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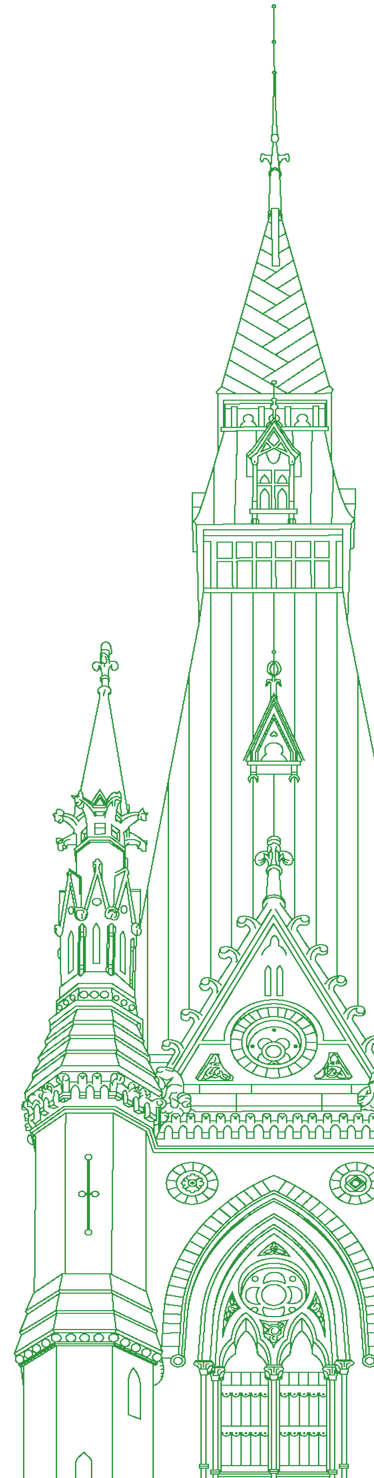

Chair: Mr. Sean Casey

Standing Committee on Health

Thursday, May 9, 2024

● (1105)

[*English*]

The Vice-Chair (Mr. Stephen Ellis (Cumberland—Colchester, CPC)): I call this meeting to order.

Welcome to meeting 115 of the House of Commons Standing Committee on Health.

Before we begin, I would like to remind all members and other participants in the room of the following important preventive 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 the microphone 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 help prevent audio feedback incidents. All earpieces have been replaced by a model that greatly reduces the possibility of audio feedback. The new earpieces are black, whereas the former earpieces were gray. Please only use a black, approved earpiece. By default, all unused earpieces will be unplugged at the start of a 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.

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.

Thank you all 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.

For your information, this part of the meeting will run from 11:00 until 1:00, and then, from 1:00 until 1:30, we shall have in-camera committee business.

On the topic, appearing as an individual, we have Sarah Lovegrove, registered nurse, by video conference; Eugenia Oviedo-Joekes, professor, school of population and public health, University of British Columbia, by video conference; Martin Pagé, executive director, Dopamine, by video conference; and Elenore Sturko, member of the Legislative Assembly of British Columbia for Surrey South. She is here in person.

Thank you all for being here.

With that, we will start our statements. You will each have five minutes. I'm a bit of a stickler for time. We'll keep on track and have a nice meeting. We look forward to hearing from you all.

With that, Ms. Lovegrove, you have the floor for five minutes.

Ms. Sarah Lovegrove (Registered Nurse, As an Individual): Good morning. Thank you for having me here today.

My name is Sarah Lovegrove. I'm a registered nurse and professor for the Bachelor of Science in nursing program at Vancouver Island University, VIU. I'm grateful to be joining you today from the traditional unceded territory of the Sununeymuxw First Nation, colonially referred to as Nanaimo.

I am also an activist and a member of the Harm Reduction Nurses Association, and I am absolutely infuriated by the federal Ministry of Health's decision to support and enable B.C.'s political move to walk back decriminalization.

Drawing strength from the brave university students using their voice to stand up for justice, including the powerful students at VIU, as well as those at my alma mater, the University of Ottawa, I'll be taking this opportunity today to say what needs to be said.

Much like the genocide of Palestinians in Gaza, this worsening toxic drug crisis, killing 22 Canadians each day, is a result and perpetuation of the ongoing settler colonialism and white supremacy that makes up the fabric of our governments, policies, communities and health care system.

Indigenous people are disproportionately impacted by this crisis, experiencing death and injury related to an unregulated drug supply at a significantly higher rate than the rest of the population. Substances like alcohol were introduced to the indigenous peoples of Turtle Island at the time of colonization, and have since been weaponized as a tool of coercion and control to uphold the settler state.

[*Translation*]

Ms. Andréanne Larouche (Shefford, BQ): On a point of order, Mr. Chair.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): One minute, Ms. Lovegrove.

[*Translation*]

Ms. Larouche, you have the floor.

Ms. Andréanne Larouche: Mr. Chair, the interpreters are complaining that the sound quality is preventing them from doing their job properly.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much.

[*English*]

Just hold, Ms. Lovegrove. We'll see if we can make it better for you.

I apologize, colleagues. We had some problems with Ms. Lovegrove's sound originally. We thought it was good, but it's not quite where it needs to be. Our suggestion is that we'll halt her statement now. We'll come back and allow her to finish it.

We'll have to move on to Ms. Eugenia Oviedo-Joekes, professor at the University of British Columbia.

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

Ms. Eugenia Oviedo-Joekes (Professor, School of Population and Public Health, University of British Columbia, As an Individual): Thank you very much. I will try to speak slowly as sometimes my accent might not be the best for the translators, so I apologize for that.

Thank you so much for having me. My name is Eugenia Oviedo-Joekes. I am a Latina woman. I am today speaking from the beautiful unceded territory for the Squamish people, people of the water. I am a professor at the school of population and public health. I am a Canada research chair in person-centred care in addictions.

Following up from the statement from Sarah Lovegrove, and as a continuation of what she was bringing up, one of the key things for continuing this statement is that the overdose crisis emphasizes that we need diverse strategies, and action and co-operation are key. The problems continue escalating, and we need thoughtful and intentional actions, because this is not a problem with one face. It's time to hold fast and continue moving forward, not retreat.

We have a few medications in Canada that we can use for opioid use disorder that are shown to be effective— however, they are very few. There are a couple of other injectable medications that have shown to be effective, but they don't seem to be rolled out as we expected.

As such, the way we deliver these very few medications doesn't seem to be enough to attract everybody, particularly if we leave the non-rural epicentres. We need other strategies. We need to co-operate with other geographic areas. We need to be flexible. We need to designate facilities and expand take-home doses. We need mobile, outreach, home-based models. Other methods have been established to be effective to reach people with disabilities, to reach people who have caregiving responsibilities, to reach people who are far from the facilities.

The people we see come with many other issues not related to the medication. However, sustaining the treatment, making people feel safe is the first step that we need. For that, we need more than just a couple of medications that the system feels comfortable with.

Using substances cannot be a criminal act. It's not a criminal act to drink in public. Nobody goes to jail, even if it's not allowed. All the problems that we have right now over decades and generations cannot be fixed in a few years. We need to be patient and compassionate, and revise the evidence to make decisions. We need to continue improving and not give up.

Thank you for listening.

● (1110)

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Professor Joekes.

[*Translation*]

Mr. Pagé, you have five minutes.

Mr. Martin Pagé (Executive Director, Dopamine): Thank you, Chair.

Honourable members, thank you for inviting me to contribute to your work. You have heard testimony from several experts who intervene at various levels to try to stem the crisis we are experiencing. I am pleased to be able to participate directly on the ground, in a very specific, unprecedented social and health crisis context.

I am the father of two young children. I am also someone with experiential and theoretical knowledge, having worked for nearly 30 years now in the harm reduction community. I was a street worker in Toronto and Montreal and I have been called to work at the centre of many crises such as the HIV crisis, the hepatitis C crisis, the housing crisis, the COVID-19 crisis, as well as the contaminated substances crisis that we have been going through for the past decade or more.

