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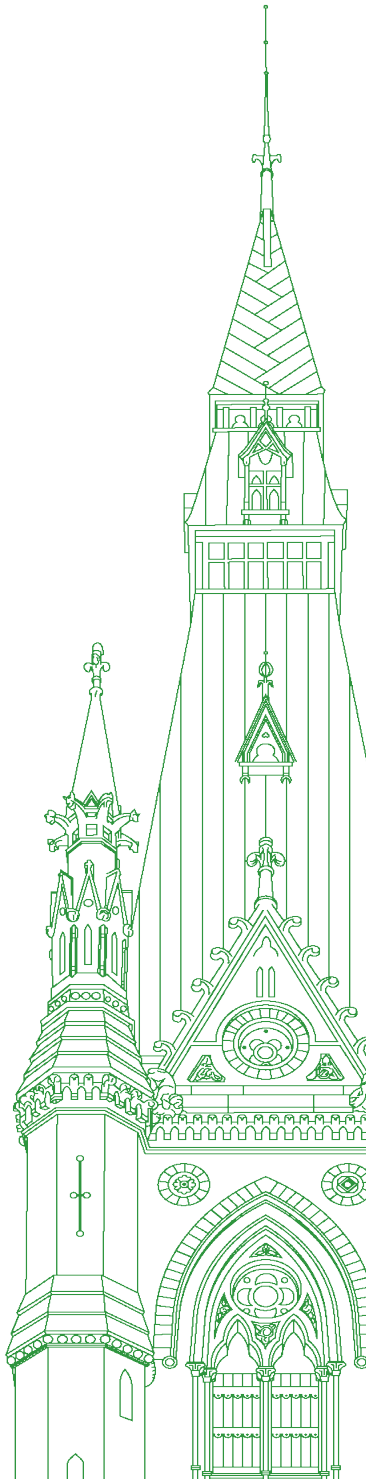

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, April 29, 2024

● (1545)

[*English*]

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

Welcome to meeting number 112 of the House of Commons Standing Committee on Health.

Before we begin, I would like to remind all members and other meeting participants in the room of the following important preventative measures.

To prevent disruptive and potentially harmful audio feedback incidents that can cause injuries, all in-person participants are reminded to keep their earpieces away from their microphones at all times.

As indicated in the communiqué from the Speaker to all members today, Monday, April 29, the following measures have been taken to help prevent audio feedback incidents.

All earpieces have been replaced by a model that greatly reduces the probability of audio feedback. These new earpieces are black in colour, whereas the former earpieces were grey. Please use only the black, approved earpieces.

By default, all unused earpieces will be unplugged at the start of the meeting.

When you are not using your earpiece, please place it face-down in the middle of the sticker for this purpose. You will find it on the table as indicated.

Please consult the cards on the table for guidance to prevent audio feedback incidents.

The room layout has been adjusted to increase the distance between microphones and reduce the chance of feedback from an ambient earpiece.

These measures are in place so that we can conduct our business without interruption and to protect the health and safety of all participants, including the interpreters.

I thank you for your co-operation.

In accordance with our routine motion, I am 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 of the opioid epidemic and toxic drug crisis in Canada.

I would like to welcome our panel of witnesses. Appearing as an individual by video conference, we have Dr. Nickie Mathew, who is a physician. On behalf of the Canadian Centre on Substance Use and Addiction, we have Dr. Alexander Caudarella, the chief executive officer. On behalf of Moms Stop The Harm, we have Petra Schulz, who is a co-founder. On behalf of Projet Caméléon, we have Dr. Marie-Ève Morin, a general practitioner in addiction and mental health, and who is also appearing by video conference.

Welcome to all of our guests here today.

We'll begin with opening statements. We're starting with Dr. Mathew, please, who has five minutes.

Dr. Nickie Mathew (Physician, As an Individual): Thank you for allowing me to come here to speak. I'd like to provide a disclaimer that the views and opinions I express are my own and are not attributable to any organization.

I'm an addictions and forensic psychiatrist, and I'd like to talk about the connection between substance use, psychiatric illness, overdose and violence. I want to take a case from forensic psychiatry.

So, this is John Doe. His father left the household when he was young. He experienced racism in school due to his skin colour. He found a sense of belonging in a group of friends who used cannabis. He started using cannabis in elementary school and started to skip school to use with his friends. In high school, he was transferred to an alternative school, but he dropped out shortly after. He started using opioids with hydromorphone that he bought from the street. Due to his drug use and theft at home, he was asked to leave, and he moved to the Downtown Eastside. To stay awake on the streets, he began to use crystal meth. Roughly one year prior to his index offence, he began to experience psychosis with paranoia and visual hallucinations, and he heard voices with auditory hallucinations.

On the day of the index offence, John Doe was using fentanyl and crystal meth. John Doe heard voices that the victim was going to rob him. As a result, John Doe punched the victim. The victim grabbed John Doe, who is now afraid for his life. John Doe then pulled out his knife and stabbed the victim in the neck. John Doe felt remorse after the event when he was no longer intoxicated and psychotic. John Doe did not know the victim before the event.

So, when we look between 2017 and 2022, we see that unregulated drug toxicity has become the number one cause of death among British Columbia youth, and 73% of the youth who died had received services from the Ministry of Children and Family Development. A study called the "Hotel Study" looked at the population of the Downtown Eastside and found that 95% had a substance-use disorder and 84% had a mental illness, with 74% having a current mental illness at the time of their substance-use disorder. There was also a 45% prevalence of a diagnosable neurological disorder on MRI, so there are a lot of folks out there with these disorders who are brain damaged.

Also, with the coroner's report in 2017, what they found was that 52% had a mental disorder. Concurrent disorders—a mental illness and a substance-use disorder—are the rule, not the exception.

There was a study by Kristen Morin out of Ontario, and it looked at adding psychiatric treatment for folks with opioid agonist therapy—so methadone clinics. It looked at northern Ontario and southern Ontario, and what it found was that adding psychiatric treatment decreased ER visits and hospitalizations in both northern and southern Ontario, and all-cause mortality in southern Ontario.

There's a lot of amphetamine use among these folks who overdose in British Columbia. Between 67% and 79% of the people who passed away also had amphetamines in their systems. Now why should we worry about amphetamines? There's been a rise of phenyl-2-propanone in meth, which is more potent and more likely to cause psychosis.

When you look at the folks with an amphetamine-use disorder, you will see that 40% will have experienced psychosis. As an amphetamine-use disorder increases in severity, 100% will have experienced psychosis. Psychosis is a neurotoxic event. Initially, these users won't be psychotic. Then they'll be psychotic when they're intoxicated. Then it will be when they're in withdrawal and then in times of sobriety. There's a kindling effect, and this psychosis is more difficult to treat and more severe as use continues.

What would be the recommendations?

Treating addictions is complicated. The way the opioid crisis has been approached is as if there's an opioid deficiency—so like iron-deficiency anemia, where if you add iron, you'll cure the illness. Almost the entire focus has been on giving people enough and different kinds of opioids, assuming that this will solve the crisis.

Opioid-use disorder is not an opioid deficiency. Any place on earth that has treated an opioid crisis has used multiple approaches where medication was just a small part. We need to look at a wide range of evidence and solutions. It is unlikely that we will find a home-run intervention. With the varied populations, we will need input from public health, from addictions medicine and from addictions psychiatry, among other things. We will need to have clearly defined metrics of failure for interventions and be willing to re-evaluate those interventions if they do not pass the bar.

There is recent Canadian evidence that treating patients' mental health and addictions issues concurrently will keep the population alive. Psychosis increases the risk of violence threefold to fourfold, so treating psychosis is important in treating violence. Early access to treatment for concurrent disorders can help change the trajectory of the illness and the associated risk. Clients, especially high-risk clients, need timely access to treatments.

Along with treatment, there needs to be stable housing with appropriate supports. There needs to be vocational and rehabilitation opportunities. Psychological therapies are not covered. The intervention with the most evidence for amphetamine-use disorders is contingency management, which is psychosocial treatment. There are significant gaps in the criminal justice system, especially on release, and those gaps need to be filled.

Providing concurrent psychiatric care to patients with addictions can reduce violence and save lives.

Thank you.

● (1550)

The Chair: Thank you, Dr. Mathew.

Next, from the Canadian Centre on Substance Use and Addiction, we have Dr. Caudarella for the next five minutes.

Welcome to the committee, Dr. Caudarella. You have the floor.

Dr. Alexander Caudarella (Chief Executive Officer, Canadian Centre on Substance Use and Addiction): Mr. Chair, vice-chairs and committee members, thank you for inviting me and the Canadian Centre on Substance Use and Addiction.

It was the late Brian Mulroney who created CCSA through an act of Parliament 35 years ago as a neutral, arm's length agency to provide leadership on substance use health and to advance evidence-based solutions.

As CCSA's newest CEO, I've spent my first year listening to diverse voices on how we need to act to achieve the most impact. As well, I'm a family doctor who's worked across three provinces and a territory.

[*Translation*]

My patients have told me that, when someone with an opioid issue goes to an emergency department anywhere in Canada, rarely do they get support. In fact, less than one per cent of people surveyed in a recent study co-led by the Canadian Centre on Substance Use and Addiction, or CCSA, said they would go to their family physician for help with an opioid use issue.

With Ontario youths, the rate of use of opioid agonist therapy has declined over the past 10 years. We need wide access to treatment, but people are facing closed doors across Canada. We have a responsibility to open doors to treatment and make the access way as wide as possible.

[*English*]

No Canadian jurisdiction has resolved these challenges. They are challenges rooted in pain and tragedy, coupled with a deep sense of urgency, that have sent people and organizations off in all directions.

Countries that have successfully tackled past drug crises have done so not within silos, but with humility and collective whole-of-health, whole-of-government and whole-of-community approaches.

A spectrum of care that includes treatment, recovery and harm reduction, but that arcs towards improved health is required. To reduce risk, this spectrum must also include prevention.

In 2011, CCSA published the world's first evidence-based prevention standards. With the emergency declaration first happening eight years ago, we must think of the lives we could have saved if we had invested. It is why CCSA is committed to building community prevention coalitions.

