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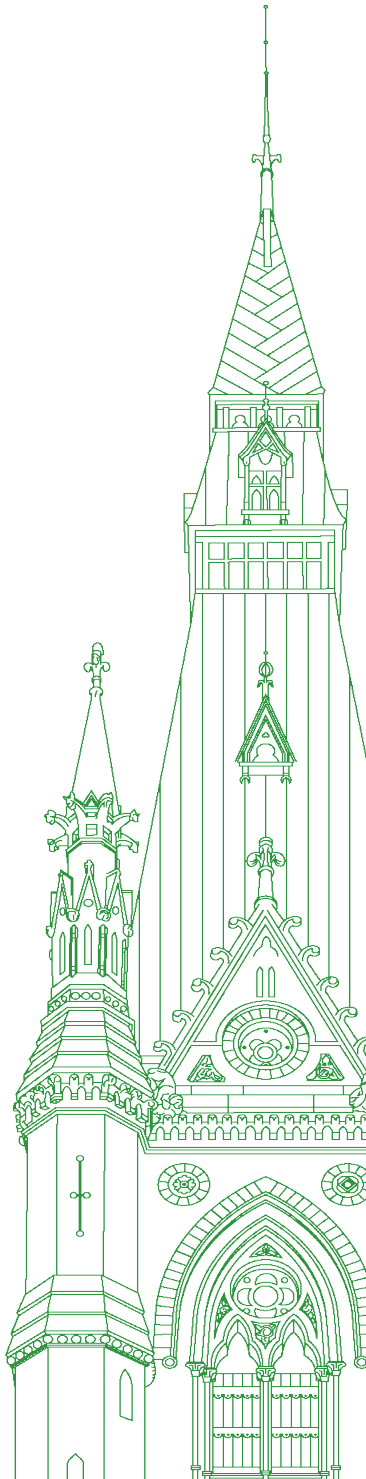

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, May 6, 2024

● (1545)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): Welcome to meeting number 114 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 cause injuries, all in-person participants are reminded to keep their earpieces away from all microphones at all times. As indicated in the communiqué from the Speaker to all members on Monday, April 29, the following measures have been taken to prevent audio feedback incidents.

All earpieces have been replaced by a model that greatly reduces the probability of audio feedback. The new earpieces are black in colour, whereas the former earpieces were grey. Please use only an approved black earpiece. 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 on the middle of the sticker for this purpose, which you will find on the table, as indicated. Please consult the cards on the table for guidelines to prevent audio feedback incidents.

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

These measures are in place so that we can conduct our business without any interruptions and to protect the health and safety of all participants, including the interpreters. Thank you for your co-operation.

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

I would like to welcome our panel of witnesses.

We have with us here in the room Dr. Sharon Koivu, addiction physician. Online is Dr. Bernadette Pauly, scientist with the Canadian Institute for Substance Use Research and professor at the School of Nursing, University of Victoria. By video conference, representing the Thunderbird Partnership Foundation, we have Dr. Carol Hopkins, chief executive officer. Finally, also by video conference, representing the Vuntut Gwitchin First Nation, is Chief Pauline Frost.

To all of our witnesses, thank you for being with us.

Parliament Hill is a place where rumours are a constant. I heard a rumour today that there's going to be a vote in roughly 45 minutes. If that happens, the meeting is likely to be interrupted, and we will be asking you to stay a little later than you might have anticipated. If you are able to stay with us to ensure that everyone gets a chance to fully converse on these matters, it will probably result in your time with us being extended from 5:30 until 6 o'clock or a little later. I'll give you a heads-up for that.

We can now go ahead with our opening statements, beginning with Dr. Koivu.

You have the floor for the next five minutes. Welcome to the committee.

Dr. Sharon Koivu (Addiction Physician, As an Individual): Thank you, Mr. Chair and members of the committee.

I have been a physician for 39 years. I have my certificate of added competence in palliative care and addiction medicine from the College of Family Physicians of Canada. I began working in addiction medicine in 2012. Until 2021, I was the sole health care provider offering comprehensive consultations in addiction medicine at the London Health Sciences Centre, where, in 2023, an interprofessional addiction team was established. I also provide addiction consultations in St. Thomas.

I have decided to speak out to bring a voice to the horrific suffering I have witnessed from safe supply.

Early in my addiction career, I identified a link between injecting long-acting hydromorphone capsules and developing a heart valve infection. An infectious disease specialist I worked with found a link between injecting these capsules and getting HIV. When this specialist and the department chair took our findings to the community agencies, we were initially criticized and called fearmongers.

Fortunately, we established community engagement and developed an integrated response. As part of the response, in 2016, the London InterCommunity Health Centre developed a program that provided high-risk sex workers using hydromorphone capsules with short-acting hydromorphone tablets, also called Dilaudid. This was the inception of the safe supply program in London. I initially supported the program. It is important to note that we did not have a problem with illicit fentanyl at this time.

Prior to the safe supply program, I rarely saw people with spine infections. In the following summer, I saw five patients in one month. The numbers continued to climb. The common thread among patients was that they were injecting Dilaudid tablets. Many told me they were buying Dilaudid diverted from the safe supply program.

Some patients were in the program. I had patients who were housed, using clean equipment and only injecting Dilaudid developing horrific infections. Spine infections cause perhaps the worst suffering I have ever seen. Not only are they unbearably painful, but they can also cause paraplegia or quadriplegia.

In June 2018, I had my first patient tell me that he left his apartment to live in a tent near the pharmacy, close to the safe supply clinic where much diversion takes place, because the safe supply pills were cheaper and more abundant near the source. I lived in the neighbourhood and watched this encampment grow.

Since safe supply began, I have been involved in about 100 hospitalizations of patients with spine infections. That's currently about one per month. However, spine infections are only a small part of the suffering we see. About 30 patients per month are admitted with another severe infection. Of patients admitted with opioid use disorder, 25% were receiving a safe supply prescription and 25% reported using diverted Dilaudid. Only 4% of the consultations we did were for unintentional overdose.

Generally, in hospital, we start patients on home medications. If we did this for safe supply patients, the results could be fatal. This is dangerous for patients and very stressful for health care providers.

For example, patient one was prescribed eight milligrams of Dilaudid, D8s, which was 40 tablets per day, along with 100 milligrams of long-acting morphine in nine capsules per day. When they were given less than half of their prescribed dose, they had a severe respiratory depression—that is, toxicity. Patient two has frequent admissions requiring intubation. They were prescribed 28 D8s per day. They tolerated about six to eight and said they never took more than 12 in a day.

The patient population has changed. I see more young patients and many more men. Now, most start opioids recreationally and not with a prescription for pain, as was the case in 2012. I am also repeatedly hearing disturbing stories that people with prescriptions are vulnerable to violence.

Importantly, as I mentioned previously, when safe supply started in 2016, we did not have a problem with illicit fentanyl. We do now. Many patients have told me that they sell or trade much of their prescribed safe supply to buy fentanyl. Others not in the program have told me that their dealer has claimed to be out of Dilaudid and has sold them fentanyl, starting them down this path.

● (1550)

Safe supply appears to be contributing to the illicit fentanyl crisis. Safe supply is not reducing illicit fentanyl or its harms within a community. Our hospital experience also shows that safe supply is preventing patients from choosing opioid agonist therapy and the opportunity for recovery.

I would like to mention a program that is showing significant benefits. The Central Community Health Centre in St. Thomas has a low-barrier approach using subcutaneous buprenorphine, also called Sublocade. They are having success serving a very similar population to that of the London InterCommunity Health Centre, without the unintended side effects. It should be a model that we are discussing.

Of note, while I have broad shoulders, I found some of the comments made by Dr. Sereda on February 26 about me and cardiac surgeons to be misleading, and I look forward to an opportunity to address this.

Thank you for your work and your time. *Meegwetch*.

The Chair: Thank you, Dr. Koivu.

Next is Dr. Pauly for five minutes.

Dr. Bernadette Pauly (Scientist, Canadian Institute for Substance Use Research, and Professor, School of Nursing, University of Victoria, As an Individual): Good afternoon. Thank you for the opportunity to be here.

I am Dr. Bernadette Pauly. I'm a professor in nursing at the University of Victoria and a scientist at the Canadian Institute for Substance Use Research. I'm a member of the research team conducting the B.C. provincial evaluation of prescribed safer supply.

