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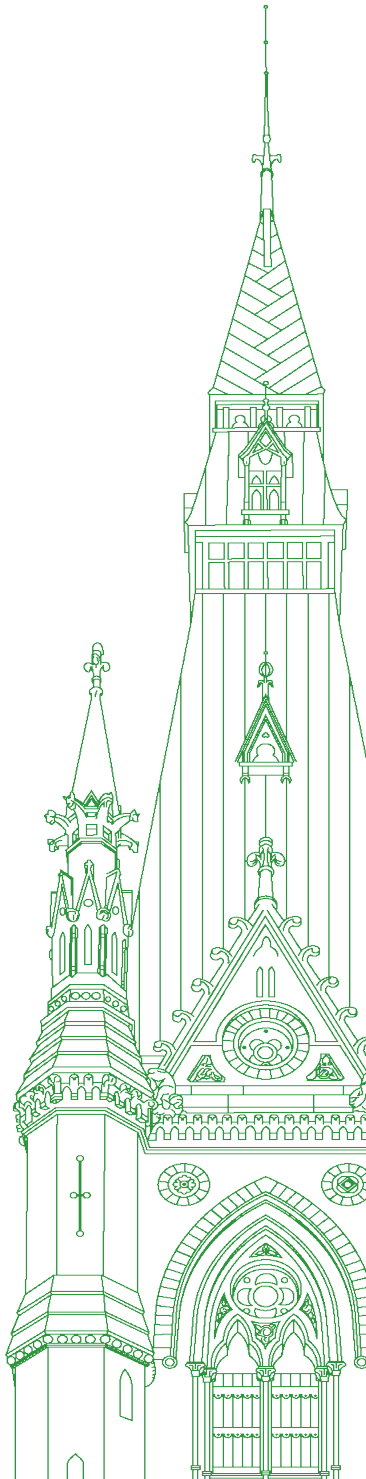

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, April 15, 2024

● (1530)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 110 of the House of Commons Standing Committee on Health.

As a safety reminder, please ensure that your earpiece is not too close to the microphone, as it can cause feedback and potential injury.

In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Pursuant to Standing Order 108(2) and the motion adopted on November 8, 2023, the committee is resuming its study on the opioid epidemic and toxic drug crisis in Canada.

I'd like to welcome our panel of witnesses here with us today.

As an individual, we have Dr. Nathaniel Day, provincial medical director of addiction at Alberta Health Services.

Our witnesses are appearing by video conference. We have the British Columbia Association of Chiefs of Police, which is being represented by Fiona Wilson, president and deputy chief of the Vancouver Police Department. We have the Canadian Association of Chiefs of Police, which is being represented by Rachel Huggins, deputy director and co-chair of the drug advisory committee. From the Royal Canadian Mounted Police, we have Dwayne McDonald, deputy commissioner, and Will Ng, assistant commissioner.

Welcome to all of our witnesses. Thank you for being here.

I'm sure you've been advised that you have five minutes for your opening statements.

We're going to begin with you, Dr. Day. Welcome.

You have the floor.

Dr. Nathaniel Day (Provincial Medical Director, Addiction, Alberta Health Services, As an Individual): Thank you, Chair, for the opportunity to speak to your distinguished committee today.

I'm Dr. Nathaniel Day, the provincial medical director of addiction for Alberta Health Services. I am also the person who designed and, with our team, implemented Alberta's virtual opioid dependency program. I was a member of the minister's opioid emergency response commission in Alberta under the Notley government and I was the co-chair of the recovery expert advisory panel for Alberta's current government.

I will briefly summarize some of the actions we have taken in Alberta to respond to the current phase of the opioid addiction and overdose crisis. I will raise things that I think are successful and could be replicated. Of course, a long-term problem requires long-term effort in order to see maximal benefits.

As recently as 2016, Alberta, like all jurisdictions, struggled to meet the needs of people with opioid addiction living anywhere not immediately local to a bricks and mortar opioid dependency treatment program. All jurisdictions have struggled with this problem. I proposed a new approach that provided virtual care, now expanded to every community in Alberta. To our knowledge, we were the first program to ever look at exclusively virtual care with no in-person component. We collected data on outcomes for our patients, which was published in the literature. By providing virtual service, we were able to reach people who had never been reached previously. We served people in 331 different communities, villages, cities and hamlets all across our geography.

Since 2018 we have not had a wait-list for services. If you need help today, you get help today. Right now there are people in Alberta who are certainly calling in for help, and then our allied health team starts an assessment. Our physicians work on shift 24 hours per day to assess and treat. Prescriptions go out to pharmacies closest to the patient, including delivery to remote indigenous communities. Because we use virtual tools, we can also support new places where people with opioid addiction are located. Our objective is to reach anyone who needs our care, wherever they may be.

For example, we have found that police, like all frontline workers, want to help the people they encounter who suffer from addiction. Police in all jurisdictions have people who use opioids, who are arrested for any reason and who, while waiting to see a justice of the peace, are going into or are at risk of going into withdrawal. In Alberta, when a person is under arrest they can be connected confidentially, using the same rooms that a person would use to speak with a lawyer, to get a health care intervention to manage their withdrawal, and an invitation to continue with us if they choose. About 10% of those patients are filling prescriptions in community 90 days later.

We supported the Province of Alberta's encampment response. We provide support to people in shelters, low-barrier housing programs and supervised consumption sites—essentially wherever a person is who wants service. Alberta is expanding access to bed-based services. Government has funded access to bed-based treatment spaces that were previously private. Government has eliminated the copay for addiction treatment. Alberta's government has also announced 11 new recovery community treatment programs, two of which are now in operation. The others are in various stages of planning or construction.

Alberta is working with provincial corrections to expand meaningful treatment for people with addiction who are incarcerated. Alberta has legislated licensing and accreditation standards for addiction service providers. This ensures that any Albertan who accesses our system of care receives evidence-based quality services.

We have a gap medication program that gives no-cost provision of Suboxone, Sublocade or methadone to anyone with a health care number, with no application and no delay.

There is much more that we could talk about. I will conclude with this: We would not be in this situation if our communities and families were as healthy as they could be. I recommend that this committee support only initiatives that will improve community and family wellness. It is important that all people with addiction—which touches all Canadian families and communities—be offered hope. Hope is, in my opinion, the antidote to stigma. Hope is powerful, and the evidence shows that when it sets in, it increases positive outcomes.

● (1535)

The Chair: Thank you, Dr. Day.

Next, from the British Columbia Association of Chiefs of Police, we have Fiona Wilson.

Welcome to the committee, Ms. Wilson. You have the floor.

Ms. Fiona Wilson (President, British Columbia Association of Chiefs of Police, and Deputy Chief, Vancouver Police Department): Thank you.

Good afternoon, everyone. I am Fiona Wilson. I am President, British Columbia Association of Chiefs of Police, and Deputy Chief, Vancouver Police Department

In my role as president of the British Columbia Association of Chiefs of Police, I'm honoured to share with the House of Commons Standing Committee on Health our experience as police leaders with decriminalization in British Columbia.

The decriminalization exemption was issued under section 56(1) of the Controlled Drugs and Substances Act by Health Canada. It took effect over a year ago, on January 31, 2023. The exemption is part of a three-year pilot project that aims to take a health-led approach to substance use, as opposed to one led by the criminal justice system.

In British Columbia, we know all too well the severity of the toxic drug death crisis. Yesterday marked eight years since a public health emergency was declared in British Columbia on April 14, 2016. Since that time, tragically, more than 14,000 British Columbians have died from accidental overdose.

We've seen the crisis have the greatest per capita impact on rural communities, including those in northern British Columbia, on Vancouver Island and in the Cariboo. In many of these rural communities, the crisis can be double or triple the provincial average. Sadly, the highest per capita impact has been in Vancouver-Centre North, which includes Vancouver’s Downtown Eastside. Here, the stark reality is that the overdose crisis is more than 12 times the provincial average.

We recognize that the crisis has had an especially devastating impact on indigenous people in British Columbia. Alarmingly, indigenous people are six times more likely to be impacted by the crisis than non-indigenous British Columbians.

In recognition of the magnitude of this crisis, police leaders in B.C. supported decriminalization and taking a medically led approach to substance use. At the heart of it, police agree that people should not be criminalized as a result of their personal drug use.

In terms of police data, across British Columbia there has been a more than 90% reduction in drug seizures at or below the 2.5-gram threshold. Based on these results, I'm confident that frontline police officers are doing their part to implement the decriminalization exemption and to support a health-led approach to substance use.

However, the implementation of decriminalization has not occurred without criticism or concerns.

As police leaders, we were unequivocal about the need to prevent unintended impacts on community safety and well-being, especially for youth. The British Columbia Association of Chiefs of Police clearly identified some of those potential consequences prior to the submission of the exemption request, both orally and in writing. These serious concerns included but were not limited to the matters of public consumption, consumption in licensed establishments and other places such as cafés and restaurants, and impaired driving.

However, the implementation of decriminalization occurred before more extensive restrictions on public consumption and problematic substance use could be adopted. While the vast majority of people who use drugs do not want to do so in a manner that negatively impacts others, there have been several high-profile instances of problematic drug use at public locations, including parks, beaches and around public transit. In addition, there have been concerns from small businesses about problematic drug use that prevents access by customers or negatively affects operations.

To address some of these concerns, after significant advocacy on the part of police in B.C., three additional exceptions were added to the exemption on September 18, 2023. In addition, the Province of British Columbia has taken significant steps to enact legislation that would prevent problematic substance use that negatively impacts community members, especially youth. However, before this legislation came into effect, a B.C. Supreme Court injunction was granted based, in part, on the section 7 charter rights of people who use drugs.

Given the scope of the crisis, it is apparent that decriminalization is only one strategy and that it must be part of a broader, multifaceted response. Additional strategies include increased efforts in the areas of education, prevention and treatment and in the provision of enhanced health services to communities across B.C. While much work is occurring in these areas and significant investments of public resources have been made, it's clear that while decriminalization was able to come into effect in a relatively short time frame, these other strategies will take significantly longer to achieve and implement.

While working toward better health outcomes for people who use drugs, there must also be consideration of the needs and well-being of the broader public. I believe that other jurisdictions that have implemented or considered decriminalization, only to later abandon it, have done so because of unaddressed and unintended impacts on community safety and well-being.

● (1540)

Thank you.

The Chair: Thank you, Ms. Wilson.

Next, from the Canadian Association of Chiefs of Police, we have Rachel Huggins.

Welcome to the committee, Ms. Huggins. You have the floor.

