HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

# Standing Committee on Health

HESA • NUMBER 127 • 1st SESSION • 42nd PARLIAMENT

**EVIDENCE**

## Tuesday, December 4, 2018

## Chair

**Mr. Bill Casey**

# Standing Committee on Health

**Tuesday, December 4, 2018**

● (0845)

[*English*]

**The Vice-Chair (Ms. Marilyn Gladu (Sarnia—Lambton, CPC)):** Welcome to the 127th meeting of the Standing Committee on Health. Today we're studying the impacts of methamphetamine abuse in Canada.

We have a number of excellent witnesses to speak to us today. From the Bear Clan Patrol, we have James Favel, Executive Director. From the Manitoba Nurses Union, we have Darlene Jackson, President. From the Overdose Prevention Society, we have Sarah Blyth, Executive Director. From Pine River Institute, we have Vaughan Dowie, CEO, and Victoria Creighton, Clinical Director.

Welcome to all of you. Each organization will have 10 minutes for speeches.

Because James is not yet seated, we'll start with you, Darlene, for 10 minutes.

**Ms. Darlene Jackson (President, Manitoba Nurses Union):** Thank you.

"One or two hits of meth will last you hours and hours and keep you up for days. With opioids, you can totally predict what the course of treatment is going to be. We can totally handle anyone going through opioid withdrawal. With meth, in the blink of an eye it switches."

Madame Chair and committee members, thank you for inviting me here today. What I just read to you was a quote from a registered psychiatric nurse at Health Sciences Centre, the largest health care facility west of Toronto and east of Calgary. This facility is at the forefront of managing the crisis.

I wanted to begin with it because it addresses one of the unique challenges that nurses face in treating users of methamphetamine and why addressing it will require some unique policy changes.

Nurses know that the rapid increase in meth consumption has reached crisis levels in Manitoba. The impacts are ravaging many of our communities and putting significant strain on our health care system. It's time for the federal government to show leadership on this critical public health issue. I hope that some of the information I will provide today will help you make an informed decision towards action.

Let me begin by addressing the impacts on our emergency departments and mental health units. Unfortunately, emergency departments are often the only place that methamphetamine users can access treatment. Some arrive in distress, escorted by police and gripped by a drug that can change their behaviour at any moment. Others present freely, and while they can appear calm at the outset, erratic and violent behaviour can emerge in an instant. This is not only a danger to the patient. It's also a danger to the nurses, doctors and health care providers who provide care. It is also a danger to other patients in the facility, many of whom also need emergency care. They are forced to wait longer as resources are dedicated to patients suffering from meth-related psychosis and other symptoms. In Manitoba, we lack consistent security standards at our urban and rural facilities. Although ERs in Winnipeg hospitals have security guards, training and presence varies between facilities.

Health Sciences Centre has the strongest security presence, but the nurses there will tell you that security are often overwhelmed and have been told not to intervene by management. Rural facilities are left especially vulnerable. In Portage la Prairie, Virden, Thompson and many other communities, nurses are reporting a large increase in the number of meth-related presentations. These facilities typically have no security. Nurses are directed to call the RCMP, who are also stretched thin and are often unable to respond as quickly as they are needed. Too often we hear stories of nurses who have been punched, kicked and spit on, and the meth crisis has made this situation worse.

One nurse described intervening when a patient began choking a clerk who was simply there to restock supplies. The injury that the nurse suffered as a result limited her to light duties for the next several months. A nurse from Brandon told us, "I've had a patient take their IV out of their arm and try and stab me with it. We've found knives on people. We have had people destroy our rooms.... I did emergency medicine for eight years and the last three years we saw an increase in meth, and in the last year it's just exploded."

At HSC, nurses report seeing four to five patients per shift with meth-related issues. They used to see that many per month. Data released by the Winnipeg Regional Health Authority proves what nurses are telling us. Since 2013, there has been a 1,200% increase in the number of patients presenting to the ER under the influence of methamphetamine. The increase puts real pressure on nurses and other health care professionals. Often these patients require multiple people to observe or restrain them. One nurse told us that they've had to order more restraint supplies, that it takes a whole team of people —doctors, nurses, health care aides—and that all of the other patients are usually scared, too, which adds to the problem.

We know that the emergency departments are overcrowded. For some nurses, this crisis is pushing them to the breaking point and forcing them to think of leaving the profession or leaving units, such as emergency departments, that are increasingly focused on dealing with the drug. Chaotic environments often predicate violent incidences. The meth crisis has amplified this issue for nurses, but there are broader factors to consider as well.

I applaud the health committee for launching a study into security and violence against health care workers, and particularly Dr. Eyolfson from Winnipeg for championing this issue. This study is an important step forward, which I hope will lead to federal investment in security services at health facilities.

● (0850)

The meth issue goes much further than our emergency departments. Infection control is a concern. Addiction often hinders patients from getting treatment before the problem becomes acute. We know that many users inject the drug intravenously, which can lead to infections in their heart valves that require surgery.

I tell you these stories with reservation. We must not allow these patients to be stereotyped or stigmatized. They are suffering from a terrible illness. As nurses, we want our patients to get the care they need, first and foremost.

We see broader social factors at play, as well. One nurse described the struggle by saying that there aren't enough recovery programs out there. She said that 95% of patients who come in with a meth-related complaint are observed until they're capable of walking out the door and then discharged. For these nurses and for all of us, it's heartbreaking that we can't provide more care for these people.

Public housing and poverty reduction must be part of the solution to this crisis. The province has stalled on building more social housing units. The federal government's support and leadership on this file is desperately needed.

Meth is impacting all communities, and users are presenting from all walks of life. A public health nurse who works in our wealthier suburban communities, such as River East and Transcona, told me that she has seen a dramatic rise in meth use. A nurse in Portage la Prairie told me, “It's all races, all ages. Even the people that you least suspect who drive the fanciest vehicles, who have the best jobs, they are even trying it. It's a problem.”

Some users don't realize what they're taking. Recently a group of nurses doing harm reduction by testing drugs at parties reported that they hadn't seen a positive cocaine test since the summer. People thought they were taking cocaine, but 90% of it was actually meth.

What's the solution?

Harm reduction is a critical part. Ensuring access to clean needles is important. We need to ensure access beyond business hours. Safe injection sites can also reduce the risk of infection.

We also need treatment spaces for those suffering from addiction. The Manitoba Nurses Union is a strong supporter of the Bruce Oake recovery centre, which is a long-term treatment centre being established in west Winnipeg. At our last annual general meeting, we raised $30,000 for the centre. However, even Scott and Anne Oake will tell you that this centre won't be enough to meet demand. They are a private foundation inherently dealing with limited resources.

That's why we need the federal government to step up its support to combat this crisis. We need the resources to respond. Reducing the health transfer payments from 6% to 3% was a serious mistake. Targeted mental health funding is welcome, but the current level is simply inadequate and the situation is getting worse.

In Manitoba, our addiction and health care programs and mental health programs are overwhelmed with demand. Emergency departments and addiction programs need more support to deal with the unique challenge of meth use.

Nurses have suggested dedicated facilities and programs for users of meth. Patients need a place where they will be safe when coming off the drug, and then they need access to a recovery program.

Finally, we do need federal support for security. We need dedicated, adequately trained personnel in our cities' hospitals and enhanced services rurally. Patients and their caregivers need to be kept safe, so that we can focus on treatment. Unfortunately, the longer we wait, the higher the risk that one of these violent situations will result in a more serious injury than what we've seen.

In Manitoba, the provincial government is imposing significant health cuts, including the closure of three emergency rooms in Winnipeg. To date, they have failed to offer a significant response to this crisis.

In contrast, there is an opportunity for the federal government to take leadership by offering real support and resources earmarked for addictions, mental health and security.

Thank you. I am pleased to answer any question the committee may have.

● (0855)

**The Vice-Chair (Ms. Marilyn Gladu):** Thank you.

Now we'll go to James Favel, from the Bear Clan Patrol. He's the Executive Director.

Welcome.

**Mr. James Favel (Executive Director, Bear Clan Patrol Inc.):** Good morning, ladies and gentlemen. On behalf of Bear Clan Patrol Inc., and our board of directors, thank you for welcoming our voice into your house.

Bear Clan Patrol is a community-based, volunteer-driven safety patrol. Our mandate is to protect and empower the women, children, elderly and vulnerable members of our community. We do this non-violently, without judgment, and in harmony with the communities we serve.

This second coming of Bear Clan Patrol began in September 2014 in the wake of the death of Tina Fontaine, a young girl that was exploited and murdered while in the care of Manitoba's child welfare system. Our goal at the time was to interrupt the patterns of exploitation in our community to ensure that what happened to Tina would not happen to anyone else ever again.

Our role in the community has evolved, however, to include many new ways to support our community. Today's Bear Clan Patrol is active five and six nights a week doing 11 and 12 patrols per week respectively. We are active in three distinct inner-city communities in Winnipeg, and our footprint keeps growing.

Our model has been shared with communities locally, nationally and internationally. Our volunteer base has grown from 12 volunteers in 2014 to nearly 1,500 Winnipeg-based volunteers today.

So far this year, we have provided more than 30,000 hours of service to Winnipeg's inner city. We act as mentor, first responder, janitor and liaison between the community and service providers. We bring a sense of belonging and connectedness to our community members, and moreover, we provide an opportunity for our marginalized community members to step out of that role into the role of stakeholder. Amazing things can be accomplished by people with purpose, and we try to provide that purpose.

We have seen many positive outcomes as a result of our efforts, but in spite of our best efforts, we still feel the pain of loss. Even within our own ranks in the month of August of this year, we lost two of our own. Not strangers, not casual acquaintances, but two of our own Bear Clan family members were lost to addiction and overdose. Methamphetamine did play a role in both of those tragedies.

On the subject of meth abuse in Canada, I have travelled extensively in Manitoba, and to a few locations nationally. I have seen first-hand the increased rates of consumption, the increase in the level of destruction, and havoc wreaked in the lives of all of our community members. There is not one person I know that is untouched by this epidemic. The effects are being felt outside of the inner city these days, and without appropriate supports, it's only going to get worse.

In our travels through the streets of Winnipeg this year, we have recovered approximately 40,000 used syringes. We have seen a tenfold increase in the recovery of needles, year on year since our inception in 2015, from 18 syringes in 2015 to 40,000 in 2018.

We deal on a daily basis with community members in the throes of addiction, people experiencing meth psychosis, and an increase in violent crime and property crime. We're daily seeing more vulnerable people, and supports are just not keeping up.