Every community deserves to feel safe and every person deserves access to the care they need, when and where they need it. People want to help each other and we need to create opportunities for them to do so. CCSA has been working with people with lived experience, families, physicians, police and communities to move this forward. The real solutions will come from them and CCSA is committed to using its resources and data to support their collaborations.

We're hosting a series of community-level summits on the ground where the issues are felt on strategies to end substance use crises. One immediate outcome has been the establishment of competencies for prescribers of all levels.

Our failure to collaborate more effectively amongst sectors strains the broader health care system. Harms from substance use cost the country $49 billion or about $1,300 per Canadian.

I'll never forget, when I was working in the ER, watching a man lay in pain waiting for four days with a broken hip. His granddaughter never left his side. He didn't get a hospital bed because we had three people in our ICU with overdoses that they should never have had and two people waiting for heart surgery for drug-related infections that we waited to treat.

There is no turning back. We now live in an era of powerful synthetic drugs that are too cheap to make and too easy to buy, and where data and clinical practice are evolving rapidly.

In 2005, CCSA redirected resources in partnership with the provinces, municipalities, first nations, Métis and Inuit providers, enforcement agencies and key federal departments to drive everything we did towards supporting what our communities needed most. The resulting national framework for action to reduce the harms associated with alcohol and drugs was relevant, real and impactful.

We collaborated across divides then. Now, it is the time for the leaders of our field, myself included, to set the table and work together. The solutions are in the communities and we need to provide the data, the science and the resources to activate them.

Thank you for your time and for your study of these important issues.

● (1555)

The Chair: Thank you, Dr. Caudarella.

Next, on behalf of Moms Stop the Harm, we have Petra Schulz, co-founder.

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

Ms. Petra Schulz (Co-Founder, Moms Stop the Harm): Thank you for this opportunity.

I am co-founder of Moms Stop the Harm, representing thousands of families across Canada. Most mourn a loved one due to the toxic drug crisis, and many support loved ones with lived or living experience. Our website includes 600 images of loved ones who have died.

Being here today is both meaningful and difficult as tomorrow is the 10th anniversary of the day when our son Danny died. Danny was a brother, a friend and a talented chef.

Danny is a poster child for failed drug policy. He was on methadone for a while, then abstinent, but never stable. In 2014, fentanyl appeared on the market, and he was one of the early victims. There were no warnings, and he did not have access to harm reduction, which could have saved him.

Today, almost everyone knows someone who has lost a loved one. Those who die include people who use them every day, occasionally or just once—like Olivia, a 13-year-old girl from central Alberta, who died after using it with a friend. We do not know what substance the teenagers intended to use or how much, but unregulated fentanyl killed them both.

The increasing death from the toxic drug supply is driven by prohibitionist policy decisions that have failed to keep our loved ones safe. This includes a failure to robustly implement harm reduction across the country.

In Canada, almost all deaths are from unregulated drugs, with over 85% nationally; and for opioids in Alberta, it is a staggering 98%. Yet, we see political leaders create moral panic around the 2%, while ignoring the other 98%. We are told this is an addictions crisis and more beds and more abstinence-based treatment will be the answer. Yet, the example often cited, the Alberta model, has failed to save lives. The year 2023 will be the worst year on record for deaths in my home province.

According to national data, substance use has not gone up in over 10 years, yet deaths have skyrocketed. Why?

This is not a problem of addiction, but of a toxic, unregulated supply. Access to consumption services, drug checking, unregulated alternatives and decriminalization of people who use drugs are what is needed. Sadly, these measures currently in place are insufficient for the magnitude of the crisis and do not reach all communities.

This is a truth and reconciliation issue. The TRC report calls on the government to reduce gaps in health outcomes between indigenous and non-indigenous people, yet indigenous people are disproportionately affected. They are seven times more likely to die in Alberta, and five times more likely in B.C.

Sarah Auger lost her son Lakotah in 2022. He was a doting father, a loving son and proud to be Cree. He used alcohol and other substances, but his use of unregulated substances, including fentanyl that later took his life, escalated only after he was incarcerated. While we know the harm of alcohol surpasses all other substances, one drink will not kill you.

Lakotah's story and the story of Mike also illustrate the danger of forcing abstinence on people despite the well-documented risks. Mike was the son of our board chair, Traci Letts. He was playful, thoughtful and a passionate cook. Both Lakotah and Mike died shortly after incarceration.

Similarly, Angela Welz lost her young daughter Zoe, who was athletic, funny and headstrong, shortly after two failed attempts at getting help through the involuntary detention via the Alberta PChAD act.

What is so upsetting is the fact that the deaths of our loved ones have become politicized with misinformation and outright lies. This is a public health issue and needs to be treated as such. I urge you to stop the angry, harmful, misinformed, polarizing debates. Politics and ideology must be taken out of health care.

Work together and focus on what the evidence tells us. Harm reduction, including the provision of regulated alternatives, saves lives. Evidenced-based, voluntary and accountable treatment saves lives. Prevention and addressing the social determinants of health save lives. This is not a harm reduction versus recovery debate. Our loved ones need and deserve both.

Danny is on my mind every day, and I know he wanted help. The day before he died he asked me to make an appointment with his psychologist. He did not live long enough to see her. More treatment would not have saved him, but harm reduction and access to regulated substances would have.

Where there is life, there is hope. It is your responsibility to ensure that our loved ones live and that we have hope that the needless deaths will end.

Thank you kindly for this opportunity.

● (1600)

The Chair: Thank you, Ms. Schulz.

[*Translation*]

Now we will hear from the Projet Caméléon representative.

Welcome to the committee, Dr. Marie-Eve Morin.

Please go ahead.

Dr. Marie-Eve Morin (General Practitioner, Addiction and Mental Health, Projet Caméléon): Good afternoon to the committee members and the other experts on the panel.

I want to start by thanking the committee for having me today. It's a privilege to be able to share my perspective on addiction and mental health issues among young people.

The committee's study is timely. The World Health Organization just released an alarming study carried out in a number of countries, including Canada. It reveals an increase in the use of cannabis, alcohol and e-cigarettes by youth. In addition, opioid and substance-related overdoses are the leading cause of death among youth in western Canada.

I have spent 20 years as a family physician working in addiction and mental health in Montreal. I currently practise at La Licorne Medical Clinic. I've worked in a number of settings, all in the area of addiction and mental health. In 2017, I founded Projet Caméléon, a not-for-profit organization focused on harm reduction.

I have a book on drugs and addiction coming out in September. It's geared towards young people between the ages of 12 and 25, as well as parents and teachers. I care deeply about young people. I think we urgently need to educate them, in an honest and non-judgmental way, about how their brains work and how drugs affect their brains. In my experience, education is the most effective way to prevent problems. Repression is an outdated approach.

A new phenomenon since I was a teenager is the exponential growth in the range of drugs on the black market. Thirty years ago, when I was in high school, we didn't have methamphetamines, GHB, MDMA, lean, ketamine, fentanyl, cannabis vape devices—known as wax pens—or ecstasy, and we had even fewer opioid and benzodiazepine-based drugs. Putting profits above all else, drug dealers no longer have any qualms about letting fentanyl and other opioids flood the market. It's a well-known fact that the family medicine cabinet tends to be the first place where teens come into contact with opioids and benzodiazepines.

I've been giving talks in schools since 2005, mainly to audiences in private high schools. Public schools say they don't have the funding to educate students about addiction and prevention. However, if we at least invested the profits from cannabis sales in prevention, education and addiction treatment, we could really make a difference for young people.

Since cannabis was legalized, its use has been overly trivialized by both young people and their parents. Legal equals no big deal. The reality is that THC is actually an extremely potent and unpredictable disruptor, even at low doses. Despite still being illegal, wax pens are readily found in high schools across the country because they have such a high THC content. In fact, even though selling cannabis to minors is prohibited, more and more young people are reportedly going to the emergency department and being hospitalized as a result of THC-induced psychosis. Not only has legalization not come close to eliminating the black market, but it has also brought down the price of cannabis that continues to be sold illegally on the street.

Like many, I have seen the significant impact the pandemic has had on people's mental health and substance abuse, especially among those 25 and under. They were craving emotional connections and human contact. Isolation, the prevalence of screens, cellphones and social media, compulsive gaming and the lack of recreational activities have, in some cases, had devastating consequences for the mental health of young people, whose brains are still developing. What's more, these factors have been a catalyst for the development of alcohol and substance abuse among youth. In many cases, they take substances as a way to self-medicate. Keep in mind that 50% to 70% of people with an addiction also have a primary mental health issue, one that existed long before they began using. That is known as comorbidity. My colleague talked about that earlier. A teen whose attention deficit hyperactivity disorder, or ADHD, goes untreated may very well feel better and more able to function after taking speed or other such stimulant, or even a depressant such as hydromorphone.

If all my patients ended up in prison, psychiatric wards or the morgue, I wouldn't have spent the past 20 years doing this. Many people are able to come out the other side, becoming independent functioning individuals once again. However, that takes time, support and empathy, which are necessary to uncover the person's trauma and treat comorbid conditions as soon as possible. In my experience, that reduces the criminal activity and harms associated with drug and alcohol use, while improving the person's overall health.

● (1605)

My humble recommendation to the committee is that the government take concrete steps to support prevention, treatment and education around alcohol and substance use, for the benefit of all young people, in every school.

Thank you.

The Chair: Thank you.

[*English*]

We'll now begin with rounds of questions.

We'll start with Dr. Ellis for six minutes, please.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Mr. Chair.

Thanks, everyone, for being here.

Dr. Mathew, you talked a bit about comorbidities. I certainly have a concern with respect to cannabis use and psychosis associated with that.

Could you comment on your experience with how prevalent that is in society these days?

Dr. Nickie Mathew: Regarding cannabis use in Canada, we've seen in an increase in cannabis use disorder. We've also seen an increase in ER visits for psychosis related to cannabis. Legalization of cannabis hasn't decreased that.

However, a balance needs to be struck. Has that downside been outweighed by the upside of decreased criminalization of people who are using cannabis? I'd leave it to policy-makers to decide that, but there do seem to be upsides and downsides for legalization.

