issuing an emergency order to allow access to the nasal form of the drug.[39] The department is also working with stakeholders to clarify legislative requirements under the CDSA for the opening of supervised consumption sites to remove any unnecessary barriers in this area. In addition, the department is working to improve access to opioid substitution therapy by expediting drug approvals through its Special Access Program. Finally, the department also intends to introduce regulatory amendments to control six chemicals used in the production of illicit fentanyl, along with pill presses.

To address the systemic causes of the opioid crisis, the Committee heard that the Minister of Health had developed a five point action plan that includes:[40]

- better informing Canadians about the risks of opioids;
- supporting better prescribing practices;
- reducing easy access to unnecessary opioids;
- supporting better treatment options for patients; and
- improving the evidence base and improving data collection.

From a law enforcement perspective, the Committee heard that the RCMP is responding to the crisis by gathering information and data to understand the full scope of the problem, improving access to naloxone and raising awareness among its members and the public regarding the harms of fentanyl.[41] Within this context, other witnesses emphasized the importance of the police approaching the opiate crisis as a health rather than a criminal issue. In particular, Lisa Lapointe, Chief Coroner, British Columbia Coroners Service, indicated that the RCMP should consider adopting a policy of not

39 HESA, *Evidence*, 4 October 2016, 0850 (Geller).

40 Health Canada, *Health Canada's Action on Opioid Misuse*, 6 July 2016.

41 HESA, *Evidence*, 4 October 2016, 0900 (Shean).

attending 911 calls for overdose situations to ensure that individuals are able to call an ambulance and be treated in hospital.[42]

In addition, the Committee also heard that the RCMP is collaborating with law enforcement agencies in China to combat international drug trafficking networks, as well as gain support for regulatory control of fentanyl analogues in China to prevent their distribution to Canada. In terms of federal interdiction efforts at the border, the Committee heard that Canadian Border Services Agency (CBSA) is using innovative technologies and dogs to detect fentanyl at borders and maritime ports, resulting in over 115 seizures since 2010.[43]

However, Caroline Xavier, Vice-President, Operations Branch, CBSA, explained to the Committee that the Agency faces challenges detecting and intercepting fentanyl sent through the postal system[44]:

> Fentanyl powder and equivalent substances are most often smuggled into Canada mainly from China, … through the postal stream in our case.… 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.

The RCMP further elaborated that these shipments are "disguised or labelled in a variety of ways such as printer ink, toys and DVDs."[45] Once the pure fentanyl has arrived in Canada, it is then manufactured into the final product, which can be in tablet or powder form, and distributed throughout Canada and to a lesser extent, the United States. To address this issue, Caroline Xavier noted that the Agency is reviewing section 99 (2) of the *Customs Act* to determine whether removing restrictions on the Agency's ability to open packages under 30 grams should be part of the response to the crisis.[46]

C. More Action is Necessary to Respond to the Crisis

Despite the steps taken to date to address the opioid crisis, the Committee heard from witnesses that more needs to be done to ensure a comprehensive response. Witnesses identified the following areas where more steps need to be taken: harm reduction, prevention, access to treatment for addiction and mental health and national leadership, particularly in relation to monitoring and surveillance and co-ordination of an overall response. Summary of testimony in these areas is outlined below.

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42 HESA, *Evidence*, 6 October 2016, 0915 (Lapointe).

43 HESA, *Evidence*, 4 October 2016, 0915 (Caroline Xavier, Vice President, Operations Branch, Canada Boarder Services Agency).

44 Ibid.

45 HESA, *Evidence*, 4 October 2016, 0900 (Shean).

46 Ibid.

1. Harm Reduction

Dr. Bonnie Henry, the Deputy Provincial Health Officer for British Columbia, noted that harm reduction is "an important pillar" in the response to opioid-related overdoses,[47] and Dr. Jeff Blackmer, Vice-President, Medical Professionalism, Canadian Medical Association (CMA) explained that the CMA "strongly recommends" that harm reduction be reinstated as a core pillar of the National Anti-Drug Strategy.[48]

