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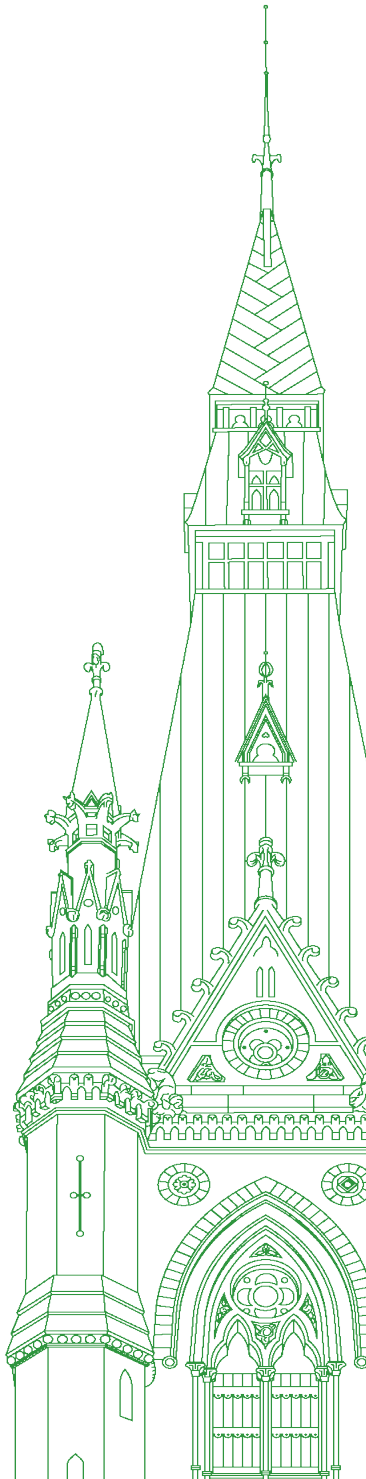

Chair: Mr. Sean Casey

Standing Committee on Health

Thursday, May 30, 2024

● (1105)

[*English*]

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

Welcome to meeting number 119 of the House of Commons Standing Committee on Health.

Before we begin, I'd like to ask all members and other in-person participants to consult the cards on the table for guidelines on how to prevent audio feedback incidents.

Please take note of the following preventative measures in place to protect the health and safety of all participants, including the interpreters. Use only a black, approved earpiece. The former grey earpieces must no longer be used. Keep your earpiece away from all microphones at all times. When you're not using your earpiece, place it face down on the sticker placed on the table for this purpose.

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. We still have two people online who have some connection problems, but we're going to proceed with the meeting in any event and hope that this can be resolved by the time they are called upon to speak. We have some challenges with Dr. Powlowski and Ms. Sidhu. As I said, hopefully we will be able to get this resolved so that they can fully participate.

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.

Before I welcome our panel of witnesses, I note that you are all participating by video conference. If you haven't already been briefed, simultaneous translation is available. At the bottom of your screen, you can choose floor, English or French to hear what's taking place in the language of your choice.

I'd like to welcome our panel of witnesses.

We have with us appearing as individuals Dr. Paxton Bach, clinical assistant professor, University of British Columbia; and Dr. Bonnie Henry, British Columbia provincial health officer. From Direction régionale de santé publique de Montréal are Dr. Mylène Drouin, regional public health director; and Dr. Carole Morissette, lead physician, harm reduction and overdose prevention. Representing the Oxford House Foundation is Earl Thiessen, executive director.

Thank you to all of our witnesses for being here.

We're going to proceed now with rounds of opening statements in the order listed on the notice of meeting. You will have five minutes.

Dr. Bach, welcome to the committee. You have the floor.

Dr. Paxton Bach (Clinical Assistant Professor, University of British Columbia, As an Individual): Thank you, and thanks for having me today. I really appreciate the opportunity to come before the committee today, and I want to thank everyone here for all the time and attention being spent on such a critical issue.

I'm speaking to you today from Vancouver, where I live and work. I work full time in the field of substance use and addiction. I work in a number of different capacities. I'm a physician. I'm an educator with our fellowship program. I'm a researcher. I hold some leadership positions. I'm more than happy to answer questions about any of these areas today for the committee. I can speak about our current activities here in treatment, harm reduction, research, education, etc.

However, what I'd like to lead with and speak about as a clinician working on the front lines of the crisis is the complexity and how the overdose crisis must be conceptualized as a wicked problem. That is, it is a problem composed of innumerable complex and evolving issues. It needs to be approached as such.

I work at St. Paul's Hospital, which is, unfortunately, one of the epicentres of the overdose crisis in North America. My colleagues and I are witness to the scale, complexity and ruthlessness of this problem and how it has evolved over the past number of years. We see people from all corners of the problem, all walks of life and all sectors of society, and we bear witness to the terrible damage being wrought by the current toxic drug supply. We see the uncertainty that touches everyone. We know how quickly it's evolving and how limited we are, and we adapt to this.

In practice, that means I watch harm reduction interventions save lives in real time. I also see people failing to access that and suffering the consequences, or I see them being asked to solve problems they cannot solve. I see our treatment system and help people navigate that treatment system. I see successful outcomes, and I see those who have been unsuccessful in accessing or navigating our treatment programs—who have not found what it is they're seeking from our current treatment systems. Probably most importantly, my colleagues and I are faced all too directly, on a daily basis, with the realities of inequity and how significantly our system as a whole is failing to address many of the root causes of substance use and some of the ultimate drivers of the current crisis.

I'm all too aware that all the prescription pads and treatment programs in the world are not a replacement for things like primary care, appropriate prevention, appropriate care for physical and mental pain, and fundamental needs such as shelter and community.

From those experiences and that reality, it's all too apparent to me and my colleagues—and I think anyone working on the front lines in this sphere—that there is no one approach and no one solution that will address all the highly specific, rapidly evolving needs of every one of these individuals and communities in context. It is not possible to frame our approach in such a simplistic way.

I'm sure I am not describing anything to this committee today that they haven't heard already or were not aware of. Really, the need to conceptualize our response to the overdose crisis as a continuum of resources and approaches that speaks to all of these needs concurrently and is adapted to the many different contexts and variations we're finding across such a geographically and culturally diverse country is inarguable and, I don't think, controversial.

In summary, for the committee—as I said, I'm more than happy to talk about any of our activities or research at length today—my testimony for you, and my plea on behalf of the 20 Canadians who will lose their lives to overdoses today in our country, is that we collectively acknowledge this crisis as a wicked problem, with the complexity and sophistication it deserves. It is a problem that is non-partisan and that touches us all.

It is an emergency and one of the defining problems of our time, but it is solvable. We have evidence-based solutions and expert opinions for each of these individual contributors, which we can be talking about and implementing if we all get on the same page about so many of these challenging issues. In order to do that, we really must envision our response as an ambitious, emergent, broad and comprehensive one, and recognize that it needs to be adapted and tailored to so many different settings, to so many different communities and to so many different populations.

In the absence of recognizing this complexity and talking about it with that level of sophistication, we're going to continue to spin our wheels. I'm worried the progress that is attainable will not be there.

● (1110)

The Chair: Thank you, Dr. Bach.

Next we have Dr. Henry for five minutes.

Welcome to the committee. You have the floor.

Dr. Bonnie Henry (British Columbia Provincial Health Officer, As an Individual): Thank you.

Good morning. I'm Dr. Bonnie Henry. I serve as the provincial health officer here in British Columbia.

I also want to acknowledge that I'm speaking to you today from the traditional unceded territories of the lək̓ʷəŋən-speaking people, the Esquimalt and Songhees first nations. I'm very grateful to be able to speak to you today.

I want to start by also remembering and recalling that these are our people, our communities, our brothers, uncles, children, colleagues and neighbours. Poignantly, I have heard from our first nations, Inuit and Métis leaders that too many young people in their communities are being lost to this crisis. Indigenous peoples, we know, are disproportionately affected due to the compounded ongoing effects of colonial racist practices and structures, including residential schools and intergenerational trauma.

We can't lose sight of this, that this trauma, this crisis, is affecting real people in our homes and in our communities. We can't lose sight of that as we debate and discuss in sometimes disconnected settings.

I want to talk a bit about what's reflected in the challenges we're facing right now in this “wicked problem”, as Dr. Bach just described.

We know that the number of deaths increased dramatically in 2020 due to compounded effects for myriad reasons: isolation and anxiety wrought by the pandemic; added stressors that we are facing now in our communities around inflation, food insecurity, visible homelessness and poverty; and major disruptions to the global drug trade that have led to the unrelenting changing toxicity of drugs on the street.

Really, I want to make the point that the proximal cause of this crisis is the increased potent and unpredictable drugs on the street. That is something that is very different from what we faced prior to this crisis. The potency of what is on the street right now is because fentanyl or synthetic opioids have replaced plant-based opioids like heroin—which were causes of problems in the past—because they are cheap and easy to produce.

We do ourselves a disservice when we call what's on the street “fentanyl”, because it is not. It is a hastily manufactured synthetic drug that has fentanyl-like properties but is produced in uncontrolled conditions and mixed with adulterants. Those adulterants are changing dramatically on an almost daily or weekly basis.

We know now that the average concentration in street “down”, or drugs on the street, has increased, and that more potent drugs mean that people are more likely to experience drug poisoning and to die, even if they've tried something for only the first time.

It's also very unpredictable right now. It changes. There are no labels and no quality control, and current adulterants are making these drugs much more toxic: things like benzodiazepine-like substances; xylazine, which is another sedative that's used as a tranquilizer, as we know; and non-fentanyl synthetic opioids, like nitazenes, which are increasingly being found in the drugs.

We also know that stimulants that have been used are now contaminated much more commonly than they had been in the past, and we're seeing that non-fentanyl synthetic opioids are.... Sometimes it's from intentional contamination, and sometimes it's because of a mix-ups where these drugs are being produced. Things like cocaine and MDMA are actually now much more commonly contaminated with these synthetic opioids that are manufactured in uncontrolled conditions. That is the proximal cause of why people are dying right now.

I also want to focus my short remarks on some of the concerns we have seen with what has become a very polarized and, sadly, political process.

First, I think it's very important to recognize that harm reduction and recovery and treatment are not in competition. It is not either-or. They are both essential and necessary parts of a continuum from prevention and from understanding what's on the street to harm reduction, to treatment and to recovery, and it includes everything from naloxone and access to drug checking to overdose prevention services and prescription medications for people to get them away from the toxic street drugs, with alternatives and medical assisted treatment, or OAT, as we know.