I am here today with you as the executive director of Dopamine, a community organization deeply rooted in the Hochelaga-Maisonneuve neighbourhood of Montreal that has been working with substance users for 30 years. The organization works with a harm reduction approach based on best evidence. In fact, data from several studies have largely shown the many positive effects of this approach on health care for people receiving these services and the community at large.

Today I want to tell you a little-known story: that of the people who founded the organization that I have the privilege of directing and representing to you today.

The year was 1991. The HIV/AIDS epidemic hit Montreal hard. In Hochelaga-Maisonneuve, health care institutions were struggling to reach injection drug users. The head of public health launched a pilot project to prevent infection among injection drug users. The purpose of the project was to equip community actors, directly in the substance-use environments, to distribute free needles and condoms, but especially to change the fatalist attitudes and perceptions that were driven by the stigma of HIV/AIDS.

I do not need to tell you that the initiative was met with strong resistance at first. Supported by health care bodies and political bodies, it was the stakeholders, peers and people concerned who contributed to stemming the HIV/AIDS crisis. Countless lives were saved. They contributed to making the neighbourhood safer for everyone. Their courage changed the course of history.

Since then, every member of the Dopamine team continues to develop adapted, effective solutions that are focused on the real needs of people who use drugs. They continue to fight to defend and improve the quality of life, the right to health, but especially the right to dignity.

In light of this new crisis, I am speaking to you in favour of recognizing the evidence and the science and I stand by the many experts working in the four corners of the country in order to contribute positively to solutions that are courageous to be sure, but necessary. It is high time that we come back to a pragmatic and humanist approach, instead of fuelling a polarizing debate on Canada's situation based on moralist, anecdotal and sometimes false approaches that only maintain the status quo. It is high time that we have courageous conversations and get to work on the ground, where human lives are lost every day.

We are asking for a number of measures to be taken in that regard.

First, we are calling for the overdose epidemic to be declared a public health emergency across the country.

Then, we must also pursue and guarantee a safer, pharmaceutical-grade supply based on the substance chosen by each individual.

It would also be important to provide increased support to the organizations to facilitate the implementation of supervised consumption services across the country.

We are also asking to ensure that naloxone is broadly available and easy to access for all communities.

What is more, the leadership of people who use drugs needs to be substantially included in all the work that concerns them.

Finally, we must advocate in favour of decriminalization, even the full legalization of drugs.

I would add that we need to look at, even rectify the way the war on drugs has been used to disproportionately criminalize groups such as racialized individuals, first nations communities, people living in extreme poverty, as well as queer and trans individuals, who are bearing a lot of the consequences of this war right now.

I invite you to come sit down with us. I invite you to come talk with those who are grieving. I invite you to come see all the efforts being made to reduce the number of deaths and to save lives in our communities. We need pragmatic and humanist policies for our communities to live.

● (1115)

Thank you from the bottom of my heart for listening.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Pagé.

[*English*]

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

Ms. Elenore Sturko (Member, Surrey South, Legislative Assembly of British Columbia): Good morning, everyone.

As the B.C. official opposition shadow minister for mental health and addictions and recovery, I'm here today to address the profound failure of British Columbia's illicit drug decriminalization pilot and its dangerously labelled “safe supply” program. These initiatives, while presumably rooted in good intentions, have, unfortunately, yielded alarming consequences due to what many forewarned as a lack of preparedness and vigorous oversight.

In February 2023, at the outset of this pilot's implementation, I warned against the B.C. NDP government's lack of preparation and failure to meet several criterial prerequisites outlined in the federal government's letter of requirements. These included expanding treatment capacity, engaging key stakeholders, and developing monitoring and evaluation frameworks. Here we are, 15 months later, witnessing the ramifications of not meeting those requirements. My worst fears, that British Columbia was entering into an experimental policy without the necessary infrastructure safeguards, have materialized. The results have been nothing short of a disaster.

Former federal minister Carolyn Bennett promised British Columbians, “a robust set of indicators as well on both the public health and the public safety that we then will monitor in real time”. However, these commitments and transparency for real-time data have not been met. The absence of comprehensive data collection has directly compromised public safety, leaving our communities vulnerable, and it's British Columbians who are suffering the consequences. Commuters are being exposed to toxic drug smoke on public transit; children find discarded drug paraphernalia in playgrounds; and nurses, who should be safe in their workplaces, suffer assaults and exposure to toxic drug smoke within hospital walls. All of this is occurring while the B.C. NDP government fails to provide equitable and timely access to health and social services to people suffering with addiction.

Despite early warnings from law enforcement, critical safety and enforcement issues were overlooked, and the pilot program was allowed to commence without mechanisms in place to respond to problematic drug use and without the ability to deter behaviours that put others at risk. Moreover, the diversion of hydromorphone from the so-called safer supply program has persisted unabated since 2020. It took three years and substantial pressure from the medical community before a review was conducted in 2023. This review confirmed what many warned about: widespread diversion and limited evidence supporting the program's efficacy. Despite these findings, the B.C. NDP government continues to misleadingly promote this as “safer supply”.

Tuesday's announcement from the federal government, which modifies B.C.'s section 56 exemption to prohibit public drug use, is a stark admission of the failure of government at both levels—the failure to properly consider public safety, and confirmation of the danger and disorder that's been unleashed by this experiment. The modifications shift this crisis back onto the shoulders of police, who are being asked to move people along but with no services to move them along to. It's merely a band-aid on a gaping wound, addressing public drug use while doing nothing to address addiction itself. This policy U-turn does not address the core issues but instead serves as political damage control, an attempt by government to mask the catastrophic outcomes and divert attention from the harms of their policies.

This was an experiment that was doomed from the outset by a failure to provide social services, access to life-saving treatment, housing and health care. Over the past 15 months it's become painfully clear that the decriminalization policy has not saved lives and reduced drug overdoses, and instead has propagated harm and disorder throughout our communities. As we discuss these developments, we have to recognize that this isn't just a policy failure: It's a humanitarian crisis that continues to claim six lives a day in B.C., and we cannot continue on this path. The decriminalization and safer supply experiments have proven ineffective and dangerous, and it is time for us to reject these policies. It's unacceptable to launch into population-level experiments, ignoring obvious harms and being selective in the collection of evidence.

● (1120)

We need strategies that focus on comprehensive treatment options, social supports and robust public safety measures that genuinely protect our communities. We must develop policies rooted in evidence, prioritize public health and provide real solutions to the drug crisis affecting our province and our country. We must prioritize recovery, uphold safety and secure a safer and healthier future for everyone.

Thank you.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Ms. Sturko.

Ms. Lovegrove, we are going to try this again.

Madam Larouche, let us know if there's any issue.

Ms. Lovegrove, you have two minutes remaining.

Ms. Sarah Lovegrove: I just want to make sure everyone can hear me okay.

Considering that we are sitting at the crux of both Mental Health Awareness Month and National Nurses Week, I feel called to share my perspective on the complex ripple effects of this public health crisis within the—

[*Translation*]

Ms. Andréanne Larouche: Mr. Chair, I rise on a point of order.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Excuse me, Ms. Lovegrove.

We have a point of order from Madame Larouche.

[*Translation*]

Ms. Andréanne Larouche: The interpreters are complaining that the sound is not good enough to allow them to do their work.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): My apologies for that to all of you in the committee. We thought we had it fixed, but clearly we do not.

There's a point of order from Mr. Julian.

[*Translation*]

Mr. Peter Julian (New Westminster—Burnaby, NDP): Mr. Chair, could the technicians have a look at Ms. Lovegrove's connection?

Also, if the connection is secure enough, could you ask her not to speak so quickly? I think that is also part of the problem.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Thank you very much for that, Mr. Julian.

I think we've attempted many of those things, but we'll continue to do that. If we're able to resolve the issue, then we will. We have checked the Internet connection. We have checked its speed. We've done the headset check, etc. For reasons unknown, it doesn't appear to be working.

Given that, we will halt that at this point. Again, I extend apologies to the witness and to the committee on behalf of all of us.

That being said, we will continue to work on that in the background, colleagues, and hopefully resolve that as the time goes on.