Mr. Stephen Ellis: Dr. Mathew, you talked a bit about psychosis associated with methamphetamine use.

In your experience—and if you don't have experience in this I'm happy to ask someone else—is it the same type of psychosis you would see with schizophrenia or with cannabis use disorder?

Dr. Nickie Mathew: That is a large question.

Psychosis is a symptom and a loss of touch with reality. These could be fixed false-beliefs, which are delusions, or it could be hallucinations, which are false sensory perceptions, or you could have disorganized thought.

Whether someone has an intrinsic, organic psychiatric illness like schizophrenia or whether they have a substance-induced psychosis, such as cannabis-induced psychosis or amphetamine-induced psychosis, it's very difficult to tell these apart clinically.

One thing we have found is that people can have psychosis that is substance-induced that lasts a very long time. The textbook that we use in psychiatry, the *Diagnostic and Statistical Manual*, would describe a substance-induced psychosis as one month long. However, recent research from Shah et al found that 80% of cannabis-induced psychosis will last longer than a month. We know that with amphetamine-induced psychosis, 27% will last longer than a month. It's actually very common for these psychoses to last longer than a month, and clinically it's very difficult to tease these two apart.

It ends up being that the treatment is the same so you would use anti-psychotic medication to treat both.

Mr. Stephen Ellis: Dr. Mathew, thank you for that.

Through you, Mr. Chair, to Dr. Mathew again, when we're talking about making the diagnosis of someone who has substance-use disorder and a concomitant mental health illness—let's just put it generically as "psychosis"—is it possible to tell those apart when the person is continuing to use their substance of choice?

Dr. Nickie Mathew: There was a study, and the author's name escapes me now, but what they looked at was folks who came into an addiction treatment facility. They used a scale called the "brief severity index" and they looked at different types of psychiatric symptoms such as depression, anxiety, and paranoia, which they called "psychoticism".

They found that of everybody who came into this addiction treatment facility, 39% of them had psychiatric symptoms. However, after one month in sobriety that dropped 13-fold to 3%, and that 3% held steady six months out. This is what's recommended in the DSM, which I mentioned earlier. That is, you should wait a month into sobriety before diagnosing a psychiatric illness.

To answer your question, if someone is currently using substances and they don't have a month of sobriety and you don't have a longitudinal history of clinical records, it's very difficult to make a psychiatric diagnosis before they've had that time in sobriety.

● (1610)

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

Through you, Mr. Chair, if I understood you correctly, Dr. Mathew, you would suggest treating that person with medication for the psychosis even though they continue to actively use their substance of choice?

Dr. Nickie Mathew: For anti-psychotic medication, you will find that if someone has a substance-induced psychosis and they have an anti-psychotic medication on board, the anti-psychotic medication won't prevent their from becoming psychotic.

Earlier in my talk I spoke about a kindling effect that occurred with substance use. As I mentioned earlier, what happens is you'll become psychotic during toxication, and that extends into sobriety, which extends into...and it becomes more severe. It actually prevents that progression from happening, and that's the benefit of it.

Also, if someone is acutely psychotic, it will help treat their acute psychotic symptoms.

Mr. Stephen Ellis: Thank you very much, Dr. Mathew.

Through you, Chair, I do have a motion that I'd like to move, as follows:

> That, given
>
> Prime Minister Justin Trudeau's dangerous experiment of the decriminalization of drugs, such as cocaine, crack, methamphetamines, fentanyl, and more, in British Columbia has resulted in a significant increase in deadly drug overdoses and compromised the safety of Canadians;
>
> The current drug decriminalization experiment has resulted in carnage and chaos, causing detrimental impacts on public health and community safety;
>
> Last week, British Columbia's Premier David Eby has recognized the failings of this experiment, and called on the federal government to help them backtrack out of this reckless policy decision;
>
> The City of Toronto has made a request to Health Canada asking for drug decriminalization, referring to it as the Toronto Model, drugs would be legal to use everywhere except childcare centers, K-12 schools and airports;
>
> Canadians from coast to coast have been calling for the end of decriminalization, knowing that it is a recovery-oriented system that leads to saving lives, rebuilding families, and eliminating chaos;
>
> The committee report to the House its recommendation that the government immediately dismantle all drug decriminalization programs in Canada.

Thank you.

The Chair: Thank you, Dr. Ellis.

The motion touches on the subject matter that we are now considering. It is therefore in order, given that we are studying the opioid epidemic and toxic drug crisis.

I rule the motion in order. Therefore, the debate is on the motion.

I'll go to Dr. Hanley first and then Mr. Doherty.

Mr. Brendan Hanley (Yukon, Lib.): Thank you, Mr. Chair.

This is a really important meeting today. We have four excellent witnesses. We've only just begun to hear the testimony. I think the motion, although in order, is not something that we need to debate right now. What we really need is to hear testimony from the witnesses.

I suggest that this is a frivolous motion, and I hereby move to adjourn debate.

The Chair: The motion to adjourn debate is a non-debatable, dilatory motion that must proceed directly to a vote.

By a show of hands, shall the debate be adjourned?

(Motion agreed to)

The Chair: The motion is adopted and the debate is adjourned.

Dr. Ellis's turn is up.

Next up is Dr. Hanley for six minutes.

Mr. Brendan Hanley: Thank you very much, Mr. Chair.

Again, thank you to all of the witnesses for appearing today with some very important testimony.

Dr. Caudarella, I'd like to begin with you. You've written about how responses and solutions may vary by community. You talk about a diversity of approaches that respond to communities' needs, but also what builds a successful approach as a spectrum of care.

Can you talk about a community or an approach that has been successful in integrating the important components in a community-based approach? It could be a real example or perhaps even a hypothetical example of what would actually work.

● (1615)

Dr. Alexander Caudarella: When we talk about these approaches, often they are places that have had linkages between sectors that haven't traditionally worked together. They're places where you'll see law enforcement and health working together, or where you'll see cities working with families and different pieces.

A couple come to mind. Iceland, for example, tackled very high rates of alcohol use among its youth. Really, what they were able to do was make it everyone's problem. It wasn't just experts. It wasn't just specialists. It was parents. It was schoolteachers. Everyone felt they had a role, when they woke up in the morning, in contributing to the reductions of the harm. It was very successful.

In France, during a heroin epidemic in the nineties, again, they kind of made it everyone's problem. Every prescriber was taught how to use Suboxone and how to do these different things.

We've actually found, through some of our recent conferences and different pieces, that with the right supports, you can put people with diverse ideas in the same room as long as they're feeling like they're moving forward and as long as they're feeling engaged. I think a lot of the anger and frustration we're hearing from community members is actually a desire to be more involved in the process. People want to be involved in what is happening in their communities, but they also want to be involved in the solutions.

Mr. Brendan Hanley: Thank you.

Ms. Schulz, thank you for your testimony. I'm really sorry about Danny and the approaching 10-year anniversary. I am sure you must be rehearsing over and over again, maybe a thousand times or more, what might have happened.

If Danny were here today in that situation, what would be the ideal support to help him survive and even thrive?

Ms. Petra Schulz: Thank you for the question and your kind words.

With Danny, obviously he was not at a point where he wanted to stop using. Many people who use substances are not at a time or in the right position to stop using, but everybody deserves the right to live.

At that point, if Danny had had access to regulated alternatives, they would have given him a chance to use a substance that would not have killed him, and would also have connected him to a health system and opened doors for him to get other supports.

He also struggled with some mental health issues that could have been addressed at the time, which would have been a key element. At that time, there was no harm reduction available, which has now been expanded. He was always very safety conscious. Even the day before he died, he bought fresh needles. We saw that receipt, and it was very hard.

It would have been better if there had been a safe place to use. He died a short walk from where we later had a consumption site in Alberta, but which was subsequently closed.

To those who feel that recriminalization will end public substance use, I invite them to come to Alberta. There is a lot of public substance use happening because we have closed safe places. As long as we don't have housing and safe places for people to use, we will see public substance use, and we'll also see people like Danny using at home alone.

Another thing that would have helped Danny is decriminalization. He was very aware of his substance use, and he felt shame. He felt it was causing our family shame and stigma. Stigma is a huge issue. We often talk about stigma, but we will not remove stigma until you end the criminalization of substance use.

Mr. Brendan Hanley: Excuse me, as I only have a minute or two left. That was fantastic, thank you.

Do you think that criminal use of drugs was a factor in Danny's death and Olivia's death that you described, yes or no?

Ms. Petra Schulz: It was most certainly a huge factor, the fact that he had access to only unregulated substances and that he felt he had to hide his use. His dream was to join the army. That was one thing he wanted to do, and he knew that having a record of substance use would have prevented that, so he very much wanted to hide that from the public eye, but also from his family, which ultimately meant that he was alone when he died.

● (1620)

Mr. Brendan Hanley: Thank you.

In the brief time I have left, following up on Dr. Caudarella's comment, there's a bit of an us-and-them problem. How do we help to augment the idea that this is everybody's problem, a problem for all of us?

Dr. Alexander Caudarella: Thank you.

I think we have their attention. We have people's attention. It's not an awareness issue now. Really, this comes down to people knowing and believing that we have both the evidence and the data to move things forward.

I think this is where I've become increasingly a fan of community coalition work, which is an evidence-based prevention tactic to try to raise people's.... I don't know that people don't want to be involved. I think right now it's that they don't know what to do. We know there are a lot of things that work for prevention, treatment, recovery and harm reduction, but I don't think they know what their role is. How do we set up that skeleton, and how do we support them?

Realistically, a lot of these things are tremendously cost-effective, but—

The Chair: Thank you, Dr. Caudarella. That's all the time for this round.

[*Translation*]

We now go to Mr. Thériault for six minutes.

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

Thank you to the witnesses for their input.

Dr. Morin, you've been working in harm reduction for two decades. I don't want to waste too much time talking, since I have just six minutes. I really want to hear your thoughts.

A number of witnesses have told the committee that something had to be done to combat the crisis caused by contaminated street drugs and the near epidemic of deaths. Safe supply is one such measure, and now we're seeing that supervised consumption sites are problematic.