I want to refer the committee to the report I released in February of this year reviewing our prescribed alternatives or safer supply program here in B.C. It has been submitted to the clerk, but not in time to be translated. It is also publicly available. There's a lot of nuance in there that I think is important for us to understand some of the problems we are faced with.

● (1115)

Also in there is an ethical review of what we're faced with right now and why these programs are so important.

I also want to acknowledge that recovery is a spectrum. I accept that many in the recovery community and many clinicians equate recovery to abstinence. Many recovery homes won't accept, for example, people who are even on medically assisted therapy.

I believe this is a false dichotomy as well. We talk to people who have used drugs. The term “recovery” is not a medical term. It's not about abstinence; it's a process. It's a process through which people improve their health.

The Chair: Dr. Henry, it pains me to do this, but I would ask you to wrap up. You'll have lots of opportunity to elaborate on your opening remarks in response to questions.

Could you bring it to a conclusion, please?

Dr. Bonnie Henry: I will conclude then by saying that this is real people. This crisis continues to ravage our communities, taking the lives of our young people. We need to work together on this. I believe we all have the same goal, which is vibrant, thriving and safe communities.

I'm committed and my colleagues are committed to working together to find these solutions, and not giving in to the discourse that we have seen. The very lives of our families, our friends, our neighbours and our children depend on it.

The Chair: Thank you.

[*Translation*]

We will now go to the representatives of the Direction régionale de santé publique de Montréal.

Ladies, you have the floor for five minutes. You may split up your time as you see fit.

Dr. Mylène Drouin (Regional Public Health Director, Direction régionale de santé publique de Montréal): Good morning, everyone.

Thank you very much to the members of the committee, particularly MP Luc Thériault from the Bloc Québécois, for inviting me to participate in this meeting.

It's no secret that Canada as a whole is facing an unprecedented toxic drug crisis. That's why leadership by all orders of government is needed to coordinate an effective response at all levels.

Since this crisis is affecting Canada's major cities in particular, I've partnered with my fellow public health officers and public health physicians from Vancouver and Toronto to present a brief today with possible solutions. Some federal levers could admittedly help us, in our provinces and especially in our cities, to deal with this crisis. In my presentation, I chose to focus on the Montreal region, where I live and work.

As we know, since the pandemic, supply networks have changed significantly in Montreal, which was not exactly in the same situation before that. To give you an order of magnitude, currently there are 86 emergency response actions per month at our supervised consumption sites. That's six times more than we had in 2020. We've more than doubled naloxone distribution in three years. We're also seeing a monthly increase in deaths, which is in no way comparable to the number in western Canada, but we still have 17 deaths per month, compared to 12 three years ago and four in 2010.

It's a very concerning trend. I don't think we should hide the fact that there's a crisis underlying this situation. I'm talking about the housing crisis, which adds to the toxic drug crisis and in turn generates a homelessness crisis. The combination of these crises creates a dangerous cocktail in our neighbourhoods.

As the previous witnesses said, we're seeing a phenomenon that's not exclusively related to an overdose crisis. It's also related to a contaminated drug crisis, that is to say, drugs modified when they are being procured. This is not because people are miscalculating the amount to be consumed or because there are more users. It stems from the fact that drugs contain toxic substances, such as fentanyl, nitazene-derived substances or benzodiazepines not currently in commerce.

This obviously affects vulnerable populations, but I think we have to keep in mind that it also affects all sectors of society. Three-quarters of those who die from overdoses die at home, not on the street. People who die in this way account for half the deaths in Montreal. In addition, there are a lot of casual users. This phenomenon is therefore very broad, and it doesn't only affect marginalized populations, even if more of them die from overdoses.

In Montreal, we've been responding to this problem for decades by working hand in hand with the community sector, the health care sector, the police or public safety and the municipal sector to come up with a continuum of responses from monitoring to prevention and harm reduction, all the way to treatment. As was said earlier, treatment can't be the only option. Obviously, it's this continuum of services and this ability to prevent and stay on top of changes in the modes of use on the ground and the types of drugs that allow us to quickly adapt our action plans and strategies with our partners.

In addition, treatment must be paired with major harm reduction strategies. As we know, we'll never be able to treat all users, because there are a lot of barriers to access and delays. That's why we have people who are not in treatment. Obviously, substance abuse can be seen as a chronic disease. There are periods of relapse, and when someone relapses, they are at an even greater risk of overdose.

Finally, we know that even in pharmacological treatments there are some drugs for which we have few therapeutic options. So we need more research and development to continue to move forward and enhance our capacity to treat.

In terms of the harm reduction arsenal, the evidence is very clear that harm reduction reduces overdoses and the risk of infection. In Montreal, over the past few decades, we've seen the prevalence of HIV and hepatitis C drop among drug users as a result of our strategies.

In addition, our harm reduction services reduce consumption as well as the presence of contaminated equipment on the streets. We have supervised consumption services, and we will need to add consumption by inhalation, because it's become a much more frequent practice in recent years.

● (1120)

We need to expand the distribution of naloxone and injection equipment. We must also expand all drug testing or analysis services. This helps people determine the risk of using a drug and helps us assess the drugs available in the area.

Mobile testing sites are also needed at festivals. We know that young occasional users can be exposed to lethal drugs at festivals.

As I said, we need to bear in mind that only a minority of users currently have access to treatment. We need to look at the possibility of expanding this access.

● (1125)

The Chair: Dr. Drouin, please wrap up your presentation. You have gone over your time. You'll have the chance to say more during the question period.

Dr. Mylène Drouin: That's fine.

We submitted some recommendations to the committee. In particular, we want more flexibility and easier access to exemptions. We also want to break down administrative barriers.

Of course, as I said earlier, we recommend increased funding for research in certain areas of treatment and also for the development of new pharmaceutical solutions and harm reduction strategies.

The overall message is that we need a proportionate response to the current crisis. We can't afford to become divided. We must do the opposite. We're losing lives in our community right now. We must stand together.

This crisis requires a number of sectors of society to work together. This includes the health care system, of course. Scientific evidence helps us identify the solutions that will have the greatest impact. We can't afford to fail in this crisis.

The Chair: Thank you, Dr. Drouin.

[*English*]

Finally, we will hear from the Oxford House Foundation, represented by their executive director, Earl Thiessen.

Mr. Thiessen, welcome to the committee. You have the floor.

Mr. Earl Thiessen (Executive Director, Oxford House Foundation): Thank you, and thank you, all, for the previous comments. It's an honour to be here.

I bring a different perspective, the lived experience. I am an indigenous man in long-term recovery for 16 years. I'm the creator of pre-treatment housing and peer and culturally supportive indigenous recovery homes. We have long-term, peer-supported transitional homes with no end date.

I'm here to provide my lived experience, along with professionals, with battling homelessness and addiction, which for many of us, including me, means healing. I'm here to provide my thoughts on solving the addiction crisis.

My unresolved childhood trauma eventually led me to the streets, to being homeless for seven years and to my unwillingness to face my demons and my use of alcohol and drugs, including pharmaceutical opioids. This was an emotional response to my childhood trauma, which was so powerful. The shame of being sexually abused is so intense that many men and women lose their lives to addiction or suicide, refusing to speak about it.

We gain knowledge when teaching through words and actions. We heal the same way. The first time I talked about my sexual abuse was while in treatment and doing my steps with a female elder. I cried for two and a half hours telling her about my childhood trauma. I walked out of her room a different man. I had held that childhood trauma for 25 years, and that's what kept feeding my addiction. That kept bringing me back to the same vicious cycle that progressed into what we're dealing with today.

After starting my recovery journey and healing from my childhood trauma, I reconnected with my heritage. It played and plays still a significant part in my healing journey.

I'm going give you a brief, lived experience. I want to tell you a story about a young boy who suffered numerous challenges and trauma in his life, a young boy who grew into a youth who was taught not to show his true emotions, a boy who grew into a young man who had endured so much trauma that he thought he was alone and chose to live a lot of his life just like that—alone.

This young man was a victim of sexual abuse, physical abuse and mental and emotional trauma as well as spiritual trauma. This coping mechanism took the next 20 years of his life. It took his family away. His friends did not want to be around him due to his alcoholism and deceptive tendencies. Eventually, he burned all his bridges and hurt his family so much that everyone gave up on him. He ended up being dropped off at a homeless shelter because nobody could trust him.

This terrified man-child had finally found a place where he was accepted without judgment, without prejudice, and he thought that this was where he belonged, with no self-esteem and no self-worth. This man accepted that this was his destiny.

Living seven years as a homeless, alcoholic addict was what his unresolved trauma led him to, a life with no meaning or purpose, no aspirations or goals, and no love for himself or others. After one of the largest losses in his life at the time, his partner of two and a half years being murdered, he reached a point where he had lost all he was willing to lose due to his addiction and unresolved trauma.

On November 13, 2007, he was arrested for being drunk and disorderly in downtown Calgary. The arresting officers brutally beat him in the back alley. His foot was broken, his eye was swollen shut, and he suffered numerous bruises all over his body. They found that he had 11 warrants for his arrest, so he went to the drunk tank to face the justice of the peace. He had an opportunity to speak with the justice of the peace that morning. He was honest for the first time in his addicted days. He explained that he wanted help, help to deal with his trauma and his addiction issues and help to deal with the murder of his partner.

The justice of the peace asked her name. He responded, Jackie Crazybull. The justice of the peace stated that he had heard about the murder and offered his condolences. He then proceeded to speak with the devastated and defeated man. He said, “I'm going to release you on your own recognizance. I want you to go get the help you so desperately want, and I want you to clean up all these criminal charges.”

That morning, upon his release, this man limped up to medical detox to start his journey towards healing. After almost a full year of treatment and reconnecting to self, culture and community, he made small goals that turned into huge accomplishments. Today, that little boy who suffered all that trauma, that young man who turned to drugs and alcohol as a coping mechanism, that young man who ended up homeless for seven years, turned his life around and is now the executive director of the very same organization that helped save his life.

My name is Earl Thiessen, and I am a wounded healer.

● (1130)

Now I'll move on to the professional part.

As an indigenous leader in Alberta, when it comes to recovery, recovery housing and supporting the continuum of care, I see firsthand the damages of opioid use. In fact, I'm raising my sister-in-law's daughter due to her mom's passing from an overdose.