If it's the will of the committee if we do resolve it, then I think it only fair that we allow Ms. Lovegrove to finish her statement, if that works. It will be a bit unusual, perhaps a bit clunky, but we will do it anyway.

We will start a round of questioning now.

Mrs. Goodridge, you have the floor for six minutes.

● (1125)

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

I want to thank all the witnesses for being here today and providing their testimony.

Professor Oviedo-Joekes, I understand that you were involved with both the NAOMI and SALOME studies, which are used as the evidence that brought forward the safe supply programs.

My understanding is that both of those studies used witness dosing. Is that correct?

Ms. Eugenia Oviedo-Joekes: Yes, that's correct.

Mrs. Laila Goodridge: Based on that, a study that would use witness dosing, how can it be used as evidence to support giving take-home pills of 30 to 40 Dilaudid hydromorphone pills a day?

Ms. Eugenia Oviedo-Joekes: First of all, the study, as you said, was injectable. We do hope that people who are ready for it can take the doses with them in the cases that are indicated by the prescriber in a conversation with the physician. There was always the intention that as clients evolve, the treatment will evolve with them.

We did have—

Mrs. Laila Goodridge: Did the study look at that evolution?

Ms. Eugenia Oviedo-Joekes: No, we didn't. We had a trial, and the trial ended. We did show that for our participants injectable was more effective than oral.

Mrs. Laila Goodridge: I appreciate that. Does the diversion and the reports of diversion of the take-home hydromorphone, the Dilaudid pills, concern you?

Ms. Eugenia Oviedo-Joekes: First, the diversion that is shown is so minimal that the scientific perspective is expected for the number of people. In a big scope, there is a very small percentage of people who are struggling with opioid use disorder and who are getting the Dilaudid pills. Then possibly the number of people who might be sharing or selling the medication because that's not the medication for them, because we have few options, is a number that is expected.

Mrs. Laila Goodridge: To clarify, you are not concerned whatsoever by the amount of diversion that's happening?

Ms. Eugenia Oviedo-Joekes: It's expected.

Mrs. Laila Goodridge: Okay. I appreciate that.

[*Translation*]

My next question is for Mr. Pagé.

Among the 49 neighbourhood police stations in Montreal that were assessed by the City of Montreal police force in 2021, the Hochelaga-Maisonneuve neighbourhood, where the Dopamine organization is located, ranked fourth in terms of crime rate. We are talking about 57.8 crimes per 1,000 residents.

Given the significant presence of parks, playgrounds for children, schools and the Edmond-Hamelin park located across the street from the organization, I would like to know what measures you have taken to ensure that supervised injection centres for hard drugs such as fentanyl, crack and heroin do not exacerbate the crime situation, which is already disastrous in that area.

Mr. Martin Pagé: In fact, Dopamine's supervised injection service contributes positively to reducing consumption in public places. Harm reduction services absolutely contribute positively to the community. It should be noted that well before the organization's services were brought in, this neighbourhood was seen to be in a very precarious social situation. It is not attributable solely to drug use. It is also the result of the poverty and history of our community.

Dopamine's supervised injection service has only improved the situation, since instead of consuming in public places, individuals consume at our facility where we provide them with guidance and supervision. For example, our service has not caused an increase in the amount of material left behind in public spaces. On the contrary, we have seen a decline in that regard. There has not been an increase whatsoever. There has indeed been a decline in consumption in public places.

● (1130)

Mrs. Laila Goodridge: I saw in the news that parents are concerned about knowing that their children were close to the Dopamine centre.

What would you say to the parents whose children play so close to your centre?

Mr. Martin Pagé: I am not sure that you have accurate information about our organization, but there is no school located next to us. That being said, every neighbouring school has been notified. Dopamine has always maintained communication with its community. As our group comes from our community, Dopamine has always worked with the neighbouring families and schools. I want to clarify that there was no incident.

Mrs. Laila Goodridge: I am glad to hear it.

[*English*]

Ms. Sturko, one of the things you said that really hit me was that it was effectively a band-aid on a gaping wound. What did you see in your role in British Columbia, both as an elected official and as a former law enforcement officer, when it came to diversion? Does diversion scare you?

Ms. Elenore Sturko: Yes, I have a lot of concern—

The Vice-Chair (Mr. Stephen Ellis): Ms. Sturko, if I might interrupt, you have about five seconds to answer that question. You may have to come back to it.

Ms. Elenore Sturko: Sure. I will just say in five seconds that, yes, diversion is a concern. It's something I've heard a lot about, and I look forward to speaking more about it when I have longer than five seconds.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much for that.

[*Translation*]

Ms. Lapointe, you have six minutes.

Ms. Viviane Lapointe (Sudbury, Lib.): Thank you, Mr. Chair.

[*English*]

My question is for Dr. Oviedo-Joekes. In my community of Sudbury, we had the highest number of opioid-related deaths per capita in the entire province of Ontario. It is a very critical issue in my community and across northern Ontario as well, where we really have a lack of resources and a lack of infrastructure. I would be very interested in hearing your thoughts on how we can better support people who live in rural and remote communities and use drugs.

Ms. Eugenia Oviedo-Joekes: Thank you so much and I'm very sorry for the circumstances in your area.

The first thing, as I was saying, is collaboration is key. There is nothing that will come from the top that can work unless we work with the community, unless we understand the values of the community and not just come in and say, take this, do this, without knowing if this community is ready and is going to accept. We have to work from there, trying to offer all the options that we can.

As I said, each group of people has particular priorities, they have defined issues that we need to work with. For some of them, if the medications are not available, people cannot travel. That will be a very key problem that has to be resolved.

Restrictions in policy will be a barrier that we are hoping we can solve with the provincial or the federal government so we can reach all the people in the community, people with disabilities who are not able to come in daily. There are all those other intersections we might have.

Sometimes women will not want to be in a place when people who have been violent to them are in the same place.

That's kind of the idea of where to go, to start working together and understand the issues in the community and see how we can build together that side.

I'm not sure if I answered your question.

Ms. Viviane Lapointe: Thank you, Doctor.

In your opening statement, you said we need to be flexible in dealing with the opioid epidemic and toxic drug crisis in Canada. Tell us, what does “flexible” look like for all of the agencies and levels of government that are involved?

Ms. Eugenia Oviedo-Joekes: When we work with the prescribers and they want to do person-centred care, they know that certain clients require an opiate medication that they cannot prescribe because it's not indicated for opioid use. In downtown Vancouver you are going to be an advocacy group and you are going to be able to prescribe off-label, but in other places, you don't have that support. You are alone, so you can prescribe only a few things. You don't have prescribers.

The idea is to have the flexibility that we can have all these medications, that we know are evidence-based, available. Then when you have a client coming to you, you can have a conversation with them and say, don't leave, I have something for you. This is the medication that is going to be the best fit for you.

Maybe that person is not ready for take-home medications, but work with them. Maybe that person is ready for somebody going with them or a family member helping. There are so many ways to work with people who are not supervised or just left on their own.

Did that answer your question?

● (1135)

Ms. Viviane Lapointe: Yes. Thank you, Doctor.

I noted that you are a tier one Canada research chair in person-centred care in addiction and public health. Can you share with this committee your thoughts on how Canada can improve our decision-making based on evidence-based practices here? What are some other models perhaps outside Canada that we could be looking at in terms of good, evidence-based practices?

Ms. Eugenia Oviedo-Joekes: The first thing is there is evidence that the so-called “experiment” did save lives. The BCCDC published in the British Medical Journal that it saved lives. If we are going to dissent, let's dissent with the truth. It is totally fair to dissent, but let's dissent with the truth so we can build, not going backwards. Let's build because we are always short on services.

We have decriminalization that works in every country. People going to jail because they use substances doesn't work, maybe in China.... Let's build and do it better, not worse.

There are little things that we achieve; we need to do it better. What can we do better? What can we add to this? That's kind of the idea. If you disagree with that measure, build something on top of that. Let's not destroy the little things that we are building together.