With 20 years of experience in harm reduction under your belt, you are now saying we need to do even more prevention work. However, you also talked about how the legalization of marijuana was, in a way, a failure.

Is it time to once again criminalize marijuana? I'd like to hear what you have to say about that.

Dr. Marie-Eve Morin: What a great question. Thank you. I could go on for three hours.

First, it's important to make some things clear. Treating people with addictions involves a continuum of care. Harm reduction is part of that continuum, but it's not the be-all and end-all. It's one step.

Treating comorbidities is at the other end of the continuum. We know that 50% to 70% of people with an addiction also need treatment for a mental health issue. They could have bipolar disorder, ADHD, an anxiety disorder or something else. What's more, at least 50% of opiate-dependent individuals suffer from chronic pain. Therefore, when we treat existing comorbidities, whether physical or psychiatric, it's much less difficult—not to say that it's easy—for someone to get off the substance they are using.

I want to make another point. Earlier, the discussion touched on the criminal element and the criminalization of people with addictions. I spent four years working in federal penitentiaries, and I saw first-hand that 80% of the inmates had committed an offence directly or indirectly related to the use of drugs or alcohol. That finding has been studied. When it comes to decriminalization, I would say that exposure to drugs tends to lead to increased use. A few years ago, I thought it was a more realistic approach. Now, I'm not so sure we are ready for it.

Lastly, I want to point out how ironic it is that we are seeing so many opioid-related deaths. The only known addiction for which pharmacological treatment is successful nearly 100% of the time is, in fact, opioid addiction. Methadone and buprenorphine are used to treat opioid addiction and can help someone get off opioids completely when given at the right dose to the right person.

We need to tackle the root of the problem and focus on our capacity in psychiatry and general practice to treat chronic pain. As I see it, harm reduction is one step. Any alcoholic who wants to quit drinking initially tries to control themselves, before they end up quitting for good. Harm reduction is a way to get people to potentially quit using, total abstinence, or at least reduce their use through the treatment of comorbidities.

That's what I find, but harm reduction is not the gospel. It's one tool, and sometimes, it's not the right tool. It can work for all types of addictions, but it's not the be-all and end-all.

● (1625)

Mr. Luc Thériault: Yes, I understand.

You're saying more should be done in terms of prevention, but there are taboos around consumption. The first is that people are going to start by using recreationally because they like it. Nobody ever says that. If we want to focus on prevention—

Dr. Marie-Eve Morin: That's absolutely true, but it may have been truer 25 years ago, because there were far fewer drugs, and the drugs on the market were good quality. It's sad but true.

Today, there are more drugs, more kinds of drugs and contaminated drugs. Young people also mix substances. I don't know a lot of addicts who use only one drug. What I'm seeing is people who are addicted to multiple drugs.

As I said, harm reduction is a tool, but it's not a panacea. We have to tackle the root of the problem and treat comorbidities.

Mr. Luc Thériault: I was thinking of Vancouver, where the authorities are making another attempt to get the public drug use situation under control.

I understand what they're trying to do, but is legislation the better approach?

Municipal authorities could have passed a bylaw to let the police exercise discretion to avoid both stigmatization and substance use issues.

Apparently, people are using in waiting rooms. Are people using in waiting rooms in Montreal?

Dr. Marie-Eve Morin: People are using everywhere, you know, even in public washrooms.

I think backtracking would be tough. I don't want to be pessimistic, but the doors have been opened, and it'll be very hard to close them. I don't know how we're going to do it.

Personally, I think we'll need more social workers, outreach workers, psychologists and addictions workers to direct people with substance use problems to mental health or psychiatric care.

I think it would be very difficult to enforce a law. It would be a bit like trying to stop people from driving faster than 100 kilometres an hour on the highway. It's against the law, but everyone tolerates it.

In my opinion, it would be tough to walk things back without dealing with the comorbidities, the mental health and crime issues that go hand in hand with substance use, especially when people are experiencing psychosis or withdrawal.

The Chair: Thank you, Dr. Morin.

[*English*]

Next is Mr. Johns, please, for six minutes.

Mr. Gord Johns (Courtenay—Alberni, NDP): Thank you to all of the witnesses for being here.

I will speak to Ms. Schulz, first, extending my condolences as well for Danny on the eve of the anniversary of his death. You and the mothers and families know better than anybody how dangerous the toxic illicit drug supply is right now and what it's like to support someone with substance use disorder.

We have seen the numbers in B.C. somewhat plateau at about 5% year over year in the growth of overdose deaths. No overdose death is good. We have seen Ontario at 6.8%. They also have safe supply there. It's a very small amount in both provinces. I think it's less than 2.5% of people who have access to a safe supply overdose. In Alberta the numbers have shot up by 17% in your home province. In Saskatchewan, they have increased by 23%. A neighbouring state, Alaska, a Republican state, has seen an increase of 45% year over year. They have just surpassed B.C. for toxic drug deaths per 100,000, and Alberta is on a trajectory to pass B.C. by June.

Can you tell us what's going on in your home province and why there is such a spike in Alberta, Saskatchewan and possibly Alaska?

Ms. Petra Schulz: What is happening in my province is heartbreaking. We have seen a government with a myopic focus on treatment. Trust me: treatment is important. We love treatment. We love recovery as families, but we have to make sure that people are well and alive.

Even within that treatment model, a recovery-oriented system of care has been in place for four and a half years, yet, as you outlined, we have some of the highest increases in the country.

I recently tried to get somebody into detox. You have to show up at detox three days in a row at 9 o'clock in the morning to get the person in. Explain to somebody using stimulants that they will get up early, go with me three days in a row, and maybe on day three I'll get them in.

The recovery community in Red Deer has a six-month waiting list. My dear friend, Esther Tailfeathers is from the Blood Tribe in southern Alberta, where the government closed the consumption site. Lethbridge now has a per capita rate that is three times that of other communities. It was the only site that had inhalation. More people have moved to inhalation, and we don't provide these services throughout.

In southern Alberta, in Lethbridge, the Blood Tribe was promised a recovery community three and a half years ago. They have one ceremonial shovel in the ground, but no building forward.

Not only is it a myopic focus on what is called “recovery”, but it's in name only. It is actually not available to people who need it, where the drug supply is getting more toxic, and you see it in the increases.

For me, the true measure of success of any policy approach is when my friends don't have to arrange funerals. That is a true measure of success. Our board chair, Traci Letts, is just planning the future funeral of her son. As long as this is going on, the model is not successful, and Alberta's model is failing us. When people push recovery without harm reduction, without addressing prevention—nobody's talking about prevention anymore.... I'm glad my fellow speakers have raised this point.

● (1630)

Mr. Gord Johns: We had the B.C. police chiefs here, we had the deputy RCMP commissioner here. They were very clear in terms of the decriminalization model in British Columbia, which has been going for only 18 months, that they wanted tools to move people along.

They were also very clear, and Ms. Wilson said:

> ...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.

They're very clear that they don't want to go back to criminalizing people.

They also cited:

> 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.

They also called for more safe consumption sites and expanding them to include inhalation, and they also made it clear that:

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

Lastly:

> The RCMP continues to support all efforts to ensure that an overdose emergency is dealt with as a health and medical emergency.

When you hear that and you see it in testimony, and politicians come out of a hearing like that and they want to attack decriminalization and call it or safe supply as the root cause for this toxic drug crisis, how does that make you feel, as a mother of a lost loved one?

Ms. Petra Schulz: I feel anger and frustration, but I also feel disbelief that somebody, who is the leader of a national political party, can share information that is not factual and does not align with what has actually happened on decriminalization or on safe supply. I urge you all to look at the evidence that shows the effectiveness of those measures, and that's where we have to focus back.

Mr. Gord Johns: I have a very short question.

Have you, Moms Stop the Harm, met with all of the political leaders in this country, and if anyone's missing, why?

Ms. Petra Schulz: Mr. Poilievre is missing. I've reached out to him again, saying that we tried a year ago to meet with him. We've written to him several times.

I saw Minister Saks this morning. She made time. With you, I know I can reach you when I need you, but Mr. Poilievre has not heeded our calls for a meeting. We'd very much like to talk to him. We'd very much like to tell him what we feel about families, what we experience. We live this every day—every day—and it is time that he opened his door and engaged in dialogue with families who represent thousands of Canadians who have suffered this loss.

● (1635)

The Chair: Thank you. That's all the time for you, Mr. Johns.

Next we have Mr. Doherty, please, for five minutes.

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

Ms. Schulz, I appreciate your testimony here today. I don't know whether you've heard my interventions here. I have a brother who lives on the street and is addicted to drugs. I've lost a brother-in-law to overdose, and as a matter of fact I've many family members who are addicted to drugs, and it is.... When you're living it every day you don't know, when that phone rings, whether that's going to be the day you hear that your loved one has been found dead—my brother or brother-in-law—so we relive that each and every day.

Our leader has been very clear that we believe in recovery. We believe that if somebody like you or your son were ready for treatment, that a bed will be there. You don't have to wait six months or show up three days in a row. That's what our leader believes in, and it can be spun every different way.

I do want to thank you for your testimony today, but I want to ask you, do you believe that we should have safe supply of hard drugs like heroin, cocaine, crack or meth on the streets?

Ms. Petra Schulz: Not on the streets, no, but that is not what anybody is proposing—

Mr. Todd Doherty: Should we instead invest dollars in having a bed for recovery? If you need it, it's there.

Ms. Petra Schulz: It's not a one or the other. We need both.

My son wanted treatment. I made an appointment with his counsellor and with his doctor, but he was dead the very same day I made the appointment. If we don't keep people alive and well, we can have all the treatment beds: They will be empty when everyone is dead.

With treatment, it has to be a choice. It has to be evidence-based. If we focus on abstinence only, the guidelines from CRISM tell us that opioid agonist treatment is what is most effective.

The streets are not paved with safe supply. In Alberta, 98% of the deaths from opioids are from unregulated drugs; 2% are from regulated substances.

Mr. Todd Doherty: Dr. Mathew, can you explain to this committee your concerns regarding the government-funded, so-called safe supply?