Ms. Rachel Huggins (Deputy Director and Co-Chair, Drug Advisory Committee, Canadian Association of Chiefs of Police): Thank you.

Distinguished members of this committee, I'm pleased to have the opportunity to address you today on this very important issue.

It's important to begin by noting that law enforcement agencies across the country acknowledge that the opioid crisis is a public health issue. While police have a critical role to play in terms of preventing illicit drug distribution, curbing supply and safeguarding communities, we recognize and understand the need for a comprehensive approach that addresses the social determinants of health. This requires coordinated efforts across government, health care, the justice system, police and community organizations.

In July 2020, the Canadian Association of Chiefs of Police called for a broad societal response that includes prevention, education, support systems and access to treatment for those affected by drugs. We also supported the decriminalization of simple possession of illicit drugs as an effective way to reduce the stigma of substance use disorders, reduce public health and safety harms and divert individuals with substance use disorders away from the criminal justice system.

As you heard from my fellow co-chair of the CACP drug advisory committee, Deputy Chief Fiona Wilson, our early experience with formal decriminalization for simple possession of illicit drugs has had some unintended but not completely unexpected consequences.

Preliminary results of this pilot project have proven what police leaders have stated from the beginning: Decriminalization of drugs for personal use is only one part of a system and has to be part of an integrated, health-focused approach to addressing the opioid crisis and toxic drug supply.

Today the CACP reaffirms its commitment to a health-centred approach to the drug issue and reaffirms that addressing the opioid crisis includes the decriminalization of possession of illicit drugs.

In the past four years, important procedural and legal reforms, as well as training, have been implemented. These have led to a significant shift in police and public perception about substance use disorders, as well as a decline in simple possession charges, thereby reserving criminal sanctions for the most serious circumstances.

Decriminalization is about preventing the unwanted criminalization of personal substance use, creating a continuum of care to ensure that persons who use drugs are better connected with health supports and, finally, third, allowing the police to focus on serious illicit drug trafficking and production offences.

The pilot project implemented in British Columbia succeeded in achieving the first goal, which is procedurally and fiscally easy to attain.

Creating a continuum of care is much more challenging, as well as resource-intensive, but the successful achievement of goal number one depends on the successful implementation of actions to support the achievement of goals two and three.

From a police perspective and as police leaders, we see the critical importance of having the appropriate health and social structures in place before proceeding with changes to the legislative framework that would formalize the decriminalization of simple possession.

In conclusion, from a public safety perspective, Canada's police leaders believe that the success of any strategy in relation to the ongoing crisis of toxic drug supply should be measured based on its ability to improve health outcomes, reduce the impact of organized crime and address the property crimes and public safety issues that result from unaddressed substance use disorders.

The CACP believes that any strategy that is considered must be medically led and based on empirical medical research, and must provide increased health connections with medical professionals for people living with substance use problems.

● (1545)

Thank you.

The Chair: Thank you, Ms. Huggins.

Finally, we'll have the Royal Canadian Mounted Police. I'm not sure whether it's Mr. McDonald or Mr. Ng or whether you're going to split it, but you have the next five minutes all to yourselves. You have five minutes in total.

Deputy Commissioner Dwayne McDonald (Royal Canadian Mounted Police): Thank you, Chair. Good afternoon.

I'm Deputy Commissioner Dwayne McDonald, the commanding officer of the British Columbia Royal Canadian Mounted Police. I oversee over 10,500 employees, of which 6,800 are police officers. We deliver municipal, provincial and federal policing throughout B.C.

I would like to acknowledge that I'm joining you here today from our headquarters, which is situated on the unceded territories of the Katzie, Kwantlen and Semiahmoo First Nations.

I'm joined here by Assistant Commissioner Will Ng. He's our criminal operations officer for British Columbia and he serves as a single point of control and coordination of all investigative, intelligence and specialized RCMP resources within the province of B.C., ensuring alignment and enhanced delivery to the municipal and provincial contract partners.

Thank you for giving us the opportunity to speak today.

We're here to provide perspective and information about the impact the opioid crisis is having on policing for the RCMP in British Columbia. I'll explain our role, our training, our challenges and some recent investigative findings.

Since 2015, the RCMP has been grappling in British Columbia with the alarming rise in overdose deaths, a rise fuelled by the increased prevalence of fentanyl in the illicit drug supply. This crisis has not only claimed thousands of lives; it has also left a profound impact on our communities.

Since the declaration of a province-wide health emergency in April 2016, over 13,000 lives have been lost to toxic, unregulated drugs in British Columbia. This is a crisis that knows no bounds. It affects people from all walks of life and communities across the province.

Indigenous communities in B.C. have borne a disproportionate burden of the crisis, facing higher rates of opioid addiction, overdose and death compared to the general population. Persons with mental health disorders or poor mental health are also overrepresented among those affected by the opioid crisis.

It's clear that this is not just a law enforcement issue: It's a public health crisis that demands a compassionate and comprehensive response.

As you are all aware, as of May 31, 2022, B.C. became the first province in Canada to receive an exemption from Health Canada under subsection 56(1) of the Controlled Drugs and Substances Act. The exemption decriminalized the personal possession of illicit substances. We are now in our second year of the exemption, which is valid until January 31, 2026.

The B.C. RCMP continues to support our partners and stakeholders as we all work through the implementation of this exemption. As a police agency, our role is to redirect people in possession of small amounts of certain illicit drugs away from the criminal justice system and towards health and social services. The RCMP continues to support all efforts to ensure that an overdose emergency is dealt with as a health and medical emergency.

Emergency medical dispatchers assessing calls no longer call for police assistance in every drug overdose emergency. Police are only notified in overdose calls if the situation is believed to be dangerous to first responders or members of the public, or for suicide attempts, whether they are drug-related or otherwise.

It's crucial to note that drug trafficking remains an offence under the Controlled Drugs and Substances Act. The RCMP is committed to investigating and prosecuting such offences. Additionally, the RCMP prioritizes upholding the rule of law and ensuring the safety and security of the communities it serves by targeting violent offenders, deterring youth from joining gangs and combatting gang-related violence resulting from the drug trade.

Efforts also include dismantling drug production labs and curbing cross-border trafficking, including the importation of precursors.

To support the implementation of the exemption and ensure consistent enforcement, the RCMP collaborates with the B.C. Ministry of Mental Health and Addictions and the B.C. Ministry of Public Safety and Solicitor General, as well as with our law enforcement partners, to provide training and resources to frontline officers. We've equipped our officers with the skills and knowledge necessary to navigate the complexities of the exemption and respond effectively to overdose emergencies.

However, challenges persist. Despite the progress made, the management of public drug consumption following decriminalization remains a concern. Additional legislation is needed to address public consumption in non-exempted areas. We're actively monitoring the provincial government's effort in this regard. We also continue to work with our cities and our indigenous communities to address public safety concerns surrounding the unintended impacts of public consumption.

The diversion of safer supply into the illicit drug trade also presents an emerging concern that requires forthright attention. Through ongoing investigations in collaboration with health authorities, we are working to better understand and address this issue to prevent further harm. Efforts are under way to improve our data capture and our analysis with the objective of developing a clearer understanding of this issue. Furthermore, we are currently working to develop training and education tools to help support our frontline officers recognize diverted safer supply.

● (1550)

We also recognize the frustrations and challenges felt by our indigenous communities, which continue to bear a disproportionate burden under the opioid crisis. As a partner in this fight, the RCMP is committed to working alongside indigenous communities and agencies to develop and implement long-term strategies to address the root causes of drug addiction. We will also continue to hold accountable those who traffic drugs in these communities.

In closing, I want to reaffirm the RCMP's unwavering commitment to tackling the opioid crisis here in British Columbia. We will continue to partner with government agencies, communities and stakeholders to save lives and bring an end to this devastating crisis.

Thank you for the opportunity to address the committee today. Assistant Commissioner Will Ng and I are available to answer any questions you may have.

The Chair: Thank you very much.

We're going to go right to questions now, beginning with the Conservatives.

Ms. Goodridge, please go ahead for six minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

I want to thank all our witnesses for being here today and for sharing on this important issue.

I'm going to start with Dr. Day. It's spectacular to have another Albertan here in Ottawa.

One of the things that I have found to be truly revolutionary in the world of addiction treatment is what Alberta has been doing with the virtual opioid dependency program. I wonder if you could go into a little bit more detail on exactly how it works.

● (1555)

Dr. Nathaniel Day: I'd be happy to do that.

This is how it works today in Alberta. If, for example, a person is at home and they are concerned about their opioid use or maybe they have run out of their supply of drugs and they're in withdrawal, they can just call a toll-free number—1-844-383-7688—directly and they will immediately be connected with an allied health team member who will start to explore their situation. In Alberta we have the benefit of single medical health records, so we're able to see all of that person's health records from their hospital visits, previous overdoses and things like that.

Once that person completes their assessment with our allied health team, almost immediately—or usually in no more than 15 minutes, depending on how many people are phoning at one given time—they're connected with an addictions specialist who can then walk through what their treatment options are. That specialist will prescribe a pathway forward for them to start evidence-based treatment medications.

The prescription is sent to the pharmacy closest to where they live or work, according to their preference, and that person can start treatment that very day.

Our team, of course, will follow up with that person later that day or the next morning to see how they're doing, and we will adjust the care from there.

Mrs. Laila Goodridge: What would happen if that person was, say, in a rural community like Janvier, about an hour and a half away from the closest pharmacy? What would happen to someone like that?

Dr. Nathaniel Day: That is a challenge. We have many communities in Alberta that are rural and remote and present more of a challenge in accessing a pharmacy. For example, in your riding, there's a fly-in community. We've been working with the local health teams in that indigenous community to have a supply of medication stored securely on site there so we can actually send a prescription to that nursing station and the medications can be provided to someone as needed.

Further, we're also working in Alberta to address this problem by enabling our paramedic teams to carry evidence-based treatment medications as part of their kit so that we'd be able to actually connect with our integrated health teams in the EMS world to bring the treatment right to that person.

Mrs. Laila Goodridge: I think that's truly revolutionary and I know that doing it required an exemption from Health Canada to even make it possible.

Are there any other stopgaps you might have when it comes to Health Canada being in the way of you guys being able to expand this amazing service?

Dr. Nathaniel Day: To be honest, we started working with paramedics about four years ago. Unfortunately, we discovered that our work was illegal, because at that time paramedics were not allowed to carry Suboxone or Sublocade in their kits. We weren't aware of that, and our paramedics weren't aware of it either. We were actually presenting some data on how well it was going when it was brought to our attention that we actually couldn't do what we were doing.