At the end of the day, we are in this together. When people die, they don't have a party patch here. They just die. Most of the people who die are poor people.

The Vice-Chair (Mr. Stephen Ellis): Professor, I'll have to stop you there. Your time is up, but thank you for that. I appreciate it.

Ms. Eugenia Oviedo-Joekes: Thank you. Sorry, I didn't know I was out of time.

The Vice-Chair (Mr. Stephen Ellis): Colleagues, we are going to try one more time. This will have exhausted all possibilities. It's a bit unusual, as I said, but with Ms. Lovegrove, we have tried disconnecting and reconnecting.

Assuming it's the will of the committee that we'd like to hear from Ms. Lovegrove, if possible—I see general agreement with that—she does have two minutes left, so we will try that again.

Ms. Lovegrove, you have the floor for two minutes.

Ms. Sarah Lovegrove: Thank you very much.

As I was saying, I feel called to share my experience on the complex ripple effects of this public health crisis within the context of a concurrent national health care crisis and provider shortage. Canadian nurses are leaving the front lines in droves as a result of burnout, moral distress, moral injury and trauma, and I'm speaking to this specifically today because I am one of them. I left my job in the Nanaimo emergency department—

The Vice-Chair (Mr. Stephen Ellis): Excuse me, Ms. Lovegrove, could you speak a little slower, please? Perhaps that may help. Thank you.

Ms. Sarah Lovegrove: Okay.

I left my profession altogether with severe post-traumatic stress disorder in 2018, having worked through the first peak of fentanyl poisoning deaths and at the time of Nanaimo's largest homeless encampment, Discontent City.

The devastating psychological impacts of participating in countless failed resuscitation attempts, witnessing discriminatory and stigmatizing treatment of people who use drugs, having sick patients leave before receiving treatment due to fear of criminalization, and not having the necessary resources to care for people in the way I was trained to do nearly killed me. It left me hopeless, thinking that I would never have the capacity to return to this profession that I love so dearly.

Due to the increasingly toxic and unpredictable nature of the unregulated supply, people who use drugs are being injured and are dying at escalating rates in ways that we have never seen before, and, frankly, in ways that Canadian health care workers are not prepared to deal with. This is happening because of decades of bad drug policy that reduces people who use drugs to less than human.

Now, as a teacher, I'm obligated to armour my compassionate young nursing students in preparation for a career that will most likely injure them as well. I will reiterate that this is a public health crisis, not a political opportunity to garner votes during an election cycle. The politicization of this crisis is killing people, and the reactionary implementation of policy is only feeding stigma and contributing to the fearmongering spread of dangerous misinformation.

In the past few months, B.C. has seen a marked decrease in toxic drug deaths, but after this week's decision to recriminalize substance use, it breaks my heart and spirit to know that even more people will die.

● (1140)

The Vice-Chair (Mr. Stephen Ellis): Ms. Lovegrove, I'll have to stop you there. You'll have lots of time to expand on this during the question-and-answer period. Thank you for your patience, and thank you to all of you for your understanding.

[*Translation*]

Ms. Larouche, you have six minutes.

Ms. Andréanne Larouche: Thank you very much, Mr. Chair.

I want to thank all the witnesses who are here with us today. They are helping us to understand the scope of this crisis and the importance of working seriously by taking a science-based approach and not politicizing this file.

I would like to begin with a personal anecdote. As a teenager, I had the opportunity to spend time with the people from CACTUS Montréal. I can tell you that their stories likely contributed to developing my interest in community work, which I then pursued.

Mr. Pagé, I would like you to tell us a bit more about your organization. In response to my colleague's question, you said that there was no school near your organization. She also asked you a question about police services. We know full well that your approach must truly be considered from a continuum of services perspective.

In what type of physical environment is your organization located? What is in the surrounding area?

What is more, what connection do you have with the police?

Mr. Martin Pagé: That is a complex question that I probably will not have enough time to answer.

Dopamine has two facilities in the neighbourhood. Earlier, there was mention of a park across from our organization. That is our primary facility in the Hochelaga-Maisonneuve neighbourhood and it is our day centre. Dopamine has been in that house since 2013. Across from that facility, there is a park and affordable housing. There is an ongoing coexistence with the community. We want to ensure that no syringes are left lying around and that there is harmonious coexistence.

Dopamine's supervised injection service is located somewhere else, on Ontario Street. In Quebec, we have CLSCs, community health centres that provide health care services. Our organization has space at a CLSC that is open in the evening. There is a secondary school nearby. However, since Dopamine's activities at that location are held in the evening, there is no coexistence or friction. There is always honest communication between us, school stakeholders, people in the area and people in the community, whether about the Dopamine facility on Ontario Street or the facility on Sainte-Catherine.

I will try to answer the other part of your question quickly.

As far as the relationship with the local police forces is concerned, Dopamine has always had a communication relationship that is at the very least administrative with the local police force. The goal is to ensure that the officers understand our mission and what we are trying to do in the community, and to prevent incidents.

Communication is key on many levels. As I said in my presentation, Dopamine has been integrated in the community for more than 30 years now. Its presence is welcome in the community. Dopamine existed and was involved in the community long before it started offering supervised consumption services. We have always maintained communication with the public and with officials, whether about health care, police services or security.

● (1145)

Ms. Andréanne Larouche: Thank you for providing some background on Hochelaga-Maisonneuve. The members from Quebec can see that is much more complex and that this neighbourhood of Montreal has a very long history in this regard.

You also have plans to expand in order to add an inhalation site over the coming year. Are you able to do it? Can you talk to us about this project?

Mr. Brendan Hanley (Yukon, Lib.): Mr. Chair, on a point of order. Interpretation is not working online.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): The translation is not working. Let's hold on a minute.

[*Translation*]

Ms. Andréanne Larouche: I hope you stopped the clock for me, Mr. Chair.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Colleagues, we're going to have to suspend for a few minutes.

● (1145)

_____________________(Pause)_____________________

● (1145)

The Vice-Chair (Mr. Stephen Ellis): Colleagues, I think we have the issue resolved.

We do have a stop at one o'clock for this segment of the meeting, so please be mindful of that.

[*Translation*]

Ms. Larouche, you have two minutes.

Ms. Andréanne Larouche: Thank you very much, Mr. Chair.

Mr. Pagé, I will repeat the question.

I know that you had an expansion plan to add an inhalation site over the coming year. Are you able to do it? Can you give us an update on the project and explain it to us?

Mr. Martin Pagé: Yes, thank you very much.

As things currently stand, we need services and space to welcome people from the community both day and night. Our two facilities have complementary opening hours. For now, we do not provide injection and inhalation services during the day, but it is something we are trying to do. We have the green light from public health authorities, but we are still at the early stages of this initiative. First we need to assess the feasibility of the project in our building, from a technical standpoint.

That is why I was asking that the government facilitate projects like this, ones that will only improve the quality of life of communities, since people go indoors to consume, under supervision.

Finally, we are trying to complete this project to extend our hours of operation and provide services day and night. However, we have only just begun.

That being said, thank you for asking that question.

● (1150)

Ms. Andréanne Larouche: How would this improve the work that you do with people who use your services?

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Mr. Pagé, answer in about 10 seconds, please.

[*Translation*]

Mr. Martin Pagé: Okay. I would say that it would help save lives, save lives and save lives.

Ms. Andréanne Larouche: Thank you.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): That was excellent, well done and under 10 seconds.

The final six-minute round goes to Mr. Julian.

You have the floor for six minutes.

Mr. Peter Julian: Thank you very much, Mr. Chair.

Thank you to each of our witnesses.

Your testimony is indicative of how important it is for us to ensure that we are bringing down the death rates across the country. Every single death is important.

Ms. Lovegrove, as you alluded to in your presentation, every victim represents the end of a beating heart and a family and a community in mourning. We have to take action.

I want to start off by asking Ms. Oviedo-Joekes and Ms. Lovegrove the following questions: What should the federal government be doing more? Should it be declaring a national health emergency as we see numbers climb in Alberta and Saskatchewan? Should it be putting into place funding for safe consumption sites so that we can bring the death toll down, particularly on the Prairies where it is staggeringly high and increasing daily?