In my opinion, the way decriminalization and safe supply are being presented is not the path forward. They're making problems worse. They're prolonging trauma and keeping people in a perpetual state of drug use. In my opinion, safe supply is akin to pharmaceutical colonization.

There are other methods, but for the people I serve, the path forward is a recovery-focused path. The biggest thing I can see is that we need more medical detox. Withdrawals are horrible. I experienced them, hit the ground, chewed through my tongue, had two grand mal seizures, then treatment and then recovery. To accomplish long-term recovery, people need all of these, starting with detox and treatment. That's where the pre-treatment housing model came into play due to the wait-list. They need peer support, employment and recovery-focused housing.

There is only one sure way to 100% avoid overdose, and that is not to use. That being said, I fully understand there is a process to go through to get to this point. Saying that one must understand.... Want and need are light years apart. Every person who has an addiction needs to seek help, but it's those who want to seek help who actually can and will recover.

For those who do not want to recover, we need to provide positive reinforcement and show them, through lived experience, success stories that recovery is possible and that they can find recovery. We pray for them. This is all I could do for my sister-in-law. She lost her life.

Many people and organizations focus on the biopsychosocial aspect of trauma and recovery—

The Chair: Mr. Thiessen, I'm very sorry. This is powerful testimony. You had five minutes and we're now into the eighth minute. As much as it pains me to ask you, could you please wrap it up? There will be lots of opportunity to respond to questions and elaborate on your story.

Mr. Earl Thiessen: It's no problem.

We need to extend that focus further into biopsychosocial, spiritual and cultural aspects of recovery. We need to look at and evaluate all aspects of recovery and have like-minded individuals living in the same environment.

In closing, I would like to read Truth and Reconciliation Commission call to action 21:

> We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

Thank you.

● (1135)

The Chair: Thank you, all.

We're going to begin with rounds of questions, starting with the Conservatives.

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

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Wow. Thank you, Earl, for sharing your truth with us. Thank you for putting a face to trauma and a face to recovery and the power of recovery. I was having to wipe away my tears, so thank you.

In your statement, you said something that really struck me. You said that, in your opinion, “safe supply is akin to pharmaceutical colonization.” Could you elaborate on that?

Mr. Earl Thiessen: Yes. This is my opinion. My people have experienced colonization before, and this, to me, is exploitation of a vulnerable population. It's not getting better.

There needs to be a path forward to healing. Of the 95% of people who are using, it's due to childhood trauma. To me and to the people I serve, this isn't the proper approach. It's corralling people. I don't think that's the way our country should be operating. We did that once, and it's a black eye on our country.

Mrs. Laila Goodridge: Yesterday, the Minister of Mental Health and Addiction said she thought that decriminalization was a success in British Columbia. Do you agree with her?

Mr. Earl Thiessen: No. On the approach out there, decriminalization wasn't that approach. Decriminalization for me is to give the person the option to either seek treatment or to accept a charge for the illegal activity that's taking place. The Portuguese model is being altered, I guess you could say. In my opinion, it's just not the way to go.

[*Translation*]

Mrs. Laila Goodridge: Thank you.

Dr. Drouin, recent news reports about the Maison Benoît Labre described how young parents and their children needed to get around drug users in front of the entrance to the organization.

The residents of the neighbourhood are worried. What do you have to say to them? Do you think that this situation is acceptable?

Dr. Mylène Drouin: The parents are indeed worried.

We're part of the good neighbours committee, which is looking for solutions. As I said earlier, the Maison Benoît Labre is primarily a shelter and day centre for homeless people.

The organization has added two rooms for supervised inhalation and consumption, which serve a minority of users. About ten users a day access the room, while hundreds of people visit the centre each day.

The homelessness issue is multi-faceted. One matter that certainly warrants consideration concerns the mitigation measures needed for the locations chosen for these centres. We must look at how to ensure that young people and the school receive the support needed to reduce these harms or, at least, overcome the challenges of cohabitation.

Mrs. Laila Goodridge: Thank you.

Do you think that supervised injection and inhalation sites should be located right next to a school?

Dr. Mylène Drouin: There aren't any standards or regulations in this area.

Let me draw a parallel with the legalization of cannabis. When discussing this issue, we often wondered where the sale sites should be located.

If a supervised injection centre must be located about 200 or 500 metres away from day cares or schools, an issue arises. Day care centres and schools are all over Montreal. Supervised consumption sites would end up in fields or along rail lines, for example. However, to reach the clients and make a harm reduction strategy work, the sites must be in the right places.

That said, I completely agree with the need to think ahead when deciding to open this type of site. It isn't just about day cares and schools. It's also about the neighbourhood.

We must think about how to implement mitigation measures to ensure that the cohabitation goes smoothly. We must also think about having a number of sites to avoid crowding.

There currently aren't enough resources to accommodate the number of people who need homelessness services. As a result, these people congregate in the same places.

● (1140)

Mrs. Laila Goodridge: Would you like to see hard drugs legalized, as was done in British Columbia?

Dr. Mylène Drouin: Of course, we know the challenges posed by stigmatizing groups of people and using the courts to solve problems. We also understand the potential impact on people who want to find housing or employment and reintegrate into society.

In Montreal, we're working on this issue. However, at this time, we find that the conditions aren't right in terms of services to call for decriminalization rather than legalization. I think that we must pay attention to the terms that we use.

Mrs. Laila Goodridge: Do you plan to support decriminalization in Montreal, as was done in British Columbia? Yes or no?

Dr. Mylène Drouin: I have already spoken about this topic. The decriminalization of groups of people plays a role in the continuum of services. However, we need the right conditions for implementation. Obviously, we'll be waiting to see the outcome of the work done in British Columbia. At this time, we find that the conditions aren't right in Quebec and Montreal.

Mrs. Laila Goodridge: Do you think that it's working in British Columbia?

The Chair: Ms. Goodridge, your time is up.

Thank you, Dr. Drouin and Ms. Goodridge.

[*English*]

We're going to see if Dr. Powlowski's sound is good enough to ask some questions, and if not, we'll go to Ms. Brière.

Dr. Powlowski, you have the floor if everything's working.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Let's give it a shot.

Dr. Henry, in your report entitled, "A Review of Prescribed Safer Supply Programs Across British Columbia", on page 27 of the report, you actually admit that diversion is taking place. It says there that it was "reported by PSS program staff and clients as a common occurrence".

Is my sound okay?

The Chair: The jury's out. Keep going.

Mr. Marcus Powlowski: Okay.

You say in the same report that there is limited data on youth, but it doesn't appear that there's any increased opioid use [*Technical difficulty—Editor*].

[*Translation*]

Mr. Sébastien Lemire (Abitibi—Témiscamingue, BQ): Mr. Chair, I have a point of order.

The interpreters can no longer do their job.

[*English*]

The Chair: Dr. Powlowski, it was a valiant effort.

Madame Brière, you have the floor.

[*Translation*]

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Good morning.

I want to thank all the witnesses for their remarks. Some of them were quite moving at times.

The committee members have just returned from a trip to Vancouver, Calgary, Red Deer and Montreal. We had the opportunity to meet with some of you. I would like to thank you for hosting us. You spoke about your realities and all your great initiatives to help fight the overdose and toxic drug crisis.

Dr. Drouin, I want to continue the discussion started on clearly established scientific evidence. You were speaking about the range of measures needed, an action plan and a strategy to help fight this crisis.

Can you elaborate on this?

Dr. Mylène Drouin: I think that Quebec's strategy for preventing overdoses provides a good overview of the evidence and the required components. Obviously, the whole monitoring system is important. We need to work with our partners to understand the situation on the ground. It's a key way to help us adjust our services.

I spoke earlier about harm reduction near consumption sites. We know that these sites have a major impact on overdoses and also on infectious risks. In Montreal, it's worth noting that our supervised consumption sites provide connections with preventive care, treatment and social reintegration services.

I didn't have time to talk about this earlier. If we want to take a broader look at the issue, we also need to address housing, employment and the reintegration of people who have substance abuse problems.

We must also consider the whole preventive aspect. I didn't have time to talk about this earlier either. One of the witnesses spoke about child development from the perspective of childhood trauma. We need to protect young people. We know all about the paths taken by certain young people who, given their background and childhood trauma, face the highest risk of drug abuse or homelessness. These issues often overlap. We must tackle the root causes, so to speak.

In our view, this continuum should be looked at as a whole. We can't focus on one component of the continuum more than another. Of course, this means that a group of partners must work together with the same vision and ambitious resources, because this is a major crisis.

● (1145)

[*English*]

Mrs. Élisabeth Brière: Dr. Bach, I'm happy to see you again.

I was very impressed by the road to recovery initiative at St. Paul's Hospital. You said in your remarks that there was not only one way for the drug user but that we have to suggest or propose a lot of options for them.

Could you speak a little bit more about that initiative and what your goal with it is? I think you would like to open it to all the provinces.

Dr. Paxton Bach: Thank you for the question. I'm more than happy to speak about the road to recovery initiative.

To the other part of your question speaking about options, as has been alluded to by all of the speakers, every individual has a different relationship with substances. There are different origins and different needs and those change over time. It's really important that we recognize that diversity and that every individual at any point in time is going to have different different needs and expectations. It's important that we make that easy to access.

The road to recovery initiative is a new, coordinated treatment program that we've launched at St. Paul's Hospital in Vancouver. It is focused on addiction treatment specifically, but really is about making treatment easy to access. It is challenging enough for somebody dealing with a substance use disorder and many of the other factors that come along with that to seek help and navigate the system. It is imperative that we, as those who are working in the system, make them as easy to access and navigate as possible.

Historically, at least in our province—and I think probably most places in North America—that has not been the case. It has not been easy to access or navigate these systems. They have often been quite siloed and challenging to work through.

The road to recovery system is about co-locating all of these various aspects of a treatment system under one roof, such that patients can flow through it seamlessly in a way that they can focus on themselves rather than the navigation. Whether that's accessing an outpatient clinic, a detox facility, short-term treatment or long-term housing and follow-up, it ensures that all these services work together in one cohesive way, so that individuals don't have to spend their time trying to piece those parts together.

The Chair: Thank you, Dr. Bach.

Thank you, Ms. Brière.

[*Translation*]

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

Mr. Sébastien Lemire: Thank you for your welcome, Mr. Chair.