Unfortunately, it's taken several years to get the change made that now allows us to move forward. It happened just recently, in the last couple of months. We're looking forward to being able to announce and implement a province-wide program in just a few weeks from now.

Mrs. Laila Goodridge: Thank you for explaining that.

I think that just highlights how challenging the bureaucratic mess of Health Canada can be. You did something that is truly revolutionary, getting Suboxone and Sublocade in absolutely evidence-based treatment modalities into communities using innovative solutions, yet the bureaucracy said that it can't happen, and it took years to get that.

As my next question, can you walk us through what the ODP would look like in Alberta Correctional Services?

Dr. Nathaniel Day: In Alberta Correctional Services, of course we continue people who are on evidence-based treatment medications after they are arrested. We will also start people on treatment medications.

Unfortunately, Canada's largest correctional facility is in Edmonton, the Edmonton Remand Centre. The average length of stay is about two weeks. What we were finding was that there are a large number of people coming in who were not able to start treatment right away. The wait time to get treatment was as long as four to five months. You can imagine that many people were coming in and were not able to start treatment. Then they were released before they had access to treatment, which is a problem.

The way that it works today is that when a person goes in, they are immediately screened for opioid use disorder. They are able to provide a toxicology screen to support that. We do a video recording and connect that with our virtual opioid dependency team. That person is now able to be assessed and initiated on treatment. I think the average is now 0.9 days from arrival. We've completely resolved the wait-list problem there by using technology.

● (1600)

The Chair: Thank you, Ms. Goodridge.

Next we'll go to Dr. Hanley, please, for six minutes.

Mr. Brendan Hanley (Yukon, Lib.): Good day, everyone.

Thank you to all the witnesses for appearing and for the learning.

I want to echo Ms. Goodridge's congratulation on the virtual care program. I think there's a lot for the whole country to learn from the successes there, Dr. Day.

I'm going to focus on other areas.

A new paper just out yesterday or today in the Canadian Medical Association Journal shows that in 2021, one in 13 deaths among people under 85 in Alberta was opioid-related. I'm sure you're familiar with the paper. For Albertans aged 20 to 39, incredibly, opioids accounted for one in every two deaths. In some of the graphs in the article, the differences between Alberta and the other provinces is, frankly, quite alarming.

Towards the end, the article says, "...the burden of premature death from accidental opioid toxicities in Canada dramatically increased, especially in Alberta, Saskatchewan, and Manitoba." This suggests that Alberta is outpacing the rest of Canada when it comes to opioid-related premature mortality. From what I've seen, the 2023 data do not look any more reassuring.

At the same time, that contrasts with, I would say, quite a positive note struck recently by your premier, who said that, over time, "far fewer" Albertans have lost their lives to addiction in our province and that "many drugs have their lowest mortality on record". I know that she's referring to the decrease in other areas apart from illicit opioids, but the death rate from toxic illicit opioids by far eclipses all other causes and continues to rise.

All this is to say that when we have six Albertans dying per day and when aspects of the full spectrum of approaches are being pulled back at the same time, perhaps you could summarize and maybe justify the approach Alberta has taken.

How is the Alberta experiment going so far?

Dr. Nathaniel Day: Thank you for that question.

If we look at the overdose crisis overall and the number of fatalities, we see that British Columbia has the highest rate per 100,000 population in Canada. Alberta comes in second, and Ontario is third. Certainly the arrival of fentanyl and carfentanil in our jurisdiction does not go unnoted. None of us are happy with the number of fatalities that are happening because of fentanyl and carfentanil usage.

That being said, the reality is that we have an obligation. I view my obligation in Alberta Health Services as an obligation to ensure that we're building the best possible treatment system that we can, one that's accessible to people when they need it so that they can move along the continuum of care and receive evidence-based care.

Unfortunately, part of the story of what's happening in Alberta has not been narrated by Alberta. For example, in Alberta and previously, as I discovered looking at transcripts for this committee, Alberta does have exactly the same number of supervised consumption sites today as it had six or seven years ago. Alberta recently, just last year, opened six narcotic transition service sites that provide hydromorphone by injection or orally under supervision. Those medications cannot leave the site. The sites are intended to help people with the most extreme form of opioid addiction and the most negative consequences of it.

Furthermore, Alberta, as an example, distributed nearly a quarter of a million naloxone kits last year, so there are a lot of things happening in the harm reduction space that don't really make it to the front pages. I wouldn't say that Alberta is not investing in or working on those areas.

Where Alberta perhaps is different is that Alberta is trying to implement a recovery-oriented system of care, so that a person who enters care at a narcotic transition service site or in a supervised consumption site is encouraged, and there's work done to try to connect that person with treatment supports going forward.

● (1605)

Mr. Brendan Hanley: I have to interrupt you at this point. Thank you for that.

I would love to get more solid data, and perhaps you could help to provide that, but my understanding is that Alberta has about half the number of supervised consumption services as it did prior to the pandemic, and we had the closure of ARCHES and other supervised consumption sites. I believe my colleague talked about this closure in Lethbridge, for example. There's also resistance to acknowledging that inhalation is a primary mode now of illegal drug use. Alberta has resisted this.

The Minister of Mental Health and Addiction in Alberta talks about strong outcomes for Albertans on the path to recovery. Can you talk about outcomes for Albertans who may not yet be on that pathway to recovery?

Dr. Nathaniel Day: I'm not sure that I can speak to the outcomes of people who aren't engaged in the health system. It's very difficult to measure that.

To your comment, there was a supervised consumption site in Lethbridge run by a not-for-profit society, and it was closed, but the services were immediately transitioned to a site that's under my supervision. It's called an overdose prevention site, so it's not technically a supervised consumption site, but it has booths. It's operated by our public health care system. It's located in the parking lot just outside of the Lethbridge shelter that is operated by the local indigenous community, actually.

In terms of outcomes overall, I can say with assurance that whether it was the previous government or the current government, all efforts are looking towards improving outcomes for Albertans. Every initiative, every project we have is intended to make our system better, more comprehensive, with fewer gaps, so that people who need the services will be able to receive them.

The Chair: Thank you, Dr. Day.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you, Mr. Chair.

I will try to speak slowly in case some of the witnesses struggle with French.

I'll start with the police agencies. What I understand from the testimony of you three is that decriminalizing simple possession has had more positive impacts than negative impacts in the fight against opioids and overdoses. Am I wrong?

[*English*]

Ms. Rachel Huggins: Thank you for the question.

It has had positive effects. That is what we're seeing with the numbers. There has been a significant decrease in criminalizing individuals for simple possession offences. It also gives police the opportunity to divert those individuals to those pathways of care to get them whatever support or additional resources they require from a community perspective.

I think the—

[*Translation*]

Mr. Luc Thériault: Thank you. I'm sorry to interrupt you, but I didn't want a very elaborate answer. I just wanted to make sure that your three organizations share the same opinion.

Ms. Wilson, do you agree with Ms. Huggins' comments?

[*English*]

Ms. Fiona Wilson: I'm sorry. I only just turned on my translation. I did not understand the question.

[*Translation*]

Mr. Luc Thériault: So I will turn to you, Mr. McDonald.

[*English*]

D/Comm Dwayne McDonald: Pardon me. I'm in the same situation as the deputy chief.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, on a point of order, could you tell the witnesses how to turn on the interpretation, as they're not understanding my questions? I'd also like to get my time back, since I'm losing a lot of it.

The Chair: Yes, you won't be disadvantaged by that.

● (1610)

[*English*]

For those of you who are participating remotely, you'll see at the bottom of your screen something that says “Interpretation”. That gives you the choice of listening to the floor here or having simultaneous translation in French or English.

As anglophones, you probably want it on English, and then you'll get the voice of the interpreter when French is being spoken here.

Ms. Fiona Wilson: Thank you.

[*Translation*]

Mr. Luc Thériault: I'll go back to my question, Ms. Wilson.

I was just saying that, after hearing from the three police agencies, I get the impression that the decriminalization of simple possession has been seen as having more positive impacts than negative impacts in this fight against the opioid and toxic drug crisis. Do you agree with that statement, which was echoed by Ms. Huggins? I would like a short answer, not a demonstration. I want to move on to my other questions, but before I do, I want to at least establish that.

[*English*]

Ms. Fiona Wilson: I do not agree with that statement.

D/Comm Dwayne McDonald: I would concur with Deputy Chief Wilson.

[*Translation*]

Mr. Luc Thériault: You do not agree with the statement that decriminalization has had more positive impacts than negative ones, if I understand correctly. Please explain what you mean.

[*English*]

D/Comm Dwayne McDonald: Thank you.

Yes. I don't agree with that.

I would say there are positive results from decriminalization, as Deputy Chief Wilson has indicated, in terms of the number of people charged with criminal offences and attempts to divert them away from the criminal justice system. However, we note challenges in public consumption and similarly criminal behaviour.

[*Translation*]

Mr. Luc Thériault: Okay. In terms of the overdose crisis and being able to save lives, take charge of people and direct them to help, you believe that criminalization should be restored. Is that what you're saying, Mr. McDonald? Are you saying that simple possession should be recriminalized?

[*English*]

D/Comm Dwayne McDonald: No, that's not what I'm saying. What I'm saying is decriminalization has not come without its challenges.

For example, since decriminalization, our overdose deaths have not decreased in the province of British Columbia, nor have our overdose rates. We are still in the early stages and there's still much work to be done, but in terms of finite numbers of overdose deaths and rates, they have not decreased since decriminalization. What has decreased is the number of charges with respect to simple possession. We have increased our number of referrals and are working with other agencies to divert people from a pathway of criminality to a pathway of health.

[*Translation*]

Mr. Luc Thériault: In your presentation, you say that there are other challenges that worry you, such as the diversion of safer-supply drugs into the illicit drug trade. You say that, through ongoing investigations and collaboration with authorities, you are working to better understand the problem. How are you gaining a better understanding of the problem and where are you at in that understanding? Since you say a little further on that you are developing training and education tools, you must have understood that. Tell us about it.

[*English*]

D/Comm Dwayne McDonald: One of the challenges of identifying safer supply drugs once they are diverted into the criminal marketplace is that we first have to identify them if they're out of their packaging, and they're often not stamped as safer supply drugs. When we locate prescribed drugs that we believe to be safer supply, we want to be sure that they're properly identified, because we do not want to stigmatize legitimate users of those drugs.

In many cases, safer supply drugs may be diverted from one area through the criminal element to a broader marketplace. You've likely seen the news releases on Prince George and perhaps Campbell River, areas where we have made criminal seizures of safer supply drugs.