Ms. Oviedo-Joekes, you talked about dissenting with the truth. How much harm are people doing, are politicians doing, when they say things that are simply not true when it comes to dealing with this public health care emergency?

Ms. Eugenia Oviedo-Joekes: I will allow Sarah to speak first.

Ms. Sarah Lovegrove: It's my full, wholehearted belief that we need to be doing absolutely all of those things to curb this crisis. The federal government also has the opportunity to regulate the drug supply and offer a legal supply of drugs to the entire country to curb the deaths that are a result of the unregulated toxic supply.

We need to declare a national emergency. We need to institute overdose prevention sites in every single community across the country, invest in harm reduction and offer a regulated, safe supply to everyone in this country.

Mr. Peter Julian: Ms. Lovegrove, on my second question, the issue of being truth-tellers, how much harm are those who are providing false testimony or false information doing?

Ms. Sarah Lovegrove: They're doing irreparable harm to this to the country, to the people who use drugs in this country. People are dying as a result of stigma; people aren't accessing services as a result of stigma.

When politicians utilize this as an opportunity to get election votes or get ahead in their careers, they are doing harm that is killing people. They need to be rooting their decisions and what they say in public with evidence and utilizing the expertise of people like the witnesses here today rather than listening to the opinions and prohibitionary stigma that is feeding the opinions of folks across this country and only further inflaming the stigmatizing belief system around substances.

Mr. Peter Julian: Thank you.

Ms. Oviedo-Joekes, I'll ask you the same question, both in terms of what we need to do and in terms of that dissent with the truth that you spoke about.

● (1155)

Ms. Eugenia Oviedo-Joekes: Following on what you're saying, we need to have all of the options open for people. If I was a person struggling with drugs, we don't know where I would be today or in 10 years. It's not a death sentence, but it has been demonstrated that treatments based on not using any substance—so-called “abstinence-based” treatments—have a success rate of only 5%.

Just holding the *bandera*—sorry for the Spanglish—of “that's what we have to do” is not good for people because there is no one treatment that we need to proclaim. We need to proclaim all of them because people are going to be in different places at different times.

We need to proclaim a young person maybe wanting to be on that path. Another person might be ready to start out with others. For another person, the only thing they might want is injectables. For another person, it has to be evidence-based.

If you lie and say that it is proven that this didn't work and you have authority and the floor and you just said that because you saw it in the news, you create panic and fear for the people who have children, for the people who don't read. You then get an entire community saying that this doesn't work. Abuse of power is not a good thing.

Mr. Peter Julian: I am deeply saddened by the Alberta death rate, which is now the highest in the country. The death rate in Lethbridge is 137.5 per 100,000. I'm deeply saddened by these statistics of a 17% rise in Alberta and a 23% rise in Saskatchewan.

When we talk about these tragedies happening now in places like Alberta and Saskatchewan, what is your reaction?

The Vice-Chair (Mr. Stephen Ellis): I'm very sorry, but we are already over time, Mr. Julian. You'll have to hold that question and answer for your next round.

Thank you, colleagues.

In the next round, we'll be moving into different amounts of time, so I encourage the witnesses to listen carefully as to how much time the questioner has left to answer the question.

With that, Dr. Kitchen, you have the floor for five minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

I thank all of the witnesses who are here today. It's greatly appreciated.

I'll start with Mr. Pagé.

I apologize.

[*Translation*]

I speak a little bit of French, but I speak more slowly in French.

[*English*]

So, I will speak in English.

I found it quite interesting that your organization is called Dopamine. I find that interesting because 80% of the catecholamine content of the brain is basically what dopamine is. It deals with pleasures, satisfactions and motivation. It also deals with concentration and movement. I found it interesting how you used that as the name for your organization.

You also mentioned naloxone. The impression I got from that conversation is that it isn't readily available to a great extent in your area. Over the years, and in my discussions with paramedics, etc., that has been a big concern for paramedics: actually being able to utilize naloxone.

The concern, in some cases, when they are utilizing naloxone is that they have to step back because of the fear that the moment they give that naloxone to the patient.... When it brings that person out of the state that they're in, they often come out in a violent manner. I'm just wondering if you would mind commenting on that aspect of naloxone.

[*Translation*]

Mr. Martin Pagé: I hope I understood the question properly.

I was saying that it was important for naloxone to be accessible and easily distributed in the communities because there are still places where it is harder to access, unfortunately. It remains an effective antidote to opioid overdoses.

As for the fear of first responders, I would say that it is not so much a violent reaction. That is often the reaction that is perceived, but it is more that naloxone often puts a person in a state of withdrawal. I would add that despite their sometimes rather dry reaction after receiving a dose of naloxone, people are happy to know that they are still alive.

That type of rhetoric needs to be balanced out. Naloxone saves lives. Harm reduction saves lives.

That is the effect of the antidote: People sometimes end up in withdrawal. I have never heard any stories or anecdotes where a person had a violent awakening or something like that. They end up more agitated or surprised. It is about having the right intervention techniques. You have to know not only how to administer naloxone, but also how to work with the people who use drugs. That knowledge is also necessary for working in our field.

● (1200)

[*English*]

Mr. Robert Kitchen: Thank you very much.

Ms. Sturko, thank you very much for coming. I appreciate your being here in person.

You touched a little bit on treatment and rehabilitation. Canadians are watching this debate that we're having here, and a lot of them are concerned. Where are the steps that are being taken to rehabilitate? That prioritization of recovery, I think, is a very important thing.

We look at the fact that more than 23,800 people, due to drug addiction, are having hypoxic brain injuries. That's going to have a huge impact on provinces on how to deal with those individuals in caring for them. I'm wondering if you would mind commenting on that.

Ms. Elenore Sturko: What we're seeing in British Columbia is certainly a large number of people who have acquired brain injury as a result of overdose.

I myself have administered naloxone to people in the course of my duty. I'm a former RCMP officer. I can say that one of the things that really worried me is that, at times, I'd be dispatched to a call for a person who was unconscious with a suspected overdose, and there was no ambulance ready in B.C. It would take me five or six minutes to get there. That person, in all of that time, either has very shallow breathing, not very much breathing, or is not breathing at all. Then the naloxone—

The Vice-Chair (Mr. Stephen Ellis): Ms. Sturko, I'm sorry; I have to interrupt you again. The member's time is up. I apologize for that. You can get back to it, I'm sure.

[*Translation*]

Ms. Brière, you have five minutes.

[*English*]

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

Ms. Sturko, in your remarks, you were saying that indicators haven't been met.

I'm PS to the Minister of Mental Health and Addictions. Health Canada is monitoring B.C.'s indicators and is telling us that they are met. Could you please tell us what your sources are?

Ms. Elenore Sturko: What I'm referring to is what was promised by the minister and then what was delivered. I can share with you a little bit about what was promised by the minister at the time. It was that we would be getting baseline indicators and that we would have a robust set of indicators on health and public safety. The minister, who was Carolyn Bennett at the time, in May 2022, said that we would be able to ascertain not only how many lives were saved but how many emergency department visits and hospitalizations there were, and what we were hearing at the time from urban mayors about petty crime. She said that they were all the things that we know are indicators of whether we're really stemming the tide of this crisis.

I just want to go eight months later. There was another press conference in British Columbia, and that was at the outset of the pilot project. At that time, Minister Bennett said, “I would say that we need at least three months to be able to get this sorted out...also, I think as we let people know what indicators have been chosen”. Eight months later, they didn't have the indicators chosen, it seems. “if people have ideas or they have other indicators that they would like, whether it's a small business or whether people are saying, you know.... What would be other things that we could be measuring that would help determine the efficacy?” One thing that was in the letter of requirements was that the amount of treatment and health care would be scaled up.