Harm-reduction measures include increasing the availability of naloxone. The Committee heard that not all first responders across Canada have been trained on the use of naloxone.[49] While access to naloxone has been significantly improved, Sean Leblanc from the Drug Users Advocacy League (DUAL) recommended that the dose of naloxone that is part of the kits that are distributed should be increased to better counteract overdoses,[50] and Guy-Pierre Levesque from Méta-d'âme noted the importance of short training sessions on the use of naloxone provided by peers.[51] Dr. David Juurlink expressed the opinion that naloxone should be available at no cost in a wide range of locations.[52]

In some First Nations communities, access to naloxone is a challenge. Dr. Claudette Chase, a family physician who works with Sioux Lookout First Nations Health Authority, proposed that nurses include naloxone as part of the sterile drug injection equipment kits they provide to individuals on-reserve.[53]

Supervised consumption sites such as Insite are another evidence-based harm-reduction measure. A number of witnesses expressed the opinion that changes to the CDSA introduced through Bill C-2, An Act to amend the Controlled Drugs and Substances Act (Respect for Communities Act) in 2015 are a barrier to establishing other supervised consumption sites across the country and should be repealed or significantly amended.[54]

2. Prevention

Training for physicians and other health care providers, and prescribing practices

Witnesses suggested that overprescribing of opioids by physicians has contributed significantly to the opioid crisis in Canada, including the rising number of addictions and

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47 HESA, *Evidence*, 6 October 2016, 1020 (Henry).

48 HESA, *Evidence*, 18 October 2016, 0845 (Dr. Jeff Blackmer, Vice-President, Medical Professionalism, Canadian Medical Association).

49 HESA, *Evidence*, 18 October 2016, 0905 (Leclerc).

50 HESA, *Evidence*, 6 October 2016, 0930 (LeBlanc).

51 HESA, *Evidence*, 20 October 2016, 0850 (Guy-Pierre Lévesque, Director and Founder, Méta d'Âme).

52 HESA, *Evidence*, 6 October 2016, 0925 (Juurlink).

53 HESA, *Evidence*, 25 October 2016, 0945 (Dr. Claudette Chase, Sioux Lookout First Nations Health Authority).

54 HESA, *Evidence*, 6 October 2016, 0925 (Leblanc); 6 October 2016, 0955 (Henry); 18 October 2016, HESA, *Evidence*, 0845 (Blackmer).

increased risk for overdoses.[55] Witnesses emphasized the need for physician education on proper opioid-prescribing practices to address this issue,[56] as well as the importance of adhering to new prescribing guidelines forthcoming in 2017.[57]

Inadequate training for physicians and other health care providers relating to identifying substance-use disorders and intervening appropriately was also identified by witnesses. Dr. Evan Wood noted that "we need a primary-care based strategy to train physicians,"[58] and that this could be offered through the College of Family Physicians.

Prescription-monitoring programs were mentioned as an effective tool to identify problematic prescribing practices, as well as potential prescription drug misuse among individuals.[59] Real-time prescription monitoring is available in only two jurisdictions in Canada.[60] Alistair Bursey, Chair of the Canadian Pharmacists Association suggested that moving beyond prescription monitoring programs to an integrated drug information system is desirable.[61]

Public education

As part of both preventing substance misuse and treating overdose incidents, many witnesses advocated for greater public education on these issues. [62] As Dr. Bonnie Henry, Deputy Provincial Health Officer, British Columbia, stated, "I think we do need to talk to people in a very forthright and open way about drugs, about their uses, their benefits, and their harms, so they can make those informed decisions. When we do it right, we've seen that it works."[63] She further noted that public education needs to be targeted to different groups, including recreational and habitual drug users, individuals legitimately prescribed opioids, youth and their families and friends. The Committee also heard that education needs to address not only the risks and harms relating to opioid use, but should also encompass patient education relating to pain management.[64] To that end, the CMA recommended new federal funding for prescriber, patient and public education and training resources.[65]

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55 HESA, *Evidence*, 6 October 2016, 1015 (Juurlink).

56 HESA, *Evidence*, 4 October 2016, 0925 (Notarandrea); *Evidence*, 6 October 2016, 0925 (Juurlink); HESA, *Evidence*, 18 October 2016, 0850 (Blackmer).