There have been some new resources made available in Manitoba with the recent opening of rapid access addiction medicine, or RAAM, clinics. This started up at the end of August of this year. These clinics provide services to addicts on a walk-in basis, which is good, and we have referred many community members already. The only problem is that they operate two hours a day, five days a week. Given the scope and urgency surrounding the meth epidemic and the simultaneous opioid crisis that our communities are facing, those hours are terribly underwhelming.

Our patrols are conducted in the evening after most service providers are gone home for the day. When we come across people in crisis, there are very few options for us to offer. Typically, police or ambulance do a wellness check. Our main street project provides only the most basic services, essentially three hots and a cot. Even there, community members experiencing meth psychosis are not welcome because of the associated violence.

There are many things we need in our communities if we're going to make it through this epidemic. We need reliable access to resources in a timely fashion. Community development is not done nine to five, Monday to Friday. There needs to be a greater commitment. We need mental health supports to be more readily available. We need greater access to emergency shelters space. We need access to more affordable housing.

A community constantly existing in crisis mode is a community prone to all sorts of social abuses. I'm sure it's no surprise when I tell you that the biggest issue we keep coming up against is the blinding poverty that affects us and so many other communities around the nation. The poverty and disconnectedness in our community triggers addiction in our community members. That addiction feeds the random violence, feeds the rampant poverty, property crime, and it self-perpetuates: street, hospital, prison, repeat.

Safe consumption sites, needle exchange programs, 12-step programs, treatment opportunities, these are all good things, but if you're hungry or you woke up on a friend's couch that's another challenge. If you can't afford transportation to and from programming, job interviews, doctors' appointments, and even banks and shopping centres, these are beyond the reach of many of our community members.

● (0900)

If those underlying issues related to poverty are not addressed, there will be no meaningful progress. If poverty alleviation is not part of whatever strategy we employ, we are not going to get anywhere.

For the record, it is easier to get bongs and crack pipes in my community than it is to get good and healthy food, and by that I mean we have two chain stores in our community that sell produce and wholesome foods, but we have two dozen stores or more that sell bongs and pipes in our community. The store at the corner of my street even sells the Brillo piece by piece to feed that. This is a problem.

For our part, we have begun to collect and distribute produce and baked goods directly to community members. Last year we did 21 tonnes. This year we've done 55 tonnes so far, and I fully expect we'll deliver 60 tonnes by the end of the year. Last year we provided $35,000 in temporary work placements through our volunteer base. This year we did more like $90,000 in temporary work placements. We're very proud of these stats but, sadly, we're only scratching the surface. The need in our communities far outweighs our capacity to provide currently. It's time to change the way we value people. It's time for us to start working together in a much more meaningful and collaborative way. There needs to be a real shift in our thinking and it needs to happen now.

**The Vice-Chair (Ms. Marilyn Gladu):** Thank you very much.

Now we're going to go to Sarah Blyth, the Executive Director of the Overdose Prevention Society, for 10 minutes.

**Ms. Sarah Blyth (Executive Director, Overdose Prevention Society):** Thank you, Madam Chair.

Thank you for having me here today.

I want to start with a personal story about going to California in the nineties to work and living with a bunch of young people. Lots of people went to school. Everybody had jobs in the sports, entertainment and music industries, and everybody was using meth and speed in order to get through school and the pressures of working all the time.

I think what had happened was that it just became so common and so easy. Now all across the States people are using crystal meth, and it actually just recently came here. It's actually quite easy to access in the schools, as well, these days. My son's in school, and he says drugs are just so easy for young people to get access to that it's incredible. Also, it's not surprising that if young people are using drugs, they would use them later on in life.

I'm the executive director of the Overdose Prevention Society, located in the Downtown Eastside of Vancouver. Our facility includes an outdoor smoking area that seats 13 people, and it's one of only two in Canada. We also have an indoor area that seats 13 people, which is an injection area. We see up to about 700 people a day at our site.

We're located in one of the two alleys that are most used by drug users in Canada. It's one of the busiest sites. It's on par with InSite right now.

At our site, no one's ever died. Around half of our participants use crystal meth now. Many use it in conjunction with heroin and fentanyl, including speedballs, which are both at the same time.

The reason people use crystal meth is that obviously it takes away some of the pain and suffering, but it's cheap and lasts longer than most other drugs. In the Downtown Eastside, many of the drug users are most regularly using what's cheapest and easiest to attain, and crystal meth is definitely one of those.

People who use stimulant drugs like meth and cocaine are also at risk of overdose from fentanyl and other contaminants. Safe supply means pharmaceutical-grade stimulants that are easily accessible to people. Therefore, getting people safe access to drugs that include crystal meth would probably be one of the better things you could do just in terms of a stimulant that's not going to be contaminated with everything under the sun. A lot of the behaviours and illnesses people are experiencing are from the contamination.

They use laundry detergent and pig dewormer. There's fentanyl in the crystal meth. There's everything you could possibly imagine, and we have no idea how some of these affect behaviour or even people's livers. The long-term health effects of that are just incredible.

It's really in the Downtown Eastside, especially, that everything's made out of garbage. Anything you can imagine is in there, and it's really quite horrible. We know that, because we test the drugs. We do testing of drugs and we can test up to, I think, 100,000 different things, so we can see that they're highly contaminated.

We see people who have been awake for days quite frequently. This can lead to psychosis, paranoia, violence, hallucinations and hospitalization. Unfortunately, hospitals don't have the capacity to deal with this.

The other night we brought in a woman who's homeless and who uses our site frequently. She also volunteers with us. She uses a combination of drugs. It took one of our volunteers four hours waiting at the hospital for her to get in, and she was released immediately untreated and came back to us. I've been down there working for 12 years, so I'm capable of helping people in these situations, but it's really challenging.

● (0905)

It's really difficult that the hospital system can't accommodate it. It's just overwhelmed with other situations, including the overdose crisis in general.

Recommendations to improve health outcomes for drug users would be safe alternative prescriptions with known potency and ingredients, safe harm reduction supplies, safe smoking sites... People are turning to shooting drugs because there's no place to be seen safely using smoked drugs, so they're injecting them or just learning to inject them. It's really important that we give people a safe smoking area, which in B.C.... Actually in Edmonton they have a state-of-the-art facility, which I don't think is necessary. You can have some of these as really basic pop-up services in the crisis that can help people immediately and are not that high a cost.

The truth is that the high cost is to continue on with these crises the way that they are, criminalizing people and having people do crime and survival sex trade, women putting themselves at risk. That's going to be the high cost for Canada in the long term. Really what is needed is to do the right thing by giving people safe places to use, treated by professionals, safe access to drugs that won't harm them or cause damage to them. It will reduce crime, all these things that I think would be really important.

Rehabilitation includes a safe supply and detox that includes safe drug alternatives, getting people onto something that's not going to hurt them long term. There are a lot of people who we see who have mental and physical health conditions, permanent conditions that are really painful, like terminal cancer, who may need something for the rest of their life. They're self-medicating with things that are going to hurt them and actually make things worse for them. We really need to figure out how to help these folks. There are a lot of simple ways of doing it.

Thank you.

● (0910)

**The Vice-Chair (Ms. Marilyn Gladu):** Thanks very much.

We're now going to the Pine River Institute. We'll start with Vaughan Dowie for 10 minutes.

**Mr. Vaughan Dowie (Chief Executive Officer, Pine River Institute):** Thank you, and we'd like to thank the committee for the invitation.

My name is Vaughan Dowie. I'm the CEO of Pine River Institute. I'm here with my colleague Dr. Victoria Creighton, who is our Clinical Director.

We thought that the best contribution we could make to the committee's deliberations is to talk to you about the importance of adolescent treatment services, particularly residential treatment for youth in need of service for addictive behaviours. To provide you with context, let me tell you a bit about Pine River Institute.

Pine River Institute is a residential treatment program for adolescents with addictive behaviours and, frequently, other mental health concerns. We serve a population of adolescents between the ages of 13 and 19. We are mandated to accept both girls and boys from across Ontario. Our main campus is located just outside of Shelburne, Ontario, about 100 kilometres northwest of Toronto. We operate 36 beds, 29 of which are funded by the Ontario Ministry of Health and Long-Term Care. For those 29 beds, we have a wait-list of more than 200 youths.

Our program is unique in Canada. All our students begin with the wilderness phase of the program, either in Muskoka or Haliburton, depending on the time of year. We're now in the Haliburton time of year. They then move to our campus. After a time there, they spend increasing amounts of time back in their home communities to practise what they learned in the program.

After transition from the residential program, we offer aftercare support. Our program works not only with the youth. Family involvement in the program is a requirement of admission. We require our families to be engaged in the program through workshops, retreats and regular parent groups over and above the work they will do with their child.

Pine River is involved in ongoing research. In particular, since our inception 12 years ago, we've invested in ongoing outcome research. We track a number of indicators, particularly those involved with substance use, school or workplace engagement, contact with the legal system, hospitalizations and other crisis indicators such as running away. We track these indicators pre-admission and after discharge and every year thereafter until the youth turns 25 to measure whether the change that takes place is maintained. We publish these results annually as a way to inform our funders, potential clients and other stakeholders of our outcomes. I have brought a few copies of the most recent report with me if anybody would like a copy.

Pine River's clinical philosophy centres on trying to increase the maturity of the youth who we see. We believe that the youth in the program have delays in maturity. This can be caused by trauma or other obstacles. We define maturity to include a future orientation; a social ethic; emotional regulation; the ability to be autonomous and not be part of a puppet relationship, either as a puppet or as a puppeteer; empathy; plus, a lack of narcissism. Often these elements are also described in some literature as part of “healthy emotional intelligence”.

The Pine River program has a variable length of stay. By that, I mean that unlike other programs in the sector with a fixed time for treatment—21 days, 90 days, four months, whatever—we allow our students to complete the treatment at their own pace. Our average length of stay is about 14 months.

As for substance use, the majority of our students are polysubstance users. They will use whatever is available. We do ask about the drug of choice. The number one drug of choice is cannabis, but of interest to this committee for the purposes of this hearing, we ask parents prior to admission what substances the youth is using, and the results for methamphetamine were the following.

In 2015, 2% of our parents reported meth use for their child. In 2016, again it was 2%. In 2017, it was 5%, and in 2018, it was 16%. Contrast that to our students' self-report of what they are actually using: in 2015, it was 18% for meth use; in 2016, 53% reported meth use; in 2017, the number was 22%; and, so far this year, we're at 16%.