Dr. Nickie Mathew: Sure. One thing that we should look at is the supply of opioids in a population. If you look at the countries that had the highest overdose rates in 2020, the number one country was the United States of America. I think it was around 271 deaths per million population. This is also the country that had the highest supply of opioids among the population.

Fentanyl is an important aspect of this, but how do people end up overdosing on fentanyl? Oftentimes the story is that people started with legal substances that were prescribed, and then they become addicted and develop a tolerance, and then that no longer works for them. They shift to the illicit market at that point, because they need something stronger.

I mentioned 2020, and in that year, the rate of overdose deaths in British Columbia was 340 per million. It's much higher than what's occurring in the United States. It's much higher than in any other province in Canada. As of last year, it's gone up to, I think, 444 per million, so there's been a massive increase as well. What I worry about is the supply of opioids among the population.

Mr. Todd Doherty: In your opinion, will decriminalization and so-called safe supply fix our opioid crisis?

Dr. Nickie Mathew: I'll start with decriminalization. If you look at decriminalization, there are different models for it. It's important to distinguish the two. For instance, you had a model like Oregon's, which was very similar to what they did in Vancouver, where they allowed public drug use. What they found was that between 2022 and 2023, there was a 45% increase in overdose deaths, which was the highest increase of any state. That's why this past March Oregon repealed their decriminalization.

Portugal had a different model. What they did with decriminalization was to have people either face legal sanctions or go into treatment. There was sort of a coercion into treatment, and that's the shift that Oregon has made. I actually commend the B.C. government, because when they found more information, they were able to pivot, as well. Regarding—

● (1640)

The Chair: Thank you. I'm sorry about that. You took a pause at about the five-minute mark and allowed me to jump in. I'm sure that you'll get a chance to expand upon your answer.

Thank you, Mr. Doherty.

Next we have Ms. Sidhu, please, for five minutes.

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

Thank you to all of the witnesses.

Thank you, Ms. Schulz, for sharing Danny's story. No mother should go through what you went through.

The opioid crisis affects people from every walk of life. Given the stigma attached to substance use, we can understand why professionals, people in school and people with families are afraid to even admit they're using drugs.

Could you expand on this? Why is it important to remove stigma and barriers to care?

Ms. Petra Schulz: Thank you for your kind words.

Stigma is a barrier to getting help. As long as substance use is as deeply stigmatized as it is now, people will hide their use, and we know that men are disproportionately affected among the victims; about 80% are men. Stigma makes it harder for people to reach out. Any measure that we take to reduce the stigma means that people feel more open even to discussing it with a friend or a family member, or a student may reach out to a teacher.

Nothing stigmatizes people more than the criminalization of substance use. We know that a criminal record affects what you can do for education, where you can travel, where you can live and what you can study. That is just such an enormous barrier that we can remove with decriminalization.

Ms. Sonia Sidhu: You talked about education. At what age does education need to start about the awareness of drugs?

Ms. Petra Schulz: It should be age appropriate. I'm an educator, and I get this question a lot. We should discuss substance use when we discuss other issues young people need to learn about, like how to address alcohol and safe sex, and we should not separate it out. Put it in the entire package when we discuss, at an age-appropriate level, of course, with our young people how to keep them safe, and we should focus on, as much as possible, reducing.... Abstinence is always a goal when we talk to young people.

When we take a harm-reduction approach, that also means they stay safe. As we all know, we'll never get all teenagers to abstain from having sex, but we want them to be safe. By the same token, we want teenagers to be safe if they use substances.

Ms. Sonia Sidhu: You have been a strong advocate of a person-centred approach to care.

What do you think about that and the community-led approach for youth?

Ms. Petra Schulz: Community-led approaches are really important because the community is not only those who have experience, but also the ones who can carry it forward. That is why it is so important to include affected communities.

Something that is not often talked about is that in some of our communities in Canada, substance use is even more stigmatized. It's important to take the messages into these communities, in different languages and with people from the community.

Ms. Sonia Sidhu: You also talked about misinformation.

Do you want to elaborate on that? What kind of misinformation is it?

Ms. Petra Schulz: For example, it's saying that the streets are plastered with safe supply. They are not. Alberta shows you that. Even in British Columbia, we hear that from the chiefs of police. We hear that from the chief coroner. Safe supply is not what is killing people; unregulated drugs are.

That is something we hear over and over again from certain corners—that people are dying because of safe supply.

The other thing is that decriminalization causes social disorder. When people are unhoused and have no safe place to use, they will use in public, whether it's in British Columbia, Alberta, Ontario or any other province or territory in this country.

Ms. Sonia Sidhu: Thank you.

Dr. Caudarella, I have a question for you.

What types of treatments or services must be available for individuals using substances in response to physical or sexual abuse, or any form of trauma?

● (1645)

Dr. Alexander Caudarella: Thank you.

In health care, we talk about trauma-informed care, which is this idea, essentially, that not everyone will disclose their trauma to begin with, so it's about opening that door and treating everyone in a way that is sensitive and appropriate. I think we probably need something fairly similar when it comes to substance use and making the assumption that any person could potentially have a substance use disorder and may need some help.

This is where understanding.... People want to be resilient. People want to be able to bend and bend back. I think that being able to build that out is probably one of the most important things we can do for people from a trauma-informed lens. We need to be having a lot more conversations about how we build skills.

Even when we talk about some of these prevention programs that, for example, have done amazing things like reduce by half the initiation of drugs or alcohol, it's really about skill-building. It's about building communication with families. It's about helping people survive better in the world.

More than anything, it's about being able to meet people at the moment they are in.

Thank you.

The Chair: Thank you, Dr. Caudarella and Ms. Sidhu.

[*Translation*]

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

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

Dr. Morin, you said that we should avoid taking an ideological stance when deciding on a strategy. I agree with you.

You talked about teens and the importance of prevention.

I'll give you my two and a half minutes to talk to them. What would you say to them before they get to your clinic, so that they don't end up there?

Dr. Marie-Eve Morin: In all humility, I've been working on prevention in schools since 2005.

Earlier, someone asked when we should start talking to kids about these issues. If conversations about drugs and sex haven't happened by the time a kid is 12, I think that's the right time to start. Those conversations need to start in grade 7.

Young people are smart. They should not be underestimated. We have to use straightforward, easy-to-understand language, to let them know how toxic these substances can be. We have to teach them that, for all of us, life is about making free and informed choices. I think the problem is that young people don't have enough information. We can make sure they're informed by talking to them in plain language and explaining the facts.

There was a discussion about skills earlier. Young people are capable of learning. Their brains are sponges. Young people aren't being informed these days. Schools still take a repressive approach. But we can tell young people what substances are. We can tell them that substances can feel good, but can also be risky. For example, people who use MDMA may have panic attacks or suffer from a neurological syndrome. Cannabis use increases the risk of psychosis. Alcohol consumption can result in a coma. Taking opioids is like playing Russian roulette. We know now that when you use opioids, you don't get a second chance.

Yesterday, I attended my favourite patient's funeral. She was 48 years old, and she died of a fentanyl overdose even though she'd been an injection drug user for 20 years. It doesn't matter if you're a first-time user or a long-time user. In her case, it was just bad luck.

I think young people are much more tuned in than we think, and we need to trust them. If we tell them the truth, they'll make better decisions. A lot of young people make these choices because they don't know better or their friends dare them or pressure them.

Unfortunately, many copy their favourite artists. We know that rap culture in particular promotes Xanax and lean, which are also opioids. We all had our childhood idols, and they all had their habits, but I think that celebrities are promoting really dangerous things nowadays, including opioids and benzodiazepines.

Number one, young people need to be informed. As soon as they turn 12, they're able to understand.

Thank you.

The Chair: Thank you, Dr. Morin.

Mr. Luc Thériault: In terms of experience—

Am I out of time already, Mr. Chair?

The Chair: Yes, you're almost at three minutes.

[*English*]

Mr. Johns, you have two and a half minutes.

Mr. Gord Johns: Thank you.

We heard the expert task force on substance use from Health Canada. They made it very clear, with unanimous recommendations, to support decriminalization, safer supply, treatment on demand, recovery prevention and education, and to scale up all those areas. They were unanimous. They had the police chiefs association, health experts, indigenous leaders on substance use, and people with lived and living experience. The police chiefs of Canada put out a report that reflected that as well.

Portugal delivered a model of that, which included a coordinated, compassionate and integrated approach.

Right now, we have a government that's taking an incremental approach in a public health emergency. We have politicians who are spreading disinformation—

A voice: Like yourself....

Mr. Gord Johns:—in the middle of a public health emergency. Both cost lives.

I don't appreciate being heckled here at this committee, Mr. Chair.

Secondly, we put forward Bill C-216 to take a health-based response to the toxic drug crisis, hoping it would get to committee and at least have an opportunity to be looked at.

We have had a summit on the theft of autos, which is, of course, an important issue, but this is the leading cause of death in my home province for those under the age of 59. There's still nothing. We have not had the government declare a national public health emergency. We were glad today in question period to finally see that they're going to reinstate, under our pressure, somewhat of a form of the expert task force on substance use. That's a relief.

Portugal implemented an expert task force and the politicians were heroes because they got out of the way. They let the experts lead instead of ideology.

Can you speak, Ms. Schulz, about the importance of listening to the experts and letting evidence-generated policy lead versus ideology and politics, and about how that is costing lives?

● (1650)

Ms. Petra Schulz: We see it again with the Alberta model. That is failing because Alberta has chosen to keep a focus on only a narrow scope of opinions, whereas when we let the experts lead, we look at all the available evidence and follow that.

Having experts lead means that we can have people in the room who use drugs show us what works for them and what is effective.

That is what has also happened in other countries. I was recently at the United Nations Commission on Narcotic Drugs, where I was amazed that the U.S. put forward a policy that had the words “harm reduction” in it. For the first time in the history of the United Nations, harm reduction was one of the pillars that was included. Switzerland talked about how it continues to provide safe supply.

The world is moving in that direction. Canada cannot move backwards.

The Chair: Thank you, Ms. Schulz.

Next we have Mrs. Goodridge, please, for five minutes.

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

Thank you to the witnesses for taking time to be here today.

I'm going to start with Dr. Mathew.