There was a study that was released by the Journal of Community Safety and Well-Being, and it stated that, just prior to decriminalization coming into effect, 64% of the communities served by the RCMP in B.C. did not have any access to any drug rehabilitation or treatment. That means that the majority of British Columbian cities did not have any access to these services. While that is not the only service that should be provided, it was one of the requirements to scale up these to make sure that we were ready. As stigma would be driven down and people could be connected to services, they would exist. Unfortunately, they just haven't existed.

● (1205)

Mrs. Élisabeth Brière: Okay, but all of these indicators are posted, and Health Canada confirmed that they are meeting the letter of requirements.

Ms. Elenore Sturko: Well, the other part of it, too, is that, in the beginning, Minister Bennett promised citizens of British Columbia that we would have a dashboard that was going to be updated monthly. The dashboard would be publicly facing and it would be monitored in real time. The context of the data collection was then altered, and that was allowed to become a selective snapshot. I can tell you that I'm very concerned. One of the pages of the snapshot of April 2024, which is the most recent one, provided the number of treatment beds and individual clients who are served. Unfortunately, the snapshot is from the fiscal year 2022-23, so it only captures 59 days of decriminalization.

For us to be able to say at this point that they've captured data that would suggest they could understand fully that people have access to more treatment.... There are no indicators on whether or not that was successful or whether or not people stayed in those services, and it's very concerning.

Mrs. Élisabeth Brière: I have some quotes that came from you in October 2023. You said that this government has introduced a safe supply where they're giving hydromorphone. They gave it to individuals to help get them off illicit drugs and that we need to continue exploring. You also said that this government was said to be exploring options for pharmaceutical alternatives to illicit drugs, and that that's what they should be doing. You said that you absolutely support harm reduction.

I would like to know if you still stand by these quotes?

Ms. Elenore Sturko: I think that what's important to note are the concerns I've raised over the duration of my time as a member of the Legislative Assembly. They is a lack of evidence of the efficacy of the program and certainly the absolute failure to look at things that are potential harms to the community.

While it's important that we continue the research and finding ways to treat people and to ensure that they can be protected from overdose through things like pharmaceutical alternatives under supervision and witnessed programs, very little data, if any at all, in British Columbia has been collected on things like the diversion of safe supply, which is of extreme concern to me.

The Vice-Chair (Mr. Stephen Ellis): Ms. Sturko, I have to interrupt you again. I apologize.

[*Translation*]

Ms. Larouche, you have two and a half minutes.

Ms. Andréanne Larouche: Thank you, Mr. Chair.

I will turn to Mr. Pagé again.

I would like to come back to your comments on coexistence. There is a lot of talk about coexistence in places that have organizations like yours. To improve coexistence between people who are suffering with addiction and the rest of the population, should we have supervised injection sites?

We were talking about your expansion plans. Tell us why it would be important to have more supervised injection sites and supervised inhalation sites for improving coexistence.

● (1210)

Mr. Martin Pagé: It is important to have harm reduction services for the simple reason that these projects have been in operation for many years. We are talking here about safe injection sites, but we could also be talking about prevention for infectious diseases such as hepatitis C.

When drug users in a community are in contact with workers in the community services sector or the health care sector, we can do prevention work that will have long-term positive effects. What is more, it improves coexistence since the people are no longer hiding in an alley or a park to consume their substances. Instead they are going to safe, clean sites that are free from stigma, both day and night. That is why we want to increase these services.

We also need to have good communication. I talked about that earlier. Community organizations need to have enough funding not only to keep the services going, but also to have workers who are in communication with the people in the community. I am thinking here about the street workers, the community workers, or even people working with the schools. We need other intermediaries to ensure healthy coexistence in a community.

We must not create tension within the community with respect to harm reduction projects, whose purpose, I repeat, is to save lives and maintain a quality of life during periods of consumption.

Let's not mix up these two concepts, even though they go hand in hand. We have to establish good communication with the community, but especially provide services that save lives. So—

The Vice-Chair (Mr. Stephen Ellis): I am sorry to interrupt you, Mr. Pagé. I know that two and half minutes is not long.

Thank you very much.

[*English*]

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

Mr. Peter Julian: Thank you, Mr. Chair.

Ms. Sturko, welcome. As British Columbians, we have a responsibility, I think we would agree. We have to get a handle on this toxic drug crisis. I appreciate you being here today.

I'd like you to tell us what the death rate for toxic drugs in British Columbia was in March 2023, and what it was one year later in March 2024, according to the B.C. coroner's service.

Ms. Elenore Sturko: I don't have [*Inaudible—Editor*].

Mr. Peter Julian: Okay. I'll tell you. It was 46.2 in 2023 and it was 40.3 in 2024. That difference means the saving of hundreds and hundreds of lives in British Columbia.

Now, as Ms. Brière asked you, you have been on record...and I know in conversations with you before, you've said things like, “We're not backtracking on the need for harm reduction”; “With our whole hearts, we want to save people”; and that you support decriminalization and harm reduction.

You weren't clear in your answer to Ms. Brière. Have you changed your position on decriminalization? Given these figures, why would you not be supportive? Though we need to tweak and improve the program, why would you not be supportive when lives are being saved?

Ms. Elenore Sturko: First of all, yes, I have changed my opinion of decriminalization. I want to be clear, too, that it is important to note that there have been, even in previous years or months, decreases in overdose deaths, even several months in a row, only to be then followed by increases. This is certainly the case. I've heard people on this committee speaking about this before.

I can tell you that in multiple years we have seen trends like this before, only to spike up in other months, then to be followed by, again, year after year, the worst records for overdose deaths that we've seen.

Mr. Peter Julian: I'm sorry. It is my time, and it's very short.

I wanted to ask you about Moms Stop the Harm. Have you met with them?

Ms. Elenore Sturko: No, I have not.

Mr. Peter Julian: These are our families of victims of the toxic drug crisis. They have been very strong on having a range of services, including harm reduction, decriminalization and safe supply.

Why would you not meet with them to hear those families out and understand the importance of having a variety of tools to lower the death rate, which I think is something we would agree needs to happen?

● (1215)

The Vice-Chair (Mr. Stephen Ellis): I'm sorry, Mr. Julian. You're well past time. I apologize for that. I ask all members to watch their time closely.

Ms. Sturko, hopefully you'll have time to answer that at some other point. Of course, you could submit your answer in writing to the committee.

With that, we'll move on to Mrs. Goodridge.

You have the floor for five minutes.

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

Ms. Sturko, you're going to stay in the hot seat for a little bit longer.

You haven't had an opportunity to explain your concerns around diversion due to some of the time constraints. As someone who lives in the Lower Mainland and represents a Lower Mainland riding, and as a former law enforcement officer, how concerning is diversion to you, and what have you seen on the ground in British Columbia?

Ms. Elenore Sturko: My concern with the diversion of safe supply is twofold.

The first concern, and probably the one that has hit me the hardest, really, is the impact it has had on young people. I've met with physicians, but I've also met with the parents of young kids who have succumbed to overdose.

One of the first dads I met with was named Dave. His daughter died of a fentanyl overdose. At the time of her death, she had several bottles of safe-supply hydromorphone in her bedroom that were not prescribed to her. In talking to him, he said his daughter had started with cannabis and then moved on to experimentation with other drugs.

That was alarming to me. I think that, given the fact that there hasn't been any study, really, in British Columbia about the impacts of diversion of hydromorphone on the overdose crisis, it's needs more attention.

The second concern I have is we are seeing now, in British Columbia, that diverted hydromorphone is being discovered by police in their drug investigations. Police have even testified, I think, to this committee, that there is a nexus between some of these investigations and organized crime.

Mrs. Laila Goodridge: Are you effectively saying that police in British Columbia are figuring out that government safe supply—or so-called safe supply—is fuelling organized crime and gangs?

Ms. Elenore Sturko: Yes.

Police have put out news releases and have reported in the media about drug investigations that have a nexus to organized crime. Gang activity in British Columbia is obviously a concern, so any kind of diversion or government program that would in any way put money into the hands of organized criminals and gangs is a top concern.

That doesn't mean we have to stop helping people, but when there are ways that we can mitigate risks and help stem the flow of drugs into the hands of criminals, we absolutely have to do that.