We take from that a couple of conclusions. First, generally speaking, the use of methamphetamine has been much greater than suspected, even by parents who are really concerned about the behaviour or the habits of their kid. Second, while the numbers seem to fluctuate with our clientele, it's a significant factor in the drugs they choose to use.

As the committee tries to integrate the various perspectives regarding the issues that arise out of methamphetamine use in Canada, here are the take-aways we'd like to leave with the committee.

One, it is imperative to invest in services for young people in order to address the underlying issues as soon as possible. Not only is it the right thing to do, but it makes good economic sense.

● (0915)

We work with the DeGroote School of Business at McMaster University to look at the social return on the investment made in the youth in our program as a result of government funding. The answer was somewhere between seven and 10 times return on investment. I've also brought copies of that report if anybody would like to have it.

There needs to be a significant expansion of accredited residential resources aimed at youth. Our waiting list of over 200 speaks eloquently about the lack of quality resources for youth in this age group. Very often, governments hesitate to invest in residential programs because it's the most expensive end of the continuum, but working with youth who are abusing substances is so important because, as time goes on, the problems become more ingrained, thereby making change in their lives and brains more difficult. This approach is as important—if not more so—for methamphetamine as for any other substance.

Public education should always be a component of any substance use approach and should provide real and believable information about the impact of the substance to young people. Otherwise, we rely on word of mouth and bad information that often minimizes potential harms.

We commend the committee for its interest in this important subject. The complexities of the issues that are linked to meth use and abuse require a multi-faceted response. Within that response, we ask the committee to remember the need for effective youth treatment services as part of our national approach.

**The Vice-Chair (Ms. Marilyn Gladu):** Thank you.

Now we'll go to our first round of questioning. We're going to start with my colleague, Robert-Falcon Ouellette, for seven minutes.

**Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.):** Thank you very much, everyone, for coming here today. I really appreciate it.

We only have seven minutes. I have a number of short questions I'd like to ask each and every one of you.

James, I was wondering if you could discuss a little bit more the “street, hospital, prison, repeat” cycle that you were talking about. As well, I'd like you to discuss the stores that sell more crack pipes, the only two grocery stores in a certain radius, and what that does to an environment and how people access quality food.

**Mr. James Favel:** We're living in a food desert in our community, and one of the biggest problems that we're having is with the corner stores that we have in our community. Everything is overpriced there, and you can't get really good, wholesome food in those stores. Crack pipes, bongs, papers and all that kind of stuff are all there, but the food is not. There's a Safeway, and there's a Sobeys cash and carry in our community. Those are the only stores accessible inside our community limits. The Sobeys cash and carry is kind of off in a corner that is hard to get to for most community members.

Sorry, what was the other question?

**Mr. Robert-Falcon Ouellette:** Street, hospital, prison, repeat....

**Mr. James Favel:** Right. That's what we're seeing. We're seeing our community members come out of prison, get back into the addiction, get caught up in trouble, go to the hospital and go to prison. It just keeps happening over and over again. We have two volunteers currently who are going through that right now. Last night, I was dealing with it until three o'clock in the morning.

**Mr. Robert-Falcon Ouellette:** Are you saying that there's not enough support when people are actually released from prison?

**Mr. James Favel:** There's not enough support when people are released from prison. The EIA system is kind of punitive. In our community, it's about $100 per month for food for people coming out and need that service. If you're coming out of prison and you're given $97 a month to survive, it's not going to bear positive results.

**Mr. Robert-Falcon Ouellette:** Thank you very much, James.

Darlene, I have a few questions here. You mentioned that nurses have suggested a dedicated place for users. Can you discuss that a little more?

**Ms. Darlene Jackson:** I think what we recognize is that meth is a different drug than opioids. It is incredibly addictive, it is incredibly accessible and it is inexpensive. We understand that the treatment for someone struggling with a meth addiction is going to have to be totally different from someone with a different addiction. It needs to be long term. I can certainly respond to James when he speaks about the RAAM clinics, the rapid access clinics. I think they're a wonderful idea. However, two hours per day is not adequate.

I've worked in emergency. I've worked in health care for years, and it's like anything else. When someone who has an addiction makes the decision that they want to make a change in their life, it has to happen there. You can't say to them, "I can have a treatment bed for you in three months" because then they're back out on the street, and they've lost that need for change. We need to be very proactive. We need to be ready. When that client is ready, when that patient is ready, we need to be there for them to provide that care. It needs to be long term, and there needs to be support after treatment to ensure that they maintain.

● (0920)

**Mr. Robert-Falcon Ouellette:** In the emergency wards, because there are meth addiction issues—you said four to five a day—what does that cause for the users, or other patients, who want to go to that facility, for children and others who might want to go down to the Health Sciences Centre or any other health care emergency ward?

**Ms. Darlene Jackson:** Our emergency departments have been closed. We've lost two and we're going to lose a third one, which is going to mean our city has three access points for emergency.

One issue we've identified is that the Health Sciences Centre is in the core of the city. Many residents who live in that core area do not have access to a taxi or a bus to get to an urgent care facility or a walk-in clinic.

Despite the fact that our government and our regional health authority in Winnipeg says, "The right care at the right time in the right place", the bottom line is that many of our individuals who live in those areas don't have access to the right care. They have no way to get there. They go to the closest facility, which is our Health Sciences Centre, because they have no choice. There's nowhere else for them to go. To take a cab to Victoria General Hospital is absolutely out of their range of income.

Saying that you need to be at the right place at the right time for the right care is a platitude. It doesn't work for the communities in that area. I think part of the issue is that many of our patients who present with a meth-related issue are volatile. Things can change. On the spin of a quarter, their whole demeanour changes. Often they need a lot of resources to ensure they're safe and to ensure care providers and other patients are safe, which means that the wait for other patients in our emergency departments is longer.

**Mr. Robert-Falcon Ouellette:** Thank you very much, Darlene.

I have two final questions: one for Sarah, and one again for Darlene.

You talked about training. I was wondering if you could, in about 30 seconds, discuss the idea of training for nurses and other health care professionals, and how it needs to be increased.

Also, I'd like Sarah to discuss self-medication for pain, and pharmaceuticals and how people obtain legal pharmaceuticals versus illegal drugs.

You have 30 seconds each.

**Ms. Darlene Jackson:** I'll try to be brief. Brevity would be my friend.

I think we definitely need to look at specific training for meth-related issues for hospital personnel, and that is much bigger than violence prevention. We need to talk about how to safely protect yourself and your other patients and families. That's a big issue, because our government and our employers have not invested in that. As one nurse said, "We didn't learn how to deal with meth in school, and we have no way of learning how to deal with it now, unless someone takes the time to teach us."

**Mr. Robert-Falcon Ouellette:** Sarah.

**Ms. Sarah Blyth:** We have a place called the Crosstown Clinic in Vancouver. Probably no one has heard about it, except maybe Don and a few others. It gives safe access to heroin to about 100 people. It's injectable, and there are doctors available there to help them. It's a very small program, and it's shown that people using that program every day gets them back to sort of a normal life.

Having that for stimulants would probably be really great. I mean, it would be a great idea, because getting people using stimulants when they know what their dose is.... A lot of times, people don't know what the dose is, so if they take a stimulant, we don't know how strong it is. If they take a really strong stimulant, don't know what the dose is and don't know what's in it, it is more likely they're going to have a psychotic episode or go into psychosis immediately, especially if they're injecting.

● (0925)

**The Vice-Chair (Ms. Marilyn Gladu):** I have to cut you off. That's your time.

Now we're going to go my colleague, Ben Lobb.

**Mr. Ben Lobb (Huron—Bruce, CPC):** Thanks very much.

The first question I'd like to ask is this. There was a recent case in Ontario where a 27-year-old was charged with trafficking many drugs. Some of the stuff he had was 316 grams of meth, 149 grams of heroin, 5.6 kilograms of cocaine and 8.1 kilograms of marijuana. The Crown attorney's proposing a six- to eight-year sentence. His lawyer thinks a five-year sentence would be appropriate for this drug dealer.

I know you're not here to give opinions on the legal system, but my point is that 316 grams of meth is 316 doses of meth. He's wrecking tens if not hundreds of lives, potentially, and costing the system tens of millions of dollars—maybe hundreds of millions of dollars—and his sentence, potentially, could be five years. Is that right, or do we need to look at that as well?

**Ms. Sarah Blyth:** In my opinion, the more people we get safe access to drugs, the more we're taking people like him out of the picture completely. We need people to get safe access to dosed drugs and to be seen and cared for by medical professionals. I think that's really the biggest solution in terms of government. It's something that the government—

**Mr. Ben Lobb:** When you say "dosed drug", do you mean a dose of crystal meth?

**Ms. Sarah Blyth:** Yes, or a stimulant replacement.

People need to get care. Some choose to use drugs, but a lot of folks are using drugs because they're self-medicating for a variety of reasons and they need medical care. A lot of these people are the most vulnerable in society. We need to work on doing something that we haven't done before.

**Mr. Ben Lobb:** Okay.

Mr. Dowie, I'm from Ontario and not too far from Shelburne. With regard to the 28 or 29 beds you have at your facility that OHIP or the local health network pays for, can someone come into your facility to an OHIP bed if they're on methadone?

**Mr. Vaughan Dowie:** It's no to methadone but yes to Suboxone, and the reason is relatively easy. As I said, we start people off in the wilderness program. In Ontario, to be able to administer methadone, you have to be a member of a health college, whether that be as a physician, a nurse, a pharmacist or whatever. Our staff in the woods, because they're in the woods, aren't able to do that. They're not members of the college so they're not able to safely administer methadone. They can't go to the local pharmacy, because—

**Mr. Ben Lobb:** Suboxone is similar—I'm not a pharmacist—but not exactly the same. Is that right?

**Mr. Vaughan Dowie:** You could administer it. It's a pill, basically, to be administered. You don't need to be a member of a health profession to do so.

**Mr. Ben Lobb:** Then why don't the doctors prescribe Suboxone instead of methadone to people?

**Mr. Vaughan Dowie:** I can't answer that. I think there's a shift going on now. There's a little less methadone being prescribed and a little more Suboxone being prescribed.

**Mr. Ben Lobb:** It's seems a little unethical. We've had a number of people come through our office and they have no money. Their parents have spent their retirement trying to help these people out, and they can't get access.

I'm not being critical of you. I'm kind of being critical of the government or the doctors who shouldn't be prescribing this. They should be helping their patients so that they can get an OHIP bed—if they can actually get an OHIP bed.

**Mr. Vaughan Dowie:** In a lot of metropolitan areas, going to a methadone clinic or whatever is no more of a hardship than anything else. You can go to the pharmacist and get your methadone there. We're an outlier in that we're in the woods, so we're not able to safely administer it.