It's important to note that we have to train our officers in how to identify those drugs should they not be in the accompanying packaging, or should they not be identified right at the first outset as safer supply drugs, because we want to make sure that we're accurate. When we do seize safe supply drugs, we engage with health authorities in the province of British Columbia so that we can better track and identify those drugs and identify where they've come from.

● (1615)

The Chair: Thank you, Mr. McDonald.

[*Translation*]

Mr. Thériault, that's all the time you have.

[*English*]

Next we go to Mr. Johns, please, for six minutes.

Mr. Gord Johns (Courtenay—Alberni, NDP): Thank you.

Thank you all for your testimony and especially for your service to the people of our communities and our country.

Ms. Wilson, you're the deputy chief constable with the Vancouver Police Department, but you've also had a long career in law enforcement with lots of frontline experience, including walking the beat in the Downtown Eastside of Vancouver. We know that drug use is a long-standing issue and that things have become increasingly complex in recent years.

Can you tell us about what has changed over the last 10 years or so with illicit drugs and the opioid epidemic from a policing perspective?

Ms. Fiona Wilson: The most significant thing that's changed over the last number of years is the toxicity of the illicit drugs. It's only in the last 10 years or so that we're seeing the incredible toxicity in the drug supply, which is really what's contributing to overdose deaths. Unfortunately, initiatives like decriminalization are not going to change that fact. It's the drug supply that is killing people. It's not that they're using too much but that the drug supply itself is toxic.

I'd say that's the single largest change that I've seen in my 25-year policing career.

Mr. Gord Johns: The BC Association of Chiefs of Police and the Canadian Association of Chiefs of Police both came out with policy statements supporting decriminalization, supporting a safer supply to replace the toxic drugs that you're talking about.

There's been a lot of media focus around diversion lately. The B.C. RCMP recently issued a statement saying that the presence of confirmed safer supply prescriptions are in the minority of drug seizures.

Maybe you can tell me this: Is diversion of prescribed medications in drug seizures something new, something that started with the introduction of pharmaceutical alternatives? Also, from a policing perspective, what drugs are having the biggest impact in driving the toxic drug overdose crisis?

Ms. Fiona Wilson: Diversion of prescription medication is nothing new. When I walked the beat in the Downtown Eastside 25 years ago, there was always somebody standing at Main and Hastings offering T3s, for example, so the issue of diversion is not new.

I think the devil's in the details when we're talking about diversion, because there's certainly diversion of prescription medication, which is different from, but inclusive of, the diversion of the safe supply medicine chain.

Then of course there is what is a much more pressing issue to me as a police leader: the matter of counterfeit pills that are produced, and can be produced, in very large quantities. The problem with that is they look exactly like prescription pills, so the possibility of someone dying as a result of taking what they think is a diverted prescription is actually quite high, because we don't know what's actually contained in those counterfeit pills. From an organized crime perspective, that can be really scaled up. Unlike diverted prescriptions or diverted safe supply, which is very limited and more of a street level phenomenon, the issue of counterfeit prescription medication is capable of really scaling up, and that's a huge issue. Certainly, that's one thing.

When it comes to what is the most deadly part of our drug supply, it's fentanyl, absolutely, since 85% of overdose deaths are attributable to fentanyl. Then come cocaine and then methadone.

What we don't see, at least not in Vancouver.... I can't speak for the whole province on this, despite the fact that I am here in my capacity as president of the British Columbia Association of Chiefs of Police. I don't know the nuances in all communities across the province, but in Vancouver that's where our focus is, because that's what people are dying from according to the coroner's data. They're not dying from diverted safe supply and they're not actually dying from diverted prescription medication; they're dying from fentanyl, coke and meth, and that's where we really focus our enforcement efforts.

● (1620)

Mr. Gord Johns: Would you say that the deadly fentanyl is easier to access than the diverted hydromorphone on the street?

Ms. Fiona Wilson: I would say it's more prolific. There's more of it.

In British Columbia, we have somewhere between 4,500 and 5,000 people who are on a bona fide safe supply program, so there's a limited amount of drugs to be diverted. The same goes with prescription medication; it's quite labour-intensive.

Mr. Gord Johns: Sure. I really appreciate that.

We're here, and we have seen rates in Alberta skyrocket. Overdose deaths have gone up 17%. In Saskatchewan it's 23%. Both provinces are without a safe supply program. B.C. rates have plateaued, it looks like. We're seeing about 46 deaths per 100,000 in B.C. and 44 in Alberta. In Alberta, half of the people who have died between the ages of 20 and 39 have died from toxic drugs.

Would you believe that a safer supply, when you hear the information that's being put out, is the driving cause of toxic drug deaths in British Columbia, or do you believe that's disinformation?

Ms. Fiona Wilson: We know that's not the case.

Having said that, diversion's an important issue. It's something we're always watching very closely, but we know from coroners' data that diversion is not what's killing people in British Columbia.

Mr. Gord Johns: Thank you so much.

Do you believe we should reinstate the expert task force on substance use that your colleague Mike Serr used to co-chair?

Ms. Fiona Wilson: Yes. I think that would be helpful.

The Chair: Thank you, Mr. Johns.

Next is Mr. Doherty, please, for five minutes.

Mr. Todd Doherty (Cariboo—Prince George, CPC): Thank you, Mr. Chair.

I want to preface my comments today by thanking those from our police forces, who are our witnesses here, for your service and for your sacrifice. It is greatly appreciated.

Deputy Commissioner McDonald, have you or anyone else at the RCMP been asked by anyone in the B.C. NDP government or the federal Liberal government, from the beginning of 2023 to today, including elected officials, staff of elected officials, department staff or anyone, to not speak publicly about safe supply-related drug seizures?

D/Comm Dwayne McDonald: Thank you for the question.

No.

Mr. Todd Doherty: Deputy Commissioner McDonald, in April a memo was leaked from your division, E Division, to all frontline personnel as well as all detachments in British Columbia, essentially saying that it is an election year and that there are so-called “hot-button topics” such as safe supply and that you or your office has asked for frontline officers as well as detachments to not comment publicly on these hot-button political issues.

D/Comm Dwayne McDonald: I'm sorry. Do you want me to respond? Is there a question there?

Mr. Todd Doherty: Where did that come from, and what concern was there that caused that gag order to be issued?

D/Comm Dwayne McDonald: First off, yes, that memo was directed by our communications director here in the province. The police have a very important role to play in many instances of public safety issues, particularly in the illicit drug challenge that we face in British Columbia, and it's very important that police be objective in this. Any comments that may be perceived to either support or not support any one particular party can have a negative impact on the objective role of the police.

Our job is to get out the facts, and—

Mr. Todd Doherty: I appreciate that, sir, but whether it's an election year or not, do you believe that British Columbians and indeed Canadians deserve to know the truth about criminal activity in their communities?

D/Comm Dwayne McDonald: They absolutely do, and we share that information regularly, as you have seen from many news releases recently about seizures of illicit drugs and some cases of safe supply drugs.

Mr. Todd Doherty: With all due respect, the memo came out after Prince George released a statement regarding safe supply and ongoing investigations, as well as in Campbell River. We know that Victoria, Nanaimo, Kamloops and Kelowna are all seeing the same.

Doesn't it seem, as it would appear at least publicly, that there's a concern from E Division and those above that...communities in our province deserve to know the truth about what's going on in their regions?

D/Comm Dwayne McDonald: I completely agree that the communities deserve to know the truth, and it's our responsibility to provide the facts and the evidence to the communities when we see occurrences.

● (1625)

Mr. Todd Doherty: Sir, the definition of “widespread” is “distributed over a wide region, or occurring in many places or among many persons or individuals”.

Assistant Commissioner John Brewer is on the record as saying, “there is currently no evidence to support a widespread diversion of safer supply drugs in the illicit market in BC or Canada.”

We know from testimony as well as from reports of these investigations and, indeed, from these arrests that it is taking place in Prince George, Campbell River, Victoria, Nanaimo, Kamloops, Kelowna and, indeed, first nations across our area and in Alberta. Just by the very nature of all those communities, common sense would say that is a widespread problem.

D/Comm Dwayne McDonald: Thank you for the question.

I think it's important to provide the context for that statement by Assistant Commissioner Brewer.

It was in response, at the time, to statements made that we had safer supply diverted to most communities in British Columbia and outside of the province. At present, we do not have evidence to suggest that safer supply has been diverted outside of British Columbia. I agree with you that we've seen it in some of the communities you listed. Those are also the same communities that have a predominant criminal and illicit drug market and organized crime groups in them. As we identify them, we're addressing them, but we have not seen it everywhere.

However, I will say that it is an emerging concern and something we're following very closely.

Mr. Todd Doherty: Would your 6,800 frontline officers in British Columbia agree with the statement that there is no evidence to support widespread diversion? They're seeing it every day on the ground.

D/Comm Dwayne McDonald: Again, thank you for the question.

I would say that it depends on the community in which they serve, because we're not seeing it in every community. We are seeing it in some communities.

The Chair: Thank you, Mr. McDonald and Mr. Doherty.

Next we have Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you all.

Let me start off by saying that like all of you here, my sympathies are overwhelmingly with those who've lost people to the drug crisis.

However, I want to talk about a different aspect of this problem.

A few months ago, I was in a downtown bar here in Ottawa—not that I do that very often. One of the colleagues I met up with was assaulted as he was going to the bar. Another one was threatened. Also, within about a month of that, I was returning down Wellington Street from downtown, from the Rideau Centre. My son, who is 15, was coming after me. It was nighttime, and there was someone out in the middle of the street yelling, screaming and accosting cars. I spoke to the parliamentary police and told this to them. They said that he's someone they know and not to worry about him. My son didn't know that, so I waited for him. I didn't want him to have to face some crazy person accosting him in the street.

There is certainly the perception among a lot of Canadians that a lot of downtown cores are out of control. Certainly there's also the perception that around places like safe supply and safe injection sites, things are worse—that there are people openly stoned in the street and getting CPR performed on them in the street, or that there are needles and excrement in the street.

One of the pillars of the Swiss approach to their drug problem is trying to decrease harm to society. I would note that this is not part of the Canadian approach. Does that need to be part of the approach?

I'm asking this of the representatives of the police out there: Do you agree that this is a problem? Do you agree that a lot of Canadians who aren't involved with drugs are increasingly unhappy with society in the downtown cores that are this way? Do you want to do more about this? If so, what do you need to better address this situation?

Let me start with the RCMP and then we'll go on from there.

D/Comm Dwayne McDonald: I would note that in our experience, one of the success factors required for decriminalization is public support.