Ms. Drouin, I want to start by thanking you for your commitment and your remarks. You asked us to look at the big picture and take comprehensive action, particularly with regard to the health determinants.

Can you elaborate on this?

Dr. Mylène Drouin: Given the overdose crisis, this means taking proactive preventive action. We need to work on risk factors faced by young people, protective measures starting in childhood and socio-economic conditions. These are known as the structural determinants of health.

There's also the whole issue of trauma in indigenous communities. The more we work proactively, the more we can build a society that protects our children and young people.

However, in the case of the overdose crisis, we must work a bit less on health determinants and a bit more on harm reduction, up to and including treatment. We must try to reduce the negative impact of drug use on individuals. This means implementing a range of services to reduce deaths and overdoses. We must bear in mind that, even though overdoses fortunately don't always kill people, they do lead to complications. We must also take into account treatment and everything that affects people's skills.

This means implementing a continuum of services. In terms of the health determinants that require proactive steps, we must opt for a preventive approach to help us identify the risk factors and protective factors surrounding consumption and harm reduction.

● (1150)

Mr. Sébastien Lemire: You just touched on the issue of harm reduction. I would like us to explore it further.

Can you explain how harm reduction fits in with a treatment approach that supports innovative treatment and rehabilitation measures?

Dr. Mylène Drouin: Obviously, treatment can't be the only solution. People have a wide range of needs and different substance use journeys. They may face delays or barriers in accessing services, or they may not be ready. Meanwhile, harm reduction strategies are needed to protect them; provide a safe environment; and reduce the risk of death, infection or various complications.

Addiction should be likened to a chronic disease. It sometimes takes several attempts at rehabilitation and treatment, as well as several relapses, before a person can recover. During these relapses, harm reduction strategies are needed.

Moreover, in terms of treatment, no substance or pharmacological option can replace all the drugs currently on the market.

Under these conditions, it can be much harder for some people to access treatment or stop using. They have few alternatives, so we need to protect them.

One public health mandate is to protect the health of the entire population. As a result, these people must also be protected. We can't expect all drug users to seek treatment at the same time.

Mr. Sébastien Lemire: In Montreal, your approach integrates the various levels of intervention. These include the regional public health department; the Centre hospitalier de l'Université de Montréal, or CHUM; frontline care facilities; and resources on the ground. The result is greater synergy among workers and better results.

In your opinion, how would this crisis unfold without the pillar of harm reduction and the integration of different services, which you're advocating for in Montreal?

Dr. Mylène Drouin: Integration is key. It's what makes our work possible.

I could give the floor to Dr. Morissette. She developed the strategy in Montreal over decades. This strategy helps us and all the partners monitor and understand the situation, so that we can develop and adapt our services.

Above all, we must be able to set up new services, such as the services currently available for substance inhalation. If research provides new evidence, facilities such as CHUM must be able to address it. We can't be caught off guard by new trends.

Dr. Morissette, do you have anything to add?

Dr. Carole Morissette (Lead Physician, Harm Reduction and Overdose Prevention, Direction régionale de santé publique de Montréal): I think that, without harm reduction and the implementation of our supervised consumption services, we would likely have seen many more deaths than we're seeing now. We know that it prevents deaths.

To address the severity of the current crisis, we must implement more services. Harm reduction services must be considered a solution rather than a problem. This means increasing and diversifying the services.

We also need to provide access to housing. I'll come back to the dual crisis of overdoses and homelessness. For a person on their journey, having a place to live is one factor that may lead them to take the first step towards reducing or even stopping drug use.

Again, harm reduction and treatment aren't mutually exclusive. They're part of a continuum. All these strategies are needed to achieve success.

● (1155)

Mr. Sébastien Lemire: Thank you so much.

The Chair: Thank you, Dr. Drouin and Dr. Morissette.

Thank you, Mr. Lemire.

[*English*]

Next, we have Mr. Johns for six minutes, please.

Mr. Gord Johns (Courtenay—Alberni, NDP): First, I want to thank all of the witnesses for their important testimony and the important work that they all do.

We heard from the chief coroner of British Columbia. Dr. Bonnie Henry, you're also the chief medical officer of British Columbia.

The B.C. chiefs of police and the Canadian Association of Chiefs of Police, the First Nations Health Authority in British Columbia, the B.C. First Nations Justice Council, as well as the Health Canada expert task force are all saying that this is a complex issue that requires a comprehensive response. Every single organization and individual I listed were clear that we need to replace the toxic street supply with a safer supply of substances, stop criminalizing people who use substances and create a system with treatment on demand, investing heavily in recovery, prevention and education.

Dr. Henry, we just had the decriminalization model in British Columbia come into effect in January 2023. In the month prior, the death rate per 100,000 per day was 7.5. In the last two months, the death rate dropped to 6.1 and 6.2.

Do you believe that the decriminalization trial in British Columbia is working and has been working?

Dr. Bonnie Henry: Thank you for that question.

You're absolutely right that we need to focus on what this is. It's one of a suite that we have heard is necessary. The decriminalization of people—that's the important thing—is about removing criminal penalties for possession of small amounts of controlled substances. It is not legalization, and it is not a free pass to violent or threatening behaviour. It is not the full solution. It's one important tool to help, for a couple of reasons.

One reason is that we see the people who are visible to police, and that is what a lot of the focus is on. It's uncomfortable for us to see homeless people on the street who don't have a safe place to go to use their drugs or to connect with people. It also is important for those who are not visible, who are also dying, and we've heard that this morning. It could be young people, who may be experimenting or are occasional users. It could be the young man who's working in the trades, whose family I hear from all the time and who didn't know that he was using drugs again or had relapsed, because of the shame, stigma and fear of a criminal record. This keeps people from talking about their drug use and reaching out for help.

In that sense, yes, the decriminalization of people here in British Columbia has levelled the playing field across the province so that it's not discretionary about who gets their drugs seized or who gets a criminal record. We've seen that in the statistics on drug seizures and on charges for people who use drugs.

Mr. Gord Johns: Dr. Henry, you've been the chief medical health officer since 2014. In 2014, there was a death rate of 7.9 per 100,000. It skyrocketed to 30.3 in 2017, in just over four years, under the Christy Clark government. Since then, it has gone up as high as 46.2 and is now at 40.3, a 33% increase versus a 383% increase under the Clark government.

When you hear politicians throw out anecdotes and blame safe supply or decriminalization as the causation of the spike in the toxic drug crisis, can you explain the harm that might cause?

I will cite Alaska's death rate, which went up 45% last year without decriminalization and without safe supply. Alberta's went up 17% and Saskatchewan's went up 23%. Baltimore has a death rate of 190 per 100,000 versus 40 in B.C., without decriminalization and safe supply.

Can you talk about the importance of peer-reviewed research instead of anecdotal policy?

Dr. Bonnie Henry: Thank you for bringing that up.

I think it is important to recognize that many of the issues we're dealing with—and we've talked about that—are related to underlying concerns and issues people have. We know that when homelessness goes up and when poverty goes up, along with income insecurity and inflation, all of these things drive the anxiety and mental health issues that lead people to increased substance use.

It is important for us to look at data and what it is that supports people across the spectrum of people who use drugs. It is important for us to not focus on one particular thing and try to make political points, because it is harming those who we all, I believe, want to include in our community and help find their way to their road to recovery.

● (1200)

Mr. Gord Johns: Dr. Bach, you worked really hard on an evidence-based and expert-led project there at road to recovery.

Can you talk about the harm disinformation causes to you and your team and to the work you're doing on the front line?

Dr. Paxton Bach: Absolutely. I work with tremendous colleagues in my institution and all across Canada. There are really good people who see viable solutions and are working towards them.

As I mentioned in my remarks, seeing many of these complex issues oversimplified and, to be frank, often made to be such political issues is really challenging for those who are working on the ground and alongside one another, despite many differing opinions, and who are seeing that complexity and that need for different responses in different contexts. To see this turned into something that has become a political issue is very challenging. It's very distracting. It's very demoralizing. I think it really prevents us from talking with the level of sophistication that these topics deserve.

The Chair: Thank you, Dr. Bach.

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

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

Thank you to all the witnesses for being here.

It's interesting, Dr. Henry. One of our colleagues perhaps started asking you this question.

Dr. Henry, you've said multiple times in the media that diversion is happening. Is that true?

Dr. Bonnie Henry: We have to recognize that this is a symptom of unmet needs. We know that there are many different types of people sharing their drugs with others who don't have access to systems. We have heard that this has happened. It happened before we had our prescribed supply program and it continues to happen.

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

Diversion is happening. We know that.

Could you remind the panel what the leading cause of death in children 10 to 18 in British Columbia is?

Dr. Bonnie Henry: It's the toxic drugs that are on the street right now.

Mr. Stephen Ellis: It's overdose, is it not, Dr. Henry?

Dr. Bonnie Henry: It's the toxic drugs that are on the street right now.

Mr. Stephen Ellis: You can tell this panel equivocally that no so-called safe supply is part of the overdose deaths in 10- to 18-year-olds in your province. Is that correct?

Dr. Bonnie Henry: You will have known that the chief coroner just put out a report on that this week. While hydromorphone, which comes from a variety of different sources, was there in a small percentage of young people who died, it was not the sole substance found and was not the cause of death. The cause and the challenge right now—

Mr. Stephen Ellis: Thanks for that, Dr. Henry.

Dr. Bonnie Henry: —are the toxic drugs, obviously.

Mr. Stephen Ellis: Excuse me, Dr. Henry.

What we do know is that hydromorphone has been found in 10- to 18-year-olds who have died in your province due to overdose. That's disturbing to me.

Dr. Bonnie Henry: Hydromorphone has not been found by itself in any of—

Mr. Stephen Ellis: I don't think that I asked you a question, Dr. Henry.

Dr. Henry, excuse me. This is my time to ask you questions. Please, if you'd be respectful of that and answer the questions, that would be incredibly helpful.

When we talk about legalization, has the imported supply of heroin ever been allowed in Canada?

Dr. Bonnie Henry: I'm not sure what the question is. Are we talking about legalization?

Mr. Stephen Ellis: Well, we probably should be. I believe, in your statement, ma'am, you said, “What we're doing with legalization [around] cannabis”, etc. You also talked about “monitoring and safety of the product” and “So in the long term, would that be a way to counter the toxic street drugs and take that business away from organized crime? Absolutely.”