● (0930)

**Mr. Ben Lobb:** What about the cost of a bed? I read an article in regard to London and Windsor in Ontario that said that 20 beds could cost $5 million to $15 million. Now, how could there be such a range for that? Amongst the industry, what is the cost of a bed?

**Mr. Vaughan Dowie:** Like a lot of things in life, it depends. For us the cost of a hospital bed is about $460 a day. What we get from the government is really about $412. That gives us about $4.3 million for the 29 beds. It depends on your staffing model and how it is done. For instance, we are more clinically intense than other programs in that we have more therapists involved, so it's a little more expensive.

As for what goes into the hospital bed, those are your labour costs, your facility costs, your food costs and all the other things that go into it. Your staffing model is an important element in that. I would say that the cost of a youth bed in Ontario, which is all I can talk about with any certainty, is probably somewhere between $300 and $450 a day.

**Mr. Ben Lobb:** Mr. Falcon Ouellette and I used to have an apartment in the same complex downtown. In the downtown here—I'm sure Mr. Falcon Ouellette has seen the same thing—there are three shelters, and I'm not being critical of the shelters when I say that they are the epicentres of social issues. Just in my time down there, I've seen people shooting up on the staircase of my condo where you enter. I've seen people pass out and crack their forehead wide open. I've seen a multitude of things, as many probably have in their own communities.

What I can't understand is that there is a non-stop flow of the fire department, the ambulance, EMS vehicles and police officers. It is just a continuous circle. I think to myself, if your cost is approximately $4 million a year, why would the provincial or federal government not partner with the city and put 200 beds in? The cost of the policing and the EMS has to be 10 times, even 100 times that.

Where is the disconnect here between governments and people who actually know what they're doing?

**Mr. Vaughan Dowie:** I will answer really quickly.

As I said, we have a social return on investment study. We're able to show that for every dollar the government invests in our program or in youth treatment generally, they are going to get a ten-time return.

Why is it that people don't do that math? I would say it's probably because government thinks really short term, one mandate at a time, and these are multi-mandate payoffs. I think that's part of what goes into the equation.

**The Vice-Chair (Ms. Marilyn Gladu):** That's your time.

Now we will go to Mr. Davies, for seven minutes.

**Mr. Don Davies (Vancouver Kingsway, NDP):** Thank you, Madam Chair.

Thank you all for being here. I can tell that your front-line experience dealing with the full gamut of substance use and addiction is powerful and something that this committee really needs.

I'm going to do something a little bit different.

You have all answered all the questions I had by describing very accurately what the roots of the problems are, so I'm going to pick up on something that was said. I think Ms. Blyth said the words "doing something we haven't done", and someone else mentioned that we need a fundamental policy shift.

Here are the answers I heard you give that I was going to ask, but it's redundant now.

I heard that there is widespread contamination of drug supply across this country. I have numbers and figures. It was 39% of the drugs tested recently in British Columbia that were not at all what the person purchasing the drugs thought they were. I heard Ms. Jackson say that cocaine is actually meth, so we know there's widespread contamination.

We know that there is—let's just call it what it is—grossly inadequate access to timely treatment in this country across the board, every modality, every population, from indigenous people to women to young people. Whether you're dealing with alcohol all the way to heroin, people can't get access when they need it. If there's one thing we know about addiction, it's that when a person is ready to seek treatment—if they are ever ready to seek treatment—you have to get them in now or it's a death sentence.

I think, Mr. Favel, you described this endless cycle, this 19th-century approach to drug use and addiction, treating it as a criminal issue as opposed to a health issue.

I'm going to get right to what I think are some of the foundational solutions and get your opinion on this.

To each one of you, isn't it time that we stop treating drug use and addiction as a criminal issue and start dealing with it as a health issue?

● (0935)

**Mr. James Favel:** It's what I've been saying for years already.

**Mr. Don Davies:** Thanks.

Ms. Jackson.

**Ms. Darlene Jackson:** Although the Manitoba Nurses Union does not have a position on decriminalization, our nurses believe that we need to treat. We need to be there to provide treatment and get patients healthy. Putting them in jail doesn't solve that issue.

**Mr. Don Davies:** Ms. Blyth.

**Ms. Sarah Blyth:** I see people in and out of jail all the time. Even the police I speak to, the ambulance people, the firefighters, all know that we need to get folks safe access to something that's not going to kill them. That's the first line of front-line treatment, especially with people who have been addicted for many, many years. They need someone to come to. Organizations like our overdose prevention site is the first line of recovery. They need people to help them.

I guess that's all I have to say about that.

**Mr. Don Davies:** Mr. Dowie or Ms. Creighton.

**Dr. Victoria Creighton (Clinical Director, Pine River Institute):** I would just say that treatment does work. It works when you work with the family, you work within the community and you focus beyond the symptom, when you really look at the underlying yearnings that a child has. It does bring about change. They will have a life worth living.

**Mr. Don Davies:** Mr. Dowie or Ms. Creighton, what is the current wait-list?

I think you had the number of people. What's the current wait-list for government-subsidized beds at Pine River Institute for young people?

**Mr. Vaughan Dowie:** It's 200 youth, about a year and a half wait.

**Mr. Don Davies:** I'm a parent. I have a 14-year-old kid who's on crystal meth. I come to you and I say my child needs treatment. You tell me come back in a year and a half.

**Mr. Vaughan Dowie:** I would tell you that we will put you on a wait-list and that you should be looking somewhere else.

We don't encourage people to wait in the absence of service. We say that we will put you on a wait-list but you should be trying other options.

**Mr. Don Davies:** Okay.

My next question is that if we're treating addiction and substance use disorder as a health issue, our health care system certainly isn't treating it that way. If I need a cardiac operation and I need it next week, and you said come back in a year and a half, we wouldn't accept that, but we do with substance use.

Is it time that we need substantial—I'm going to say "massive"—public investment in treatment facilities in this country?

**Mr. James Favel:** Absolutely, we are in a really bad spot right now. If things don't change quickly, we're going to be overrun by this. Right now it's only four years in and we can still change things.

**Mr. Don Davies:** I'll come this way, because you're running a treatment centre, Mr. Dowie.

**Mr. Vaughan Dowie:** Absolutely, the need grossly outstrips the capacity, and governments need to invest. I agree that “massive” is the right word.

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

Ms. Blyth.

**Ms. Sarah Blyth:** I believe that it's going to cost our country a lot more if we continue the way we are going right now, and that we need to do something we haven't done before. This is a national health crisis. We need to call it that and move forward in a big way, or else we're in big trouble.

**Mr. Don Davies:** Ms. Jackson.

**Ms. Darlene Jackson:** I'm going to tell you a fast story, and I know I'm not always fast. I talked to a nurse from the neonatal intensive care unit, where they're seeing many babies coming from addicted moms, and what she was telling me is that women with addictions will get pregnant to jump the queue to get into a treatment bed. We are in desperate need of treatment beds.

**Mr. Don Davies:** Ms. Blyth, quickly, your overdose prevention site, is it operating legally or illegally in this country right now?

**Ms. Sarah Blyth:** It's operating under the basis that it's a provincial crisis. We don't have a federal exemption, but it is operating because of the provincial crisis.

● (0940)

**Mr. Don Davies:** Do you get any federal funding?

**Ms. Sarah Blyth:** No, we don't.

I've been working in shelters in the Downtown Eastside for years, in housing. Dealing with folks who come in who are in crisis, our staff is some of the best. We have people from InSite, but it can be very difficult and we certainly don't have the support we need. We could use some federal support just being a centre for folks so they don't have to go to the hospital; they can come to us. We could use additional help.

I agree with you that there needs to be a place that's separate for drug users to get the help they need, with nurses and also staff who are trained to help people in mental health crisis.

**The Vice-Chair (Ms. Marilyn Gladu):** All right.

We'll go to Mr. Eyolfson for seven minutes.

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

Thank you all for coming.

Ms. Jackson, thank you for your kind words on the violence study. I'd like to pass on my thanks to Sandi Mowat, your predecessor, for helping to champion this issue.

As you know, I was an emergency doctor for 20 years, the last eight years at the Health Sciences Centre.

I have a number of questions about all of this. You put something out that was quite a good observation that I think the public needs to understand. You talked about nurses in different hospitals seeing it. Would you say this is something, particularly from the Winnipeg perspective, that you see in all neighbourhoods and all over the city?

**Ms. Darlene Jackson:** We're definitely seeing it in our emergency departments now. It's sort of changed the game, because Winnipeg no longer has a catchment area for ambulances, so if there's a client in the core area who's two blocks away from the Health Sciences Centre and an ambulance is called, they may be taken out to Concordia Hospital, which is on the other side of the city. There's no catchment area any longer. What used to be Health Science Centre's biggest issue is now turning into the biggest issue for all the facilities that provide emergency services.

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

You mentioned infection control. This is something we've dealt with. I've always been a champion for supervised consumption sites based on the issue of infection control. People say we shouldn't waste the money on this, but when hepatitis C costs $300,000 a year to treat and HIV costs about a million dollars over the life of the patient, all of a sudden the money seems well spent at that point.

Do you know if there's any information through the hospitals on their incidence of blood-borne diseases among the people who are having problems with meth, whether this population has incidences of hepatitis C and HIV?

Ms. Blyth, you might be able to help us out on that as well.

**Ms. Sarah Blyth:** I do know that you can pass it on with pipes, that clean pipes would be helpful. I don't know the statistics, but I know that clean pipes, clean equipment, clean needles, obviously, do the same thing.

**Mr. Doug Eyolfson:** All right.

Ms. Jackson.

**Ms. Darlene Jackson:** I don't have statistics for you but I do know that having a needle exchange program or providing safe injection sites, absolutely, there will be a cost, but it will be an efficiency and will save dollars in the end. When you have someone who's using meth, who's injecting and needs a valve replacement, that is a huge cost to the health care system. We do have individuals who have used for many years, who have had more than one valve replacement, so that is a huge cost to the system, but it's also a huge cost to our cardiac program.

We know that we're cancelling surgeries. We're short of beds and short of staff in that program. I believe that safe injection sites and needle exchanges, clean needles, absolutely will save dollars and save lives.

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

As you know, our current provincial government and I think the new provincial government in Ontario are actually very resistant to the concept of safe consumption sites. They claim that there isn't the need in Winnipeg for this. What would your response to that be?