Prior to the introduction of the prescribed safer supply policy, evidence of the need for that intervention was well demonstrated by the overdose deaths caused by the unregulated drug market. However, it's critical to generate evidence of ethically justified interventions and determine whether or not prescribed safer supply reduces overdose risk. To answer that question, our team designed a rigorous mixed methods study using state-of-the-art approaches combining administrative and primary data.

In January 2024, the team led by Dr. Slaunwhite and senior scientist Dr. Nosyk published the first-ever population-level study in the British Medical Journal, a high-impact journal. Everyone receiving risk mitigation safer supply prescriptions was included in the study and was carefully matched with people not receiving them on multiple variables, including receipt of opioid agonist treatment. For those receiving opioids through this program, the risk of dying from any cause was reduced by 61% and the risk of dying of an overdose was cut in half. If they received four days or more, their overdose risk was further reduced to 89%. This is known as a dose-response relationship, and the finding was independent of opioid agonist treatment. A similar pattern was found for stimulants, but the sample size was smaller so there was less certainty. This protective effect continues week after week as long as they're able to access a prescription.

However, only 7.6% of those with an opioid use disorder and less than 3% of those with a stimulant disorder received the intervention during the period of study. There was limited implementation, with implementation occurring mainly in urban areas like Vancouver and Victoria and among prescribers who had larger caseloads of people with substance use disorders and more complex problems. While the intervention did not fix all their issues, nor was it expected to, it was protective for reducing risk of overdose death and all causes of death.

In a qualitative analysis, we found that prescribers were hesitant to take up the intervention out of fear of audit from regulatory colleges, as well as criticism and censure from colleagues. Where there were networks of prescribers who had support, there was increased continuity of prescribing. However, prescribing alone is an inadequate response to a systems issue, namely prohibition and an unregulated, unsafe supply of drugs.

The intervention was often difficult to access. Participants in the qualitative arm of the study reported the need to climb a steep staircase with many steps. Often, potential participants did not know about the risk mitigation guidance or safer supply. When they got their hopes up, they had to find a prescriber and navigate highly medicalized systems to get an appropriate prescription, and then pick it up daily to keep it. This required self-advocacy and fortitude. In a primary survey of 197 people, less than half of participants received a prescription sufficient to reduce withdrawal. Reducing withdrawal is a minimum requirement, so there's room for improvement.

Prescribed safer supply is a not a competitor to OAT or any form of treatment. It provides a pathway for people to access a life-saving intervention as part of individual recovery journeys. It does not replace or threaten the need for treatment. In fact, as part of a system of care, treatment options must be available for people if and when they are ready. In spite of this, the number of people dispensed a prescription in B.C. is decreasing.

Fears of diversion causing death are unfounded. Hydromorphone was detected in 3% of overdose deaths in 2023. It's unregulated fentanyl that's responsible for 85% of the toxic drug deaths. The root problem driving this emergency is toxic drugs, which is a consequence of prohibition. The unregulated market is accessed by those with substance use disorders and those without.

● (1555)

We need to expand access to alternatives beyond the health care system to ensure safe and regulated access to substances of known safety, quality and composition. We should be scaling up, not scaling back, safer alternatives to the unregulated drug market and looking to end prohibition.

Thank you. I look forward to the questions and comments.

The Chair: Thank you, Dr. Pauly.

Next, on behalf of the Thunderbird Partnership Foundation, we have Dr. Carol Hopkins.

Welcome to the committee. You have the floor.

Dr. Carol Hopkins (Chief Executive Officer, Thunderbird Partnership Foundation): [*Witness spoke in Lunaape*]

[*English*]

I'm Carol Hopkins of the Lenape nation in southwestern Ontario. I'd like to acknowledge the lands that you are joining us from and that we're all coming together on today.

In 2023, the number of first nations deaths due to drug poisoning was 36 times those in the general population in Ontario. In eight short years, from 2016 to 2023, first nations deaths due to the toxic drug supply grew at a rate of 33 times those seen in the Ontario population.

During the pandemic, from 2019 to 2022, 28% of first nations people used opioids in a harmful way, and 18% used methamphetamines to survive in an environment where there were no resources for housing, food security or income security. Those who reported food insecurity were two times more likely to use methamphetamine, according to a survey that Thunderbird ran. Forty per cent of first nations people reporting methamphetamine use felt hopeless to change their lives. It was this hopelessness that increased their risk for using opioids in a harmful way.

This population also reports a high rate of trauma, grief and loss, with a lack of resources close to home to support their mental wellness. The use of fentanyl, benzodiazepines and xylazine has been increasing across all regions of Canada, including in first nations. They are core to the opioid and toxic drug crisis that we are talking about today. The impact of these drugs requires community-based health resources that often first nations communities lack. First nations communities that declare a state of emergency report no capacity for preventing deaths due to the toxic drug supply. They also report their vulnerability to gangs, gun violence and murders, as well as human trafficking, which is now present in many first nations communities for the first time.

The war on drugs, including the criminalization of people for their health and social needs, has been a long-standing experience of first nations people in Canada, who are only 5% of the population yet represent 32% of those incarcerated. Indigenous women represent 50% of the incarcerated population. The war on drugs and incarceration have not increased safety from the toxic drug supply, have not reduced crimes of survival for people who live with opioid dependency and have not eliminated the illicit and toxic supply.

Indigenous Services Canada does not provide for physician or pharmacy services in first nations communities. We know those things are the responsibility of the provinces and territories. In this context, the opioid crisis and toxic drug crisis do not depend on geography. Rural and remote first nations communities are not exempt from the toxic drug supply or opioid crisis. The crisis is about a lack of equitable, available and accessible health care for first nations, with access to primary health care, physician services, pharmacies and public health resources. These are all necessary components of a response to the toxic drug crisis. Live-in drug treatment aimed at abstinence is not the evidence base for addressing opioids, and it is not the first line of evidence-based intervention. Abstinence-based programs will not change drug dependency or address physical withdrawal from opioids.

Where live-in treatment programs have additional resources—for example through provincial health authorities, harm reduction networks and first nations-governed culture-based and land-based services—and have options for readmitting or keeping first nations people on a continuous basis, clients have gone on to gain employment, obtain housing and maintain their own wellness.

Buprenorphine treatment is initiated by the community's primary care physician, when they are lucky enough to obtain a partnership; by addictions physicians through telemedicine; or by fly-in locums, who dispense daily under supervision. It has proven to be effective, along with a recovery program involving community mental health workers who provide both conventional counselling and culturally relevant healing practice. This comprehensive approach has enabled many patients or first nations people to stop or manage their opioid use and return to work, school and family. A year after such programs have been initiated, criminal charges and medevac transfers decreased, the needle distribution program dispensed less than half its previous volume and rates of school attendance increased.

● (1600)

Addressing the opioid crisis has been challenging for first nations communities, most significantly because of inconsistent support and resources to community-governed and culturally relevant treatment. One study of community-based opioid misuse reported that among adults aged 20 to 50, 28% were on buprenorphine or naloxone, double the rate of adults in the community living with type 2 diabetes.

First nations people have the right to live—to live life. They have the right to the sacred breath of life, and that has to be our focus in any drug policies that are humane and sensible for first nations communities.

First nations communities require increased capacity for reducing harms related to opioids, opioid analogs, methamphetamines and xylazine, such as consistent support; access to prescribers, pharmacies, safe housing, food security and medication to address withdrawal; and a choice to continue to use drugs safely. Harm reduction kits and resources are needed. Human resources are also needed—

The Chair: Dr. Hopkins, I'm sorry to interrupt. If I could get you to wrap up, you will get a chance to expand on your presentation in questions and answers.

Dr. Carol Hopkins: Human resources are needed in community. The existing resources of treatment centres can also play a role, but they need additional resources and capacity.

Thank you.

● (1605)

The Chair: Thank you.

Last but not least, from the Vuntut Gwitchin First Nation, we have Chief Pauline Frost.

Thank you for being with us. You have the floor.

Chief Pauline Frost (Vuntut Gwitchin First Nation): Thank you. I appreciate the opportunity today.

I am the chief of a very small community—

The Chair: Excuse me, Chief Frost. I'm sorry. The bells are ringing, and that means we're obligated to vote unless we have unanimous consent to continue.

Do we have unanimous consent to allow Chief Frost to finish her opening statement before we head off to vote?

Some hon. members: Agreed.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Mr. Chair, while we're at it, to avoid interruptions, could the volume in the room be lowered a bit so that I can hear the interpretation better without having to turn up the sound? It's too loud in the room.