It would appear from that, ma'am, that you are a supporter of legalization. Is that true?

Dr. Bonnie Henry: I think what has gotten us into the situation we're in is prohibition. We've seen that in many different situations over time. We saw that with alcohol prohibition. We see this with cannabis. I think legalization and regulation minimizes harms.

Mr. Stephen Ellis: You would be a supporter of the legalization of hard drugs such as opium, heroin, cocaine and methamphetamine?

● (1205)

Dr. Bonnie Henry: I don't think the term “hard drugs” is a term that—

Mr. Stephen Ellis: I don't think that I asked you that, ma'am. What I asked you is this: Would you be a supporter of the legalization of hard drugs such as methamphetamine, cocaine, heroin and opium? Would you support that?

Dr. Bonnie Henry: I believe that legalization...and prohibition is the cause of the issue. Legalization and regulation minimize the harms of all drugs.

Mr. Stephen Ellis: Is that a yes or no, Dr. Henry? You're being very obtuse in your answer.

Dr. Bonnie Henry: I'm not being obtuse. I'm being truthful in what I believe, which is that prohibition is one of the causes that has led to—

Mr. Stephen Ellis: The question is, Dr. Henry, this: Would you support legalization?

Dr. Bonnie Henry: —the crisis that we're in.

Mr. Stephen Ellis: I'll ask you a third time.

Dr. Bonnie Henry: I support the legalization and regulation of drugs to minimize harms.

Mr. Stephen Ellis: Thank you.

Do you know of the business called Fair Price Pharma that exists in your province?

Dr. Bonnie Henry: I know of it.

Mr. Stephen Ellis: Do you know that Fair Price Pharma arranged for the importation of 15 kilograms of heroin into Canada?

Dr. Bonnie Henry: That would be under the Health Canada regulations.

Mr. Stephen Ellis: I didn't ask you about the regulations. I asked you if you knew that they imported 15 kilograms of heroin.

Dr. Bonnie Henry: No, I did not.

Mr. Stephen Ellis: Thank you.

Do you know a person named Perry Kendall?

Dr. Bonnie Henry: Of course I do. Perry Kendall was the provincial health officer in British Columbia.

Mr. Stephen Ellis: Have you ever met with Mr. Kendall?

Dr. Bonnie Henry: I meet with him regularly.

Mr. Stephen Ellis: Is it true that he is the founder of Fair Price Pharma?

Dr. Bonnie Henry: That's not correct.

Mr. Stephen Ellis: That is not correct. Okay—fair enough.

Does he have any relation with Fair Price Pharma?

Dr. Bonnie Henry: Not that I'm aware of right now.

Mr. Stephen Ellis: Has he had in the past?

Dr. Bonnie Henry: He has had in the past, I believe.

Mr. Stephen Ellis: He was an official in your government—not that you're the premier there—and now he runs a company that has imported heroin into Canada. Is that true?

Dr. Bonnie Henry: No, that's not correct.

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

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

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

Thank you to all of the witnesses for being here with us.

Before I start my questions, Mr. Thiessen, I want to recognize you for your bravery and strength. Thank you for sharing your story with the committee today.

Dr. Henry, my first question is for you.

You're known to most Canadians for your response to the pandemic in B.C. Could you talk to this committee about the impact this pandemic had on mental health, especially that of British Columbians?

Dr. Bonnie Henry: Thank you for that.

I think that is one of the challenges that we face that is most critical. I'm particularly concerned and have been for some time. The data has shown that the issues of mental health and anxiety in young people in particular have gone up dramatically throughout the period of the pandemic. While we have seen some recovery, there are still higher rates of anxiety and mental health issues for young people. We know that when those issues increase, many people turn to substance use to help support them in their world. We've seen an increase in substance use.

Substance use disorders in young people remain low, thankfully. We have not seen an increase in that over the past number of years. What we have seen is increased occasional use and challenges for people who have problems accessing mental health and substance use support.

Those are the issues that we really need to focus on right now. It's a broad spectrum of how to support young people to recover from the traumas that they've been through over these last few years.

Ms. Sonia Sidhu: From a public health perspective, do you think forced treatment is a good idea?

Dr. Bonnie Henry: Data has shown over the years that if you force treatment, or a treatment is done when people aren't ready, that can leave them more at risk when they have relapses or when they leave treatment. As well, doing that undermines the relationship of trust they may have, particularly with their health care providers.

We say all the time that the opposite of addiction is connection. Having a trusting relationship with their health care provider is what people tell me they crave, they want and they need to help them on their road to recovery.

Ms. Sonia Sidhu: My next question is for Dr. Bach or Mr. Thiessen. It's about stigma. What recommendation or examples of successful policies can you give to this committee to address stigma in British Columbia or across Canada?

● (1210)

Dr. Paxton Bach: I can speak to that more just in the sense of how much I see as a physician, as somebody working on the front lines, how stigma does impact the way we provide care for people who use substances and accordingly their willingness to access care. It is very rare that I see a patient who hasn't experienced stigma related to their substance use, whether it's from friends or family, in the workplace or in the health care system. We can't ignore how significant an impact that has on people's willingness to be forthcoming about their substance use, to seek help and to have trust in that help.

As far as specific policies that have been successful in addressing stigma go, that's something I'd have to give some thought to. I can't really speak to that, but I think that unfortunately it goes much deeper than any one specific policy. This is about a cultural shift in the way we think about substances and substance use disorders. This is a process and something that I think really must inform every discussion we have and every intervention we're talking about, because if we don't address that as one of those fundamental upstream drivers, we are going to continue to struggle.

Ms. Sonia Sidhu: Mr. Thiessen, do you want to add on to that?

Mr. Earl Thiessen: That's a very good question, and that is a huge driver right now in society in general.

To me, stigma and shame go hand in hand. It plays both sides. Right now there's a huge stigma towards recovery. When I was addicted, I had a lot of people stigmatize me and everything. The way I see it now and the way I speak to people who are on the cusp of entering recovery and everything is that looking at yourself through other people's opinions is really a rotten way to live your life. It should be based on your opinion about yourself, and I think there has to be a societal shift and change with respect to how every aspect of a recovery-oriented system of care is viewed. It shouldn't be stigmatized. It's hurting more than anything right now. Shame is a huge feeder of addiction, and those coincide with each other.

The Chair: Thank you, Mr. Thiessen.

[*Translation*]

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

Mr. Sébastien Lemire: Thank you, Mr. Chair.

Ms. Drouin, what regulatory barriers could the federal government remove to simplify the process; to ensure that health authorities and community agencies can apply for and receive exemptions; and to provide supervised consumption, overdose prevention and drug analysis services? Above all, why should these barriers be removed?

Dr. Mylène Drouin: I'll let Dr. Morissette, who manages all this paperwork, tell you about it.

Dr. Carole Morissette: We really want to point out that, as you know, to set up supervised injection or inhalation services, we must obtain an exemption from the Controlled Drugs and Substances Act.

In our situation, we need to increase and diversify the services. We want lighter administrative processes so that we can provide more services and, in particular, inhalation rooms.

This means less reporting. We know that it's a demanding process. All the partners work hard to meet the requirements of an exemption application. However, I think that making the process easier and reducing the time required to obtain exemptions would be a major step forward.

Mr. Sébastien Lemire: Street drug analysis is a key measure in the toxic drug crisis.

Can you tell us more about the effectiveness of this measure and how to make it even more effective?

Dr. Mylène Drouin: I can start answering your questions, and Dr. Morissette can chime in.

Drug analysis has a number of objectives. The first is to give users in different places the opportunity to find out about the risks involved and the content of the drug that they're about to take. These drug sample tests help us understand the drugs currently going around and adjust our harm reduction strategies accordingly. This concerns both our public health organization and our partners.

Obviously, we carry out these tests in supervised consumption centres. However, we're conducting the tests in an increasingly wide variety of places. We even go to major festivals—Montreal is known as a festival city—where young people, including our children, often have the opportunity to use drugs. These drugs can be contaminated and fatal. We also use the tests to prevent overdoses in these places, especially since the people are occasional users.

● (1215)

Mr. Sébastien Lemire: Thank you.

The Chair: Thank you, Dr. Drouin.

[*English*]

Next, we have Mr. Johns for two and a half minutes.

Mr. Gord Johns: Thank you.

I'm going to ask Dr. Bach to talk about the road to recovery model and care at St. Paul's. I know some of the committee members have been there. I've been there to meet with you and your team. I had a visit to better understand the work you're doing.

Can you talk about the status quo versus the alternative model you're delivering?

Also, can you talk about gaps and opportunities in the medical education landscape in Canada, and how addressing these may help build a workforce of physicians who can respond to this crisis with quality addiction care?

You have about two minutes. I'll give you the rest of my time in this round.

Dr. Paxton Bach: Certainly. Those are two excellent questions.

I already briefly discussed the road to recovery model at St. Paul's, and we were very happy to host some of the members there. Once again, we're talking about a coordinated model of care where, essentially....

There's already a question here about forced or coerced treatment. We have not traditionally done a particularly good job in Canada of making treatment easy to access, participate in and navigate—making it patient-centred, flexible and coordinated. Before starting more conversations about forcing people into treatment, I would suggest we start by trying to make it appealing and attractive while speaking to people's individual needs, goals and situations. Just make treatment easy.

Again, the road to recovery program is about coordinating a whole host of services under one umbrella so patients can enter at different points and move through it in ways that speak to their particular needs and trajectories, which are seldom linear, as we know. Then—

Mr. Gord Johns: Dr. Bach, I'm sorry to interrupt.

Do you think it's almost premature to even have a conversation about mandatory treatment, when people who want help can't even get it anywhere in Canada?

Dr. Paxton Bach: Yes. I would suggest that we need to be focusing on making treatment available and easy for those who are asking for it. That's the bare minimum in terms of where we can start.

Moving to your second question—which I think is a very critical one, and one we don't talk about enough—one of my roles is director of our fellowship program here, which I'm very privileged to sit in. We train 10 fellows per year, approximately, at St. Paul's. That's 10 addiction medicine experts per year. Unfortunately, about a third of the capacity for the entire country is coming out of our centre. We simply do not offer a lot of training opportunities for people who are seeking, in the medical field, to work in this space. Therefore, when we talk about increasing access to all these services, we really need to be mindful of our workforce and look at ways of incorporating opportunities for education for any number of different health professionals—making that education available.