**Ms. Darlene Jackson:** I speak to nurses. Those are the individuals I get information from, and I can tell them they are wrong. This is a crisis that is getting bigger every day. I have nurses who don't even want to go to work anymore. I actually had a nurse say to me, "I know every day when I go to work I'm going to be assaulted. I just pray it's a verbal assault and not a physical assault." I think this is a terrible shame. I think the government is burying their heads in the sand on this one.

● (0945)

**Mr. Doug Eyolfson:** Thank you. I agree about the consequences of assault. I was assaulted twice in my emergency career and it tends to shake one up and make one a little hesitant to go back to work.

Ms. Blyth.

**Ms. Sarah Blyth:** I just want to say that we are trained, and I've been trained, over time, in bringing down violence. It can be done but you need the proper training for that. It's very difficult on nurses in that environment, I think.

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

Mr. Favel, what would your response be to the Manitoba government saying that they don't need safe injection sites in Winnipeg?

**Mr. James Favel:** I'd say they're wrong. As I said, we are seeing that the addicts are becoming younger and younger. We're seeing more and more of it. As I said, there's a tenfold increase in our community year on year, since we started. That's incredible. Last year we picked up 4,000 syringes, and I didn't believe that it was possible that we would find 40,000 syringes this year, and we've done that. The WRHA is scheduled to release 1.5 million needles into our community in the name of harm reduction. I'm all for harm reduction, but it needs to be holistic. It needs to take into consideration the needs of our community members as well. In the summertime, we have kids running barefoot through our communities and we're out there five and six nights a week making sure that they can do that safely. We can't keep up.

**Mr. Doug Eyolfson:** Absolutely. I can't imagine what that would be like. I grew up in Winnipeg and it's something we didn't used to see.

**Mr. James Favel:** In our first year we saw 18 syringes; the second year, 300; last year, 4,000; and this year, 40,000.

**Mr. Doug Eyolfson:** Wow.

Ms. Blyth, you work in a safe consumption site. I've never actually heard this from any peer-reviewed publication, but I hear comments from people. It's along the lines of "I went to one of these neighbourhoods and talked to someone who said", and there are claims that there are increases in crime and increases in drug use in the areas where these are set up. What's your response to that?

**Ms. Sarah Blyth:** The one that we set up is in one of the two most used alleys for drug use, and it had been before we set up. My response to that would be where people are using drugs, you would set one up there already, so that it doesn't have an impact on neighbourhoods. Also, we make sure that there are volunteers in the neighbourhood on a regular basis cleaning up needles in the alley that they're in, even though it had been scattered with needles in the past.

The great part is that for people who are injection users, we are discarding all of those needles there. A lot more could be on the streets, like buckets. There are buckets of them. We see 700 people a day, so we're making sure that those needles aren't in the street. It's a place for people to come inside who would otherwise be in the streets and alleys.

**The Vice-Chair (Ms. Marilyn Gladu):** Very good.

Now we'll go to Mr. Webber for five minutes.

**Mr. Len Webber (Calgary Confederation, CPC):** I was talking to Sarah just briefly earlier about my visit out to east-side Vancouver. I was in your neck of the woods. I've been down the alleys, and I've seen the needles everywhere and the devastation that was going on down there. I would recommend to any of you guys to check it out just to see the reality, which is overwhelming. It really is.

I was able to meet with Dr. Gabor Maté, an expert in addictions. He is an Order of Canada recipient who received his award because of the work that he does with addictions treatment. It was really an insightful weekend.

One thing I want to ask you, Sarah, about the tainted drugs or meth that is out there is if there is a way of testing methamphetamine to determine whether it's dangerous or not.

**Ms. Sarah Blyth:** Yes, we have a drug testing machine that comes in a few days a week, and then we can test all drugs that come in. I think it's like 100,000 drugs and other analogues including.... You would be shocked at what people inject into their bodies and that they don't know what strength they are taking. I think even the most conservative views on the issue, really, for safe drug supply, honestly.... When it comes down to really understanding it, that is really the biggest thing we need to do in order to stop crime, everything.

● (0950)

**Mr. Len Webber:** We need more access to test machines in order to determine....

**Ms. Sarah Blyth:** I don't know if any of the you know him, but Dr. Mark Tyndall from the B.C. Centre for Disease Control has a pilot project that he would like to bring that would make it easy for people to get safe access to heroin. I think that it should include stimulants as well, because people are using stimulants.

**Mr. Len Webber:** I have some questions on the needles that are out there. They are everywhere in East Hastings. They are distributed free by InSite. You can get safe needles anywhere in that area, yet we have diabetics out there who can't even afford needles, so they are reusing the needles they have. They don't have access to free needles, but it seems like drug addicts do.

For example, James, the 40,000 needles that you're finding, where are they getting them from? Are they buying them or are they...?

**Mr. James Favel:** Street Connections gives them out free. There needs to be a more stringent needle reclamation process for our communities. If they hand out 100 syringes, they should hand out a sharps container with that. I would much rather pick up hundreds of sharps containers rather than thousands and thousands of needles.

**Mr. Len Webber:** Right.

**Mr. James Favel:** We've also had a half a dozen of our volunteers pricked while doing that job. It's stressful.

**Mr. Len Webber:** I just don't understand why the diabetics don't get free needles as well.

**Mr. James Favel:** If they identify as an addict, they can get it for free.

**Ms. Sarah Blyth:** The main thing is disease prevention. It's cheaper to give people a needle than to have people go through all the treatments of hepatitis or HIV long term.

**Mr. Len Webber:** I have a quick question to Mr. Dowie or Ms. Creighton.

You talk about the costs of the bed, the $460 a day and the $412 you get from government. Who pays the remainder, the patient or the patient's family?

**Mr. Vaughan Dowie:** We do have some program fees that we ask for, though if somebody can't afford it, that's not a barrier to treatment. We have a foundation we work with. It could be knocking on your door next week asking you for money, so it's a little bit of footwork.

**Mr. Len Webber:** It's volunteers, okay.

James, is it all volunteer work at the Bear Clan Patrol?

**Mr. James Favel:** We have 1,500 Winnipeg-based volunteers and six full- and part-time staff.

**Mr. Len Webber:** Again, the resources for the paid staff, how do you get the money for that?

**Mr. James Favel:** For now we're getting most of our salary dollars through private donations. Just recently the province has come to the table and has given us a couple hundred thousand dollars, but that's all earmarked funds and it's not available for salaries. Even my salary is in jeopardy after January.

**Mr. Len Webber:** Naloxone is used as an antidote for fentanyl, but there is nothing for methamphetamine. The police down in East Hastings say that when they use naloxone on some of these patients who are overdosing, they come out of their drugged state and then become violent because they are angry. They are angry because of the fact that they have been taken off of their high when they worked so hard to get it.

Would that be one of the reasons people are migrating over to methamphetamines, because it's a long-lasting drug for them?

**Ms. Sarah Blyth:** Yes. In the Downtown Eastside there are a lot of people who use whatever is available and cheapest. I've done so many overdoses—you can't imagine—and I don't see people get up and be violent that way. People get upset. Sometimes they cry. They don't know what's happened to them.

It's all in who's standing there above them, whether they're gentle and kind to them, and reassuring. If you wake up and don't know where you are, and there's a police officer hanging over you, it might be a bit scary for some people.

I'm not really sure, but I can tell you it's all about how you approach the situation.

**The Vice-Chair (Ms. Marilyn Gladu):** Now we're going to go to Mr. McKinnon for five minutes.

● (0955)

**Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.):** Thanks, Madam Chair.

Ms. Blyth, you operate an overdose prevention site, not a safe consumption site. Is that correct?

**Ms. Sarah Blyth:** Yes. It's an overdose prevention site, but it is a safe consumption site. People can use drugs, and we observe them to make sure that if they overdose, they're rapidly responded to.

We started it because there were so many overdoses in front and in the alley where I was working.

**Mr. Ron McKinnon:** Is there a technical difference between the two designations?

**Ms. Sarah Blyth:** Not really, no.

**Mr. Ron McKinnon:** Where is it, exactly, that you operate?

**Ms. Sarah Blyth:** I operate in the alley in the Downtown Eastside. There are two alleys that are the most used by drug users. I was working at another social enterprise, and people were knocking on our back door.

**Mr. Ron McKinnon:** Is it near to InSite?

**Ms. Sarah Blyth:** It's about two blocks away.

**Mr. Ron McKinnon:** Does there need to be more of these kinds of sites in the Downtown Eastside or elsewhere in the Lower Mainland?

**Ms. Sarah Blyth:** Yes. They've just put one at St. Paul's Hospital, so that's really good. It would be great to have them in hospital areas, as well, where people can come and have.... They're very simple to operate.

We have drug users who take care of each other. They get paid to be volunteers and to help each other. It really works out well, because you're paying people and they have a routine. It actually helps them to get their life back. They're watching each other. They learn how to use Narcan and they can bring that back to their communities. It helps take the burden off the hospital staff in that the right people are dealing with those overdose crises.

Especially when they're having psychosis, I find that people in crisis are much more responsive to people they know from their own community and people they trust on a regular basis.

**Mr. Ron McKinnon:** Vancouver is seen as the epicentre for the opioid crisis, whereas Winnipeg is the epicentre for meth. Are you seeing a growth in the meth problem in Vancouver, or is there any kind of a shift from opioids to meth?

**Ms. Sarah Blyth:** There was a recent study showing it was on par, but I would say that about half of the people we see in the Downtown Eastside use meth to some degree.

**Mr. Ron McKinnon:** Is that an increase?

**Ms. Sarah Blyth:** Yes, it's an increase over the years.

**Mr. Ron McKinnon:** Do you see this becoming a crisis in this locality, similar to the crisis in Winnipeg?

**Ms. Sarah Blyth:** Yes.

Unfortunately, there are multiple crises going on right now with different drugs in general. More and more people are using drugs. Fentanyl can be in anything. We can test meth and find it in that. It's in crack cocaine. A lot of people smoke meth. When fentanyl is smoked, it seems to have an effect whereby the user drops immediately.

We really have to think about doing things much differently than we ever have in this crisis of all drugs. It will save taxpayers so much money in terms of ambulance rides and long-term health, if we just get people safe access.

They've proved it at Crosstown Clinic with their 100-people program. They're not doing survival sex trade all day. They're not doing survival drug dealing. You're removing the criminal element from it and the going to jail over and over again, just by giving people safe access to drugs. It's like giving people needles. They have people they can come to. You can do it in a low-barrier way.

I have a medication management licence. I can hold drugs and give them out to people. It would be very simple and very cheap, actually, to do it, if we just were able to do it legally.