57 HESA, *Evidence*, 6 October 2016, 1015 (Juurlink).

58 HESA, *Evidence*, 20 October 2016, 0925 (Wood).

59 HESA, *Evidence*, 4 October 2016, 0925 (Notarandrea); HESA, *Evidence*, 18 October 2016, 850 (Blackmer).

60 HESA, *Evidence*, 18 October 2016, 0850 (Blackmer).

61 HESA, *Evidence*, 18 October 2016, 0855 (Alistair Bursey, Chair, Canadian Pharmacists Association).

62 HESA, *Evidence*, 4 October 2016, 0930 (Notarandrea); *Evidence*, 6 October 2016, 0940 (Leblanc).

63 HESA, *Evidence*, 6 October 2016, 1030 (Henry).

64 HESA, *Evidence*, 4 October 2016, 0925 (Notarandrea).

65 HESA, *Evidence*, 18 October 2016, 0850 (Blackmer).

3. Treatment

Addiction Treatment

Witnesses expressed their frustration that there is a significant shortage of publicly-funded, accessible and timely addictions treatment in Canada.[66] As the Chief Coroner, British Columbia Coroners Service stated, "if you develop a terminal illness, or an illness that is potentially terminal, a cancer, for example, you expect that you will be treated and that treatment will be available. If you become addicted to drugs, treatment should be available."[67] In a similar vein, Dr. Mark Ujjainwalla, Medical Director at Recovery Ottawa, stated that "[t]he real issue is the inability of the present health care system to treat the disease of addiction. An addiction is a biopsychosocial illness that affects 10% of society, probably more if you include families, and it is the most underfunded medical illness in our society."[68] Dr. Evan Wood recommended that access to these services could be increased through the provision of targeted funding separate from funding for mental health services.[69]

Sean LeBlanc from DUAL noted that individuals need access to treatment programs other than detoxification,[70] and Dr. Bonnie Henry explained that detoxification programs do not work for opioid users as the physiological dependence created by opioid addiction requires opioid-substitution therapy, such as Suboxone®, at least as a first step.[71] The need to provide access to opioid-substitution treatment in First Nations communities by expanding the scopes of practice of nurses working in the community was also emphasized. As Carol Hopkins, Executive Director of the National Native Addictions Partnership Foundation explained, Suboxone® "has to be the first line of treatment for Indigenous populations with an opiate addiction because it allows them to stay in their community and it allows for a team-based approach."[72] Dr. Nady el-Guebaly, Professor, Department of Psychiatry, University of Calgary, further recommended that Health Canada provide access to other opioid-substitution therapies not available in Canada, such as Vivitrol®, which have new methods of delivery (such as being injected monthly) that support medication compliance.[73]

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66 See for example HESA, *Evidence*, 4 October 2016, 0925 (Notarandrea); HESA, *Evidence*, 6 October 2016, 0925 (Henry); HESA, *Evidence*, 6 October 2016, 0925 (Juurlink); HESA, *Evidence*, 6 October 2016, 0925 (Leblanc).

67 HESA, *Evidence*, 6 October 2016, 0955 (Lapointe).

68 HESA, *Evidence*, 20 October 2016, 0910 (Dr. Mark Ujjainwall, Medical Director, Recovery Ottawa).

69 HESA, *Evidence*, 20 October 2016, 0925 (Wood).

70 HESA, *Evidence*, 6 October 2016, 0925 (Leblanc).

71 HESA, *Evidence*, 6 October 2016, 0950 (Lapointe).

72 HESA, *Evidence*, 25 October 2016, 0920 (Hopkins).

73 HESA, *Evidence*, 25 October 2016, 0910 (Dr. Nady el-Geubaly, Professor, Department of Psychiatry, University of Calgary).