Mrs. Laila Goodridge: One other piece I find really interesting is that the overdose rates for kids in British Columbia are steadily increasing. The children's minister actually stated that she thought the federal Minister of Mental Health and Addictions was doing a great job and had faith in this policy and the direction.

We know opiates are highly addictive. We've had many doctors come and present to our committee on this. What is the impact on the families whose children started out on this so-called safe supply that they believed was safe because it has been marketed as safe?

Ms. Elenore Sturko: One of the most impactful and devastating stories I heard first-hand from a father named Greg. His young daughter started using drugs at age 14. She died at age 15. The widespread impact was that her group of friends was using drugs together. One of the kids in the friend group is still living. She said that they did start off by getting Dillies, which is the street name for Dilaudid, for hydromorphone. They did think it was safe.

They started to become sick. At first they started off by taking it once in a while, then they started feeling the need to take it more. Then it came to the point where if they stopped taking it, they would feel sick. When the withdrawals were no longer being managed, even just by taking the Dillies, the one girl who actually survived started taking fentanyl. Even though she had access then to OAT, she still continues to use drugs now. I know her mother very well. It is an absolutely awful journey that they're on.

There are not enough supports and services, but this is widespread. Especially when we're talking about kids or even young adults or adults, it's affecting their friend groups.

I think one of the biggest things that's really concerning to me.... If I can just read this into the record, this is actually from Purdue Pharma. This is their patient medication information. It says:

> Never give anyone your DILAUDID. They could die from taking it. If a person has not been prescribed DILAUDID, taking even one dose can cause a fatal overdose. This is especially true for children.

It also says:

> Even if you take DILAUDID as prescribed you are at a risk for opioid addiction, abuse and misuse. This can lead to overdose and death. To understand your risk of opioid addiction, abuse, and misuse you should speak to your prescriber

My concern is the lack of research on this—

● (1220)

The Vice-Chair (Mr. Stephen Ellis): Ms. Sturko, I'm sorry. I'll have to interrupt you there. I think that's a good place to stop.

Next up, Dr. Powlowski, you have the floor for five minutes, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): We've heard both sides on the issue of safe supply. We've certainly heard people say that there's plenty of evidence for the beneficial effects of safe supply, and by that, they meant the Canadian version of safe supply, which is getting a whole bunch of Dilaudid and going home with it.

We've also heard the opposite from members of Health Canada, who generally seem to be supportive of the idea. However, they admitted that there wasn't a lot of evidence for a safe supply in the Canadian context.

We also heard the same thing from the Stanford-Lancet Commission, which was very much against safe supply. I would note that the B.C. Provincial Health Officer, in her review of safer supply, also said that there wasn't a lot of good evidence for safe supply.

What there is a lot of good evidence for is iOAT, injectable opioid agonist treatment. NAOMI and SALOME, as Mrs. Goodridge pointed out, offered directly observed treatment. A lot of the evidence from Switzerland and the studies that are again cited as evidence for safe supply also offered observed treatment with injectable drugs—heroin, at the time.

The concerns about diversion, I think, are totally legitimate. The Swiss have this approach because of the concerns around diversion. A lot of people in B.C. continue to die because of fentanyl. That's what's killing them. Even though they get Dilaudid, it's not enough for them. They use fentanyl.

What do you think about intravenous observed treatment in this kind of Swiss model, where people can come into a treatment facility and get observed injectable doses of fentanyl?

Would you be in favour of that or at least willing to contemplate this?

Ms. Elenore Sturko: I wrote a letter to Minister Ya'ara Saks, which I also carbon-copied to Premier David Eby, to the effect that I actually support a call from doctors across Canada, addiction specialists, including 72 in British Columbia, who are calling for witnessed prescribed alternatives that are recovery oriented.

My purpose in coming here today isn't to stop people from getting life-saving medications, if this is what is important. I want to make sure that we understand the scope of the risk to the population. There is a population-level risk that is even identified by Dr. Henry, for example, in her report that you referred to, which was released on February 1.

If we're going to be providing treatments, which, as you stated, in Dr. Henry's report, have not enough evidence at this point to be described as fully evidence-based, we need to make sure that we're not causing unintentional harms.

Mr. Marcus Powlowski: I've heard from addiction specialists who are in favour of iOAT that our safe supply was kind of a poor man's version because iOAT, where you bring people in and you witness them getting injections, is a lot more costly. That is obviously an issue for governments. Do you think we should be putting more money into providing more of that kind of therapy versus the present kind of safe supply?

Ms. Elenore Sturko: It's a “pay now or pay later” scenario. And what is the cost of a life? When we reduce these things to what will it cost and we look at the human cost, six people a day in British Columbia are losing their lives. I think that if there are alternatives that can protect the public from diversion, make sure that we're ramping up things like prevention strategies and actually warning people that it is not safe to take other people's medication and actually safeguarding the public.... Of course, we need to invest in a whole scope of services, but also in social supports, housing, things to help people become stable so that if they do access medical programs they have the social stability to maintain their use of those programs.

• (1225)

Mr. Marcus Powlowski: Maybe I can ask the same question to Professor Oviedo-Joekes.

Should there be more facilities that would allow directly observed treatment, including potentially intravenous and/or smoking drugs as an alternative to the present safe supply with pills that you go home with?

Ms. Eugenia Oviedo-Joekes: That is definitely an alternative. This option should not just open new facilities, but integrate them with the services that are already there. Opening new facilities can be costly. If you integrate them with the services, you make it mainstream. Then people who leave a treatment can go to another if they are ready to switch from injectable to oral medications.

Mr. Marcus Powlowski: Thank you.

The Vice-Chair (Mr. Stephen Ellis): Colleagues, just so everyone has an idea of where we are, it appears that we have at least one more round, which will take us about 25 more minutes or so.

Mrs. Goodridge, you have the floor for five minutes.

Mrs. Laila Goodridge: After nine years of this NDP-Liberal government, we have tragically seen over 42,000 overdose deaths, rising child overdose deaths and rates.

Do you think that the Trudeau government is doing a good job at managing this crisis, Ms. Sturko?

Ms. Elenore Sturko: No, I don't think governments at either level, provincially or federally, are. I think that not enough emphasis has been put on prevention, certainly. We keep having these discussions about individual services. While they're important, what we really need to do is start developing a true framework for the country and for individual provinces that is a recovery-oriented system of care that has strength in all four pillars, not the one-legged stool of simply trying to look at one service option at a time but vastly scaling up all parts of the pillars, including enforcement.

One of my greatest concerns is the lack of prevention and education. I'm especially troubled to see young kids and families and especially having to meet with families of people who've lost a child. I really want to be strong in my statement here today. This isn't about stopping people from getting help; this is about making sure that when people reach out for help, first of all, it's there, and that in any treatment options and pharmaceutical options that go forward we make sure that we're not increasing the risk to other people.

Mrs. Laila Goodridge: Actually that's a great segue to my next question. What is the approximate delay or how readily accessible is detox in your riding or B.C. more generally, and what is the wait time for government-funded treatment in your province, approximately?

Ms. Elenore Sturko: Unfortunately, and I do have some notes on it, it's incomplete data. Here we are talking about a government that has had almost a decade in power. In our province we've been in a public health emergency for eight years. I heard the comments today about whether Canada should declare a public health emergency. I want to be clear that it does not help you to declare a public health emergency unless you treat it like an emergency. In our province, to have declared a public health emergency and then have no data on wait times for treatment, to have so many communities without access to services, even scaling up things like access to OAT.... We just saw when the province came and asked Prime Minister Trudeau to roll back on his decriminalization parameters—

Mrs. Laila Goodridge: I was proud they finally decided to copy something Alberta was doing and rolled out the virtual opioid dependency program.

Ms. Elenore Sturko: Yes, but why would it take that long?

Here we were eight years into an emergency, and only at the 11th hour of a failed experiment were we introducing something that could have provided access to a variety of medications and treatments to people across the provinces, particularly in locations where they don't have bricks and mortar services. It's disturbing.