**Mr. Ron McKinnon:** You said that we need to do something that we haven't done before.

Is this what you're talking about?

**Ms. Sarah Blyth:** In our safe injection site, if we were able to give the 700 people who come a day something that we know the dosage of and that we know isn't contaminated with pig dewormer, rat poison and all kinds of you can't imagine what. They're injecting it into them. It causes all kinds of problems.

When they start getting a clean supply of drugs, then we can start to work back to what the issues are. They can be issues of severe mental health or they can be issues of someone having an accident, cancer or any reason people get into using opiates or drugs in the first place.

● (1000)

**The Vice-Chair (Ms. Marilyn Gladu):** That's your time.

Now, we'll go to Mr. Lobb for five minutes.

**Mr. Ben Lobb:** Again, to Ms. Blyth, do the people coming into these injection sites bring their own drugs?

**Ms. Sarah Blyth:** Yes, they do.

**Mr. Ben Lobb:** Is there a way that you guys can test to see what...?

**Ms. Sarah Blyth:** Yes, we do.

We have a person who tests the drugs that come in.

**Mr. Ben Lobb:** If it's contaminated, do you discard it then? Is that the idea?

**Ms. Sarah Blyth:** No, not necessarily. They would just choose to use it. They might use a little bit at a time.

There's a lot of avoidance of overdoses just through their knowing how much is in there.

**Mr. Ben Lobb:** Would this test show that it had fentanyl in it or anything?

**Ms. Sarah Blyth:** Yes. Most of the drugs that are in the Downtown Eastside are fentanyl now.

**Mr. Ben Lobb:** Are they straight fentanyl or laced with fentanyl?

**Ms. Sarah Blyth:** They are fentanyl, laced with fentanyl or a combination.

Fentanyl is highly addictive, so if someone's taking.... Right now, what's popular with the kids is Xanax. It's super easy to get. They use it to pill press and they put fentanyl in it. All of a sudden, the kid's addicted to fentanyl and didn't even really know it. It's highly addictive, really awful to come off of and younger and younger people are....

When you're at that issue, you want to be helping these folks as soon as possible so that they're not using something that's highly—

**Mr. Ben Lobb:** If you said, “Whatever you have in this little package, I advise you not to take it,” what percentage of people would choose not to take it?

**Ms. Sarah Blyth:** It's a very low percentage. It would likely be that they use a smaller amount.

If you said, “This is high in fentanyl”, they'd be monitored and they would use a smaller amount at a time. We would advise them.

**Mr. Ben Lobb:** I ask Ms. Jackson or Mr. Favel: Is an emergency room the appropriate...? I'm not saying it is or it isn't. I'm just asking if the emergency room.... You talked about a RAAM clinic. It seems to me that maybe a hospital emergency room could possibly not be the right place to take people who are in this condition.

Is that accurate to say? Am I wrong in saying this?

**Ms. Darlene Jackson:** I think it's accurate to say, but unfortunately there's no other access point for these patients who are wrestling with this drug. We have no other options.

**Mr. Ben Lobb:** Should there be?

**Ms. Darlene Jackson:** I believe there should be. I think the RAAM clinics are a really good start. They've been started with our government, but at this point, they're not able to look after someone in a meth-induced psychosis. Those clients have to go to an emergency department to receive treatment. Then, hopefully, if the RAAM clinic's open and they're looking for treatment, we can get them into a RAAM clinic.

I believe that there are better options in emergencies, but right now they're not available.

**Mr. Ben Lobb:** It seems to me that part of what we've discussed in the past two meetings is the apparent scarcity and lack of resources to do many things. I look at the legalization of cannabis and I'm just wondering. Are governments wrong not to take 100% of that money and reinvest it in trying to fix all the social ills that are caused, maybe not by marijuana but everything else?

Hundreds of millions of dollars will be going into the system. Does anybody have a thought on that? Is this something where advocacy groups and governments should be saying, "Let's plow this into this, and not plow it into some other pet project"?

**Ms. Sarah Blyth:** I agree with you.

I think that we should be putting the money that we get toward.... Well, I think we don't put enough money in general into this crisis. It hasn't been a priority. It needs to be a priority. Yes, it would be great if we could get some money for treatment and for getting people onto safe drugs, including cannabis.

Cannabis actually has been seen to be an option for pain relief for some people. There are a lot of people who know they have addiction issues with respect to opiates and they go to the hospital and they're looking for pain relief. Cannabis has been shown to help people who are dealing with pain and even trauma. This includes seniors and veterans.

● (1005)

**Mr. Ben Lobb:** Mr. Dowie, would you have any comments on that? Is that maybe what we should be doing?

**Mr. Vaughan Dowie:** Absolutely. We've advocated for an investment in treatment from the money from cannabis. One can make similar parallels with the money from alcohol, where government is also making money. One can also say the same for money from gambling.

The question to government is this: Should you be profiting from your take on these businesses or should you understand that there are consequences to this, and as a result, be investing in the full range of treatment approaches?

**Mr. Ben Lobb:** Yes. It's not too many years since I've been in high school, but obviously, by my haircut these days, it's been a few years. When I was in high school—I know Mr. Oliver and I think he grew up in Bruce County for a period of time—if you got a case of beer on the weekend, you thought you had the world by the tail.

Why do kids now think they need to take cocaine, crystal meth and fentanyl? What is it that has changed since that time? Is it availability or price?

**Dr. Victoria Creighton:** I would say it's a breakdown of the family. The kids are actually not operating from the mindset of a young adult—like you did as a high school person—but from, "what can I do to alleviate any pain and not feel?" They don't have a future orientation in mind when they're behaving. They're not thinking that tomorrow they have a test. They're thinking that they just want to escape this world.

**The Vice-Chair (Ms. Marilyn Gladu):** Wow.

I want to hear more about this, but I have to go to Ms. Sidhu for five minutes.

**Ms. Sonia Sidhu (Brampton South, Lib.):** Thank you, Madam Chair. Thank you all for being here.

I heard there's a big jump. In 2015 there's 18% and in 2016 there's 53%. It's mostly a jump in our youth.

As you said, why do these kids need to use this meth? How can we educate them? Do we need to educate them in our schools? What kind of program do we need to put in place? I just want to ask everyone.

**Dr. Victoria Creighton:** I can respond.

Education is definitely needed. It's also educating the families and empowering the parents to parent. Oftentimes, they actually don't feel empowered to set a limit. When I go out speaking to schools, parents will just thank me at the end, saying, "Wow, you gave me permission to say no to my kid."

That containment and that structure actually helps kids mature and grow up. We live in a very permissive society. Kids don't have those limits, so they don't develop the internal structure to say no to drugs or other things. It's both empowering the families and helping the kids develop that internal structure. Schools can play a huge part in that as well.

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

Darlene, you said you had programs of 21 days, 90 days or 14 months. How do you determine which person needs to do 21 days, 90 days or 14 months?

**Ms. Darlene Jackson:** I don't remember saying that, but I'll speak to that.

I do know that many of our treatment beds have a 21- or 28-day program, with huge relapse. For alcohol use, drug use or gambling there is huge relapse. The programs are not long enough to actually get the patient to the point where they are ready to make a change and are empowered to make that change and keep that change going when they get to their community.

I believe that a 21- or 28-day program is not long enough. The programs need to be long enough to ensure that those clients are empowered. Then there needs to be follow-up. There needs to be some sort of support in the community that continues to help them stay empowered in the community and not backslide.

**Ms. Sonia Sidhu:** You also said the right time and right care is not available out there, like the transport services. What kinds of transport services do they need?

**Ms. Darlene Jackson:** I've been thinking a lot about that. One of the criticisms is that so many people go to the emergency department or Health Sciences Centre with issues that are not true emergencies. There is probably merit in that. Those clients are better served being seen at perhaps a quick care clinic, a walk-in clinic or even an urgent care facility, but those facilities are miles away. For someone who is marginalized and who lives on a very small income or lives on the street and has no income, getting two blocks from the Health Sciences Centre out to the Grace Hospital or over to St-Boniface is monumental. They have nowhere else to access health care. That's why they're presenting where they are.

If we're going to say that they need to access health care in a different area, then we have to support their getting to that area. Maybe we need a shuttle bus. I don't know what we need, but we need to ensure that those clients are receiving care. If they can only get to HSC emergency, that's where we need to provide care for them.

● (1010)

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

What specific policies, programs and initiatives need to be put in place to prevent this happening to vulnerable people?

My question is to James.

**Mr. James Favel:** Again, I think the biggest issue that I'm coming across is the poverty in our community. People can't afford to get out of the community. They can't afford to go places and that needs to be addressed.

This discussion is fantastic, but if we don't address the underlying poverty issues, when people get out of prison, they're going to relapse, so they're going to go back to what they know. They don't have enough money to survive and that's the only way they know, so you're going to have drug dealers come out and they're going to go right back to it.

I've seen homeless people in my community and ask them, “Why are you homeless today?” They say, “It's because we don't have a bank account”. If you don't have a bank account, you can't get your EI cheques direct-deposited. They're homeless. We're talking about 20-year-old kids that are homeless like that because of these rules that we have. We need to address those rules. There needs to be more money for these kids, when they finally come out of something like that. The one volunteer who I'm dealing with right now was clean and sober for 11 weeks, but she was stifled. She was stuck in her apartment and she couldn't go anywhere, so she relapsed.

There needs to be more sports and more things need to be available. There has to be programming available. It has to be easier.

**The Vice-Chair (Ms. Marilyn Gladu):** Excellent.

Now, we'll go to Mr. Davies for three minutes.

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

Thanks, Mr. Favel. I mentioned earlier that substance use and addiction ought to be treated as a health issue, but I think you're also raising the point that it has to be treated as a social justice issue as well.

Does anybody on this panel think that criminalizing drug use is helping the situation?

**Mr. James Favel:** Not a chance.

**Mr. Don Davies:** Nobody.

Ms. Blyth, it's my understanding that crystal meth is ingested in a number of different ways, but primarily it can be smoked and snorted as well.

You've mentioned that you're one of only two locations in North America—I think the other one is in Lethbridge—that permits clients to smoke drugs or inhale in a supervised setting. What are the barriers? Why aren't more consumption sites allowing inhalation of drugs? Can't you die from an overdose inhaling or smoking?

**Ms. Sarah Blyth:** Yes. It's actually quicker. If you have fentanyl in it, it ignites. The chemistry that's involved just makes the person immediately overdose, so they just drop immediately from smoking.

Yes, we're one of two. Surrey is getting one soon. The one that's in Edmonton is a state-of-the-art facility. What we do is really quite simple. I think you've seen it, but it's a little wooden tent and there's outdoor air coming in, so it's simple.