Improved access to mental health supports

For First Nations communities, Chief Isadore Day, Ontario Regional Chief with the AFN, stated that "the creation of a community-centred and culturally-driven health promotion framework is essential for building effective alternatives to the current treatment system,"[74] and that providing communities with stable, needs-based funding to allow for the implementation of the First Nations Mental Wellness Continuum Framework is critical to addressing substance misuse in First Nations communities.[75] As Carol Hopkins stated, "[w]e have dedicated funding, thankfully, to address the issues related to diabetes in our communities, but we don't have the same type of resources when it comes to dealing with the opiate crisis."[76]

The Committee heard that improved access to mental health services more broadly would also support people who use drugs. Dr. Bonnie Henry further noted improved access to mental health supports and addiction treatment for offenders in the federal correction system was also necessary.[77] In addition, access to mental health services for frontline workers is critical to ensure their wellness and continued ability to provide support to others.[78]

4. National Leadership/National Strategy

The need for national coordination and leadership in relation to data collection was emphasized. As Dr. David Juurlink explained, "[y]ou can't fix what you're not even measuring."[79] The call for national leadership went beyond data collection and included the need for a national strategy that would be multi-faceted,[80] including providing clear directions to all jurisdictions with respect to protocols to be adopted in the face of what many witnesses agreed was a "national public health emergency."

COMMITTEE OBSERVATIONS AND RECOMMENDATIONS

Throughout the Committee's meetings on the opioid crisis in Canada, witnesses emphasized the need to focus on substance misuse as a health issue, rather than a criminal justice one, and to renew the importance of harm reduction as one facet of a multi-pronged approach to addressing the opioid crisis and substance misuse more generally. Within the context of health and health care, improved training for physicians with respect to opioid prescribing practices to prevent addiction, and improved training for health care providers with respect to recognizing, supporting, and treating individuals with

74 HESA, *Evidence*, 25 October 2016, 0850 (Day).

75 Ibid.

76 HESA, *Evidence*, 25 October 2016, 0855 (Hopkins).

77 HESA, *Evidence*, 6 October 2016, 1015 (Henry).

78 HESA, *Evidence*, 18 October 2016, 0940 (Lee Lax, Representative, International Association of Fire Fighters Local 18 and Vancouver Fire Fighters' Union - Local 18).

79 HESA, *Evidence*, 6 October 2016, 1035 (Juurlink).

80 HESA, *Evidence*, 18 October 2016, 1010 (Blackmer).

substance misuse issues was highlighted, as was the need to communicate information to the public about the misuse of opioids and other substances.

Witnesses also underscored the importance of improving access to evidence-based treatment for individuals who misuse drugs and to mental health and pain management services more broadly. The Committee heard that providing First Nations communities with stable, needs-based funding to allow for the implementation of the First Nations Mental Wellness Continuum Framework is critical to addressing substance misuse in these communities.

A number of witnesses noted the difficulties in addressing the opioid crisis without having access to national data. National leadership and a national strategy in relation to the opioid crisis could provide the framework for collecting and analysing data across Canada, and it could also facilitate the development of a national prescription monitoring system.

Finally, testimony from federal law enforcement officials indicated that greater efforts were necessary to prevent illicit synthetic opioids and other drugs from entering the country through enhanced engagement with China and other international partners. Border officials also indicated that detecting and seizing illicit synthetic opioids sent through the postal system require more robust measures.

In response to the issues raised and solutions proposed by witnesses and recognizing that collaboration among all levels of government and stakeholders in necessary to address this public health crisis, the Committee makes the following recommendations:

RECOMMENDATIONS

General

Recommendation 1

That the Government of Canada declare the opioid overdose crisis a national public health emergency.

Recommendation 2

That the Government of Canada create a national multi-sectoral taskforce on the opioid crisis.

Recommendation 3

That the Government of Canada work with provincial and territorial counterparts to immediately develop an ongoing and fully coordinated pan-Canadian surveillance system for drug overdoses.

Harm Reduction

Recommendation 4

That the Government of Canada reinstate "harm reduction" as a core pillar of the National Anti-Drug Strategy, and also define "harm reduction."

Recommendation 5

That the Government of Canada work with the provinces and territories to establish a network of harm reduction facilities.

Recommendation 6

That the Government of Canada work with the provinces and territories, and first responders' regulatory authorities, to ensure that first responders, individuals who use drugs and others have access to naloxone and appropriate training on how to use it.

Recommendation 7

That the First Nations and Inuit Health Branch of Health Canada ensure that adequate supplies of naloxone and appropriate training on its use are available in reserve communities. Naloxone should be included in the safer injection kits provided on reserve by Health Canada nurses in First Nations, Inuit and Métis communities.