In the current climate, anyone seeking further training or education in this space must be able to access it. That is, if somebody is actively wanting to do this work, the least we can do is try to facilitate that exposure or training—whatever level that might be—in order to build that workforce. I am—

The Chair: Thank you, Dr. Bach.

Next we have Mrs. Goodridge for five minutes.

Mrs. Laila Goodridge: Dr. Henry, I was wondering if you could tell us how many publicly funded treatment beds there are in British Columbia.

Dr. Bonnie Henry: I don't have that data, but I can get it to you.

Mrs. Laila Goodridge: The answer is 3,663.

Do you know how many people are prescribed safe supply in British Columbia?

Dr. Bonnie Henry: Last we checked, the prescribed alternatives program had about 4,000 individuals.

Mrs. Laila Goodridge: Do you think it's appropriate that there is easier access to drugs than to treatment?

Dr. Bonnie Henry: I don't think those are in competition with each other.

There are things that work together, as we've heard about. We need a suite of things.

People accessing pharmaceutical alternatives.... We know from the data—I refer again to the report I put out; we talked to a lot of people about this—that most of the prescribed alternatives are being used in combination with OAT. That is people being able to get into treatment.

● (1220)

Mrs. Laila Goodridge: What is the average wait time for someone to be able to get into detox in British Columbia?

Dr. Bonnie Henry: That would vary.

Maybe Dr. Bach would be able to give you more details around that.

It varies. One of the things that—

Mrs. Laila Goodridge: Dr. Bach, if you can answer, that would be great.

Dr. Paxton Bach: Certainly. It's going to vary tremendously, depending on needs.

Part of the road to recovery model has been streamlining that access. For people who are deemed high priority, it's 24 to 48 hours. It certainly can be longer for those who....

There's a prioritization process. For anyone who is high risk, like youth or people with a high risk of overdose, it's generally within 48 hours, at least in Vancouver Coastal Health.

Mrs. Laila Goodridge: According to the RCMP in British Columbia, nearly two-thirds of the detachment-served communities do not have drug rehabilitation or treatment programs available.

Do you think that's acceptable?

Dr. Henry.

Dr. Bonnie Henry: Of course it's not. We want access to treatment programs across the province. We've been working to scale up that access, as with programs that Dr. Bach mentioned, and for people to be able to access them anywhere in the province and have remote support, for example.

Mrs. Laila Goodridge: Do you think that decriminalization has been a success in British Columbia so far?

Dr. Bonnie Henry: I think parts of it certainly have. With any change in policy like this, there are always unintended issues that come up. We need to be pragmatic and address those.

Mrs. Laila Goodridge: Do you think that having a record number of overdose deaths in the first year of a pilot project, having a premier beg the federal government to eliminate public drug use because it's been such a failure, and having people have to climb over needles to get to children's playgrounds is a success?

Dr. Bonnie Henry: I'm not sure exactly what you're talking about.

I think we also have to recognize that long-standing personal, social and structural stigma that keeps people silent about their drug use and creates these barriers is not going to go away in a few months or even a year. This is one of a suite of measures that we need to take away some of those barriers that allow people to reach out and connect.

Mrs. Laila Goodridge: Thank you.

Were any studies done on the impacts of children seeing open drug use before the legalization project went into play in British Columbia?

Dr. Bonnie Henry: I'm not sure what you're referring to. We don't have a legalization project.

Mrs. Laila Goodridge: Were any studies of public drug use on children done prior to going into this dangerous pilot project experiment?

Dr. Bonnie Henry: I'm not sure what you're referring to, but one of the things that we do know is that there is a perception—

Mrs. Laila Goodridge: Kids are being exposed to people who have overdosed on the street. They're having to climb past needles on playgrounds. Parents are having to sweep the Abbotsford soccer pitch on a daily basis because it is exposed to drugs.

I'm asking if anything was done by the Government of British Columbia to look at the impact of that on the development of our children before embarking on this project. Is it yes or no?

Dr. Bonnie Henry: Let's think about this. There are perceptions and stories that we are hearing—

Mrs. Laila Goodridge: It is yes or no?

Dr. Bonnie Henry: We have not seen any data that there has been increased public drug use before and after decriminalization.

Mrs. Laila Goodridge: Do you have young children?

Dr. Bonnie Henry: I do not.

Mrs. Laila Goodridge: Parents are contacting me on a regular basis, telling me about how they have to sweep for needles and drug paraphernalia such as crack pipes before they let their children play on community playgrounds.

Do you think that's acceptable, yes or no?

Dr. Bonnie Henry: Of course it's not acceptable. We all have concerns about public perceptions and public use, but this has not changed because of decriminalization—

Mrs. Laila Goodridge: It has—

The Chair: Thank you, Dr. Henry.

Thank you, Mrs. Goodridge.

Next we'll have Dr. Hanley, please, for five minutes.

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

I'm picking up halfway, so I'm going to apologize if I repeat any past themes. It's really good to be here.

I'm going to concentrate my questions on you, Dr. Henry. It's really good to see you again.

Since we're on this theme of public consumption and decriminalization, I want to allow you a little more time to untangle what I see as somewhat of a confounding between the idea of decriminalization and public consumption.

I see public consumption every day in downtown Ottawa, for example, where there is no decriminalization as of yet. We know that it's an issue that affects all of our inner cities, and it had long been an issue in Vancouver's Downtown Eastside and elsewhere in B.C. before we came to this approach of trying to remove the stigma of criminalization from personal drug possession.

I'm going to allow you a minute to really expand on this at your leisure.

● (1225)

Dr. Bonnie Henry: Thank you.

I think that is the important thing. We have seen increased visible homelessness. We know that. We know from data that, across this country, as we've come out of the pandemic, we've had increases in people living in poverty and with food insecurity, and that has led to more visible homelessness. Some of those people are people who use drugs.

Yes, I think it's very real and very concerning that we've had increases in people recognizing and seeing people on the streets. That is hard for all of us, and that is something that underlies some of the challenges we're facing with increased challenges with drug use as well. We do need to address that.

To link it to one small policy change that is around removing criminal penalties for possession of small amounts of drugs is wrong, because we know that this was a problem prior to that coming into play. It is still an issue that we all need to deal with. We need to deal with the societal issues that underlie that, which are challenges with income insecurity and challenges with home insecurity and homelessness. Those are underlying issues that we need to work together on.

Mr. Brendan Hanley: Thanks, Dr. Henry.

I was one of your colleagues in the Yukon at CMOH, and I remember well when you declared a public health emergency in 2016.

Can you give me a bit of a big picture view of where we are now compared to where we were then, particularly if we're thinking about how we leverage further federal support and national coordinated support?

I'm going to allow you to give a bit of that big picture overview with a view to ongoing recommendations.

Dr. Bonnie Henry: When we declared the emergency—it was my predecessor who did that in 2016—it was really to raise awareness about this issue that was changing, and changing rapidly, and leading to people dying at an unprecedented level. It allowed us to pull together information. It allowed us to start working on harm reduction. If we think about it, at the time, naloxone was a medication that was only available under prescription so we have come a long way. We know that the naloxone program, the take-home naloxone program that started out here in British Columbia as a harm reduction measure, has saved thousands of lives.

We were making some progress in putting together more coordination, understanding that pathway to treatment for people with a substance use disorder, and raising awareness about the toxicity and the changing nature of the street drugs. When we hit the pandemic, sadly, a lot of the supports that we had put in place that were making a difference in 2019.... When we had the concerns about transmission of the virus, things got dramatically worse, but also during that period of time, the global drug trade changed dramatically.

The importation of small amounts of synthetic opioids really took over what we were seeing on the street, and that has remained at a very high level. We have also made some progress, though the levels are still very high—too high. We have more awareness now. We have systems in place. We have programs like Hope to Health.

We are now working, finally, I believe, in our health care system at trying to get more cross-provincial support for people who have to enter into the health care system, because we know the stigma and shame that people who use drugs experience in our health care system.

We have these things, but we have to put them all together. We have to work in a coordinated way.

● (1230)

The Chair: Thank you, Dr. Henry.

Dr. Ellis, please, you have five minutes.

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

Dr. Henry, Dr. Perry Kendall was B.C.'s public health officer before you, from 1999 to 2018. Is that true?

Dr. Bonnie Henry: He was the provincial health officer. That's correct.

Mr. Stephen Ellis: You seem to have some trouble with this, but the Vancouver Sun reported that in 2020, after retiring as the public health officer, he co-founded Fair Price Pharma. Is that true or is that not true?

Dr. Bonnie Henry: I believe he was involved with it. I don't know the exact nature. He was involved with it. He is no longer involved with it.

Mr. Stephen Ellis: Right.

I'm sorry. What did you just say?

Dr. Bonnie Henry: As far as I am aware, he is no longer involved.

Mr. Stephen Ellis: He was one of the co-founders of this company that imported 15 kilograms of heroin into Canada.

Dr. Bonnie Henry: You must remember that any importation of drugs into Canada is done under Health Canada.

Mr. Stephen Ellis: No, Dr. Henry, please. This is not your stage to grandstand. This is to answer some very pointed questions.

The question would be that he was the co-founder of a company that imported 15 kilograms of heroin into this country and the answer, of course, is yes.

Do you know a Dr. Mark Tyndall?

Dr. Bonnie Henry: I do know Mark Tyndall.

Mr. Stephen Ellis: Is it true that he's the former executive medical director of the British Columbia Centre for Disease Control—

Dr. Bonnie Henry: That's correct.

Mr. Stephen Ellis: —and former deputy provincial health officer under Dr. Kendall? Is that true?

Dr. Bonnie Henry: That's correct.

Mr. Stephen Ellis: He started a company called MySafe Society. Is that true?

Dr. Bonnie Henry: I don't remember the name of it. It could be.

Mr. Stephen Ellis: Okay. Let's say it this way then. He started a company to supply so-called safe supply hydromorphone from vending machines. Is that true?

Dr. Bonnie Henry: From biometric machines, I believe so, yes.

Mr. Stephen Ellis: Fair enough.

That company then received $1.3 million from Health Canada's SUAP funding. Is that true?

Dr. Bonnie Henry: I will take your word for it.

Mr. Stephen Ellis: Well, thank you for that.

Dr. Bonnie Henry: You're asking me for things that are not details that I'm aware of or that I know of.