What was your question? I've lost my train of thought.

**Mr. Don Davies:** I guess I'll phrase it this way. I know InSite, which allows supervised injection, is federally approved. They don't allow inhalation. Are there any supervised injection sites in the country, which are regulated by the federal government, that allow inhalation?

**Ms. Sarah Blyth:** No. I think that we need to get more of those. I know that there's the one at St. Paul's. They're having issues with people that are now becoming injection users. Their tolerance goes up, so they want to be overseen because they're having overdoses from smoking. That's not good at all.

There are really simple solutions to it. I think they're very cost effective.

**Mr. Don Davies:** In British Columbia, I know there's been a provincial public health emergency declared by the chief medical officer. Given what you're seeing on the ground and the scope of the problem, do each of you or any of you think that the federal government should declare this a public health emergency?

● (1015)

**Ms. Sarah Blyth:** I've been saying that from the beginning.

**Ms. Darlene Jackson:** Yes.

**Mr. Don Davies:** Do you have any opinion? I'm seeing everybody nod.

Dr. Eyolfson was commenting on the policy foibles of Ontario and Manitoba, saying that these governments are putting their heads in the sand.

So far, our Prime Minister and health minister have both unequivocally ruled out decriminalization and regulation of drugs to ensure safe supply. They've refused to declare this a public health emergency, under the federal Emergencies Act, and the federal Liberals—despite $19 billion in deficit spending and $14 billion just allocated to corporate tax relief in the fiscal update last week—have provided no substantial increase to address the necessary massive increase in treatment funding.

Are there any comments on the federal government approach? Are we on the right track or do we need that fundamental shift?

**Ms. Sarah Blyth:** InSite has a place upstairs that's called Onsite, which people don't really hear about. People go in and out of there and back onto the streets. The fact is that we just have no place for people to go on demand. I would agree with everybody at the table here that the person who wants treatment usually comes to me in a very desperate situation, saying, “Hey, you know what, I'm ready for treatment.” They're crying. They look like they're ready to go. They've been sleeping in the alley. It's over.

That window is only for that period of the day. You can't say to them to go and use drugs for another two weeks and then we'll find them somewhere—if we can find a place for them. Then, when they do get in, they go through the system for a week and come out again, because some of the programs are so short. Then they're back in the alley, and who sleeps in an alley without doing drugs? Nobody, I mean, it's just impossible in the cold and snow. It just doesn't happen —

**The Vice-Chair (Ms. Marilyn Gladu):** I'm sorry, but that's your time.

We do have time for one more round of questions for maybe six minutes each.

We'll start with Dr. Eyolfson.

**Mr. Doug Eyolfson:** Thank you again, Madam Chair, and thanks to all of you.

In regard to our federal government's record, would you agree that our steps to decrease the barriers to safe consumption sites that previously existed have been helpful?

**Ms. Sarah Blyth:** Yes.

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

Ms. Jackson, I agree with what you're saying. Again, in my time in the ED, we saw a lot of things that were not emergencies. The emergency department was not the appropriate place to go, but it was the only place to go. It could be for anything from “I need a prescription refill because my doctor is on holiday” to “My wife gambled away my money for prescriptions and where am I going to get them?” Right now, particularly for the acute intoxications and for those who are in crisis, it's really the only place to go.

The Victoria hospital has already been converted to urgent care. They don't take ambulances. It was in the news just this week that the Concordia Hospital—I believe very soon—will no longer be accepting ambulances. Is there capacity in the remaining emergency departments to deal with this adequately?

**Ms. Darlene Jackson:** I don't believe so. The Concordia Hospital's emergency department will be closed in June. They'll have an attached walk-in clinic. I do not believe that the three emergency departments in Winnipeg are going to be adequately staffed and will able to handle all the emergencies.

We already know that the Health Sciences Centre and St-Boniface Hospital are seeing 30% more patients than was ever anticipated that they were going to see with hospital closures. Those facilities are in desperate shape. Their emergency departments are in crisis.

**Mr. Doug Eyolfson:** I understand that Seven Oaks is still operating an emergency department for the time being.

**Ms. Darlene Jackson:** Yes, for the time being.

**Mr. Doug Eyolfson:** When I worked there, it was the second-busiest hospital in Manitoba. The emergency department saw more people than St-Boniface Hospital, and with it not being a teaching hospital, the doctors also handled all the emergencies and the wards. At three o'clock in the morning, there was one doctor for the emergency department, intensive care and all the wards.

**Ms. Darlene Jackson:** Yes. They're still one of the busiest. It's still very busy there.

● (1020)

**Mr. Doug Eyolfson:** Would you expect that closing that department will cause even more problems?

**Ms. Darlene Jackson:** Yes, absolutely. We're just prepping for that as well, because we are going from six emergency departments in the city down to three.

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

We've talked about the root causes of a lot of this. Mr. Favel, I really liked what you said about poverty. I think it was Gandhi who said that poverty is actually very expensive, and that's exactly true. It leads to all these things that actually cost our social safety net and our medical care systems a lot of money. We're seeing social problems where the banks no longer have branches in poorer neighbourhoods because everyone has to go to payday loans and get that haircut of 3% off their cheques. There are these sorts of things, and I know we need a lot of economic policies that are going to help with that.

In regard to mental health, in my experience, a number of people with addiction issues have mental health issues. I had a number of patients with drug issues. When you dug into it, you saw that their mental health symptoms actually predated the drug use. I've talked to teenagers who were smoking a lot of pot. When you asked them why they liked smoking it, they'd say they started smoking it because “the voices were saying really scary things” to them. They didn't tell anyone about the voices. They just started smoking the pot, and that's what got noticed.

We have a substantial investment in mental health. Again, the provinces have been rather resistant to that. They want to decide what they do with the health care money. They don't like being dictated to, but do you think it is a good idea that we're saying that this large portion of what we're giving in health care transfers is dedicated to mental health services?

I'll ask each of you to answer in turn.

**Mr. James Favel:** We absolutely need those mental health supports. Again, we lost two of our volunteers this summer because the mental health supports were not there for them. We took 22 of our youth and trained them on how to use naloxone. The thinking behind that was that, if we changed the way they're thinking about these things and had them thinking more critically and clinically about the drugs they're using, they would be less apt to use them. For the most part it worked, but we still lost one that way this summer. We lost a second one in August as well. The mental health supports need to be there so these people have a resource to reach out to, so they can try to get healthy and stay healthy.

**Mr. Doug Eyolfson:** I'm very sorry to hear about your loss. I know it's tragic to lose co-workers and friends like that.

**Mr. James Favel:** A boy turned 18 on June 25 and graduated from our youth patrols to our adult patrols, and then we buried him on August 9.

**Mr. Doug Eyolfson:** I'm so sorry. That's horrible.

Ms. Jackson, what's your response to mental health?

**Ms. Darlene Jackson:** I think there's overwhelming evidence that addictions and mental health absolutely dovetail. There's a lot of research, and they absolutely dovetail. You're right. When Sarah talks about pain, a lot of addictions and a lot of drug use have to do with emotional and psychological pain. That's the pain we talk about. We're seeing that even younger. We're seeing kids in grade school have anxieties that we wouldn't ever have imagined. Society has changed and the way we're raising our kids has changed. I think we need to start mental health interventions much earlier. I think we need to start it in schools.

**The Vice-Chair (Ms. Marilyn Gladu):** All right. That's your time.

Now we're going to a combination of Mr. Webber and Mr. Lobb for six minutes.

**Mr. Len Webber:** Thank you, Madam Chair.

Absolutely, that's what I heard from Dr. Gabor Maté as well: Mental health is the issue here. There are underlying issues that get people into drugs. I read his book as well. I recommend you read his book. He talks about his patients, and yes, they all had underlying issues way before they even started using drugs, so we need to deal with mental health.

I want to go back to the emergency room, Darlene, and how unsafe it is for nurses, doctors and others.

Is there a policy with respect to restraint? For instance, if there's somebody who comes in high on meth, would you not automatically restrain them and keep them restrained to keep you guys safe? What's the policy there?

**Ms. Darlene Jackson:** If the patient is out of control or displaying violent behaviour, they can be restrained.

I've just come from the front lines. I worked in emergency departments. I did hear that at the Health Sciences Centre, it took 15 people to restrain a female patient who was on meth—15 people.

● (1025)

**Mr. Len Webber:** Can't you cuff them to a bed?

**Ms. Darlene Jackson:** You have to actually get them to the bed and hold them in that position.

The issue is that these patients are very volatile. You can't anticipate a change in their behaviour. For example, a clerk went in to stock a room with a patient on meth who was being very co-operative. The next thing was that this patient was actually on the clerk choking him and staff are pulling them off. You can't anticipate the behaviour. That's part of it. It's very unpredictable.

**Mr. Len Webber:** If it's unpredictable, anybody who is in for meth then should be restrained, wouldn't you think? Even though they are calm at one point in time, they could turn on you at any minute.

**Mr. James Favel:** With the attendant mental health issues, I think it's really dangerous to try to restrain everybody who comes into the hospital. That might set them off. That's one of the things you have to be very careful about. The tone you use when engaging with these people is important, because they need to be handled differently.

**Mr. Len Webber:** What do they do at RAAM, James?

**Mr. James Favel:** I haven't been inside the clinics myself but we've been sending many people over there. They're getting some support from that and we're able to build on that.

**Ms. Sarah Blyth:** We see, I would say, 200 meth users a day. Having them in the environment of the overdose prevention site and identifying those things and calmly talking to those folks, we avoid any of those kinds of issues. It's mostly just by engaging with them and having community members talk to them to help them refocus. I think taking them into a hospital environment where it's totally foreign, with police and all of that, is going to escalate the situation.

**Mr. Len Webber:** I see. Okay.

Ben.

**Mr. Ben Lobb:** Do you have a way to track the lifespan of somebody who comes into your office the first time? If they come in on a Monday and they live for two years, 10 years, or a month, is there a way you can track that or is it impossible?

**Ms. Sarah Blyth:** We haven't tracked that. I can certainly say that a lot of people I've known over the years, especially in the past couple of years, have passed away. It's completely awful for families, and it's completely avoidable by getting them medical and mental health care, and the treatment that they need and safe alternatives to the drugs they're using. I can't stress it enough that there is a solution that we're just not doing. Everybody knows. The police, the ambulance and everybody on the front lines is pushing for it. As long as we avoid that, we're going to continue on in the crisis and people are going to die.