Recommendation 8

That the Government of Canada repeal or significantly amend the *Controlled Drugs and Substances Act* where it creates barriers to communities in establishing supervised consumption sites, and in the interim, work with communities and organizations to overcome administrative hurdles in relation to seeking exemptions under the *Controlled Drugs and Substances Act* in relation to supervised consumption sites.

Recommendation 9

That the Government of Canada grant exemptions under *the Controlled Drugs and Substances Act* for the purposes of drug testing at supervised consumption sites.

Prevention – Prescribing

Recommendation 10

That all medical regulatory agencies in Canada work with their respective memberships to develop information and training tools relating to recognizing addiction (including evaluating a patient's history of prescription drug use), making appropriate referrals to evidence-based treatment programs, and treating individuals who have substance abuse issues in a respectful and compassionate manner.

Recommendation 11

That appropriate regulatory agencies develop a review system in relation to prescribing practices of physicians and pharmacists.

Recommendation 12

That the new opioid prescribing guidelines be expedited, and that the Government of Canada work with the provinces and territories to encourage provincial licensing bodies to mandate their adoption.

Recommendation 13

That the Government of Canada work with the provinces and territories to facilitate a broader approach to reducing opiate prescribing and integrate alternatives for pain management.

Recommendation 14

That Health Canada review and revise if necessary its approved indications for opioids to reflect peer-reviewed data.

Recommendation 15

That the Government of Canada work with the provinces and territories to establish a comprehensive, real-time, national electronic prescription monitoring system.

Prevention – Education

Recommendation 16

That the Government of Canada, through either Health Canada or the Public Health Agency of Canada, work with the provinces and territories to develop public awareness tools in relation to the risks associated with opioid use, and how to respond to overdoses. Public awareness tools should include materials targeted at youth.

Treatment

Recommendation 17

That the Government of Canada invest significant new funding to expand treatment for addictions.

Recommendation 18

That the Government of Canada work with the provinces and territories to significantly increase the availability of community-based, publicly funded substance abuse treatment programs.

Recommendation 19

That the Government of Canada work with the provinces and territories to strengthen existing detoxification treatment programs and create new ones.

Recommendation 20

That the Government of Canada work with the provinces and territories and their medical regulatory authorities to develop effective clinical practice guidelines relating to addiction treatment.

Recommendation 21

That the Government of Canada improve access to medications for opioid addiction treatment such as Suboxone® and other effective medications not currently available in Canada, especially for people at high risk of complication and death.

First Nations communities

Recommendation 22

That the First Nations and Inuit Health Branch of Health Canada consult with First Nations and Inuit communities to ensure that culturally appropriate care and assistance for addictions are available on reserve, and

Recommendation 23

That the Government of Canada work with the provinces and territories to ensure that culturally appropriate care and assistance for addictions is available to Indigenous individuals off reserve.

Recommendation 24

That the Government of Canada ensure that working with Indigenous communities to address the opioid crisis is carried out in the context of addressing the recommendations made by the Truth and Reconciliation Commission of Canada and the social determinants of health such as adequate housing, education, and access to health services including mental health services.

Recommendation 25

That the Government of Canada increase funding to First Nations communities to allow for multi-year health and social service provider contracts and appropriate accountability and transparency measures.

Recommendation 26

That the Government of Canada commit to providing stable needs-based funding for First Nations in order for them to implement the First Nations Mental Wellness Continuum Framework.

Recommendation 27

That Health Canada eliminate its current time restrictions on the scopes of practice of nurses relating to treating addiction on reserve.

Recommendation 28

That the Government of Canada provide a full and adequately funded continuum of services for Indigenous Canadians that includes long-term funding for community-based prescription drug abuse programs, such as opioid substitution therapy with Suboxone®, along with land-based treatment and other cultural therapies.

Mental Health Supports

Recommendation 29

That the Government of Canada work with the provinces and territories to ensure treatment for active drug users is available to address the underlying mental health issues that may contribute to or exacerbate drug addiction.

Recommendation 30

That the Government of Canada work with the provinces and territories to develop a national strategy to provide better training and mental health services for front-line workers and first responders.