I think you're faced with situations—as we've seen and experienced in our communities, and as we hear from our communities—in which public consumption in some places may lead to other members of the public feeling at risk or threatened or vulnerable to street-level crime, as you spoke about. It presents a challenge. That's because it not only creates situations in which criminal activity can occur but also puts a stigma on people who use drugs but who may not be engaged in that type of activity.

If we don't have public support moving forward, decriminalization and societal acceptance of it will be an uphill battle.

● (1630)

Mr. Marcus Powlowski: Could I ask the two other police chiefs the same question?

Ms. Fiona Wilson: Chair, I can address that question.

It's not lost on me that your example was in Toronto, where there is actually no decriminalization. I'm happy to comment on our decriminalization experience here in British Columbia as it relates to public consumption. This is because I couldn't agree more with Deputy Commissioner McDonald that the matter of public consumption on our streets is something that we were very concerned about before the application went in for the section 56 exemption, and we continue to be concerned about it to this day.

In fact, all of the concerns that we had have been realized. We've had some really concerning examples of public consumption, despite the fact that, in my experience, the vast majority of people who use drugs have no interest in doing so in front of children, for example, or in manners that I think are problematic.

I have to give our provincial government credit for doing everything it could to come up with a public consumption act. Unfortunately, that act has been prevented from coming into force as a result of an interlocutory injunction that was issued by the chief justice of the B.C. Supreme Court.

There have been efforts to address that. It would have been nice to have that matter addressed prior to the submission of the request for the section 56 exemption. It is an ongoing challenge here in British Columbia, for sure.

The Chair: Thank you.

Ms. Huggins, I'm not sure if you want to get in on that. That is the end of Dr. Powlowski's time, but if you want 30 seconds to offer your perspective, go ahead.

Ms. Rachel Huggins: Thank you for the additional time.

I think the only thing I would add is that the CACP special purpose committee on decriminalization has reconvened, and this is one of the issues that will be incorporated. We are taking another look at decriminalization, based on what we've learned in the last few years. I think it is one of the priorities that will be in that report.

Thank you for the time.

The Chair: Thank you.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

My question is for the RCMP officials. One of the pillars of the national strategy is law enforcement. What tools do you need to be more effective at law enforcement, particularly when it comes to seizures or the fight against organized crime or contaminated illicit drugs?

[*English*]

The Chair: That's for you, Mr. McDonald, I believe, or Mr. Ng.

Assistant Commissioner Will Ng (Royal Canadian Mounted Police): Yes. Through the chair, thank you for your question.

Related to tools for law enforcement, with decriminalization in place, we are not seizing quantities below 2.5 grams. We are not pursuing investigations on those offences that we would have pursued prior to decriminalization.

That said, we now need tools to target the ones who are actually selling and trafficking the illicit drugs to users and, ultimately, the ones who are actually producing the toxic drugs that are, sadly, causing the deaths. I note that there are precursors utilized to manufacture fentanyl and methamphetamines and other opioids. A number of these precursors are currently unregulated, meaning that they're legal to possess and utilize, and the police do not have the powers currently to seize or to investigate the possession of these chemicals.

It would be great for law enforcement if there was an effort made to start to schedule and regulate these types of chemicals to allow, permit and give authority to the police to seize these chemicals to prevent the manufacture of the illicit substances.

● (1635)

[*Translation*]

The Chair: That's all the time you had, Mr. Thériault.

[*English*]

We'll go to Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: Thank you.

We know that the expert task force came back with some unanimous recommendations, and it was chaired by Mike Serr, the former president of the Canadian Association of Chiefs of Police. Their recommendations were unequivocally unanimous and supported stopping the criminalization of people who use substances; providing a safer supply of substances to people who use substances and require them; and scaling up prevention, education and treatment on demand. Those are all policies that are very similar to what Portugal did.

Right now we're hearing this campaign about diversion as the dominant factor for driving the toxic drug crisis. Do you believe that diversion, in terms of the conversation around the diversion of safer supply substances, is actually causing more harm by slowing down the pace of addressing the real root causes and problems and of our responding to this drug crisis?

Ms. Wilson, I'll let you start.

Ms. Fiona Wilson: I certainly think that for us here in Vancouver, as I said earlier, we focus on what is doing the most harm, and we know that diverted safe supply and diverted prescription medications are not what's killing people.

Also, when you consider the volume or the potential volume to scale up diverted prescriptions or diverted safe supply, it pales in comparison to what organized crime is doing in terms of fentanyl production, importation and exportation. Those are really where we focus our efforts here in Vancouver, and I think it's important that we continue to use our finite resources to focus in on those areas, individuals and groups that are doing the most harm.

Although I think diversion is important and we need to keep an eye on it, it has been around for a very long time. In my mind, when we look at the overdose deaths and at the scalability, I think there are other areas that I would focus in on in terms of the individuals and groups who are doing the most harm.

Mr. Gord Johns: Deputy Commissioner McDonald, just yes or no, do you think this conversation about diversion versus scaling up a response is causing more harm,?

Ms. Fiona Wilson: I think those conversations are important.

The Chair: Thank you very much, Mr. Johns.

Next we'll go back to Mr. Doherty for five minutes.

Mr. Todd Doherty: Thank you, Mr. Chair.

Deputy Commissioner McDonald, has organized crime incorporated safe supply pharmaceuticals into their trafficking operations, yes or no?

D/Comm Dwayne McDonald: Yes.

Mr. Todd Doherty: Corporal Jennifer Cooper of the Prince George RCMP said the following:

> We have noted an alarming trend over the last year in the amount [of] prescription drugs located during drug trafficking investigations....
>
> Organized crime groups are actively involved in the redistribution of safe supply....

Do you agree with those statements?

D/Comm Dwayne McDonald: Yes. Organized crime groups are trafficking not only illicit substances but any prescription drugs that they can get their hands on.

Mr. Todd Doherty: We know of a recent investigation in Prince George related to organized crime individuals literally standing outside of pharmacies and buying or collecting the safe supply from those who were receiving it. Is this true?

D/Comm Dwayne McDonald: Yes.

Mr. Todd Doherty: From what you're hearing from frontline officers, in your opinion, has decriminalization contributed to an increase in general street disorder and illicit drug use in public?

D/Comm Dwayne McDonald: From our experience in our communities, I'm not certain you can draw the correlation that decriminalization has contributed to increased disorder. What we do see, as both I and the other police officials on this panel noted, is that the public consumption of illicit substances is presenting increasing challenges for law enforcement to deal with, and it's becoming an increasing concern in our communities.

● (1640)

Mr. Todd Doherty: Do you understand that the nature of your comments and those of others in downplaying the seriousness of the diversion problem or denying that there's a problem at all goes against every detachment and municipality fighting for more resources for policing?

Assistant Commissioner Ng just said that you need the tools, so when we're fighting for those municipalities, when municipalities are asking for more resources and when there are statements such as Assistant Commissioner Brewer's or indeed yours, those fly in the face of those of us who are trying and fighting for you to get the tools and resources to do your job. Do you understand that?

D/Comm Dwayne McDonald: I would disagree, in the sense that we're not downplaying diversion. We are identifying where it's occurring, how it's occurring and the fact that it's occurring in addition to the other illicit substances and drugs that our organized crime groups are trafficking in. We're targeting those groups, and we have a commitment to provide accurate and timely information to the public and to government officials so that they too are aware of the problem.

Mr. Todd Doherty: On March 11, the statement on safer supply indicated, “The seizure of prescription drugs, such as narcotics and opioids, that are no longer in the possession of their prescribed owner is something the police have had to deal with on many occasions.”

It continues, “there is currently no evidence to support a widespread diversion of safer supply drugs in the illicit market in BC or Canada.”

Deputy Commissioner McDonald, I am going to have to disagree with you when your frontline officers in your detachments are actually producing and presenting more evidence on that.

It's frustrating when you have folks who are fighting for you and fighting for your frontline officers—and I know they disagree with the public statements—and then you have comments such as this. It would appear that the RCMP, and indeed the B.C. chiefs of police, are covering for the government in an election year on an issue that's politically bad for them.

Can you at least agree with me that this is exactly how your comments and those of some of your officers would be taken?

D/Comm Dwayne McDonald: No, I'm sorry. I completely disagree with that.

Mr. Todd Doherty: Well, we're going to have to agree to disagree on that.

How many more communities need to report diversion of so-called safe supply before it crosses the threshold of “widespread”?

Ms. Wilson, are all of the B.C. chiefs of police on side with decriminalization and safe supply, or are there some who are concerned and want to pause this experiment?

Ms. Fiona Wilson: I can certainly say that we've expressed our significant concerns with decriminalization. There is no question about that.

I think one thing all chiefs across the province agree on is that we do not want to throw people in jail simply by virtue of their personal drug use. Beyond that, as we've learned, the devil is in the details. We have been flagging the issue of public consumption since prior to the submission of the exemption request.

What's happened is exactly what we predicted would happen. We're satisfied that the province has tried to address that through the public consumption act. Unfortunately, it's been unsuccessful to this point.

Going back to the matter of diversion, the reality is that there are seven people per day dying in British Columbia as a result of the toxic drug crisis. They are not dying as a result of prescription-diverted medication; they are dying because of the poisonous drug supply that is on our streets.

The Chair: Thank you, Ms. Wilson.

Dr. Hanley, please, you have five minutes.

Mr. Brendan Hanley: Thank you very much.

Deputy Chief Wilson, thanks for emphasizing that last point.

I continue to be puzzled by the emphasis from my colleagues on diversion, which, as you and others have stated, is a problem that needs to be addressed but that is not killing Canadians. It's our illicit toxic drug supply that is killing Canadians.

I do have a couple of short questions for you.

My colleague, Dr. Powlowski, described what it's like to take a walk around downtown Ottawa here. Certainly when I walk home every day, I encounter similar circumstances. However, this is not an area where we have a decriminalized approach.

Can you just talk about the correlation? I know there is a correlation with public acceptance and that this is a serious issue to be addressed, but can you talk about the correlation between decriminalization and public safety and public consumption?

● (1645)

Ms. Fiona Wilson: Absolutely.

Prior to decriminalization, if someone was using drugs in a problematic circumstance—for example, at a playground, bus shelter or beach—community members were able to call 911. Police were able to attend and address that circumstance.

The vast majority of drug users—I've done three tours of duty in the downtown East Side and can assure you of this—have no interest in using drugs around youth and children, for example. However, when those circumstances do arise, it's very important that police have the tools to address them. In the wake of decriminalization, there are many locations where we have absolutely no authority to address problematic drug use because the person appears to be in possession of less than 2.5 grams and they are not in a place that is an exception to the exemption.