Mr. Stephen Ellis: They are happening in your province, though, and you are the chief public health officer.

Dr. Bonnie Henry: I'm the provincial health officer.

Mr. Stephen Ellis: That company also received $3.5 million in funding.

Thank you for that.

That being said, are there other companies that you know of in Canada that have a dealer's licence to legally possess, produce, sell and distribute drugs such as opium, heroin, cocaine and methamphetamine?

Dr. Bonnie Henry: You would have to ask Health Canada that.

Mr. Stephen Ellis: Are you not aware of any of those companies?

Dr. Bonnie Henry: This is not an area of my expertise—

Mr. Stephen Ellis: I didn't ask you if you were an expert. I asked you if you were aware of any.

Dr. Bonnie Henry: I imagine there are. I don't know. Those are not areas that I focus on.

Mr. Stephen Ellis: Then what you would tell Canadians is that you have no idea that these companies exist, even though many of them are located in your province.

Dr. Bonnie Henry: I would say with all of the companies that, as part of my role as provincial health officer, I don't meet with industry, whether it's industry related to drugs or industry related to vaccines or any other thing. Those are not areas where I have knowledge, detailed knowledge, of companies.

Mr. Stephen Ellis: Thank you.

Dr. Henry, you recommended a non-medical model for safe supply. Do you have any examples of that, which you would have recommended to Canadians?

Dr. Bonnie Henry: We've been working on this, and I mentioned this—it's public knowledge—when I came out with my report in February. I think we need to look at all options around providing people with alternatives to what's toxic on the streets right now. I have a report we've been working on that will be coming out in the next few months on that.

Mr. Stephen Ellis: Do you recommend compassion clubs like the one run by the Drug User Liberation Front?

Dr. Bonnie Henry: I don't recommend any specific model. I think we need to continue—

Mr. Stephen Ellis: You're okay with the Drug User Liberation Front, though. Would that be a model that you would perhaps support?

Dr. Bonnie Henry: I'm not supporting any specific models. I think we need to look at all of the options that are available that have the important regulations around them and support them.

● (1235)

Mr. Stephen Ellis: Dr. Henry, to me it's very concerning that many individuals who were former officials of the British Columbia government, and indeed people who have occupied your position, are now involved with distributing, selling and dealing drugs such as meth, cocaine, heroin, etc., and profiting from it. Is that okay with you?

Dr. Bonnie Henry: I think what you have to do is separate between legal use, and that is under the purview of Health Canada—

Mr. Stephen Ellis: You're supporting these individuals. They did your job and you're actually saying that we should legalize more drugs in Canada. That's your pitch to Canadians. Oddly enough, these individuals are actually profiting from it. To me, that convinces me there's a significant conflict of interest here, Dr. Henry.

Dr. Bonnie Henry: What I have always said and what I continue to say is that prohibition is one of the leading causes of the issues that we're in right now, and that legalizing and regulating is one way to manage the illegal and toxic drug crises that we're dealing with.

The Chair: Dr. Henry and Dr. Ellis, we're going to give Dr. Powlowski another try, now that he's at a stationary location.

Dr. Powlowski, the floor is yours, unless we can't hear you.

Mr. Marcus Powlowski: Thank you, and hopefully you will.

Dr. Henry, I'll continue where I was before.

Certainly, I think the concern with Dilaudid is that it has become a kind of entry-level narcotic in Vancouver because it's cheap. My understanding in talking to people who work in the community is that the price of one Dilaudid tablet was $20 before safe supply. Now it's a dollar. As one psychiatrist said that he asks his kids who are on Dilaudid, “Why Dilaudid?”, and they say that, on the street, it's five bucks to buy a joint whereas they can get five Dilaudid for the same price, so which are you going to do?

Certainly, the concern is that you start off with Dilaudid and because, as you know, with narcotics, once you get used to it, you get tolerant, you have to go to something stronger to get the same kind of buzz, so they're switching over to fentanyl. Certainly, one psychiatrist who works with that population told me that of the kids he knows who are on [*Technical difficulty—Editor*], it's half on Dilaudid and half started originally on Dilaudid.

Certainly, there's the concern around safe supply. I don't know if you want to comment on that. I think that the Nguyen article in JAMA certainly suggested there was perhaps a societal harm that coincided with safe supply.

I don't know if you want to comment on that, but I want to go to the second part of the question, which is that there is good evidence for IOAT, intravenous opioid agonist treatment, the kind of Swiss model where people who are hard-core users are given heroin to use intravenously.

[*Translation*]

Mr. Sébastien Lemire: Mr. Chair, the French interpretation is no longer available.

[*English*]

The Chair: Dr. Powlowski, I'm sorry—

Dr. Bonnie Henry: The French translation came on in the middle of.... I couldn't....

The Chair: Yes, the sound quality is not good enough to allow for translation.

[*Translation*]

Mr. Sébastien Lemire: I'm told that the sound quality is good now.

[*English*]

The Chair: It was a technical problem more so than a Dr. Powlowski problem.

Mr. Marcus Powlowski: Let me try to continue.

Dr. Henry, in your report, you also mentioned the fact that a lot of people who treat addictions were frustrated by the fact that Dilaudid wasn't really helping a lot of the real hard-core users who continued to use fentanyl, and they died from fentanyl.

Given the success with IOA observed treatment, and given the possible concerns with diversion, why aren't we moving more towards directly observed treatment if necessary with intravenous drugs and getting away from from going home with a bunch of Dilaudids like we're doing?

Dr. Bonnie Henry: I'll go to the second question first because I think that is a really important thing, and that is one of the recommendations that came out of my report.

Yes, injectable therapy is working for some people. It's very difficult to get into. There are a very small number in terms of access to programs, but we also know that people's use of drugs has changed over time, and people are not injecting as frequently. We know that smoking is the much more common way that people are using drugs now, so we need to have formulations that people are able to use in that way. We've heard from people who use drugs that it's what they need as well. To be able to separate them from the toxic drugs that are on the street right now, we need to ramp up those programs. My recommendations are that these start as directly observed therapy programs, but it needs to be accessible to people.

The other problem that we have is that we can't prescribe our way out of this. We have to have ways that people can develop those relationships with a clinic. I think the Hope to Health clinic is a good example of this. People can get the medications that they need to keep them on that road, away from using the street drugs as much as possible and in the formulations that they need.

It should be witnessed as a way to start. Then, you develop that relationship over time and that trust with people, because we also know that it's very difficult for people to stay in these treatment programs when they have to go in multiple times a day or every single day. If something happens where they need to be with family or they miss the bus, or there's something dramatic happening that day and they don't get their dose, that's when we know that people go back to accessing what they can find on the streets, for example.

Absolutely, I think these are the things that we...and I've recommended that we look at how we scale up access to the prescribed substances that people need and will use. That's another way of minimizing diversion, which is a symptom of unmet needs.

● (1240)

The Chair: Thank you, Dr. Henry and Dr. Powlowski.

[*Translation*]

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

Mr. Sébastien Lemire: Thank you, Mr. Chair.

I want to thank all the witnesses for being here.

Ms. Drouin and Ms. Morissette, when we talk to workers on the ground, they say that the best way to limit the scale of the crisis is to reach out to users. They say that any measure that establishes and maintains a connection with users is a step in the right direction.

The workers also tell us that the services must be available when users need them. This obviously means having workers on the ground 24 hours a day, seven days a week.

Could you comment on this?

Dr. Mylène Drouin: I can start answering your questions.

That's exactly what we mean by the continuum of services. Community organizations that work on the street need to build trust and help people understand what supervised consumption services entail. Supervised consumption centres also have peer helpers.

Supervised consumption services are community services supplemented by nursing services. These services help us move a step further and talk about health care. As we know, on top of the overdose issues, these clients aren't used to asking for other types of care, such as treatment for wounds or infections. They don't know how preventive services work.

These centres are staffed by qualified people with whom the clients can develop a relationship of trust. These qualified people liaise with specialized rehabilitation services and services that provide treatment solutions.

That said, after establishing the relationship of trust, the workers can, if necessary, refer people to services that provide treatment options. They can also refer people to services that provide mental health support. They also liaise with community services that help with housing and social reintegration. Everything must be connected.

We have also developed expertise in our monitoring team. We have anthropologists who get involved on the ground and who meet with people in order to understand the changing consumption habits, the practices, the needs, the cultural issues, the new consumers or the various circumstances. This helps us give our teams the right tools.

Mr. Sébastien Lemire: On that note, I want to recognize the work of a local worker in this field, in Abitibi-Témiscamingue. In 2023, she published an essay based on a qualitative survey. The essay is entitled “Drug use, a ‘stupefying’ world: drugs: a glimpse into a little-known reality.” This is part of the project entitled “A look at the reality of psychoactive substance use in the MRCs of Abitibi and Rouyn-Noranda.”

The committee could find some useful data.

Thank you.

The Chair: Thank you, Mr. Lemire.

[*English*]

Next is Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: Mr. Chair, before I get started on my time, I believe I have unanimous support to move a procedural motion. I move:

> That, pursuant to Standing Order 81(5), the committee invite the Minister of Health and the Minister of Mental Health and Addictions to appear for no less than one hour each regarding the Supplementary Estimates (A), 2024-25; and that this meeting take place as soon as possible, but no later than June 20, 2024.

The Chair: Thank you, Mr. Johns.

The motion has not been provided with adequate notice, so it would normally be ruled out of order, but we can do anything by unanimous consent.

Is there unanimous consent for Mr. Johns to present the motion and for the commttee to adopt the motion?

Some hon. members: Agreed.

(Motion agreed to)

The Chair: Thank you, Mr. Johns.

Go ahead.

● (1245)

Mr. Gord Johns: Thank you, Mr. Chair.

Dr. Henry, we saw in 2014, as I said earlier, 7.9 deaths per 100,000, which is horrific, go to 30.3 deaths per 100,000 under the former B.C. Liberal-Conservative Christy Clark government. That was the largest spike in British Columbia's history—383% over four years. We saw a similar spike in 2019 to present day under the United Conservative government in Alberta of 275%.

Can you speak about maybe why this happened under those governments? Certainly, we've seen a spike under the NDP, but the spike has been far less. Can you talk about what trends you're seeing?

Dr. Bonnie Henry: Just to clarify, I don't have any comments around what government is in power around these issues. What I've seen is that it is very much dependent on what is on the street. That is what is leading to deaths.