Data, National Leadership

Recommendation 31

That the Government of Canada work with the provinces and territories to compile information relating to fatal and non-fatal overdoses due to opioid use and that this information be reported by the Public Health Agency of Canada in a timely manner.

Recommendation 32

That the Government of Canada work with the provinces, territories to establish provincial/territorial and municipal support services that will allow for the monitoring and surveillance of drug use patterns to better facilitate treatment strategies on a national scale.

Law Enforcement and Border Security

Recommendation 33

That the Government of Canada take measures to grant authority and lawful privilege to Canada Border Services Agency officials to search and/or test suspect packages that weigh under 30 grams.

Recommendation 34

That the Government of Canada develop a federal enforcement and interdiction strategy around the importation of illicit opioids.

Recommendation 35

That the Government of Canada adopt measures to regulate commercial pill presses to limit their possession to pharmacists and others who hold an appropriate licence.

Recommendation 36

That stronger criminal penalties for having a production machine be established.

Recommendation 37

That the Government of Canada provide more resources for drug testing packages and other shipments.

Recommendation 38

That the Standing Committee on Public Safety and National Security undertake a study into the primary source for illicit opioids in Canada to determine the risk to public safety and evaluate the current methods and relationships to determine if Canada can be more successful at stemming the flow of illicit opioids into Canada.

LIST OF RECOMMENDATIONS

APPENDIX A
LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
Canada Border Services Agency	2016/10/04	22
Caroline Xavier, Vice President Operations Branch		
Canadian Centre on Substance Abuse		
Rita Notarandrea, Chief Executive Officer		
Matthew Young, Senior Research and Policy Analyst		
Canadian Institute for Health Information		
Brent Diverty, Vice President Programs		
Department of Health		
Hilary Geller, Assistant Deputy Minister Healthy Environments and Consumer Safety Branch		
Supriya Sharma, Senior Medical Advisor Health Products and Food Branch		
Royal Canadian Mounted Police		
Luc Chicoine, National Drug Coordinator Federal Coordination Centre, Federal and International Support Services		
Todd G. Shean, Assistant Commissioner Federal Policing Special Services		
British Columbia Coroners Service	2016/10/06	23
Lisa Lapointe, Chief Coroner		
Drug User Advocacy League		
Catherine Hacksel, Coordinator		
Sean LeBlanc, Founder and Chairperson		
Office of the Provincial Health Officer, British Columbia		
Bonnie Henry, Deputy Provincial Health Officer, British Columbia		
Sunnybrook Health Sciences Centre		
David Juurlink, Head Division of Clinical Pharmacology and Toxicology		
Canadian Medical Association	2016/10/18	24
Jeff Blackmer, Vice President Medical Professionalism		
Canadian Pharmacists Association		
Alistair Bursey, Chair		

Organizations and Individuals	Date	Meeting
Canadian Pharmacists Association	2016/10/18	24
Philip Emberley, Director Professional Affairs		
Syndicat du préhospitalier (FSSS - CSN)		
Réjean Leclerc, Chair		
Vancouver Fire Fighters' Union - Local 18		
Chris Coleman, International Association of Fire Fighters Local 18 Representative		
Lee Lax, International Association of Fire Fighters Local 18 Representative		
British Columbia Centre on Substance Use	2016/10/20	25
Evan Wood, Professor of Medicine, University of British Columbia Interim Director, British Columbia Centre for Excellence in HIV/AIDS		
Méta d'Âme		
Guy-Pierre Lévesque, Director and Founder		
Recovery Ottawa		
Mark Ujjainwalla, Medical Director		
As an individual	2016/10/25	26
Nady el-Guebaly, Professor Department of Psychiatry, University of Calgary		
Assembly of First Nations		
Isadore Day, Ontario Regional Chief		
Carol Hopkins, Executive Director National Native Addictions Partnership Foundation		
Sioux Lookout First Nations Health Authority		
Claudette Chase, Family Physician		

APPENDIX B
LIST OF BRIEFS

Organizations and Individuals

el-Guebaly, **Nady**

Levern Health Clinic

Ministère de la Santé de la Colombie-Britannique

Professionnels de la santé canadiens en faveur de politiques en matière de drogues fondées sur des données probantes

Section 18 du Vancouver Fire Fighters' Union

Société canadienne des médecins de soins palliatifs

MINUTES OF PROCEEDINGS

A copy of the relevant *Minutes of Proceedings* (Meetings Nos.22, 23, 24, 25, 26, 29, 30) is tabled.