We had three exceptions added to the exemption last year in September, which was helpful. They include skate parks and playgrounds. There were a few other exceptions added, so we now have nine exceptions to the exemption. The reality is that there are still a number of other situations in which the public has significant concerns about problematic drug use. When that happens, if it's not in a place that's an exception to the exemption, there's nothing police can do. It is not a police matter in the absence of any other criminal behaviour. If somebody has their family at the beach and there's a person next to them smoking crack cocaine, it's not a police matter, because a beach currently is not an exception to the exemption.

That's what we were hoping to have addressed through a public consumption act. The thing I liked about the bill was that it did not further criminalize people by virtue of their drug use; rather, it required police to ask people to leave. It was their refusal to leave that would have introduced criminal sanctions, as in obstruction. I thought it was a very good balance between what we had previously under the CDSA. It's respecting the rights of people who use drugs but also ensuring that people in our community feel safe. I think that's a very important issue.

Mr. Brendan Hanley: Thank you.

Is this a failure of implementation or a flaw in implementation? Is decriminalization, in itself, a faulty principle?

Ms. Fiona Wilson: I think we all agree that we do not want to criminalize people by virtue of their personal drug use. Those days are gone. We want to support a health-led approach. The problem is, as I said earlier, that the devil is in the details. Quite frankly, police warnings were not heeded in the first instance.

We have situations in which, technically, people could use under 2.5 grams of a variety of illicit substances in a licensed establishment as long as the licensee allowed them to and they weren't contravening any smoking bylaws, for example. That opens up a whole can of worms for police, potentially. If you have a nefarious business owner who has a licensed establishment, technically you could have a situation of an 18-year-old who can use cocaine—assuming the licensee allowed them to do that—but can't order a beer.

These are all things we raised prior to decriminalization taking effect that we don't feel were adequately addressed.

However, we strongly support the notion of not trying to arrest ourselves out of this crisis. That is not going to save lives. In fact, it does quite a bit of harm if it's somebody with a significant addiction that they need medical help with or somebody who needs support. The last thing they need is to be introduced into the criminal justice system.

The Chair: Thank you.

Mrs. Goodridge, go ahead for five minutes, please.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

Thanks again to the witnesses for this.

My first question for Ms. Wilson is this: What other exceptions to the exemption would you like to see?

● (1650)

Ms. Fiona Wilson: Personally, based on this journey I've been on from the very beginning—in fact, initially with the City of Vancouver, then with the province—I would like to see additional exceptions for beaches, bus shelters, being within a certain distance from residential buildings, businesses, the entrances of workplaces, sports fields, parks and places where families and youth could reasonably be expected to be.

Mrs. Laila Goodridge: Do you think we should have an exemption for drug use in hospitals?

Ms. Fiona Wilson: Absolutely. One of the things we talked about was private and semi-private places, like, for example, in Tim Hortons or in a McDonald's. Hospitals are another great example.

We consulted with our health authority here in Vancouver. They have been dealing with the matter of people having drugs in their possession for many years, whether it be going into an ambulance or into a hospital. However, the fact is that, once again, when those conditions in a hospital become problematic, there's nothing the police can do about it.

Mrs. Laila Goodridge: Okay. I appreciate that.

It's really unfortunate that you guys don't have the tools to do what you need to do to keep our communities safe and to keep people from having new addictions.

My question is simple. Why didn't the Vancouver police arrest the Drug User Liberation Front when they handed out about three thousand dollars' worth of drugs in front of the Vancouver Police Department in 2021?

Ms. Fiona Wilson: There are all sorts of considerations that go into a decision such as that, including the Crown's likelihood of approving charges. It's not to say that we don't collect evidence with respect to that incident and others similar, but we do have a number of things we have to consider, including the Crown's directive with respect to their drug policy.

There are a number of considerations, some of which remain quite confidential, and I only mean that from a policing perspective. We employ all sorts of techniques, including covert ones, that we simply wouldn't talk about in a public setting.

Mrs. Laila Goodridge: I appreciate that.

My question is to Deputy Commissioner McDonald.

Has the inability to seize less than 2.5 grams of fentanyl, or any substance, under B.C.'s decriminalization, had a negative impact on your ability to get deadly fentanyl off the streets?

D/Comm Dwayne McDonald: Thank you for your question.

The permitted exemption for personal possession presents some challenges for law enforcement when we're conducting investigations in terms of starting at the grassroots level and leading up to those who are trafficking. We have modified our investigative techniques. We've conducted a significant amount of training. It took a while for law enforcement to adapt our approach and principles, but we haven't seen a decrease in trafficking investigations or trafficking charges in British Columbia as a result.

Mrs. Laila Goodridge: Do you think decriminalization has been successful in B.C. so far?

D/Comm Dwayne McDonald: I'm sorry. The first part of your question cut out. Could you please repeat it?

Mrs. Laila Goodridge: Do you think decriminalization has been successful in B.C. so far?

D/Comm Dwayne McDonald: I think aspects of decriminalization have been successful. In terms of the stigma attached to people who previously may have been arrested for personal possession and may have been diverted into the criminal justice system, I think we've seen positive impacts there. I think we still have a long way to go, as you've heard all the police leaders say, on aspects of public consumption. We're encouraged by the Province of British Columbia's attempt to amend the legislation and we're hoping for success in that matter.

Mrs. Laila Goodridge: Thank you.

Mr. Chair, I would like to move a motion:

> That, given that a leaked memo from British Columbia health network states:
>
> "Staff are not to search or seize patients' drugs or weapons with blades less than four inches long or restrict visitors who bring them drugs for personal use;
>
> This applies to anyone in possession of 2.5 grams or less of fentanyl, heroin, cocaine, methamphetamine or MDMA";

> and that, given the ongoing situation at Victoria General Hospital in British Columbia, where illicit drugs are regularly consumed by patients at Victoria General Hospital, exposing patients, including pregnant women at the maternity ward and health care workers, to the risks of inhaling toxic substances, coming into contact with illicit powders, and facing harm from intoxicated patients, and that this is the result of dangerous drug decriminalization policies,
>
> the committee report its support of the victims of this situation, including nurses and pregnant women, and its condemnation of policies that allow for dangerous drug use in hospitals, and that the committee call the following witnesses: the Minister of Mental Health and Addictions and Associate Minister of Health and Health Canada officials for no less than two hours; Victoria Police Department representatives; and British Columbia Nurses' Union representatives.

Mr. Chair, I think that through the last bit of testimony we've had here, it has become increasingly clear that there are some very serious issues when it comes to decriminalization, and we are seeing major impacts. We've even heard from Vancouver police specifically that there are exceptions to the exemption and that this has not been put into play in a way that is preserving public safety.

Therefore, I think it is absolutely incumbent on us as the health committee to study and to look into the direct implications that it's having in our hospitals. In reading some of these stories and some of the horrific pieces that we've had to see, I can't imagine nursing moms being told by their nurses that perhaps they don't want to breastfeed their children because there are concerns regarding the drug use in hospitals, and the drug use is so open that people are wearing gas masks.

I just share this. I hope that we can approve this motion and get back to the witnesses.

Thank you.

● (1655)

The Chair: Thank you, Mrs. Goodridge.

The motion is in order. It's clearly on the topic that is being discussed as part of the study. In fact, there was reference to it already today.

The debate is on the motion.

I recognize Dr. Hanley.

Mr. Brendan Hanley: Mr. Chair, I just want to briefly say that obviously this attests to a problem that indeed exists. However, I want to maximize our time for hearing from our witnesses, which is why we're here today. I also have concerns about the scope of the motion as it relates to provincial jurisdiction.

In that spirit, I would like to ask you to adjourn debate.

The Chair: The motion to adjourn debate is a dilatory motion that is not debatable. We must go straight to a vote.

(Motion agreed to)

The Chair: The debate is therefore adjourned.

You have 37 seconds remaining on the clock, Mrs. Goodridge.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

My next question is this: Deputy Commissioner McDonald, do you think that the decriminalization pilot project should continue for the next two years?

D/Comm Dwayne McDonald: Thanks for the question.

Decriminalization is scheduled to continue for the next two years. I would like to see, as I'm sure my police colleagues would like to see, more exemptions with respect to public consumption so that we can deal with those critical issues.

I think if we can get those exemptions in place, then we have a better chance of seeing the true impact of decriminalization in helping those who are struggling with addiction and diverting them away from the criminal justice path into a health path.

The Chair: Thank you, Mr. McDonald.

Next we're going to go to Ms. Sidhu, please, for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair, and thank you to all of the witnesses for being here.

My question goes to Ms. Wilson.

You said we need a multi-level approach to deal with the opioid crisis. We know that the realities in B.C. are different from those in Ontario—I'm from Ontario—and that many communities across the country are impacted. We also know that it's important to respect the jurisdiction of our provinces and territories and work together with them.

That said, is there anything you would like to see in terms of our work with the provinces and territories to fight organized crime, which is responsible for this deadly supply that is killing Canadians?

Ms. Wilson, can you answer that?

Ms. Fiona Wilson: I certainly think if it's the case that British Columbia does not successfully have a public consumption act or if we're not able to bring it into force, the other option of course is to add additional exceptions to the Health Canada exemption.

We are hoping that the province will exhaust the possibility of bringing the public consumption act into force, because, quite frankly, it's less intrusive when it comes to people who are using drugs. As I said earlier, there's a requirement that the police simply ask people to leave, and they leave whole. There's no ticket, and they leave with their drugs, but they do have to move on. It's the refusal to do so that would become a problem. Exceptions in the exemption mean that the exemption does not apply in those particular places, so we would revert to the Controlled Drugs and Substances Act, which is criminalization.

If there was an advocacy piece, in the absence of that provincial legislation being successfully brought in, I would hope that we would have support to work with Health Canada to add additional exceptions to the exemption.

● (1700)

Ms. Sonia Sidhu: My question is this: How can we work together to support our frontline law enforcement officers to respond to this crisis? Besides this question, is there any other...? You mentioned Health Canada. Can you elaborate on that?

Ms. Fiona Wilson: Well, certainly we have a number of things we do to try to assist our frontline officers. You make a very good point that at the end of the day, they are the ones dealing with the tragedy associated with the toxic drug crisis in terms of a frontline response, along with, of course, all the people who are impacted—the loved ones and the family and friends of people who are dying. Anything we can do to support those members, and that includes naloxone kits being issued....