We should be doing tests at the beginning of every meeting to solve the problem. This isn't the first time I've had to intervene. I haven't interrupted the witnesses more often out of courtesy. However, the discussion is becoming difficult to follow.

[*English*]

The Chair: Okay.

Chief Frost, I'm sorry for the interruption. Go ahead and finish your opening statement. We'll likely suspend once you're done.

You have five minutes.

Chief Pauline Frost: Okay. Thank you.

As the former minister of health and social services for the government of the Yukon, I was responsible for identifying the opioid crisis, as well as the COVID pandemic. At the same time, I worked as a lead negotiator for my first nation, a small, isolated aboriginal community in north Yukon. We signed our self-government agreement 30-some years ago. We exercise our inherent right to self-determination. We have responsibilities for the general welfare of all citizens, our community, the land and the resources. As an isolated community, we're a resilient people, resilient in that we are connected to our roots, our traditions. At the same time, we are deeply affected by the opioid crisis and the toxic drug overdoses in the Yukon and across this country.

The serious challenges that we face and the high cost of living.... Food security is huge. Fiscal capacity is limited in our communities, causing significant challenges in addressing mental health. Substance use challenges have arisen in our history due to colonialism, racism and intergenerational trauma. All of this is a priority for my community.

In April 2020 and 2023, we declared a state of emergency and substance use crisis in my community. The reason is that we've suffered significant loss due to opioid, alcohol and drug use and abuse. Over the last five years, we've lost 15 Vuntut Gwitchin citizens linked to substance use.

Because of the small community, this is very complex, and it affects everybody, with compound impacts and effects. Every person in my community has been affected in one way, shape or form. Because we're an isolated community, our citizens are required to travel out of the community for amenities and medical supports. Therefore, we tend to see impacts and effects when they get to the city. There's an urban centre effect on average on northern isolated people.

We have worked tirelessly to support our citizens the best we can with healing and wellness. Our approach has been comprehensive and non-judgmental. We commit to facilitating easier access to treatment services. We set aside, last year, almost a million dollars for supporting our citizens to access treatment programs. That comes out of our FTA base funding that we get for programs and services.

Ensuring consistent availability of counsellors both locally and remotely is a priority for me as a chief. We are developing aftercare programs that provide supports to our community.

What I'm saying here is that we are working hard to combat substance use in our communities. We are utilizing the Yukon's Safer Communities and Neighbourhoods Act to address and combat drug trafficking and bootlegging. We've asked for changes to the security designation for our northern airports so they can implement passenger baggage and freight screening for northbound routes, equivalent to what's seen southbound. In other words, the drug traffickers can come into our community without restrictions whatsoever because we're remote fly-in.

Our tools are limited, but we are making significant headway, and we have sent over 70 people to a treatment facility in the southern parts of B.C. because the Yukon is not equipped. Treatment options are not available to us in the Yukon; we have limited availability. We need more. My first nation needs support to implement programs and improve the wellness of my people.

As we are on the ground, we know what's happening. We have the flexibility, but we are also trying to address the crisis. Adequate and secure funding for life-saving interventions is not going to save us. It's not going to help us. We need more supports in addressing the illicit drug overdoses and for program services.

We looked at a piecemeal funding program available to us through the federal government and the territorial government, which is not sufficient. We just asked last year, at the Prime Minister's forum, for direct access to funding and support. Put it in our base, and let us provide services. We don't have that flexibility. There needs to be consideration of the political, social, economic and cultural pressures that we're facing.

● (1610)

I want to quickly say that we've just finished a coroner's inquest in the city of Whitehorse, Yukon, for four overdose deaths at the emergency shelter facility. Two of those individuals were residents of my community.

We are proud of our community, because we are resilient. We've done amazingly. We own an airline. We don't have a housing crisis. However, our people are directly affected. We have to make a meaningful difference in the services that are provided, and the only way forward is by working together and jointly addressing this. We have looked at options, like a safe exchange in our community. We've educated our citizens. We have looked at alternative options. We are looking at recovery withdrawal supports in our community. We also have to look at a distribution program.

Everything we need to do is about building on healthier families and healthier communities. For the first time, we are actually focusing on our young people now, and we have a youth wellness program. We're bringing our youth together, and facilitators are coming in—

The Chair: Thank you.

Chief Pauline Frost: *Marsi*. I appreciate this time.

The Chair: Thank you, Chief Frost. We're going to suspend now to allow members to vote.

You can expect the suspension to last for about half an hour. Then there will be probably about an hour of questions, more or less. Stretch your legs. We'll be back once we've voted.

The meeting is now suspended.

● (1610)

_____(Pause)_____

● (1700)

The Chair: I call the meeting back to order.

We've finished the opening statements and are now ready to move to rounds of questions.

We're going to begin with the Conservatives for six minutes.

Dr. Ellis.

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

Thank you to the witnesses for their patience.

Dr. Koivu, I listened carefully to your opening statement. When we look at patients—you described a couple of them—we're really not offering them any therapy other than opioid therapy. Perhaps there are other things in addition to that.

For the sake of those listening at home, we all know that people who take opioids will eventually get habituated or used to the dose they're on and will require escalating doses. If that's the kind of medicine we're going to provide, is it not fair to say that we're providing these folks with palliative care?

Dr. Sharon Koivu: Absolutely. That is one of the significant problems with opioids. As you take them, your brain has changes in neurochemicals. What you're taking, your brain becomes used to. That becomes your normal. To get the same effect, you have to increase the dose you're taking. To get the same euphoria, you have to continue to increase the dose.

Perhaps even more importantly, when your brain readapts to this new level of normal, you have to take opioids. If you miss them, your brain will miss them and you'll go into what's called withdrawal, which is a horrific experience. You get severe pain, anxiety, nausea, vomiting and diarrhea. You can feel like you're literally going to die. You keep thinking you need more and you need a higher dose. Whenever you're in a scenario where you're taking an opioid regularly, you're always chasing the high, your dose continues to escalate and you're always trying to medicate away from the withdrawal.

An important thing that isn't always mentioned, which I want to add, is that as your brain regulates and gets used to a certain amount of opioids, you can generally tolerate it if you're well. If you develop pneumonia, endocarditis or any other illness that affects your cardiorespiratory system, that same dose can be toxic or fatal. When you're taking an opioid, it could be that you're always taking the same dose of your Dilaudid or fentanyl, but if you develop pneumonia or sepsis, that dose could become toxic because your brain wants more than what your body can tolerate.

When you are in a position of getting a treatment that's given to you daily to keep you going from one withdrawal to another, it's not allowing your brain an opportunity for recovery. You're staying in a cycle in which you are absolutely dependent on the medication, and you can be at risk of developing tolerance, needing a higher dose and needing a dose that will eventually be more than you can handle. From the cases that I mentioned in hospital, patients were being prescribed substantially more than they could tolerate when we had them in a position where we could see what they were taking. Had we given them the amount they were prescribed, it would have been fatal for them.

Mr. Stephen Ellis: Thank you very much for that, Dr. Koivu.

It's interesting that you started talking about dosages. When we looked at patient 1—I wrote this down—they had 900 milligrams of morphine and 320 milligrams of hydromorphone. Using an opioid calculator to look at the overall dose of milligrams of morphine, that would be equivalent to about 2,500 milligrams of morphine. Is that correct?

● (1705)

Dr. Sharon Koivu: That is correct.

Mr. Stephen Ellis: Looking at that for the average Canadian and again doing the math, that's about 640 Tylenol 3s. You don't have to trust me on that, but I used the same calculator to do it.

The reason I talk about this is people often think it's just one tablet of eight milligrams of Dilaudid. It's a bit concerning that for those who don't use opioids on a regular basis, even though it's one tablet, it's still a significant amount of opioid.

Maybe, Dr. Koivu, you can talk a bit about that.

Dr. Sharon Koivu: Absolutely.

One tablet is also equivalent to four Percocet or 20 milligrams of OxyContin. Those are doses we consider fairly high during the opioid crisis. Taking two of them would essentially be considered relatively safe for most people. Even one can be considered toxic if someone is not used to taking it.

The numbers we're seeing are substantially higher than the milligram equivalent of morphine that I was seeing during the time when people were prescribing heavily for chronic pain. These are the highest doses I've ever seen.

Mr. Stephen Ellis: Very quickly, Dr. Koivu, if we're talking about 2,500-milligram morphine equivalents, what would be the recommended amount that a prescriber should be very cautious about going over? I realize this is a different patient population from even the usual chronic pain population, but what would be a guideline for Canadians listening out there?