In 2021, you published a piece in the British Medical Journal based on some discussions you had with a convicted drug dealer in B.C. The person said that many people who use drugs seek out fentanyl. He even said that when people see someone overdose, they want to go to buy from that person's dealer, because they know they'll get the stronger, better stuff. This seems to indicate people seek out stronger drugs as opposed to a “safe drug”, even if they know it could kill them.

I was wondering if you could explain this a little bit.

Dr. Nickie Mathew: Sure. Thanks for the question.

Something that would worry me is that what is provided will not be able to compete with the illicit market. The illicit market is often described as a "poison" drug supply. From the data available, it seems the market is supplying the demand of the end-consumer. When Paul Janssen invented fentanyl, one of the reasons was that it would have a fast onset and offset. For the end-user this means this drug does not have legs, meaning it does not provide the end-users with the duration of intoxication they seek. As a result, in B.C. roughly 50% of the drug supply has another type of drug in it, which is called benzodiazepine, that would provide the duration of intoxication. This makes the drugs provided more toxic. Because we have to think of safety, I'm skeptical that we can provide legal forms of drugs that the end-consumer will use to displace the illicit supply.

Going to your question, I think it will be difficult for the legal market to supplant the illicit market, because we have to think of safety. For instance, if someone overdoses and passes away, more people will actually go to that drug dealer to buy drugs from that person, because they have stronger stuff and that's what's sought after. Safety is not sought after as the primary end-goal of the end-consumer.

Mrs. Laila Goodridge: Thank you. I appreciate that.

Dr. Caudarella, one of the main arguments that have been used by the proponents of the so-called safe supply is that it will offset the illegal and black market. We actually have a bit of a case study here. Cannabis was legalized six years ago. Approximately what percentage of the market in Canada today is legal versus illegal?

● (1655)

Dr. Alexander Caudarella: One of the things we struggle with a lot in this country is knowing exactly how much people are using, and who is using what. It's one of the issues, for example, around opioids too. We don't actually know how many people are using opioids in this country.

When it comes to cannabis, there have been a few estimates. To the best of our knowledge, it seems to be that the legal market in the past five years has captured probably about 50% to 60% of the black market switching over, with price being one of the big factors, as well as availability.

Mrs. Laila Goodridge: Thank you. I appreciate that.

I think this is all part of this proof point. If we're going off of this as if somehow people are choosing these drugs because they're safe, we need to recognize that addiction is a medical condition and people aren't necessarily making the logical decisions we would hope they would make in these situations. This is part of the challenge.

Dr. Mathew, you're on the ground in British Columbia. Do you think the request by the premier of British Columbia to roll back a lot of the decriminalization is a good decision or a good request?

Dr. Nickie Mathew: I think it's taking all the information in, and comparing what happened with Portugal. Again, in Portugal it wasn't public drug use that was allowed; it was that either you would face legal sanctions or you would go into treatment. Seeing what's happened in Oregon as well, and also seeing what's happened in British Columbia, overdoses have only increased with decriminalization. It's an intervention that's been placed on the entire province, and we haven't seen the outcome. Again, I commend the premier for pivoting once he's had more information.

Mrs. Laila Goodridge: Thank you.

Considering this, Mr. Chair, I'd like to move a motion that I put on notice last Friday:

> That, given
>
> (a) a statement from the office of the federal Minister of Mental Health and Addictions and Associate Minister of Health states that there will be a meeting with British Columbia's Minister of Mental Health and Addictions to discuss drug decriminalization;
>
> (b) three municipal councillors within the Greater Vancouver Metropolitan area have indicated they will bring motions to their respective councils to formally call on the provincial and federal [governments] to end the drug decriminalization pilot;
>
> pursuant to Standing Order 108(2), the committee add an additional two meetings to the study of the opioid epidemic and toxic drug crisis in Canada to discuss decriminalization; and that the Minister of Mental Health and Addictions and Associate Minister of Health and Health Canada be invited for no less than two hours; and British Columbia's Minister for Mental Health and Addictions and DJ Larkin of the Canadian Drug Policy Coalition be invited for no less than two hours.

I think it is absolutely incumbent on us as legislators, when we've had such a huge development happen in the last few weeks in the conversation around decriminalization, that we look into this. We haven't heard from the federal government on where they're at. What we have heard is that the Minister of Mental Health and Addictions says that she is not planning to take any immediate action.

We have heard that the police in British Columbia do not have the tools they need to keep people safe. We have heard that addictions have gone up. We have heard that overdose deaths have gone up. We have heard that there is crime, chaos and disorder running rampant in our communities.

I think it is absolutely incumbent on us, especially as we've been undertaking this study, to continue looking into this. This has developed quite quickly since we had Fiona Wilson, the deputy police commissioner from the Vancouver Police Department, come to state that they had no tools to be able to do their job. I would ask that we be able to have this study go forward and expand this so that we can have those ministers come in and explain from their perspective how we should go forward in this, so we can make sure that all Canadians are safe and that British Columbians are safe.

There are six people every single day who die in the province of British Columbia due to overdoses. It's incumbent on us that we take every single one of those lives seriously and that we do everything we possibly can as legislators to make sure that both public safety and public health are being taken into account.

I would ask that people support this motion.

● (1700)

The Chair: Thank you, Mrs. Goodridge.

A very similar motion was put on notice, but because it directly and clearly relates to the matter we're studying, the motion is in order. The debate is on the motion.

We have Dr. Powlowski and then Dr. Ellis.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I note that we had pretty extensive discussions a couple of weeks ago about the disorder caused by public use of drugs. I'm very happy to see the announcement by the premier of B.C. to again criminalize the public use of drugs.

I personally don't disagree with this, but there's a whole raft of other issues related to the opioid crisis. Indeed, we're talking with some of the experts on a lot of those other issues. I think there is going to be a need, and I probably would agree to extending the study, but it would perhaps be on other issues as well.

Given the importance of the witnesses we have here and the fact that we'd like to ask them other questions and address other issues related to the opioid crisis, I'm moving a motion to adjourn debate.

The Chair: Thank you, Dr. Powlowski.

As we know, a motion to adjourn debate is not debatable and must go directly to a vote.

Shall the debate on this motion now be adjourned?

Mrs. Laila Goodridge: I request a recorded division.

The Chair: We'll have a recorded division, Clerk, please.

(Motion agreed to: yeas 7; nays 4)

The Chair: We're moving on with questions. Next up is Madame Brière for five minutes.

Mr. Doherty.

Mr. Todd Doherty: I believe Ms. Goodridge had 30 seconds prior to moving the motion to extend this study.

The Chair: From the stopwatch I'm looking at, by the time she moved the motion, it was very close to the time. It's certainly not enough time to allow for a question and answer, so I'll recognize Ms. Brière.

[*Translation*]

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Mr. Chair.

Good afternoon to all the witnesses. Thank you for joining us today for this important discussion.

Dr. Caudarella, can you explain to us how detox and forced abstinence increase the risk of death for someone battling addiction?

Dr. Alexander Caudarella: Thank you for the question.

Detox has been used to treat addiction for a long time. It's still used to treat a lot of substance addictions, one of the most common being alcohol addiction.

However, we know that abstinence reduces opioid tolerance. When a person comes out of detox, their risk of dying within a month or a year is higher. We see the same thing in prisons and other situations where people are forced to abstain from drugs. For example, when a person is released from prison, their risk of death is 10 times higher than a person who was not forced to wean off drugs.

We know that opioid agonist treatment is necessary in detox and treatment centres and in prisons.

Thank you.

● (1705)

Mrs. Élisabeth Brière: Thank you very much.

Dr. Morin, you talked a lot about comorbidity. We know that substance use can exacerbate mental health problems, but, on the flip side, people will use drugs to forget about their mental health problems. What should be treated first, the mental health problem or the substance use problem?

Which problem do you think should be dealt with first? Should they be seen as two separate issues that nevertheless have an impact on each other?

Dr. Marie-Eve Morin: That's the big question, the chicken or the egg. Everyone is asking that question.

Let's start by putting things in perspective. There are two types of mental health issues related to drugs.

One is the presence of comorbidities and self-medication. The most common example is alcohol use in response to anxiety disorders. A lot of people with anxiety self-medicate with alcohol. Anxiety was there first, and substance use problems came later.

The other is substance-induced disorders. For example, a lot of teenagers appear to have ADHD symptoms, but those symptoms are actually induced by cannabis use. In other words, the symptoms are triggered by substance use, not the other way around.

I would say that it's important to try to diagnose the primary disease, if there is one, and to treat that at the same time as the substance use problem. We shouldn't be doing what we used to do, which was ask patients to stop using for six months and provide care only at the end of that period. That doesn't work anymore. Addiction and the mental health problem, if there is one, must be treated together. That's called concurrent treatment, or management of comorbidity.

Your big chicken-and-egg question remains unanswered. Sometimes prolonged abstinence provides answers, as in the case of bipolar disorder or psychotic disorders.

Mrs. Élisabeth Brière: Thank you very much.

In response to a question from my colleague, Mr. Thériault, you explained how you would reach out to young people to do prevention and education.

However, we heard earlier from another witness that, when people turn to drugs like fentanyl and even more potent drugs, they're not looking for safety.

What are your thoughts on that?

Dr. Marie-Eve Morin: People are chasing the buzz. Remember, people use for two reasons: to increase pleasure or to relieve suffering. It's rarely for both reasons at the same time.

We learn a lot from peers. When I go to conferences, I bring a person in their twenties who has come out the other side. I bring a young adult who experienced prostitution, street gangs, youth centres, opioids and all kinds of other substances. I'm not in the spotlight at these conferences; those people with lived experience are. When a 22-year-old who was in jail, who experienced youth centres, prostitution and drug dealing, tells their story, that hits home for young people way more than anything a doctor could say.

That's my way of doing things, and it works very well. These conferences make an impression on young people. They remember the person who came out the other side while they were still young. That's my angle.

The Chair: Thank you, Dr. Morin.

[*English*]

Next is Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis: Thank you very much, Chair.

Thanks, everyone, for your answers thus far.

I really want to focus a bit on prevention, if I could. I'll start with Dr. Mathew.