**Mr. Ben Lobb:** The other thing I can't help but notice from my time with my place downtown here is that it seemed to me.... Everybody talked about housing and the need for safe housing, and the previous panel said the same thing. I can't disagree one per cent. The way I look at what's happened downtown in Ottawa here, it's almost like it's too many people and they should maybe spread the shelters out a little more just so people can catch a break, because it just seems like it's too many people. When you have too many people you have so many problems, not to mention there's a beer store and a liquor store right in the middle of the three housing places. I know planning and I know things happen over the course of many years, but it just seems to me almost unethical that this is how the planning has worked out in this city and probably in every city in the country.

**Ms. Sarah Blyth:** Everybody wants to live in a safe, clean environment, and people with mental health issues need extra help. Sometimes some of the services or affordable housing are in one particular area, but yes, I think that giving people options to live in different neighbourhoods would be good. It's healthy for people to live in different neighbourhoods.

**Mr. James Favel:** What I've been seeing is that people are living communally for protection and safety. In Winnipeg we have a strip through Maryland and Sherbrook where there are a lot of homeless people who hang around, and they're in the back of West Broadway and down by the river in the north end in certain areas. They congregate like that for their own safety, and we need to provide better for them so they don't have to feel that way.

**The Vice-Chair (Ms. Marilyn Gladu):** Now we're going to Mr. Davies for six minutes.

● (1030)

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

Mr. Favel, according to an article I read in the Winnipeg Free Press, last year the federal government gave the Bear Clan Patrol roughly $100,000, which, I think you described helped your organization pay staff, etc. It's my understanding that your organization has been forced to scramble this year after Indigenous Services Canada put your 2018-19 funding in limbo. Is that correct?

**Mr. James Favel:** That's correct.

**Mr. Don Davies:** Right now you don't know if the federal government's going to continue funding you for the next—

**Mr. James Favel:** We know they're not intending to. That's what we know.

**Mr. Don Davies:** Okay.

Mr. Dowie and Ms. Creighton, my colleague, Mr. Webber, has referred to Dr. Gabor Maté. My understanding is that his theory after working in the Downtown Eastside is that 100% of the people he's dealt with in the Downtown Eastside with addictions have underlying trauma. Most trace back to childhood. I'm curious about your sense of that. Is trauma of some type one of the base fundamental proximate causes of later substance use, and if so, how do you deal with that in your population?

**Dr. Victoria Creighton:** There's the big-T trauma and the small-t trauma. Every child we have had has had some form of trauma, and a lot of it often comes through the mis-recognition that is occurring within their communities, within the family, of not being seen and not being held. There are these underlying yearnings to belong, to be valued, to be seen for who they are. When that is met, the kids actually thrive and grow. It's very helpful at times to remove them from the family, get them in an environment where they are seen, involve the parents and get them to be really attuned, and the kids will bounce back. They come to life. You can actually see that happening.

**Mr. Don Davies:** Not to be a broken record in this, but once those children hit their late teens, with the current criminalization approach, how does criminalization impact that trauma?

**Dr. Victoria Creighton:** It's mis-recognition. It's not seeing accurately what's going on. It's trying to address the symptom rather than the underlying issue.

**Mr. Don Davies:** Ms. Blyth, I want to come back to you because you made a reference to the solution, but I don't think you actually articulated it.

What is the solution that we're missing, that fundamentally we need to be looking at as a federal government?

**Ms. Sarah Blyth:** The solution is decriminalization and getting people safe access to the medication that they need, which would be at overdose prevention sites or at InSite or Crosstown Clinic, where people can get safe access to drugs, safe supplies. They can have somebody there who can help them get into proper treatment facilities, especially if they're youth. This just sounds amazing for youth, for them to be able to get in there and get treatment.

We see youth on the street in the Downtown Eastside and it's totally upsetting to all of us. There's nowhere for them to go. A lot of the youth centres don't take young people who are using, so they end up in the street. It's so shocking that it's hard to sleep at night thinking about them and where they're going.

**Mr. Don Davies:** I want to be clear as well that I don't think there's a person in this room or in the country who thinks that drug use, chronic drug use, is preferable or desirable or healthy. It's a recognition that the drug use is a symptom of underlying pain that ought to be treated. If we have learned anything as a country after 150 years, it's that throwing people in jail who are essentially sick or traumatized or in need of nurturing is not only the wrong approach, but it actually doesn't work.

**Ms. Sarah Blyth:** Yes, what we see is people going out and buying their drugs in the street. That's how they use them in our overdose prevention sites. They get their drugs taken away and are criminalized that way. They get criminalized for the survival sex trade.

All of these things are causing people more trauma. The survival sex trade, if people don't want to be doing that, that causes women more trauma. It puts them at a great deal of risk in the streets. If you could give them a safe supply of something that's not going to kill them, very much as a starting point, you're not having them go through the criminal system and be further.... It's really a waste of our resources.

● (1035)

**Mr. Don Davies:** What would you say, Ms. Blyth, to those who say that if we make a safe supply of drugs available to people, somehow we're countenancing it, somehow we're approving of it, that if we're giving free or cheap drugs to people, this is showing that we approve of this drug use?

What would you say to that?

**Ms. Sarah Blyth:** I would say that we're in an absolute health emergency crisis right now, and people are using highly addictive drugs. There's no real way out of it except for giving people safe drugs so that we know that they know what they're taking, and then we can get them the proper help they need. It's the only thing we can do at this point.

**Mr. Don Davies:** Mr. Dowie, what about prevention?

That's dealing with the after-effects, trying to minimize the harm, but how can we as a country adopt policies that encourage our children and adults to avoid addiction or make healthier choices? Is there anything we can do prevention-wise?

**Mr. Vaughan Dowie:** Yes. Prevention has many elements to it. You start with education. In public education, we don't seem to have a coherent approach. We have probably 13 different approaches, one for each province or territory in the country. Then it becomes the ability to intervene early with kids, usually within schools and within the community.

It's very hard to get a national approach in this country. We have a country where it's really complicated to have any kind of coherent and concerted action. Does it make sense that you want to, first of all, educate people, and you want to intervene in problems early before they get out of control? It makes sense. Do we have a way to do this in this country? We have a bunch of ways to do this and not in any consistent way.

If I can just stop on one, very quickly, just look at the public education around cannabis. The federal government has invested a significant amount of money in the last budget, in whatever, and it gets rolled out, but then in the provinces, in the whole public education aimed at kids, some provinces are doing stuff and some provinces aren't. Some provinces are treating it like a funding program. You don't have a consistent and coherent message.

**The Vice-Chair (Ms. Marilyn Gladu):** We're going to finish our questioning today with Robert-Falcon Ouellette, who raised this issue for an emergency debate in the House.

**Mr. Robert-Falcon Ouellette:** I'd like to do that in French.

[*Translation*]

We live in a bilingual country. So it is extremely important to be able to use both languages in Parliament.

On November 14, I took part in a summit bringing together the indigenous peoples in my constituency and service providers working with people with drug addictions. A lot of solutions were suggested.

Mr. Dowie, you talked a little about prevention. One of the models mentioned was Iceland. I am not sure whether you are aware of it. Young people around Winnipeg said that it is what they needed. They want recreation programs, ways to spend time. Those programs would be useful, not only for the youth, but also for vulnerable people or those living in disadvantaged neighbourhoods. Does that model work well and is it something that should be implemented in certain areas of our society?

**Mr. Vaughan Dowie:** It is certainly one of a range of prevention services.

A few weeks ago, I gave a presentation for the Association of Municipalities of Ontario, the AMO. That was also one of the conclusions that the representatives came to. In other words, prevention services, a range of prevention services, must include recreation or leisure programs for young people.

**Mr. Robert-Falcon Ouellette:** It is incredible to me that we often end up with a model where people have to pay. It costs a lot even to go to a community centre in the city. The costs have to be paid by taxpayers, by people who are able to pay. In this case, I would like to know if perhaps we have to find grants or other ways of making it happen. For example, should the taxes on cannabis be used to fund those types of programs?

● (1040)

**Mr. Vaughan Dowie:** If you ask the AMO that question, their answer will be yes. That is what the representatives were demanding, that a part of the revenue from the sale of cannabis be turned over to municipalities to fund recreation programs.

Personally, I would like something more complex. Funding services like that is only one of the factors. Funding treatment is also just as important

[*English*]

It's important to make a series of options available. There are some kids who like sports. There are some kids who like this. There are some kids who like that. To get kids involved in activities they are good at and to have the opportunity to do that without money becoming an obstacle to participation is obviously a good solution.

[*Translation*]

**Mr. Robert-Falcon Ouellette:** Excellent.

I have some questions for you, Mr. Favel. First, one of the things I would like to tell you is that I fully support your funding request. I believe that your organization and the work that you do are extremely important.

I would just like to make sure I completely understand. You talked about property crimes. I have knocked on a lot of doors and I also see that there is a lot of crime like that: theft, shoplifting, bike theft, break-ins in cottages or garages, and so on. Why is it up to your organization to deal with those cases? Why is the police service not able to handle them? Why does your volunteer organization have to do work that is a State responsibility, such as picking up syringes or providing emergency service?

[*English*]

**Mr. James Favel:** We are acting as a supplement to the existing resources. We are trying to support the work that's going on there. We're trying to free up the police so that they can do their job better. We're trying to make it so that fewer of our people go away in ambulances because of violence. We de-escalate when we get a chance.

Our whole mandate is to be a support in our community, because we are of the community. I live in the north end of Winnipeg, on Stella between McKenzie and McGregor. It happens right outside my house. The exploitation, the drug dealing—it's all there. That's how I got involved. I want to stop it. I want to prevent it. I want to help my community members live better lives.

Again, it all comes back to poverty. It really all does come back to poverty. That's what we need to address here. People living in poverty are going to act desperately. Why do people self-medicate? To escape. To escape what? To escape pain. What's the basis of their pain? They can't function in this world.

There are not enough resources and not enough job placements available. We're trying to create job placements in our organization as much as possible, this year with 90,000 dollars' worth of temporary job placements and things like that, but now we have CRA interested in what we're doing. They're telling me we can't do the things we're doing because we're not doing it to the letter of the law with CRA.

**Mr. Robert-Falcon Ouellette:** Can you discuss that a little bit more, about the CRA—

**The Vice-Chair (Ms. Marilyn Gladu):** I'm sorry, but we're at the end of our time for today. There is so much we would love to go into.

Thank you to all the witnesses for coming and for your testimony. Certainly, we would like the copies of the reports you have suggested. The clerk will get those.

We will see you again on Thursday, team.

The meeting is adjourned.