Dr. Sharon Koivu: The guideline is the equivalent of 100 milligrams of morphine per day or less.

Mr. Stephen Ellis: And these people are receiving up to 2,500.

Dr. Sharon Koivu: Yes—or more.

Mr. Stephen Ellis: Thank you.

The Chair: Thank you.

We'll go now to the Liberals.

Dr. Hanley, you have the floor for the next six minutes.

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

Thanks to all the witnesses for being here.

I'm speaking today from the traditional territory of the Kwanlin Dün First Nation and the Ta'an Kwäch'än Council in Whitehorse, Yukon.

Dr. Hopkins, I want to address the bulk of my questions to you.

Unfortunately, Chief Frost had to leave early during our vote, but I noticed that you were listening acutely to her testimony and you were nodding. I wonder if you can indulge me. Was there anything in particular that resonated, based on your knowledge and experience, from Chief Frost's testimony as chief of an isolated northern community?

Dr. Carol Hopkins: We typically assume that the issue with resources and capacity to respond to the toxic drug supply is remoteness, that it's geographical. We are not asking for or expecting hospitals to be built in every one of our communities, but the Canada Health Act says there should be universal access to health, and its objective is accessible health care without barriers to our wellness.

I mention this because there are lots of Canadians who live in rural and remote communities, but we are talking specifically about first nations people. They have a right to access health care close to home, where they need it. When it's not available there, they will find it someplace else, which often draws them to urban environments.

In urban environments, they don't always have access to the appropriate health care they need when they have opioid dependency or addictions to methamphetamine or other stimulants or even to sedatives like benzodiazepines, which I mentioned, or the “tranq” drug xylazine, which is not a controlled substance. All of them have substantial effects on people when they don't have any health care resources close to home.

That isn't just because of geography. That has to do with decision-making. If the Canada Health Act says there should be universal access to health care for every resident in Canada no matter where people live, then where are the policies that ensure access to physician care, prescribers, nurse practitioners, pharmacies, public health resources and harm reduction resources when they exist for the rest of the population? Why are those not made available to Canadians and first nations populations no matter where they live?

Often this is referred to as a jurisdictional issue. Who's responsible? The Canada Health Act is clear: Our rights as defined in treaties, the Constitution and now the UN Declaration on the Rights of Indigenous Peoples do not erase our rights under the Canada Health Act. This is a decision, a policy decision, not just a matter of geography.

● (1710)

Mr. Brendan Hanley: If you don't mind, I'll jump in there, because my time is limited.

One thing Chief Frost referred to was having spent a million dollars of base funding from the VGFN to, in this case, send people out for treatment. I can't speak specifically to the number of individuals, but I think she mentioned 70.

We know that often when people go outside for treatment and come back into a community, they are at high risk not just for overdose but for relapse because the community supports—the aftercare—aren't there. Following up on your previous point, do you know of or could you describe models of care that work within a small community? Maybe there are success stories you know of or have seen about how care can be delivered within a community so that you have continuity through aftercare.

Dr. Carol Hopkins: There are communities, no matter how big or how small, remote or isolated, that have partnerships with local health authorities, physicians, prescribers and nurse practitioners, who deliver services by flying into the community from time to time or by monitoring their patients through video conferencing. There are partnerships with the chief and council and direction through a band council resolution on how health services are operating through the health centre, as well as these kinds of partnerships with elders and cultural practitioners. It's clinical support and medication, together with culture-based resources, that have made a difference.

I gave an example of a community in northern Ontario where that significantly reduced crime and the number of kids going into child welfare. Kids showed up to school with food in their stomachs, houses were filled with furniture, toys and food, and life returned to normal, because it's a whole-of-community approach and because the community, through a number of partners, had the resources it needed to respond to the whole population. It's not just about the impacts on the individual who uses drugs. It's about the impact on the family and the whole community.

The Chair: Thank you, Dr. Hanley. That's your time.

[*Translation*]

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

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

Thank you to the witnesses for being here.

Personally, I have no preconceived ideas about the crisis we're trying to understand and fix by means of recommendations. In listening to the various witnesses, though, I end up feeling a little confused. There seems to be no scientific consensus. In fact, increasingly, there appears to be a division within the scientific community or among the professionals working in the field.

Professor Pauly, you talked about safe supply, which saves lives. I guess that was the purpose.

First, does safe supply necessarily have to be temporary? If so, how can we assess that?

Second, why is access to opioid agonist therapy at odds with the impact of safe supply?

● (1715)

[*English*]

Dr. Bernadette Pauly: These are two very important questions.

I just want to speak for a second about the split in scientific evidence that the member referred to. There isn't actually a split when you look at what is considered peer-reviewed evidence or evidence that's been reviewed by multiple scientists in the field.

Our team did a study where we looked at all of the evidence for safe supply. There are close to 40 of these types of peer-reviewed articles, and the evidence is overwhelmingly positive: It connects people to a safer alternative, reducing overdoses; connects them to health care and other types of supports, as needed, like housing; and reconnects them back to family and community. I just wanted to mention that evidence.

Should safe supply be temporary? This is a good question, because when it was introduced in British Columbia, it was introduced as a temporary measure. However, it became clear that we needed it as part of a systems response. I really want to emphasize this piece about a systems response. In British Columbia, we had some evidence early on that when we combined multiple interventions, like take-home naloxone with opioid agonist treatment and overdose prevention, it showed some really good results. However, it wasn't enough. Safer supply comes in as another form of intervention within a comprehensive approach.

As to your question about why there's opposition, I personally don't understand why safer supply is being scapegoated, because the real harms here are coming from a very toxic and unregulated drug market. That is what's killing people.

[*Translation*]

Mr. Luc Thériault: For example, what's your opinion on Dr. Koivu's statement regarding scientific consensus around safe supply?

[*English*]

Dr. Bernadette Pauly: Our evidence has shown that it reduces overdose deaths, and I can point to other studies where it has not been shown to increase rates. Rates of addiction have not been increasing since we introduced safer supply. The description that Dr. Koivu gave is about the ever-escalating need for increasing dosages. That's not what I see happening in the way that prescribers in British Columbia are practising. In fact, in our study, we found that safer supply medications were, at least in the first 18 months, at a lower dose than we see with traditional opioid agonist treatment.

I do a lot of qualitative research. I interview people who are receiving safer supply, and I often ask them about their goals. I would say that, frequently, what they talk about is the goal of getting off safer supply. That might include using safer supply for a period of time and maybe transitioning to OAT, but they have a plan because they too want to live a full life and have a high quality of life. Those kinds of goals are, I think, really important.

That's some of the reality that I see within the work I'm doing.

● (1720)

The Chair: Thank you, Dr. Pauly.

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

Mr. Gord Johns (Courtenay—Alberni, NDP): Thank you all for your testimony.

I'll start with you, Dr. Pauly.

You heard from Dr. Koivu. She raised concerns about infectious complications for people using safer supply. Is this something you found in your research with people who were injecting fentanyl and then switching over to safer supply, or people who started on safer supply? Is this what you're seeing in your research as well?

Dr. Bernadette Pauly: I'll give you a bit of background. When people are injecting from the unregulated and toxic drug market, there are additives. My colleagues on the panel have spoken to this and to how harmful the additives in the unregulated market are. They often cause abscesses and injections.

I believe the committee had a brief submitted by Dr. Gomes, who looked at administrative data for people receiving safer supply—this was in Ontario—and the rate of infections went down when they went into a safer supply program, likely because they were no longer injecting toxic substances from the unregulated market. However, they also would have had a connection to health care, and that's a really positive outcome of safer supply types of programs. In British Columbia, we have more injectable formulations, so if there is a concern about injection-related infections, that may be why those are being used more in British Columbia.

Mr. Gord Johns: Dr. Koivu, given what Dr. Pauly said, could you please submit, within 14 days, your own research to this committee that supports your claims on infections caused by hydromorphone?

Is it the will of the committee to get support for that?

Did the witness agree, Mr. Chair?

Dr. Sharon Koivu: I can—

The Chair: Well, if you've asked her to provide it and she agrees to provide it, I don't think you need everyone else's opinion.

Mr. Gord Johns: I wanted to make sure that was on the record.

Thank you so much.

I'm going to go to Ms. Hopkins.

You were a co-chair on the expert task force on substance use. The expert task force was unanimous in recommending that we scale up safer supply, stop criminalizing people who use substances and ramp up treatment on demand, recovery, prevention and education.