Quite frankly, I think the most frustrating thing for our members right now is seeing situations where they do not have the tools to adequately respond. At the end of the day, our frontline members want to be able to deal with these problematic circumstances of public consumption, and I think that would be the single best way to support them: to give them those tools so that they would be able to do their jobs when there are community concerns about problematic drug use.

Ms. Sonia Sidhu: I have one other question.

In your testimony, you said that 85% of deaths are from fentanyl. Do you think an education campaign needs to be addressed with other organizations working on the ground?

Ms. Fiona Wilson: That's a great question.

I always talk about decriminalization as being one tiny piece of a much, much larger puzzle, and in order to put that puzzle together to see what the picture is, we need increased education and increased prevention. We also need some harm reduction services, such as having our members carry naloxone kits, and we need safe injection sites. Really, it's a multi-faceted approach to this problem. It includes safe supply initiatives, but any one thing on its own is not going to be effective.

I can't tell you how supportive police in this province are when it comes to increased education, increased prevention and an increase in health services, such as treatment on demand.

The Chair: Thank you, Ms. Sidhu.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Ms. Huggins, earlier you said that we are facing a public health crisis and that we have to take a comprehensive approach and take into account the social determinants of health. For some time now, we have been talking about the connection between the decriminalization of drug possession and public use of drugs. How can we find solutions to this problem using a harm reduction approach?

For example, are supervised injection sites inadequate, too few in number or too unattractive to encourage people to use in those places rather than anywhere else in the public space? Do these people have enough housing or places to go? When someone goes to a McDonald's, a subway station or a hospital to inject drugs in the winter owing to the cold, it's because they have nowhere else to go.

Tell us about some of the solutions you're looking at in that regard that would be part of a comprehensive approach based on the social determinants of health.

● (1705)

[*English*]

Ms. Rachel Huggins: Thank you very much for the question.

I think you're very much correct. I think Deputy Chief Wilson actually mentioned it. It is an all-encompassing approach.

You mentioned things like why individuals aren't using the supervised injection sites. I think the role of a whole-of-community approach that includes health, justice and police is really to do that kind of assessment, not only to understand what you need in your community but what those individuals may want or need at a different time with whatever issue they are dealing with.

There are quite a number of resources that we have identified as having an impact on an adequate health response. Housing has been mentioned, and supervised injection sites and location. I think the issue is that we need to all work together, with collaboration among health, police and social services to determine what is required and what those individuals in that community need.

The Chair: Thank you, Ms. Huggins.

[*Translation*]

Thank you, Mr. Thériault.

[*English*]

Go ahead, Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: This is a question for Ms. Wilson.

In terms of diversion of opioids, can you tell me about what's also happening with opioids prescribed for chronic pain and other conditions that you're seeing on the street, in terms of what's prevalent and what's changing?

Ms. Fiona Wilson: We see both. There's no question about that. We know that about 20% of patients who are prescribed hydromorphone, for example, are in a bona fide safe supply program, while about 80% of them are prescribed for pain outside of addiction issues.

We also know that about 50% of the hydromorphone pills that we come across can indeed be attributed to safe supply. That's just in recognition of the fact that someone who's on a bona fide safe supply program has a more regular significant supply of hydromorphone.

My biggest concern when it comes to pills is the number of organized crime groups that are producing counterfeit pills. I saw a photo of this just last week, and you could not distinguish the counterfeit pill from the real prescription pill. The problem is that we have no idea what's in the counterfeit pill, and it could absolutely be deadly.

Mr. Gord Johns: Thank you so much.

Deputy Commissioner McDonald, you've had an exemplary career. Do you find it offensive or insulting that it might be suggested that your testimony was misleading here at this committee or that it might be influenced by a provincial election?

D/Comm Dwayne McDonald: Thank you for the question.

No, I don't take offence. These are critical issues that have to be discussed. I understand the concern that police agencies could be directed or influenced, but I don't take exception to that, and I'm more than willing to answer those questions.

Mr. Gord Johns: Ms. Huggins, we've not had a summit on the toxic drug crisis, yet we've had a summit on the auto theft issue. Do you believe that the toxic drug crisis deserves to have a national summit at a first ministers meeting, and do you believe we should reinstate the expert task force on substance use?

D/Comm Dwayne McDonald: Was that directed towards me?

Mr. Gord Johns: It was directed to Ms. Huggins.

Ms. Rachel Huggins: I'm sorry. I didn't hear the beginning part of the question. Thank you for the question.

I think there is a lot of value in having that expert task force reconvened. I think that now that we have had the experience of decriminalization in British Columbia, there are lots of things that the whole country can learn, and we need to learn from it. The task force is definitely needed, and I think that you will see lots of support for it across the country.

I also think that a national summit is important. These are issues that affect every corner of the country, and there needs to be that exchange you heard about from Dr. Day. It's a very different approach in Alberta. We hear from British Columbia about the different issues that are facing law enforcement and the public unrest, so definitely a summit is important and will help us in the future to determine what elements need to be included in any type of approach.

● (1710)

The Chair: Thank you, Ms. Huggins.

Dr. Ellis, please go ahead for five minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thanks very much, Chair, and thanks, everyone, for being here today.

Dr. Day, we talked a bit about the amounts of drugs that have been decriminalized, and we throw around this amount of 2.5 grams of fentanyl. I've spoken about it in committee here as a former physician, but you're a current addiction specialist. Maybe it means more coming from you if you put in perspective how deadly that amount of fentanyl actually is.

Dr. Nathaniel Day: Thanks for that question.

I think I'll put it this way, Dr. Ellis. There are published case reports in the literature of people dying of an overdose from the accidental administration of three milligrams of hydromorphone in a hospital setting. There are multiple cases of that, and that's why it's a high-risk medication and why we go to so much effort to label things as morphine versus hydromorphone. Hydromorphone is extremely potent and could kill a person with no trouble if they don't have opioid tolerance.

Fentanyl is 50 times more potent that morphine, and that number of grams of fentanyl is certainly an amount that could easily kill one or more people.

Mr. Stephen Ellis: Thanks very much for that, Dr. Day.

To me, it would seem slightly ridiculous to allow people to have 2.5 grams of fentanyl when routinely, in the emergency room, if we were going to use it for a procedure to reduce a dislocated shoulder, we might use 200 micrograms.

Is that a fair statement?

Dr. Nathaniel Day: That's absolutely correct.

Mr. Stephen Ellis: Thank you very much for that.

To Mr. Ng, the criminal operations officer, you talked a bit about precursor chemicals and the difficulty in having them listed as illegal in Canada. Does law enforcement regularly communicate to the Liberal government that we need better and quicker action on that?

A/Commr Will Ng: Thanks for your question.

Through the chair, we have communicated to government through the law amendments committee and a number of other committees to advocate scheduling those precursors. So far, I think it's still a work in progress.

Mr. Stephen Ellis: Thank you very much.

Through the chair, this goes to you again, sir: Do you have any idea how long that's been in progress now?

A/Commr Will Ng: It's been brought to my attention for over two years.

Mr. Stephen Ellis: What you're telling this committee is that we know there are precursor chemicals out there that are used to make fentanyl, carfentanil and sufentanil, etc., which are incredibly potent opioids that are killing people on the street. They are part of this so-called toxic drug supply, and this government could actually make them illegal, but for two years, it's refused to do so.

A/Commr Will Ng: Through the chair, I can't comment on the refusal part, but I can comment on the time it's taken to continue to advocate for it.

Mr. Stephen Ellis: It's not happened in two years, basically.

A/Commr Will Ng: Yes.

Mr. Stephen Ellis: Thank you for that. I appreciate it.

Deputy Chief Wilson, we talked a bit about the drugs that are on the street these days.

Clearly, eight-milligram tablets of hydromorphone are incredibly potent. There's a plethora of them out there on the street. Perhaps it's one of the drugs of choice nowadays. We know that, again, eight milligrams is significant, because that is what is being issued in safe supply regimes. They're given approximately 30 tablets at a time, I understand.

Can you comment a bit on what you've seen about the price of hydromorphone on the street?

Ms. Fiona Wilson: I'm sorry. I'm not up to speed on the price of hydromorphone. I know it's very cheap, but I also know it's not hydromorphone that is killing people in our province.

Mr. Stephen Ellis: That's a fair statement.

That being said, you talked a bit about your tour of duty in the Downtown Eastside previously, which I thought was an unusual comment, given that you were serving in a metro Canadian city.

Why did you characterize it as a “tour of duty”?

Ms. Fiona Wilson: In the Vancouver Police Department, we commonly talk about different areas that we work in as a tour of duty. I've done three on the Downtown Eastside. I did a tour of duty in professional standards. It's just a common police phrase.

● (1715)

Mr. Stephen Ellis: Certainly. I have a military background, so I would not comment on serving in a downtown area or metro Vancouver as a tour of duty, but I understand you have a different way of referring to things. Thank you for that.

Deputy Commissioner McDonald, do you have any idea of the street price of hydromorphone in B.C. in general?

D/Comm Dwayne McDonald: We have specifics that we could provide at a later date. I understand, from what I'm told, that the price of hydromorphone in the illicit market has gone down significantly in the last while.

Mr. Stephen Ellis: If you could look at the prices over time and table them with the committee, we'd be very appreciative. That would be excellent. Thank you.

The Chair: Thank you, Dr. Ellis.

We'll go to Mr. Jowhari, please, for five minutes.

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair.

Thank you to all our witnesses for their important testimony and the services they provide to keep our communities safe.

Deputy Chief Wilson, you talked about education campaigns and how important they could be. You also talked about how sophisticated these criminals are becoming in making the illicit drugs look very similar to the safe supply drugs.

What kind of education campaign can all of the various levels of government work on with law enforcement and support organizations, specifically in the areas hard hit with illicit drugs?

Ms. Fiona Wilson: There are lots of opportunities for collaboration with respect to education.

To clarify, I was talking about organized crime creating what appeared to be pills that look like prescription medication. It's not necessarily safe supply, but a whole myriad of prescription medication.

However, I honestly think that when it comes to education, a lot of it should really be health-led. Police play a role in education; there's absolutely no question about it. I can certainly speak for the VPD. We have countless initiatives. We work on getting out and educating youth in particular about the perils of drug use, whether they are through our schools or community centres. There are all sorts of programs that we run.

However, I would really like to see the health sector take the lead when it comes to educating our youth and our public about the perils of drug use. I think that's a really important thing for us to consider any time we're thinking about these initiatives. If we truly want this to be a health-led approach, then we do need the health sector to take the lead when it comes to things like education, prevention and treatment on demand.

It's not to say that there's no role for police in that, but I feel like we've been doing that for many years.