You spoke a bit about prevention. I realize that you're a forensic psychiatrist, so if it's outside your scope, feel free to say so. It would appear that substance use disorder is a problem that could start very early, but it perhaps is something that we need to spend some money on with respect to prevention. We can talk about resiliency, we can talk about exercise, we can talk about friendship and we can talk about meaningful lives and all those things. Are there programs out there right now, funded by the federal government, that are talking about prevention? Do you know that answer? If you don't, that's fine. Perhaps you could talk about how you see prevention.

● (1710)

Dr. Nickie Mathew: I work in addictions and I also work in forensics. I do both.

There are education campaigns to help people understand the toxicity of the drugs out there, but there are other programs available. For instance, in Iceland they had a program where they gave vouchers to families to put their kids in extracurricular activities. As well, I forget the age of the kids, but under a certain age for teenagers there was actually a curfew. People were encouraged to not go out at night and were encouraged to engage in sports. This dramatically reduced the alcohol and drug use in that country.

The other thing I would mention is lowering the amount of opioids in the street supply. I think that's important primary prevention. There are also things like access to therapy and early treatment so that the substance use disorder, or the mental health disorder that can cause the substance use disorder, doesn't progress to something where a substance use disorder becomes severe.

Mr. Stephen Ellis: Thank you very much.

[*Translation*]

Dr. Morin, I have the same question for you.

[*English*]

Dr. Marie-Eve Morin: Can you repeat the beginning of the question? I think it's similar to what I said to Madame Brière.

Mr. Stephen Ellis: It is very similar.

Do you now have federal government money funding prevention at the current time? Are you receiving any federal government funding for the prevention that you're doing? Can you talk about what a good prevention program might look like?

Dr. Marie-Eve Morin: I can try in English.

I opened my own clinic in 2015 in Montreal dedicated only to addiction. I had to close the clinic in 2020 because the provincial government told me it was not a priority. The priority was COVID at that moment, so I had to close my clinic.

The name of the clinic was Clinique Caméléon, like the animal, the chameleon. I think if you want to work in addiction you need to be a chameleon; you need to change the context depending on the question. If someone wants to reduce drug use, it's already good. If someone wants to stop, it's very good too, but you have to adapt your approach to what the patient wants.

My mentor used to tell me that working in addiction is like working in intensive unit care: If you don't treat them when they're ready, they die. That's what we see, so we already have to be ready to help when they're ready.

[*Translation*]

Mr. Stephen Ellis: Thank you very much, Dr. Morin.

[*English*]

Dr. Caudarella, perhaps I'll pose the same question to you. Are you aware of federal government spending on prevention programs? What might an ideal prevention program look like to you?

Dr. Alexander Caudarella: Thank you.

With the evidence-based prevention we have, we know what doesn't work and we know what works. We really have to look at community-based, school-based and family-based programs, programs that build skills and resilience, and also ones that help people understand and create more linkages.

Many of the communities we're talking about around the country have a lot of strength within them. It needs to be tapped into. Often it's about supporting communities to figure out what the needs in their communities are and how to answer them.

Unfortunately, every jurisdiction in this country is guilty of responding to crises with a shorter lens. We responded by trying to treat everything that was downstream. As I said, with the first crisis declared eight years ago, those kids were 12 at that time. They're now the ones who are dying.

I hope that every government in this country, municipal, provincial and federal, is able to reinvest in prevention and see that it has a role as part of that continuum and that it also in the long-term hope of solving these bigger issues.

Thank you.

The Chair: Thank you, Dr. Caudarella.

Dr. Powlowski, you have five minutes.

Mr. Marcus Powlowski: Thank you.

A couple weeks ago we talked about the public disorder that characterizes a lot of downtown areas, seemingly swirling around drug use. I'm glad to see a couple of people here who were talking about mental health issues in part of this discussion.

I'd like to talk more about how much of the problem is drug use and how much of the problem is mental health disorders.

We've also talked about it being difficult to distinguish between the two, being a chicken-and-the-egg problem. Some drugs, like methamphetamines and even marijuana, can cause psychosis.

Maybe I can start with Dr. Mathew, but maybe go on afterwards to Dr. Morin.

How much of the kind of Downtown Eastside scenario of homelessness, drug use, crime and social disorder is really a drug problem, and how much is psychiatric problems that are being inadequately addressed?

With respect to that, in my last number of weeks in considering this issue, I've talked to psychiatrists about the availability of treatment and treatment for addictions. They said, Marcus, there are no beds. We discharge people from our psychiatric unit with rope burns around their necks from trying to hang themselves, so how are we going to find beds for them?

There are not enough beds, and certainly not enough outpatient services. I've also heard from someone in Thunder Bay who said there should be like a hundred people in Thunder Bay on court-ordered treatment, long-term anti-psychotics, but who aren't. Part of the problem is apparently concurrent disorders and distinguishing between psychiatric problems and addiction problems.

How much are these problems a result of there not being enough chronic care beds? We closed all the chronic psychiatric hospitals years ago, replacing them with long-term anti-psychotics. Should we be re-examining whether that's an issue?

I know I've talked about a lot of this, but maybe, Dr. Mathew, you could start by addressing some of those issues relating to the intersection between psychiatric illness and addictions.

● (1715)

Dr. Nickie Mathew: Sure. There's a lot to unpack, and I'll start with the last point you were mentioning.

When you look at schizophrenia, one of the most robust statistics that we have on it is that about 1% of the population will have schizophrenia. In British Columbia, where there are about 5 million people living in the province, there will be about 50,000 people with schizophrenia. Then, when you take those folks with schizophrenia, about 20% will be able to take medication, never have a relapse and live pretty normal lives. Meanwhile, 50% will have a relapsing-remitting illness, and 30% won't respond to medication.

What do you do with those folks who don't respond to medication? There's also a high amount of substance use within this population. If you have an intrinsic organic illness that causes you to have psychosis, a lot of times substances like crystal meth or cannabis-use disorder....

In my treatment facility, crystal meth is the most common substance used. It is used by about two-thirds of the clients, and about half also use cannabis. When they use these substances, it actually destabilizes them as well.

You were speaking about the closing of mental health facilities. Riverview closed down; that was the big asylum in British Columbia. My friend and colleague Dr. Christian Schütz did a study, and what he saw was that 10% of the folks in the Downtown Eastside were old Riverview patients. This was back in 2005, I think, so it's an older study, but it shows what happens when these folks aren't housed. We're talking about thousands and thousands of these people, so you do have to provide long-term supportive housing for these individuals. I think that's one of the key things that's missing in the spectrum.

At this moment, I'm in Switzerland trying to figure out how they are treating substance use and mental illness so differently and why they have much better retention rates. One of the things they have is wraparound services, and they have supportive housing, so every patient will get a social worker and a nurse and a family physician, and they'll get a psychiatrist, and these folks will follow them longitudinally in the community. Also, with the housing, they'll have support getting medications provided to them.

There's so much more support out there in the community, which we don't seem to have in Canada, in comparison with Switzerland.

Regarding your first question about violence and mental health issues, I actually don't have any statistics on that. I can tell you anecdotally what I've been seeing.

One of the things I do is overnight assessments for the courts. What happens is that someone commits a crime and gets arrested, and then there are concerns about their mental health and whether they should be at their bail hearing the next day. I am asked to assess the patient to see whether they are mentally well enough to go to court the next day.

Before the pandemic, roughly one in five folks I saw for overnight assessments were in for random stranger attacks. They didn't know the victim, and, for whatever reason, whether it was an intrinsic organic psychosis or a substance-induced psychosis, they went and attacked someone.

A couple of years ago, that became one in two. There was a dramatic increase in stranger attacks. Now I think it has decreased to maybe one in three, but there has been an increase. I think there are a lot of issues with this. I think one was the destabilization that occurred with COVID, and two—

● (1720)

The Chair: Thank you.

This is very interesting. I was reluctant to interrupt, but we were well over time.

[*Translation*]

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

Mr. Luc Thériault: Dr. Morin, earlier you said that intensive care units have to be ready when the patient arrives and is ready to receive treatment.

The problem with the toxic illicit drug crisis is that patients do not necessarily come to intensive care by ambulance. Treatment has to be available where they are. Regardless of the treatment plan, which should take relapse into account, health care workers have to build a connection with these patients and be in contact with them.

What are your thoughts on that?

Dr. Marie-Eve Morin: Well, I can give you a very concrete example from Projet Caméléon, a non-profit I started in 2017 at the beginning of the opioid crisis.

Projet Caméléon sends a team of doctors, pharmacists, nurses, medical students, volunteers and outreach workers to electronic music festivals, where almost 95% of people are under the influence of drugs.

We respond to GHB and ketamine overdoses on site. You don't see a lot of opioids or alcohol at these kinds of festivals, but you do see a lot of psychedelic drugs, such as LSD and magic mushrooms.

The year before, we went to the Eclipse festival, which took place in Sainte-Thérèse-de-la-Gatineau near Gatineau. Twenty-seven ambulances were called to the site. There were paramedics on site, but no doctors.

The first year that Projet Caméléon provided on-site response, only four ambulances were called. Last year, we set a record: no ambulances were called.

We provide on-site treatment. We administer injectable antipsychotics, naloxone and benzodiazepines to treat panic attacks, among other things.

There's clear evidence that treating people on site prevents deaths and a large number of hospitalizations, hospitalizations that may not always be necessary.

A number of organizations, such as CACTUS Montréal and Spectre de rue, have street workers serving downtown Montreal.

We haven't covered everything today, but Projet Caméléon workers also do drug testing so people can have drugs tested before they use them. When we think we've found traces of fentanyl in a substance, we let people know, and they just don't consume it.

Someone said earlier that people are using street fentanyl. That's true. I think there is now a fentanyl addiction epidemic. Some people are now addicted to fentanyl.

I also want to point out that there are products on the street now that are much worse than fentanyl, such as carfentanil and isotonitazene. People can get all kinds of other opioids that are even more potent than fentanyl.

Drug testing is a service that can be provided on the street, and it can save lives. I hope it's available in Vancouver.

Contrary to what some people think, this service does not increase substance use. It actually tends to reduce it.

Thank you.

The Chair: Thank you, Dr. Morin.