You had a really wide spectrum on the expert task force on substance use. Can you speak about your disappointment, maybe, with the government not following through with the recommendations and your experience with how important it would be to reinstate the expert task force and implement those recommendations?

Dr. Carol Hopkins: We're talking about using evidence, and the question is about whose evidence is more credible. That's quite a common conversation when it comes to first nations people, whose world view and culture-based evidence are typically set aside. However, that does not mean, for example, that culture and safer supply are completely incompatible.

Safer supply is one more tool in the tool box. There is no silver bullet. There is not one medication. There is not one strategy, method or form of care that will solve the opioid crisis or the toxic drug supply. There are many strategies that have to be used together in combination, like—

Mr. Gord Johns: I don't know if the question was heard properly. I apologize for that.

We just heard from the First Nations Leadership Council and the B.C. First Nations Justice Council. They're calling for an emergency cross-governmental and multilateral strategy that ensures the safety of people who use drugs.

Dr. Sayers, a BCFNJC member, said that "the toxic drug crisis needs to be treated and addressed as a public health issue, not a criminal justice issue." Grand Chief Stewart said that how we're proceeding right now is "very much wrapped up in the destructive impacts of colonialism."

Can you add your thoughts on those statements?

● (1725)

Dr. Carol Hopkins: I just want to emphasize the importance of safer supply. That's one tool that needs to be available to everybody.

In addition to understanding the context of first nations people, as I said earlier, we do not have the community-based resources necessary to address the impacts of opioid toxicity or the toxic drug supply. We don't have services close to home where people need them, when they need them. That often leads them to move, travelling off reserve for periods of time. Often, the crowds they find most welcoming are those involved in selling illicit drugs. Then they come back into the community, and now we're creating a new relationship that has significant impacts on families and the whole community.

For the first time ever, first nations communities are reporting murders, not by first nations people murdering first nations people, but by gangs from large urban environments coming onto reserves and committing these crimes. Gun violence and human trafficking have increased.

If we look at what the perception of that is, we could say that because of racism in Canada, first nations people will be blamed for those kinds of activities; they did this to themselves. That's the same sentiment for people who use drugs. They should just stop; they can just decide to. Why don't they choose something different when they're losing all these things? We're blaming the victims without supporting their right to health and social services.

The United Nations—

The Chair: I'm sorry. Thank you, Dr. Hopkins.

We'll go to Mrs. Goodridge, please, for five minutes.

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

I want to thank all the witnesses for being with us and for being patient. It's unfortunate that Chief Frost had to leave us before we got a chance for questions. I found her testimony incredibly insightful.

Dr. Pauly, did the study you cited look at diversion as an issue?

Dr. Bernadette Pauly: That's such an important question, because it's definitely the issue that I would say is creating the most controversy.

I will speak to two ways in which.... While the study didn't directly look at diversion—

Mrs. Laila Goodridge: It didn't look at diversion.

Dr. Bernadette Pauly: No. I will explain—

Mrs. Laila Goodridge: It's yes or no. We have very limited time and I asked a very short question. The convention in this committee is that witnesses answer for about the same amount of time that the question took to ask.

Did diversion get looked at?

Dr. Bernadette Pauly: Diversion was not apparent, because there was a dose-response relationship. In other words, if people got more days of the medication, there was less risk of overdose, which suggests they were taking their medications.

There was a dose-sensitivity relationship. Higher doses meant less risk.

Mrs. Laila Goodridge: Thank you.

Dr. Bernadette Pauly: What this led to was people taking their meds in many cases.

Mrs. Laila Goodridge: Dr. Koivu, I'm sure you've seen the proposals coming out of the city of Toronto asking to move toward decriminalization for that city. Do you think that will have impacts on communities like London?

Dr. Sharon Koivu: I think anything that happens in Toronto is definitely going to have an impact on London. What we're seeing in London has been largely affected, I think, by decriminalization as it is.

We're certainly seeing a lot more open drug use. It's very common to see people injecting in parks, smoking fentanyl in parks and injecting Dilaudid in public spaces already, so I think that's something we'll have a problem with.

Mrs. Laila Goodridge: Really quickly, have you seen a change in the drug deaths in London since the so-called safer supply program came in?

Dr. Sharon Koivu: Absolutely.

I don't know how to answer that very quickly, but the first thing I'll say is that in 2016, our overdose deaths were equal to the province's. In 2022, for which we have information, the provincial rates went up by about 2.7% and London's went up almost fourfold. There's a significant increase in overdose deaths compared to the provincial average. There's also a significant increase in overdose deaths compared to the other community I work in just south of there, which had exactly the same rate in 2016 and now continues to be the same as the provincial average.

The other place where I see significant change is in youth. If you look at the youth population—this data is all available on Public Health Ontario's opioid tool—for people 15 to 24, London's rate was lower than the provincial average in 2016 and now it's substantially higher. It's the same with people 25 to 44. When I'm looking at people I would consider young, there has certainly been an increase in deaths.

The other thing is that hydromorphone is absolutely more common. It's twice as common to find hydromorphone in deaths in London than in the provincial average. Often, the provincial averages dilute things. If you go to Ontario, you'll find that where safer supply has been available, there are increases over provincial averages.

● (1730)

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

I'm now going to move a motion that I put on notice on Friday. It says:

> That the committee invite the Minister of Mental Health and Addictions and Associate Minister of Health before the committee for no less than two hours; and that the study of the opioid epidemic and toxic drug crisis in Canada be extended by six meetings to invite further witnesses.

I think it is absolutely incumbent on us, as we've been hearing testimony and seeing the entire situation shift, that we have more witnesses come so we can explore some of the public safety and other aspects that we have not been able to fully explore through this committee. I understand that we've had some conversations about amendments.

With that, I will cede the conversation.

The Chair: Thank you, Mrs. Goodridge.

The motion is in order. The debate is on the motion.

Dr. Ellis has the floor.

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

I appreciate the comments from my colleague on the need to continue this discussion. It's important that we underline for Canadians the fact that some controversy exists here. Not all of it is based on science and much of it is based on opinion, which is not necessarily helpful when we know there are good scientific-based arguments. Many of my colleagues may not like that those exist, but they do.

It's important to continue on this road to enable this committee to understand that some of the science that has been referenced here does not answer the questions that we need answers to. It's also important to understand that the Government of British Columbia has asked for an end to the decriminalization experiment, which has certainly been outlined by communities such as New Westminster, Richmond, Campbell River, Kamloops and Sicamous. As Canadians hear more and more about the experiment, Canadians are fearful for their own communities. They're fearful for their communities because of contamination from used paraphernalia. They are concerned because of the potential for exposure of drugs to children, and we've heard even to pets in some areas.

The other thing that I've heard directly from Canadians is they are concerned about the loss of accessibility to their downtowns. That's a concern that we heard very clearly from a deputy chief constable in Vancouver, who testified at this committee not that long ago. She made it very clear that the decriminalization experiment has led to the loss of downtowns. Substances are being used outside of businesses, outside of residences, on transit and near schools, parks and beaches. The deputy chief constable's testimony noted that police were powerless to stop this type of activity.

The Minister of Mental Health and Addictions has spoken very forcefully about this in the House of Commons and in the media in attempting to explain away the request by the Government of British Columbia to end the experiment. I find that interesting, because it was the Government of British Columbia that came to the federal government asking for the experiment, but we all know, even though this is not scientific in a sense, that when an experiment is going awry and the people in charge of the experiment say they need to end it, it needs to end. When doing a scientific experiment such as a randomized controlled trial, if the lead investigators understand that something has gone awry, they don't continue the experiment. They stop it, and they don't wait for days and days to stop it. They stop it immediately when those signals are out there.

I'm very disappointed in the NDP-Liberal government, and specifically in the Minister of Mental Health and Addictions. The British Columbia government has asked for the experiment to end, and now there are negotiations with the NDP-Liberal government to continue the experiment. If we want to talk about this and we use the metaphor I used, even though I realize it's not scientific, then we know clearly that the experiment must end now for the betterment of this country, because it's a failed experiment. We've heard that over and over. We know it's a failed experiment. The B.C. government knows it's a failed experiment.

The question that I have—

● (1735)

Mr. Gord Johns: I have a point of order, Mr. Chair.

Mr. Stephen Ellis: —is this: When will the NDP-Liberal government will know it's a failed experiment?

The Chair: Dr. Ellis, there's a point of order from Mr. Johns.