• (1230)

Mrs. Laila Goodridge: I often get messages from moms who are having a hard time because their children are addicted to drugs. Just today I got a message from a mom who wrote, “I'm so sorry it has been so long. I've been in survival mode fighting to save my daughter. Her 13-year-old friend just died yesterday here in rural British Columbia from overdose at the local hospital after the local hospital released her from an overdose on Friday. Please help us. I can't bear going through another child's funeral. These children deserve so much more than this ignorant system. Doctors should have held her under the Mental Health Act until she could have gone to detox. Another family ruined, many who loved her traumatized and more deaths to follow if something doesn't change.”

That message, as a mom and as someone who sits there....The fact that that beautiful 13-year-old child couldn't get into detox and was released after having an overdose at 13 speaks to how broken this system is.

Ms. Sturko, have you seen any increase in detox capacity in the last two and a half years or five years?

The Vice-Chair (Mr. Stephen Ellis): I'm sorry, Ms. Sturko, but please answer very briefly.

Ms. Elenore Sturko: The increase has not been notable—only incrementally marginal—and, in fact, when it comes to youth, we know that the only complex mental health and addictions treatment centre that was located in Vancouver is actually closing.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much.

Now we'll turn to Ms. Sidhu.

You have the floor for five minutes, please.

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

Thank you, witnesses, for your testimony.

Mr. Chair, before I proceed to my question to the witnesses, I have one matter I want to address. Hopefully it won't take much time.

Given the comments of Pierre Poilievre last week in which he suggested he would use the notwithstanding clause if given the chance, the petition tabled by Arnold Viersen on Tuesday to restrict abortion access in Canada and the anti-choice March for Life in front of Parliament Hill today, I feel it is relevant to move the following motion, of which I had given verbal notice on February 15.

Mrs. Laila Goodridge: I have a point of order.

The Vice-Chair (Mr. Stephen Ellis): Excuse me, Ms. Sidhu. There is a point of order.

Ms. Sonia Sidhu: Mr. Chair, it is my time.

The Vice-Chair (Mr. Stephen Ellis): There is a point of order, Ms. Sidhu.

Mrs. Goodridge, please present your point of order.

Mrs. Laila Goodridge: I was just curious where she was going with this, but she has made it clear that she is talking about the motion she had on notice.

The Vice-Chair (Mr. Stephen Ellis): Very good. Thank you.

Please continue, Ms. Sidhu.

Ms. Sonia Sidhu: I move:

> That the Standing Committee on Health affirm its support for reproductive and sexual health rights across Canada; recognize that the right to safe and legal reproductive and sexual care is the right to health care; condemn any effort to limit or remove sexual and reproductive rights from Canadians; and emphasize the importance of protecting and expanding access to reproductive and sexual health care, including abortions and contraceptives.

I hope this motion is in order, Mr. Chair, and I hope it is not going to take much time to discuss this before I proceed with my questions to the witnesses.

The Vice-Chair (Mr. Stephen Ellis): Very good. Colleagues and witnesses, this motion is in order, so now the debate will be on that motion.

Mrs. Goodridge, you have the floor.

Mrs. Laila Goodridge: Thank you, Chair.

Because that motion was sent out quite a while ago, could the clerk possibly resend it to the committee members? I know we have a few new members on the committee who aren't normal members, so it might be helpful to make sure everyone actually has that.

Also, could we adjourn debate?

The Vice-Chair (Mr. Stephen Ellis): Thank you very much.

Ms. Sidhu and colleagues, we all know that a motion to adjourn debate is not debatable, and therefore we shall have a vote right away.

Ms. Sonia Sidhu: Mr. Chair, can I ask when we could vote on that? I put this on notice—

The Vice-Chair (Mr. Stephen Ellis): I'm sorry, Ms. Sidhu. We're having a vote on the motion to adjourn debate.

(Motion negatived: nays 6; yeas 3)

The Vice-Chair (Mr. Stephen Ellis): Mrs. Goodridge, you have the floor.

● (1235)

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

I think it's incredibly troubling. We have some amazing witnesses here today who have been presenting some very powerful testimony. I know I have a series of further questions that I was hoping to get on the record. Unfortunately, the government is using this as an opportunity to play partisan politics when it comes to women's health. Frankly, I think it is unfortunate.

I appreciate the fact that members opposite do want to study women's health, and this is precisely why I brought forward my motion on breast cancer screening.

It was interesting. This morning, the Canadian Cancer Society actually changed its guidelines. It deviated from what the federal government and the health task force put forward when it comes to women's health. Its official recommendation is to lower breast cancer screening to 40 years old from 50. It shows how behind the times this government is when it comes to women's health and how lacking the task force has been on health screening here in Canada. The fact that the Canadian Cancer Society had to come out and change its recommendation ahead of what the government has done because they've been sitting on their hands doing nothing, allowing more women to unnecessarily suffer with breast cancer.....

I say this because, as members of this committee know, this is something that is deeply troubling to me. I lost my mom to breast cancer. I was 21; she was 49. It is something that, as my kids get older, as I get older, I think about every single day. What would it mean if my children had to grow up without a mom like I had to grow up without a mom? My brothers had to grow up without a mom.

Every single day, I talk to people from right across the country who tell me their stories and the impact that breast cancer has had when it comes to their lives.

I think it is very troubling that this government has not acted on this. I passed a motion back in April during Cancer Awareness Month. It should be prioritized for study in the health committee.

We've had a tradition in this committee of having these very broad studies and not actually getting to the crux of any one particular issue. When it comes to having these broad studies, one of the biggest challenges is that we can't actually find these solutions.

I wasn't trying to play any politics when I moved forward—

[*Translation*]

Mrs. Élisabeth Brière: Mr. Chair, on a point of order.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Madame Brière, go ahead.

[*Translation*]

Mrs. Élisabeth Brière: What does this speech have to do with the motion that my colleague just moved?

● (1240)

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Madame Brière.

I think all members of committees know that we allow a lot of latitude for people who wish to speak in committee. I understand that you've not been at our committee previously, but in the spirit of Mr. Casey—who, unfortunately, is not here—we allow members significant latitude. Certainly, those committee members who have been here previously would recognize that. I realize that I don't sit in this chair all the time, but I will continue to operate in the same spirit that Mr. Casey has for the last two and a half years.

With that, I will return the floor to you, Mrs. Goodridge.

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

I think it is actually extremely relevant to be talking about breast cancer screening, because the breasts are, in fact, a sexual organ, and they play a major role in women's health and women's health rights. This motion, which was deposited, is exactly in this space. I think this is part of the overall issue. We should be having conversations here in this committee about the tragic overdose crisis that is gripping our nation. The fact that, in nine years of this NDP-Liberal government, we've had more than 42,000 people—

Mr. Peter Julian: I have a point of order.

The Vice-Chair (Mr. Stephen Ellis): Go ahead, Mr. Julian.

Mr. Peter Julian: Thank you, Mr. Chair.

There is an issue of relevance. The motion is about reproductive and sexual health rights. This shouldn't even be something that is—

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Julian.

I think that I've already spoken about relevance.

Mr. Peter Julian: Mr. Chair, there is an issue of relevance.

The Vice-Chair (Mr. Stephen Ellis): Mr. Julian, please, while I'm speaking, if you could—

Mr. Peter Julian: I'm going to challenge you, Mr. Chair, on your ruling, if you do not allow members to speak. I challenge your decision.

The Vice-Chair (Mr. Stephen Ellis): Mr. Julian, please, if you continue to be—

[*Translation*]

Ms. Andréanne Larouche: Mr. Chair, on a point of order.

I apologize. I just want to say that—

The Vice-Chair (Mr. Stephen Ellis): Wait a minute, please, Ms. Larouche.

[*English*]

Colleagues, if we cannot maintain order, I will have no choice but to adjourn the meeting.

Mr. Julian, I will be very clear: I have already ruled that this is how this committee is operated. You too, sir, have not been here, so shame on you for attempting to do this.

Mr. Peter Julian: I challenge your ruling.

The Vice-Chair (Mr. Stephen Ellis): The meeting is adjourned.

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