Mr. Majid Jowhari: Thank you.

I want to go to Deputy Commissioner McDonald.

We've talked about a number of different issues, from safe supply to safe consumption sites to illicit drugs that are killing people. However, the bottom line is that these drugs are getting into Canada. What are some of the programs that are being rolled out at the border to block these illicit drugs from getting into our country?

D/Comm Dwayne McDonald: I'll comment from a federal policing perspective.

Combatting transnational organized crime, whether it's at land borders, ports, through air services or marine, is one of the top priorities for our federal policing units. We work with countless partners all over the word to combat the entry of primarily pharmaceuticals or their precursor materials. We've had great success, but there is much more work to be done.

Part of the success is intelligence sharing—we have excellent relationships with our partners—and part of it is in the joint forces operations. We work with the Canada Border Services Agency, which works with United States partners and others to combat that, and we continue to do so.

Mr. Majid Jowhari: Our border with the U.S. is one of the largest land borders. Can you give me an idea of the degree of the challenge that we have in managing that big border, or is that an issue?

● (1720)

D/Comm Dwayne McDonald: Certainly, we do have one of the largest undefended or open land borders in the world, but we also have excellent relationships with the U.S. authorities and our partners.

It does present challenges. We clearly have large commercial transportation networks for legitimate goods that transit throughout North America. Those also present opportunities for organized crime elements to manipulate those transportation routes to import illicit goods.

However, we have had great success and we continue to have it. The border presents challenges, as you're aware, but we've increased our technological aspects, our intelligence aspects and our joint enforcement aspects as well in combatting those crimes.

Mr. Majid Jowhari: I have 10 seconds.

Where, internationally, are we getting most of these drugs being imported into Canada?

D/Comm Dwayne McDonald: If we're talking about the precursor materials that are predominantly used for fentanyl production, they're coming from Asia, India and South America.

Mr. Majid Jowhari: Thank you.

The Chair: Thank you, Mr. Jowhari.

To our panel of witnesses, this almost never happens. We've now completed three full rounds of questions and we have just under 10 minutes left on the clock. I'm going to propose two minutes for each of the parties to finish up our time.

Is everyone okay to proceed in that fashion?

If witnesses can stay with us for another 10 minutes, we're going to go now to Dr. Ellis for two minutes.

Mr. Stephen Ellis: Thanks, Chair.

I'll go to you, Deputy Chief Wilson, if I might.

You talk about multiple exceptions to the exemption in the decriminalization experiment. It would appear to me that there wouldn't be many other public places for people to use drugs if your wish were to come true, which would allow people to take back the downtowns that they would like to visit, like Dr. Powlowski.

Was that the aim of your comments?

Ms. Fiona Wilson: Recognizing that part of the challenge here is that when people use drugs alone, they are more likely to die because there's no chance for intervention if they are not with other people, I think it's really important for us to balance the safety and feelings of safety of all community members with the rights of people who use drugs and with our efforts to keep them safe, so yes, I do think that we should we expand the locations in public spaces where people will not be allowed to use drugs.

Mr. Stephen Ellis: Thank you very much, Deputy Chief Wilson.

Dr. Day, how does the federal addiction policy impact your incredibly innovative way of delivering your policies in Alberta for drug addiction and treatment? Is it positive or is it negative?

Dr. Nathaniel Day: I think that Alberta does not feel particularly well supported in its policies around the response to the drug crisis. I think we would appreciate seeing certain things happening.

For example, one of the greatest predictors of a person's staying in recovery—if they've gone through treatment and are on evidence-based treatment medications—is employment. Are there opportunities for the federal government to support employers to take on people in early, sustained recovery? Are there opportunities for the unemployment insurance system, for example, to support persons in active addiction who have lost their jobs to receive supplemental funds so that they can successfully attend treatment, recover their lives and go back to work?

There are a lot of things that we could be talking about that I don't think are controversial, that I think could have broad support in the public to support recovery for our population.

The Chair: Thank you, Dr. Day and Dr. Ellis.

Next is Dr. Powlowski, please, for two minutes.

Mr. Marcus Powlowski: I previously brought up the fact that I think public consumption is detrimental to society in many ways. As a committee, if we're going to make recommendations, what do we do about it? If we allow and decriminalize possession, where are people supposed to use their drugs? When people are homeless and are users, are they supposed to go into their tents and quietly die there so that we can't see them? What is your solution?

I really mean this. If you don't have a solution now, think about it. Do we put the safe injection sites out of the public domain? Do we patrol around there? How do we do it so that we let people who are addicts use drugs, but not in public, because of the detrimental effects?

That's for anyone who wants to answer.

● (1725)

Ms. Fiona Wilson: Sure. I can jump in.

I think you really speak to the importance of having services like overdose prevention sites readily available to people in the community. We have 12 of them here in Vancouver, but now we recognize that 60% of the people who are dying are dying through inhalation, not injection.

It's a question of pivoting and being able to accommodate those individuals so that they are able to use safely if that's what they choose to do. That's why services like safe consumption sites are so incredibly important.

Mr. Marcus Powlowski: If anyone else wants to add their two cents' worth there, go ahead.

D/Comm Dwayne McDonald: Perhaps I could add to Deputy Chief Wilson's comments.

People like choice. They like to have options when it comes to anything in life. When it comes to the consumption of drugs, if there's only one option and it doesn't suit them, then they're going to go where it suits them, and that may be public consumption.

As noted, in some of our supervised consumption sites or overdose prevention sites, there are no inhalation rooms or there is no ability to inhale. We find that most of our overdose deaths are related to fentanyl and to inhalation, so we need to provide spaces, I think, that would allow for that, but it can't be a space where someone has to take a bus for four kilometres and go across the city to find that space. Those spaces need to be readily available.

However, there also need to be multiple options in terms of treatment, counselling and safer places. I think it deserves a conversation so that we don't force people into one pathway that may not work for them.

The Chair: Thank you, Dr. Powlowski and Mr. McDonald.

[*Translation*]

Mr. Thériault, you have the floor for two minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

My question is for Deputy Commissioner McDonald or Assistant Commissioner Ng.

During the drug seizures in Prince George and Campbell River, the Minister of Public Safety and Solicitor General for British Columbia stated that there was no evidence of widespread diversion of safer-supply drugs in British Columbia, which was supported by RCMP Assistant Commissioner John Brewer.

A month later, do you agree with what he said? Why? What should be done to avoid such diversions? What are your solutions?

[*English*]

D/Comm Dwayne McDonald: I'm not aware of the Attorney General's comment. I do know that the Province of British Columbia acknowledges that there is diversion of safer supply drugs, just as there is with other prescribed drugs. In the case of Prince George, we have direct evidence, which has led to criminal charges, identifying safer supply drugs that have been diverted and were seized in conjunction with a multitude of other illicit substances.

I think that to move forward in dealing with the diversion of drugs, whether they be safer supply or prescribed drugs, we first have to be well educated to be able to identify them properly. Once we determine that they may be diverted safer supply drugs, we need to know where they have been diverted from, if that wasn't made evident in the investigation. If they are coming from a particular outlet, we need to work with our health authorities to find out where the cracks are and how those drugs are being diverted.

If they are being transported by a criminal network from elsewhere in the province, we need to know where they originated, and then we can work with the health authorities to identify problematic users who may be diverting their safer supply and trading in the illicit drug market.

[*Translation*]

Mr. Luc Thériault: However, if I understand correctly, you have had no answers to your questions and you don't know where these diverted safer-supply drugs are coming from at this time.

[*English*]

D/Comm Dwayne McDonald: To clarify, in some contexts we know exactly where it's coming from, because the investigation has borne that out through direct observations. In many cases, some of the drugs are being seized in their original packaging. Often, however, the identifying information, such as the original customer's name or location, has been scratched off of those bottles, and there's no tracing element that is put into safer-supply drugs. If those drugs are located outside a package or have been repackaged in a plastic bag, for example, we will not be able to determine their initial origin was.

The Chair: Thank you.

The final questions will come from Mr. Johns. You have two minutes.

● (1730)

Mr. Gord Johns: Deputy Commissioner McDonald, when you were asked earlier about the prices of hydromorphone, you said that they've dropped significantly.

Can you talk about the prices of toxic and deadly concentrated fentanyl, benzos and tranquilizers? Have the prices of those on the street also dropped significantly, or even plummeted?

D/Comm Dwayne McDonald: Since we saw the initial influx of fentanyl into the market here in British Columbia some years ago, it has become cheaper. It is the drug of choice. Unfortunately, it is easily accessible. That is why, in my opinion, it is such a killer: You have a cheap drug that is readily available, and in small amounts it can result in death.

Mr. Gord Johns: Toxic fentanyl is driving down the price of all drugs. Would you say that?

D/Comm Dwayne McDonald: I don't know if I could say that it's driving down the price of all drugs; it's just that fentanyl is so prevalent in the market that it's becoming cheaper and cheaper. It is by far the drug of choice among users who are attracted to opioids.

Mr. Gord Johns: Deputy Chief Wilson, you heard from Deputy Commissioner McDonald about the need for safe consumption sites to allow inhalation and to be closer to people.

Can you talk about how increased homelessness in major cities is contributing to public drug consumption? Would you say that adding more safe consumption sites and allowing inhalation would help counter some of the concerns around the decriminalization policy in British Columbia?

Ms. Fiona Wilson: Absolutely. It's a great example of the need to have a multi-faceted approach to this problem.

It's not just about decriminalization and it's not just about safe supply and it's not just about education, treatment and prevention. It's about everything together. I think increasing the number of safe injection sites and safe consumption sites where people can inhale, as opposed to just injecting, is a very important piece of that approach. When you overlay our increases in homelessness, I think it's really important to provide individuals with safe places where they can use drugs. We know that's what many people are choosing to do in any event.

I heard recently from a person who was actually in the Downtown Eastside for 20 years, and he has now been clean for 11 years. It took him literally dozens of times in treatment, and he's only alive today because of the intervention of harm reduction and safe supply services.

I think this is a very complex issue. It's really important that we take this approach that covers all different sets of circumstances. Ideally, we provide prevention and education so that people don't start using in the first place, but we also have to address the fact that there are some folks who are entrenched and who are using, and we want to try to keep them alive. Then there is everyone in between.

That's probably my main comment today: We really do need a multi-faceted approach, and no one approach is better or worse than the other. They're all really necessary.

The Chair: I want to thank all of our witnesses for being with us today. The level of professionalism and the conciseness of your answers are really appreciated. We appreciate what you all do to keep us safe every day. Thanks for being with us.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: We're adjourned.

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