Respectfully submitted,

Bill Casey
Chair

Len Webber
Colin Carrie
Rachael Harder

Dissenting Opinions from the Conservative Caucus Members

The Standing Committee on Health conducted an emergency study on the Opioid crisis that our nation is currently facing. Opioid related overdoses continue to increase at an alarming rate across the country. The goal of the study was to hear testimony from knowledgeable witnesses and bring forward valuable recommendations and possible solutions that would ultimately aid in lowering the amount of opioid related overdoses and deaths. The Conservative Members felt it was important to investigate the accessibility of legal opioids and solutions to control the influx and distribution of illicit opioids in Canadian communities.

It is the opinion of the Conservative Members that the interim report tabled by this Committee has not accomplished this objective. Witness testimony was limited and the review process of the recommendations was immensely rushed. As a result, the report lacks basic, yet vital, details such as a clear definition of the term “harm-reduction”, which is utilized numerous times throughout the report.

The timeline for opposition members to submit dissenting opinions was limited due to the majority of members pushing a last-minute deadline. This only gave opposition members one day to put their dissenting opinions together, if it were to be included in the interim report.

The summary of the evidence in the report does outline the seriousness of the situation; however, the recommendations do not adequately or effectively address the severity of this emergency study as the interim report does not acknowledge the main source of the crisis. Conservative Members of the Committee saw a great need to address the problem at its root-source. It was clear from a multitude of testimonies that China is the primary source of these illicit drugs yet, there is no clear indication of this in the report’s recommendation section. Government members preferred to ignore the root causes and instead looked to Band-Aid solutions which facilitates ongoing substance abuse and ignores affected communities. With this in mind, Conservative members also

acknowledge the importance of facilitating the quick integration of patients into treatment programs with long-term sustainability and protecting the community at large.

With this in mind, the Conservative Members of the Standing Committee on Health propose the following supplementary recommendations to the Committee's report.

RECOMMENDATIONS

MONITORING:

Numerous witnesses mentioned the lack of treatment centres across the country. They felt that there was a need for a better system which provided real-time data for people seeking treatment and a need for better access and education for first responders.

Recommendation 1: That the Public Health Agency of Canada provide statistics on opioid overdose and death in a more timely manner to better inform policy and resource allocation decisions[1].

Recommendation 2: That Health Canada report annually on the various publically-funded treatment options available across Canada and provide wait times for these treatments[2].

Recommendation 3: That Health Canada work with the provinces and territories to offer thorough and standardized training for those responding to overdose emergencies[3].

POLICING & ENFORCEMENT

[1] Ms. Lisa Lapointe (Chief Coroner, British Columbia Coroners Service)
[2] Dr. Evan Wood (Professor of Medicine, University of British Columbia, Interim Director, British Columbia Centre for Excellence in HIV/AIDS, British Columbia Centre of Substance Use)
[3] All Testimony

Numerous witnesses agreed that China is the main country responsible for illegal opioids, specifically fentanyl, entering Canada. Todd Shean, Assistant Commissioner, Federal Policing Special Services, RCMP, stated:

> *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.*

Recommendation 4: That the Government of Canada publicly acknowledge China as the primary source of Illegal Opioids and one of the root-causes to the Opioid crisis in Canada.

Recommendation 5: That the Royal Canadian Mounted Police provide annual updates on the referrals received from Canada Border Services Agency and Canada Post for illegal drug shipments and report on the conviction rates arising from these investigations[4].

Recommendation 6: That the Government implement stronger criminal penalties for possessing raw materials and/or a production machine intended to manufacture illegal drugs[5].

Recommendation 7: That the Royal Canadian Mounted Police and Canada Border Services Agency be provided more resources for drug testing packages and other shipments[6].

Recommendation 8: That the Government improve Canada's importation regulations for smuggling, scanning for smuggled drugs, and testing suspect packages[7].