Mr. Gord Johns: Mr. Chair, just for clarification, the B.C. government has not asked to stop decriminalization in British Columbia—

Mr. Stephen Ellis: Excuse me, Mr. Chair, but that's not a point of order.

The Chair: Thank you, Mr. Johns. That is not a point of order. It's a question of debate, so I'm going to cut you off there.

Mr. Gord Johns: Mr. Chair, I think it's been ruled by the chair—

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

When my colleague wants to have the floor, he can raise his hand and have his turn. He should know that. He's been here long enough. Even though perhaps he is ideologically motivated by his wacko comments, we need to continue on with this.

That being said—

Mr. Gord Johns: Mr. Chair, on a point of order, it is completely unacceptable for a member to be calling another member wacko.

The Chair: Mr. Johns, please contain yourself. He said that your comments were wacko. That may be unpleasant to hear, but it wasn't an attack on you. Your interruptions do not constitute points of order. I would ask that you wait your turn. You are on the speaking list; you're third.

Dr. Ellis, go ahead.

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

I don't mean to disparage the member. As I said, his comments are wacko. I think it is important to understand that the citizens of this country no longer want to tolerate ongoing difficulties with the experiment. It has been termed by my friend and colleague Dr. Hanley from the Liberals as an experiment from the outset. It was part of the motion of this study here at the health committee.

I'll end my comments there. Thank you, Mr. Chair.

The Chair: Thank you, Dr. Ellis.

Madam Brière, please go ahead.

[*Translation*]

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

First, Dr. Ellis is clearly conflating decriminalization with drug use in public spaces.

Second, the government of British Columbia didn't request an end to decriminalization. Rather, it asked that its request be reviewed.

Regarding the motion, since the minister has already appeared before the committee and there will be a four-hour committee of the whole in the House before the end of the month, and given our upcoming trip next week during which we'll have the opportunity to meet people on the ground and ask all our questions, I suggest amending the motion to read as follows: “that the study of the opioid epidemic and the toxic drug crisis in Canada be extended by two meetings to invite further witnesses.”

[*English*]

The Chair: All right, we have an amendment. The amendment is in order. The effect of the amendment is to replace identifying the minister and the number of meetings, simply bringing it down to two additional meetings to hear from witnesses.

The debate is now on the amendment, and Mr. Vis has the floor.

Mr. Brad Vis (Mission—Matsqui—Fraser Canyon, CPC): Thank you, Mr. Chair.

I won't take too much time. I am a British Columbian, and it's nice to see you again. It's been a few years.

The Leader of the Opposition mentioned the Abbotsford Soccer Association in question period today. My son was playing on the weekend, and I asked Coach Gill, the youth coordinator for the first kicks program, about what was taking place and the letter that was featured widely in our local regional media.

Decriminalization in British Columbia has led to widespread chaos. There were kids who saw a woman get raped at our soccer field last year, and she was on drugs when it happened. The stuff is devastating. My office is adjacent to Haven in the Hollow, which was a homeless shelter that became a safe injection site. During the pandemic, it became a place where people could openly do any drugs they wanted and consume alcohol. It brought chaos to the neighbourhood where my office is. The Legion came to me a few weeks ago. It's less than a block away from the site, and every day they have to ask people not to consume meth, crack and other hard drugs on site.

The decriminalization order put forward by the government was very clear that it wouldn't apply to those types of places, but since it has been unleashed, the consequences have been grave for the residents of the Fraser Valley. I'll note as well, in the context of decriminalization, that in the health region where I reside, the Fraser Health region, we had, I believe, last year—and don't quote me on this—one of the highest per capita death tolls after Northern Health in British Columbia. At the same time as we had a record number of deaths proportionate to the rest of the population in British Columbia—the second- or third-highest number—there was no increase in funding to help people get clean and help people access a detox bed and a site that would give them the treatment they needed.

Decriminalization is killing a lot of British Columbians, and I would encourage everyone to vote for this motion. I think it's a good one.

Thank you for your time.

● (1740)

The Chair: Thank you, Mr. Vis.

Next we have Mr. Johns, and then it's Dr. Powlowski and Monsieur Thériault.

Mr. Gord Johns: Thank you.

First, in terms of extending the number of meetings, there are lots of reasons why we should have more meetings.

I look at Fort McMurray. They had an all-time high drug poisoning death rate in the last year. Alberta's death rate from toxic drugs has gone up 17% over the last year. They're on a trajectory to pass British Columbia by June. There are 43.3 deaths per 100,000. British Columbia is at 46.6 deaths per 100,000. Lethbridge has triple the toxic drug death rate of British Columbia. That's all without decriminalization and without safer supply. Regina has a 43% greater death rate per 100,000 than British Columbia.

It is absolutely a tragedy what is happening in the provinces without safe supply and without decriminalization. We are seeing a literal disaster happening. It's a health emergency. In fact, up in Alaska, which neighbours those provinces, there was a 45% increase in toxic drug deaths last year. It's a Republican state without safe supply and without decriminalization.

We're constantly hearing about the need to.... We heard from the police chiefs association that the diversion of safer supply is not what's killing people; it's deadly fentanyl. We heard from Dr. Pauly today that 85% of deaths are from fentanyl, and only 3% of people who died had traces of hydromorphone.

The police were clear that criminalizing people who use substances causes more harm. That's what we heard from the expert task force and the police chiefs association, and what we continue to hear from chief medical health officers, including every single chief medical health officer on Vancouver Island. They have been unequivocally clear that criminalizing people causes more harm and that safer supply reduces deaths.

We have peer-reviewed data that the very small amount of safe supply that is used to replace toxic street drugs—which are unregulated, and manufactured, marketed and sold by organized crime—reduces the risk of toxic overdose deaths. We have had a multitude of reports. I believe the chief medical health officer for Toronto is also asking for the government to consider decriminalization.

We've heard from the police chiefs association repeatedly about the fact that there is no going back on criminalizing people. “Those days are gone.” That is a quote from the president of the British Columbia Association of Chiefs of Police. They were looking for tools in British Columbia to move people out of public spaces so that they could make sure the public felt safe. At the same time, they were clear that they want to see more safe consumption sites.

I'm disappointed that we won't be in Lethbridge, because Lethbridge is where they closed a safe consumption site, and Lethbridge is ground zero in Alberta. It has the highest death rate in the province of Alberta. It has three times the toxic drug deaths that we're seeing in British Columbia. In Medicine Hat, there are 63 deaths per 100,000. That is almost 40% greater than the death rate we're seeing in British Columbia, and it's almost the highest death toll we've seen in any health authority in British Columbia.

I just wanted to highlight these really important reasons why we need to have more meetings. I support having two more meetings. I hope we can centre one of those meetings on getting a purely indigenous perspective. I think we should invite Ms. Hopkins back, out of respect, since this meeting might be cut short and her testimony might be cut short and minimized. I would hate to see that happen, especially when we know that indigenous people in my home province are seven times more likely to die from a toxic drug overdose. In her community, it was 36 times more.

● (1745)

We also heard from Ms. Petra Schulz from Moms Stop the Harm, when she testified, that the recovery model in Alberta is just a name. We heard that for a nation south of Lethbridge that was promised a therapeutic treatment centre, the only shovel that's gone in the ground was a ceremonial one three years ago. People are waiting. They're waiting up to six months to get help in certain parts of Alberta. That's if they want help.

The goal should be to keep people alive. Harm reduction, treatment and recovery go hand in hand. We don't need to have one without the other. This is a crisis that is ravaging North America. It is skyrocketing in Conservative provinces and Republican states. We need to change direction. We need to work collectively.

In Portugal, politicians were successful when they got out of the way and let the experts lead with evidence-based policy, evidence-generated policy and peer-reviewed research. That's how they moved forward. I can't think of another health issue where politicians are having their say like this and interfering with what is truly a health issue.

I support going to two meetings. I also wanted to make sure that my comments were on record.

The Chair: Thank you, Mr. Johns.

Dr. Powlowski, please go ahead.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I would like to get back to the expert witnesses we've invited here and not listen to other MPs wax on about their views on this subject. I was certainly tempted to move a motion to adjourn debate, but I won't.

Can we not all decide to vote on this? There seems to be unanimity. Let's vote and let's get back to the witnesses. We are doing a study on this subject. We invited these people here to ask their opinions, and I'd like to get their opinions.

Thanks.

The Chair: Thank you, Dr. Powlowski.

[*Translation*]

Mr. Thériault, you have the floor.