[*English*]

Mr. Johns, you have two and a half minutes, please.

Mr. Gord Johns: I'll go back to Ms. Wilson, president of the British Columbia Association of Chiefs of Police, who said at our last meeting that, "we know that diverted safe supply and diverted prescription medications are not what's killing people". She said as well that, "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."

Ms. Schulz, maybe you can talk about how easy it is to get toxic fentanyl on the streets of Canada and about how hard it is, or what the steps are, to get a safer supply in the provinces that allow it. My apologies to the other witnesses, but I'm giving you the rest of my time—a minute and a half—because I know that some politicians don't want you and other moms to be heard. I'm going to make sure you get that time to speak.

● (1725)

Ms. Petra Schulz: Thank you, Mr. Johns.

We all know how easy it is to get any illicit drugs anywhere in the country. Drug dealers don't check IDs. I gave the example of the young Olivia who died.

In terms of safe supply, there are huge barriers for people who need this to save their lives. In British Columbia, where it is available, it takes a prescriber who is willing to work with the person. Only a small number of people in British Columbia, roughly 5% of the people who could benefit from it, are on safe supply. In Alberta, thanks to a court injunction, we have one person left on safe supply who thankfully is doing well. She would be dead today, she told me, if it weren't for the court injunction.

We throw huge barriers in people's way for a life-saving measure, whereas it is easy to buy on the street. It is too often lethal. We also ignore that the people who die are not only those who need treatment; they're also people who use occasionally. They're people who use just once, like young Olivia. These are the people we need to see as well. That is where issues like drug-checking are important. We need to remove the barriers to save lives and implement evidence-based measures. Otherwise, the numbers in this country will continue to climb.

At the same time, we should start making treatment immediately available when somebody wants to work on prevention. What nobody talks about in prevention is poverty and the influence of poverty. You don't have prevention with just some education programs. You have to make sure that people have good lives.

The Chair: Thank you, Ms. Schulz.

Next is Ms. Goodridge, please, for five minutes.

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

Dr. Mathew, B.C. developed protocols to prescribe recreational fentanyl to youth. I'm just wondering if you could share with the committee what your thoughts are on providing recreational fentanyl to youth rather than mental health and addiction treatment.

Dr. Nickie Mathew: One thing that's important is that I don't think we should rule out any intervention outright, but we need to apply the precautionary principle in the development of such protocols. What does that mean? There is an author, Nassim Taleb, who produced a paper in 2010. What he said was that you have to look at two factors. One, is the risk systemic or is it local? Does it cause a low amount of damage or a high amount of damage?

For something like this, where you're increasing the supply of fentanyl in the community, that would fall under systemic risk and high downsides, so that would be the type of thing you would apply the precautionary principle to. What you want to do is figure out if this works first.

If that were something that needed to be done, we'd need to look at small pilot projects that rigorously and objectively look at the upsides and the downsides, and many of the studies done so far in these areas do not look at downsides. That way we can measure the risks and benefits of such a program, and if such a pilot program took place and showed that objective benefits outweighed the risks, then that is something that should be implemented. However, if this has not been done, we should look at the precautionary principle when we have interventions that can increase the supply of addictive drugs in the community.

Mrs. Laila Goodridge: Do you think it's problematic to base political policy decisions on pieces that have not been rigorously studied and to look at only the impacts to people who are using drugs and not to community and public safety?

Dr. Nickie Mathew: I think we definitely need to have a 360° view in these things. We need to look at the upsides and downsides, not just for the treatment population, but when you're looking at the supply of addictive drugs you have to look at the population writ large.

In the nineties, when physicians were pushed to prescribe opioids, it was to treat pain as the “fifth vital sign”. It was Dr. James Campbell, who was the president of the American Pain Society, so this was a very respectable individual who was pushing this. However, this led to a huge number of downsides, so we really need to study the upsides and the downsides because, as a physician, you want to know that what you're prescribing has benefits that outweigh the risks.

● (1730)

Mrs. Laila Goodridge: Thank you.

You brought up the OxyContin crisis. Are you seeing similar things when you're looking at the safe supply, which is flooding our streets with potent opioids? Are you seeing something similar to what existed in the nineties with the OxyContin crisis?

Dr. Nickie Mathew: I want to take my opinion out of this and I just want to look at what the government has produced. There is a document called “Youth Unregulated Drug Toxicity Deaths in British Columbia”. What they looked at were the years 2017-2022. What they found was that, if you looked at the deceased youths, there were zero per cent deceased youth with hydromorphone in their systems in 2017, 2018 and 2019. In 2020, the year safe supply came out, 5.5% of the deceased youth had hydromorphone in their systems. In 2021, 8.3% of youth had hydromorphone in their systems, and by 2022, this number had increased to 22.2%. What we're seeing is an increase in the number of youth who have hydromorphone in their systems at the time of death.

I want to be clear. This doesn't mean that the youth died from hydromorphone, but it certainly doesn't help to have hydromorphone in your system at the time of death. What I worry about is that this might be a marker for increased use among youth. We don't know. That needs to be studied more, but it's certainly something that needs to be looked into. The data for adults hasn't been released, so I just want to stick with the facts, and those are the statistics for that.

Mrs. Laila Goodridge: I really appreciate the fact that you want decisions based on facts and not on pieces here, and I think this is one of the challenges. I know members of the NDP like to say that we're spreading disinformation, but the reality is I simply want public policy decisions based on facts and peer-reviewed science, not based on feelings and trying to save the world while allowing the next generation to succumb to addiction because we make drugs so much easier to access. If you could say something to youth right now, who are potentially thinking about using, going out and buying safe supply hydromorphone, what would you tell those youth in British Columbia?

The Chair: Answer as briefly as you can, please.

Dr. Nickie Mathew: I would tell them that any sort of opioid is addictive, and that with something like hydromorphone, if you become tolerant, you might actually move on to more dangerous things like fentanyl—to be careful around any sort of opioid use.

The Chair: Thank you.

The last round of questions for this panel will come from the Liberal side.

I believe it's Dr. Hanley.

Mr. Brendan Hanley: Thank you.

I will leave time for Dr. Powlowski, as well, especially if you remind me.

First of all, I just want to thank my colleague Dr. Ellis for bringing up Planet Youth and prevention.

I just want to emphasize again, as Ms. Schulz said, how vital that is. I'll also just note—because not everyone may know this—that there was $20 million in funding dedicated in the federal budget, starting in 2023-24, for Planet Youth initiatives, with up to $125,000 in funding per community initiative.

This is a great start, I think, down another avenue for prevention, which we need to be very aggressive at in supporting our youth.

Dr. Mathew, just very briefly, I really commend you for being in Switzerland. I wonder if you have also been in Portugal.

Dr. Nickie Mathew: I have not been in Portugal.

Mr. Brendan Hanley: I just want to clarify that because there may have been a misperception that coercion is part of the cornerstone of Portugal's approach. I was fortunate to be able to travel to Portugal with my colleague Mr. Johns and to directly have a prolonged meeting with Dr. Goulão.

Coercion is definitely not part of the Portugal approach. There is a dissuasion panel. There is a host of measures using the five pillars, including reintegration, that really address the clients' needs, whether that's housing, harm reduction, Suboxone or methadone, or a readiness for treatment, along with the capacity for all of those based on compassion, central coordination and an integrated approach.

I'll pass it to Marcus.

Maybe I can get one minute back at the end, Marcus.

● (1735)

Mr. Marcus Powlowski: I would just like to let Dr. Mathew finish his story about increasing random attacks. I think he was going to tie that in to mental illness and drug use.

Maybe you could just finish that story, and then I'll give it back to Brendan if we have any time.

Dr. Nickie Mathew: Sure.

I mentioned it in my talk, but I think one of the big issues is the rise of phenyl-2-propanone meth. I said that earlier in my introduction.

When they were making crystal meth.... There are two enantiomers, two types. They're like handedness. The l-methamphetamine is a nasal decongestant, and the d-methamphetamine is the psychoactive component. They made it so that it's pure d-methamphetamine, so when you take the same amount, you're more likely to have a psychoactive outcome.

I think the rise of this in the drug market has helped fuel a lot of the psychosis that we're seeing.

I think all of these things combined are the things that are leading to increased random-stranger attacks in the population.

The Chair: You have two minutes.

Mr. Brendan Hanley: Excellent.

Dr. Caudarella, I want to come back to you. We have touched a little bit on decriminalization here and there during this meeting. I know that you are based in B.C. I want to know what Canada should learn from the B.C. pilot to date, and what you would be advising Toronto and potentially other jurisdictions about what to incorporate to make a decriminalized approach successful.

Dr. Alexander Caudarella: Thank you.

Although I did work in Vancouver, I am now based in Ottawa.

There are a number of really important lessons. First of all, most decriminalization or alternatives to criminalization have required various adjustments at various points. The community has made it clear that they want to be involved and and to negotiate part of how public spaces are used.

We need to create more opportunities for people to talk, and to talk in different ways. There needs to be really good access to treatment. I also think we need to remember that if, for example, we're going to ask a police officer to take someone to a hospital instead of to jail—I can tell you because I've seen this so many times—we can't expect the police officer to wait there the whole day for the patient to be seen.

We need a lot of different levers. We need to make sure there are tools in that tool kit. What we've heard from law enforcement and the partners we work with is that this is part of a long arc that's trying not to punish the people for the symptoms we're trying to treat. At the end of the day, the goal is really to provide people with as much access as possible through as big of an open door as possible.

What we're hearing from people is that they want to be part of this. They want to have discussions. CCSA will be hosting a summit in the coming months on open drug use because people want to be involved in this discussion. They don't want to penalize people. They don't want to punish people, but they want to have this discussion about what it is. We need to listen to people. We need to adjust. It's not just small groups of people. We need to make sure that everyone's involved in that discussion.

The Chair: Thank you, Dr. Caudarella.

That concludes the questions for today's panel.

I want to thank you very much for the passion you bring to your work and the patience you've brought to this meeting. All of it is greatly appreciated and will be extremely valuable to us in making recommendations to Parliament and to the government.

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

Some hon. members: Agreed.

The Chair: We're adjourned.