[4] A/Commr Todd G. Shean (Assistant Commissioner, Federal Policing Special Services, Royal Canadian Mounted Police), Dr. Jane Buxton (Professor, University of British Columbia; Epidemiologist and Harm Reduction Lead BC Centre for Disease Control, As an Individual)
[5] Ibid
[6] Ibid

PREVENTION

Recommendation 9: That Health Canada work with the provinces and territories and their respective professional organizations to require physicians, pharmacists and patients to receive better education with regards to the risks associated with the use of Opioids[8].

Recommendation 10: That Health Canada work with the provinces and territories and their respective professional organizations to implement stronger accountability measures for prescribers[9].

Recommendation 12: That Health Canada and the Public Health Agency of Canada create and promote drug education programming for youth that specifically targets opioid abuse[10].

Recommendation 13: That the Government require the use of tamper-resistant medications whenever possible[11].

TREATMENT

Witnesses strongly agreed that more needed to be done to ensure that there was better access to treatment. Throughout this study the term “harm-reduction” was used, yet there is no consistent definition.

Recommendation 14: That the Government recognizes the success of any community based treatment or injection facility is dependent on the broader support of the community and therefore requires mandatory

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[7] Dr. Jeff Blackmer (Vice-President, Medical Professionalism, Canadian Medical Association), Mr. Alistair Bursey (Chair, Canadian Pharmacists Association), Dr. Philip Emberley (Director, Professional Affairs, Canadian Pharmacists Association)

[8] Dr. Jeff Blackmer (Vice-President, Medical Professionalism, Canadian Medical Association), Mr. Rejean Leclerc (Chair, Syndicat du prehospitalier, FSSS-CSN)

[9] Mr. Alistair bursey (Chair, Canadian Pharmacists Association)

[10] All testimony

[11] Dr. Philip Emberley (Director, Professional Affairs, Canadian Pharmacists Association),

community consultations prior to locating such facilities within a community[12].

Recommendation 15: That the Government immediately address the inadequate access rural Canadians and reserve-based Canadians have to prevention and treatment programs[13].

Recommendation 16: That Health Canada provide their definition of 'harm reduction' to facilitate a consistency in the public's understanding of related policy.

Recommendation 17: That Health Canada look at a broader approach and consider a patient-centered approach to reducing opioid prescribing and integrate evidence-based non-pharmacological alternatives for pain management[14].

Recommendation 18: That provinces and territories be encouraged to strengthen mental health support services and programs[15].

The Conservative members of the Committee were generally supportive of most of the recommendations put forward in the main report and recognize that the status quo is not an option. We strongly disagree with motions that called for less community involvement and reducing safe-guards when it comes to injection sites as we would prefer resources be put into treatment rather than promoting facilities for ongoing substance abuse.

[12] Mr. Pierre Poirier (Executive Director, Paramedic Association of Canada), Dr. Meredith MAcKenzie (Physician, Street Health Centre, Kingston Community Health Centres)
[13] Chief Isadore Day (Ontario Regional Chief, Assembly of First Nations), Dr. Claudette Chase (Family Physician, Sioux Lookout First Nations Health Authority), Dr. Mark Ujjainwalla (Medical Director, Recovery Ottawa
[14] Dr. Mark Ujjainwalla (Medical Director, Recovery Ottawa), Dr. Evan Wood (Professor of Medicine, University of British Columbia, Interin Director, British Columbia Centre for Excellence in HIV/AIDS, British Columbia Centre of Substance Use), Mr. Lee Lax, Mr. Chris Coleman (Representative, International Association of Fire Fighters Local 18 and Vancouver Fire Fighters' Union-Local 18),
[15] Chief Isadore Day (Ontario Regional Chief, Assembly of First Nations), Dr. Claudette Chase (Family Physician, Sioux Lookout First Nations Health Authority),

We have great concerns about the call for additional funding to indigenous communities without ensuring the Government of Canada's accountability in providing these valuable resources in a timely fashion.

We disagree with repealing Bill C-2 as we believe this legislation ensures that the safety and security of communities across Canada should be the primary responsibility of the government. Removing consultations and safe-guards is an abdication of this responsibility.

In short, we felt that the recommendations in the Interim Report would not fully target the root causes, would not reduce the problem of substance abuse, nor would they increase the safety and security of our communities.