● (1750)

Mr. Luc Thériault: Mr. Chair, I find it quite ironic that a motion is being tabled to hold more meetings and hear from further witnesses, while our witnesses are being sidelined today. We had many questions to ask them.

I'll be brief, so as not to contradict my previous statement. I said I was willing to extend the duration of this study. I believe we can trust ourselves. We want to present recommendations that will matter and not just be shelved. We'll be going to see what's happening on the ground. I would have been very comfortable with extending our study. If, one day, we realize that we need four meetings, we'll hold four meetings.

However, for today, I would like to hear what the witnesses have to say. This isn't the first meeting that has been interrupted by a motion. We should perhaps take a look at how the committee works. I would rather discuss our business in a subcommittee than during a study, where we make a spectacle of ourselves in front of witnesses about our understanding of the issue. I find it disrespectful. I'll stop there.

I'm ready to hear any proposals. However, when we have witnesses with us, let's ask them questions so that they can provide information.

In two and a half minutes, I would like to ask the remaining witnesses what they think of the situation in Vancouver and what they think of criminalization being reinstated in British Columbia.

The Chair: Thank you, Mr. Thériault.

[*English*]

There are no further speakers on the list. I presume that we are ready for the question.

The question is on the amendment. Just to be specific, the amendment is to delete the following words from the motion: “That the committee invite the Minister of Mental Health and Addictions and Associate Minister of Health before the committee for no less than two hours; and”. It would also change the word “six” to “two”.

The amendment would be the following: “That the study of the opioid epidemic and toxic drug crisis in Canada be extended by two meetings to invite further witnesses.”

All those in favour of the amendment?

(Amendment agreed to)

(Motion as amended agreed to)

The Chair: The motion is adopted unanimously.

Thank you, everyone. That brings us back to the witnesses.

Mrs. Goodridge, you have 47 seconds left in your turn.

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

I'll go really quickly to Dr. Pauly.

More people are dying in British Columbia despite both safe supply and decriminalization. Why do you think that is?

Dr. Bernadette Pauly: They're dying because 85% of deaths are caused by a toxic, unregulated drug market, and we haven't adequately scaled up interventions like harm reduction and treatment. It's a combination of those things that will reverse the trend.

Mrs. Laila Goodridge: Do you believe recovery from addiction is possible?

Dr. Bernadette Pauly: I believe recovery is absolutely possible, and it is an individual journey. There are many pathways to recovery.

The Chair: Thank you, Mrs. Goodridge.

I'll go to Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski: Dr. Pauly, I'm sorry for putting you on the spot, but help the committee out. In response to Mr. Thériault, who said that the experts seem to have different opinions as to the evidence for safe supply, you said that you did a peer review and it seemed to pretty overwhelmingly show the benefits of safe supply.

Let me just point out what else our committee has heard. We asked Health Canada to appear before the committee. We had the experts who I think were behind approving B.C.'s request, and they seemed to be in favour of safe supply. They themselves admitted that there wasn't very good evidence for the benefits of safe supply. I would note the B.C. health officer, in a review of prescribed safer supply, said:

> Most of the limited published peer-reviewed studies lack a control or comparison group and the actual intervention received by study participants is in most cases a combination of broader access to wrap around health services including [safe supply]...and primary care, making it difficult to attribute any benefits to PSS alone.

They suggested that they need to have more studies.

The Stanford-Lancet commission, which looked at the opioid crisis—and I would point out that these aren't a bunch of right-wing fanatics—in their study said, “the evidence clearly shows the folly of assuming that population health inherently improves when healthcare systems provide as many opioids as possible with as few possible regulatory constraints as possible.” They, too, were against safe supply. We talked to the head of that commission, and he said the problem with safe supply is that basically you're replicating what has caused the problem to begin with, which was doctors prescribing too many narcotics, people getting on them and then people having trouble getting off them.

Do you continue, though, to say that no, the evidence is clear that safe supply is good?

● (1755)

Dr. Bernadette Pauly: I really appreciate that question about the science, because it has been very confusing and disturbing to see the way that some of the debates have played out.

To begin, many of the citations that you provided preceded 2020 and were from the very early days of the development of the body of evidence on safer supply. Since 2020, it's doubled. In fact, some of the strongest evidence has emerged in about the last six to 12 months. Our team is obviously at the forefront of producing evidence in British Columbia, where we are seeing positive impacts.

Yes, I stand by my statement. After a review of over 40 studies, the findings were overwhelmingly positive. What I really want to urge this committee to do is separate ideology from evidence. I don't think any of my colleagues wouldn't say we need more treatment, yet we know there are still challenges with treatment. People come out of treatment and do relapse. We need to look at what kind of comprehensive system we're creating instead of creating these ongoing tensions.

I'll stop there if you have a follow-up.

Mr. Marcus Powlowski: The B.C health officer's report was quite recent, as was Health Canada's, and after looking at the evidence, I certainly wasn't overwhelmed with it. However, let's change the subject.

Your study wasn't a randomized control trial, which is the gold standard, and the validity of your results depends on how well you matched the people getting safe supply with those who weren't getting safe supply.

One of my concerns with your study—and you can correct me if I'm wrong—is the comparison group, the people who weren't in safe supply. You got those names from various places, one of them being the discharge abstract database, which, in my understanding, is from hospital records of people who had been admitted for either a diagnosis or something to do with using opioids. My concern is that in your comparison group, you have a sicker population, because they've been in the hospital recently, either because they overdosed—

The Chair: Dr. Powlowski, you're out of time. If you could get to a question, we can get a short answer.

Mr. Marcus Powlowski: She's heard my question. I guess I get no response for her answer, but am I wrong?

Dr. Bernadette Pauly: Is it possible for me to answer?

The Chair: Do so as succinctly as possible, Doctor.

Dr. Bernadette Pauly: Okay. Thank you.

Our study came out after the provincial health officer's report, as did a number of other studies. On the control group, multiple linked databases were used to generate, through two different methods, the control group, matching on multiple variables. I'd be happy to refer you to Dr. Nosyk's seminar, which explains extremely well how the matching occurred and the similarity between the two groups.

● (1800)

[*Translation*]

The Chair: Mr. Thériault, you now have the floor for two and a half minutes.

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

In a previous meeting, we heard from Dr. Morin, who told us that addictions are complex chronic diseases. This complicates matters because multi-pronged action is required. Furthermore, we're told that relapse is part of the process. British Columbia is trying to correct course, in a manner of speaking.

My question is for Ms. Hopkins, but Ms. Pauly can also weigh in if there is time.

How do you see the situation in British Columbia, and what do you think about the government's desire to correct course? In your opinion, must this lead to “recriminalization”?

[*English*]

Dr. Carol Hopkins: Absolutely not. Thank you for the question.

The expert task force on substance use and mental health recommended safer supply and decriminalization, but they also said that it should be within a full spectrum of supports for people who use drugs or substances, or who wish to enter into a recovery journey.

The task force clearly recommended a more comprehensive and responsive system. When you provide people with the medication they need to live life every single day but they don't have a home, they don't have income security or food security, and they don't have people they can rely on to support them.... Every person needs another person to support them and to be a champion for their belief in their ability to succeed in life, whatever that means from their perspective. Those comprehensive supports are absolutely necessary as an addition.

As I said, there's no silver bullet. There are many instruments that will support change and will keep people alive. Safer supply and decriminalization are not a silver bullet. They're not meant to end the opioid crisis and the toxic drug supply, but they will keep people alive. They will ensure that human beings have the right to live life. That should be our goal: to make sure that human beings can continue to live life. There are many tools. There have to be many tools.

This is not an easy answer, and it's not an easy solution, but what we're seeing is a focus on one technique, one answer, and on criticizing it without considering the other resources that are necessary. When those other resources are in place, we've seen positive changes that have impacted families, their children and their communities. They increase safety, decrease the number of kids in child welfare, increase the number of kids going to school and increase safety in the community. I can't stress enough that a comprehensive approach is necessary.

The Chair: Thank you, Dr. Hopkins.

Dr. Carol Hopkins: Thank you.

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

Mr. Gord Johns: Dr. Pauly, you talked about the effectiveness of safer supply, and you cited some really important information. Can you also talk about why safer supply hasn't been scaled up? What are the barriers you're seeing?

Dr. Bernadette Pauly: This is a really important question. Without a doubt, part of the barrier is the politicization of safer supply and blaming it for what is a problem of the toxic and unregulated drug market. Safer supply is part of a comprehensive solution.

Some of the challenges related to increasing access—

The Chair: Excuse me, Dr. Pauly, but we're having a problem hearing you here.

Dr. Bernadette Pauly: I'm sorry. Is that any better?

● (1805)

The Chair: Yes. Please go ahead.

Dr. Bernadette Pauly: What I was saying is that part of the reason that safer supply hasn't been scaled up is it's been highly politicized. That's a harmful narrative when the real problem is a toxic and unregulated drug supply.

In terms of scaling up, we've had quite a lot of insight from the research we've done around prescribers, and particularly the idea of prescribers not being attacked or feeling criticized by their colleagues and recognizing the importance of the intervention and the support of regulatory colleges. One interesting finding is that nurse practitioners are three times more likely to prescribe safer supply. In that finding, there are opportunities to remove barriers, particularly in rural and remote communities. I'd also mention that in British Columbia, the First Nations Health Authority has a virtual substance use and addiction program, which was found to facilitate access for people in rural and remote communities.

We haven't talked much about non-prescriber-based models, but I wanted to highlight that in British Columbia, only a portion of the people who died of an overdose actually had an opioid or substance use disorder. We have to remember to consider alternatives that provide access and that are appropriate and well regulated for people who are accessing the toxic drug market and don't necessarily meet that criteria.

The Chair: Thank you, Dr. Pauly.

Thank you, Mr. Johns.

Next we will go back to Dr. Ellis for five minutes.

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

I know it's been a bit of an up-and-down meeting for the witnesses. I appreciate your patience with all of us.

Dr. Koivu, I'd like to go back to the concept of safe supply. Maybe you could, for the benefit of Canadians out there, talk a bit about the specific difference between opioid agonist therapy and safe supply. Of course, we know that opioid agonist therapy has a significant amount of scientific literature supporting it. Could you explain the difference? I think that would be important to Canadians.

Dr. Sharon Koivu: Thank you for that question.

Opioid agonist therapy is about having people on a treatment that can stabilize them neurochemically, having them not chase what we talked about earlier with withdrawal and really allowing for recovery. The two main types of opioid agonist therapy are methadone, which has been around for years, and buprenorphine. Buprenorphine was not available at the time the study in London was started.

Buprenorphine is a chemical, an opioid. As to how it works, as you increase the dose, you don't get an increase in negative effect. It is the drug most proven to decrease the risk of overdose. When people are on it, they have a decreased risk of overdose from taking it and from taking other substances.

Buprenorphine now comes in a daily sublingual formulation. It also comes in an injectable formulation that is usually referred to as Sublocade, which is given every four weeks. This is a game-changer because it allows people to get their lives back and get back to the community. Not having to worry about accessing a pharmacy daily is certainly helpful in remote communities as well. It provides a healing of the brain to allow people to have recovery and function normally.

Safer supply programs are about continuing to give opioids at doses that aren't witnessed. I think it's important to recognize that when people are started on methadone and Suboxone, we check what they're able to take. We understand their tolerance. We work with them as we're witnessing what they're taking and we know what they're taking. When people are started on safe supply, that is not the case.

I'm going to be a bit more specific about my own community. A dose can continue to go up without reflection on whether it's a safe dose for a person or a safe dose for the community. It's generally given to them on a daily basis. Sometimes it's every few days. Then the dose is escalated. In my community, generally that's at request, without any evidence that it's what they need. Even when there is evidence that they don't tolerate their dose, it isn't necessarily decreased.

People will continue to have to go to a pharmacy, usually on a daily basis. It means that they're continuing to, from a neurochemical perspective, chase withdrawal. It is about continuing somebody in an addiction. They're maintaining their addiction. They're being maintained in a state where they are addicted to the medication.

● (1810)

Mr. Stephen Ellis: Thank you very much for that, Dr. Koivu.

I have a final question. I'm not sure if you know the answer to this or not, Dr. Koivu.

Our understanding from other testimony is that the street price of Dilaudid at eight milligrams has dropped significantly, which is evidence—perhaps not scientific—of diversion. Is that the experience in your community as well? Maybe you could talk about the price.

Dr. Sharon Koivu: Absolutely.

It's a market-driven economy. As there has been more diversion and more available.... My understanding from patients and from living in the area is that in 2016, a D8 was about $20. If you're close to the supply—close to where more diversion takes place or the core of London—then it varies, but it's usually about one to two dollars. As you get farther away, it's more expensive.

It really is about supply and demand. As the supply has gone up and there's more and more Dilaudid available in London, and from the amount of tolerance people have compared to what they're prescribed, certainly the amount I'm hearing about.... The numbers are certainly over a million D8s in a year, and as that number has gone up, the price has definitely gone down.

The Chair: Thank you, Dr. Koivu.

[*Translation*]

We will now move on to the last speaker.

Ms. Brière, you have the floor for five minutes.

[*English*]

Mrs. Élisabeth Brière: Thank you, Mr. Chair, and thank you to all of our witnesses.

Dr. Hopkins, I have one question for you. What does supporting the voice of people who use drugs mean to you?

Dr. Carol Hopkins: Many people who are experts in their field have expertise and know the science behind their expertise. They publish. They know their work very well. We rely on them often for evidence so that we make informed decisions. We don't typically understand or give credit to the experience of living life every day with the types of conditions we're talking about: living with a dependency on opioids, having to survive the processes of coming to the right dosage for them and how people feel about that. Every person's being, their physical being, is different from every other person's. The type of medication needed, the amount of medication needed to address the issues of dependency, and the neurotransmitters that are significantly changed because of the types of drugs being used are all in the story of lived and living experience. It's a credible source of evidence.

If you listen to people who use drugs, you will find similarities. Whether you're talking to somebody in Vancouver's Downtown Eastside or somebody from a first nations community in northern Ontario, they've never met each other, but they will describe the same experiences of withdrawal. They'll talk about their tolerance of incremental increases to their addictions medicine. That's credible evidence.

Listening to their voices means that we give credit to people, not because of their status in life because they're using and not because we're judging them or discriminating against them. We're listening to them because they can tell us a real story that is mimicked across the country. That's important evidence. Listening to those voices is just as important, if not more substantial, to the decisions that need to be made about the health care system and the wraparound services that are provided to any population of people to ensure they can continue living life without the mental anguish and physical anguish that go with withdrawal.

People don't wake up every morning wanting to die. They get to those hopeless stages when we have opinions that form decisions and when we make decisions without looking at all the variables that impact something like we are talking about: safer supply and the toxic drug crisis. We can look at any one perspective and say that one perspective is credible evidence, and it may be, but if we don't look at it in the context of the determinants of health, for example, and how people learn to survive every day, then we're shortsighted and we end up making decisions as though we're God. Not one of us has the right to decide who gets to live, who is expendable and who should die.

● (1815)

[*Translation*]

Mrs. Élisabeth Brière: Thank you.

You say that every individual is different and needs to follow their own path.

Do you think that a more holistic approach, which includes the four pillars, is the best option for responding to the current overdose crisis?

[*English*]

Dr. Carol Hopkins: Absolutely. We need every tool and every strategy that is instrumental for ensuring life. Not one individual can live on this earth all by themselves. We live in relationship to others. We live in relationship to the land and the environment. We have to consider those elements and those four pillars.

We have a substance use strategy in Canada that includes harm reduction. Now we have to figure out what that means. We have to ensure harm reduction, but not only for individuals. We have to ensure we make decisions, policies, resources and programs that reduce harms to families and communities. That does not mean erasing the right to medicine, the right to mental wellness, the right to live and the right to the sacred breath of life. We have to provide and look at life from a holistic perspective. We can't afford to say, “You as a population don't have the right to life” or “You as a population, because you use drugs, don't have the right to health.”

The outcome of the UN declaration on the world drug problem—which Canada supported—was that, instead of a war on people, we had to ensure the right to prevention and treatment. Unfortunately, we couldn't get harm reduction in the declaration at that point. However, this year, the UN Commission on Narcotic Drugs had a vote that passed, putting harm reduction in international drug treaties. Now it matches what Canada has said, and we have to invest.

The Chair: Thank you, Dr. Hopkins, Dr. Pauly and Dr. Koivu.

When we invited you, we told you that we would have you out by 5:30. You've been very generous and patient with your time and very thoughtful in your presentations. Our study will be better because of your contributions. Thank you so much for being with us here today.

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

Some hon. members: Agreed.

The Chair: The meeting is adjourned.