In British Columbia, we have tried to take an approach that is nuanced and that looks at all of the various aspects that we need to have in place to support people and to keep them alive, whether they are somebody who has a substance use disorder or whether it's somebody who is using drugs on an occasional basis. We know that people are dying in both of those situations.

Mr. Gord Johns: Thank you. I appreciate the qualified response. I do.

Dr. Henry, the Minister of Mental Health and Addictions keeps saying that they're "meeting the moment". This is a health emergency. Do you believe the federal government is meeting the moment? What could the federal government do?

We saw how they responded to COVID-19. We were able to work through jurisdictions and respond rapidly. What is the difference you're seeing in terms of this crisis? Is it just the stigma that is the barrier? We're seeing that, I believe, from the federal government in the inaction and the incremental approach.

Dr. Bonnie Henry: I do believe that the issue of people who use drugs is cloaked in stigma and shame. That keeps people from talking about this. We know from data that everybody in our communities across this country has been affected by this crisis in many ways. It is something on which I think we need to have a coordinated approach across the country. There is absolutely room for people doing different things in different communities to support their communities, but I would like to see a coordinated cross-governmental approach that supports people in communities across this country, because all of us are being affected.

The Chair: Thank you, Dr. Henry.

Mrs. Goodridge, you have five minutes, please.

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

I guess I will start with you, Dr. Henry. Does diversion scare you? Are you concerned by diversion?

Dr. Bonnie Henry: I think diversion, as I've said many times, is a symptom of unmet needs. In the case of the unmet needs that we are seeing, it is very concerning to me. It means that we need to take different approaches.

I also want to recognize that diversion is not new. We've seen that in many parts of this country. In B.C. the toxic drugs on the street have been the proximal cause of what we've been dealing with, but in other provinces, prescription drugs are—

Mrs. Laila Goodridge: I have very limited time.

Do you think having more drugs on the street will solve an addiction crisis?

Dr. Bonnie Henry: I don't think we're having more drugs on the street. What we're seeing is the toxicity of the drugs on the street. That has been driving this crisis.

Mrs. Laila Goodridge: Based on rough math, there are about 50 million safe-supply hydromorphone pills prescribed in British Columbia every year.

How many of those 50 million pills would it be acceptable to divert into the hands of gangs and people who are profiting off the deaths of Canadians?

Dr. Bonnie Henry: None would be acceptable in that circumstance.

Mrs. Laila Goodridge: Okay. How many would it be acceptable to divert into the hands of youth?

Dr. Bonnie Henry: None of us want our youth to be taking drugs. We know that taking prescription drugs is something we have seen for many years in young people. That's often where people start.

● (1250)

Mrs. Laila Goodridge: Because of this, what has the Government of British Columbia done to reduce diversion and prevent these potent drugs from getting into the hands of kids?

Dr. Bonnie Henry: That is one of the things we need to pay a lot of attention to. What is it that gives young people the strength to understand what's out there, go against peer pressure and—

Mrs. Laila Goodridge: I understand all of that. Peer pressure has existed since time immemorial.

What has the Government of B.C. done since they introduced 50 million pills of hydromorphone—a highly potent synthetic opioid that is stronger than heroin—into the market to prevent them from getting into kids' hands? Has anything happened to prevent them from getting into kids' hands?

Dr. Bonnie Henry: Of course we have. With the programs we have that are prescribed.... "Safer supply" means people have a prescription. They have a relationship with the prescriber to access medications. We know there are people who share medications and people who keep their drugs [*Inaudible—Editor*] for different times.

Mrs. Laila Goodridge: Do you think people sharing their safe supply is compassionate? We heard that from one witness here.

Dr. Bonnie Henry: In some cases, it is. It's a symptom of unmet needs for people who can't access.

Mrs. Laila Goodridge: As a medical doctor, are you comfortable with people sharing their safe supply with another person who is struggling with addiction?

Dr. Bonnie Henry: I think it is a better alternative than the street drugs people are required to access to maintain their addictions. That's the challenge. The challenge is that we have unmet needs. People cannot get access.

Mrs. Laila Goodridge: Just to clarify, you think it is fine to divert your prescribed safe supply, as long as the person you're sharing it with has unmet needs. It's absolutely A-okay, even if it's a teenager or a child.

Dr. Bonnie Henry: You know, I think you're trying to make this scenario into something it is not. That's not what we're dealing with. What we're dealing with is people who are not able to access programs.

Mrs. Laila Goodridge: It is what we're dealing with. It's what we're hearing.

Dr. Bonnie Henry: We need to be better at providing people with the medications they need to get them on that road we all want them to be on: recovery.

Mrs. Laila Goodridge: What is the wait time, approximately, for a 12-year-old child in Cranbrook, British Columbia, to get access to detox?

Dr. Bonnie Henry: I don't have an answer to that question.

Mrs. Laila Goodridge: Do you think it should be immediate?

Dr. Bonnie Henry: Absolutely. If that child needs it, they should have access to supports from somebody who is trained to understand their needs and is able to support them.

Mrs. Laila Goodridge: Regarding a child who is addicted to drugs and ends up in the ER in Cranbrook, British Columbia, do you think they should be released because there is no detox space available?

Dr. Bonnie Henry: I think they need to have a relationship with a provider who supports them for their needs at that moment—absolutely.

The Chair: Thank you.

Mrs. Laila Goodridge: [*Technical difficulty—Editor*] desperately seeking help is meeting their needs?

Dr. Bonnie Henry: I'm sorry. I couldn't hear that question. It was cut off.

Mrs. Laila Goodridge: Do you think releasing someone desperately seeking help is meeting their needs?

Dr. Bonnie Henry: I think it depends on the situation the person is in. We absolutely want all children to have the supports and connections they need.

The Chair: Thank you, Dr. Henry.

Thank you, Mrs. Goodridge.

Ms. Sidhu, you have five minutes. Go ahead, please.

Ms. Sonia Sidhu: Thank you, Mr. Chair.

I would like to, once again, thank all the witnesses here with us.

Thank you for the work you are doing on the ground, especially in British Columbia.

Mr. Chair, we know B.C. has already been impacted by forest fires this 2024 season. This is why, colleagues, I want to use my time in this meeting to move a motion I distributed earlier that, given Canadians and indigenous peoples experienced extreme weather events and pollution in 2023, including but not limited to wildfires that occurred coast to coast, from the Okanagan and Shuswap to Tantallon area; high poor air quality indexes across the country; flooding in Alberta, Nova Scotia, Ontario and Quebec; and industrial waste impacting communities or regions, such as the Athabasca Chipewyan First Nation or Abitibi-Témiscamingue—

● (1255)

Mr. Todd Doherty (Cariboo—Prince George, CPC): I have a point of order.

The Chair: Wait just a second, Ms. Sidhu. We have a point of order from Mr. Doherty.

Mr. Todd Doherty: Can we have a brief suspension to confer with our colleagues on this?

The Chair: Ms. Sidhu, if you could finish moving the motion, I'll suspend the meeting to allow for a huddle. I find oftentimes that expedites things. We'll probably also dismiss the witnesses at the same time.

Finish your motion. We'll dismiss the witnesses. We'll suspend the meeting, and we'll take it from there. Go ahead.

Ms. Sonia Sidhu: There's industrial waste impacting the Athabaska Chipewyan First Nation and Abitibi-Témiscamingue, and the most recent wildfires have affected Fort McMurray, Fort Nelson, Quesnel and Vanderhoof.

This is why I move:

> That, pursuant to Standing Order 108(2), the committee undertake a study of no less than six hours on the negative—

Mr. Stephen Ellis: I have a point of order, Chair.

The Chair: Ms. Sidhu, there's another point of order.

Go ahead, Dr. Ellis.

Mr. Stephen Ellis: I have a question. If this was moved quite some time ago, is the motion the same? It appears that there's some new information added. Am I mistaken?

Ms. Sonia Sidhu: Should I complete the motion?

The Chair: Ms. Sidhu, on the motion that you are moving, is that the one that was put on notice on Monday, May 27?

Ms. Sonia Sidhu: Yes.

The Chair: Okay, I think what happened was that you started speaking to the motion, and then you introduced the motion, so it looked like there was additional information.

Have you finished moving the motion?

Ms. Sonia Sidhu: I'm halfway through. I will finish quickly.

The Chair: Okay. Please finish.

Ms. Sonia Sidhu: I move:

> That, pursuant to Standing Order 108(2), the committee undertake a study of no less than six hours on the negative effects climate change and pollution have on the health of Canadians and Indigenous communities, including the cost to the healthcare infrastructure, resources and impact on vulnerable communities and populations; that the committee report its findings and recommendations to the House; and that, pursuant to Standing Order 109, the Government table a comprehensive response to the report.

The Chair: Thank you, Ms. Sidhu.

To our witnesses, we are rapidly approaching the top of the hour, which is the time that you agreed to commit to us. We're unlikely to get back to you before the top of the hour, so I'm going to take this opportunity to tell you how much we appreciate your flexibility in being cancelled at the last minute and then coming back to provide your testimony in such a patient and professional manner. We are grateful and indebted to you for all of that.

You are welcome to stay, but you're free to leave. Thank you so much.

With that, we're going to suspend for five minutes to allow everyone to figure out what they're going to do with respect to the debate on this motion.

I will say this. The motion is in order. After the suspension, the question will be on the motion.

We're suspended.

● (1255)

_____(Pause)_____

● (1308)

The Chair: I call the meeting back to order.

When we suspended, Ms. Sidhu, you had just moved the motion. I'm not sure whether or not you relinquished the floor.

The debate is on the motion. You have the floor, and Dr. Ellis is next.

Ms. Sonia Sidhu: Mr. Chair, Dr. Ellis can go ahead.

The Chair: Dr. Ellis.

Mr. Stephen Ellis: Thanks very much, Chair.

I appreciate Ms. Sidhu wanting to move this motion. There are just a couple of things that I think are important to point out.

One is that, most importantly, today was scheduled for drafting instructions related to a study on women's health. I think there are some incredibly significant things that we need to get to, on behalf of all women in Canada, with respect to that study. There are issues that I think we can all agree need to be said out loud. I'm not entirely sure why, in this committee, we seem to struggle to get through reports without having more and more motions come forward.

The other issue, Chair, is related to the fact that we really haven't had a planning meeting to try to better understand what we are going to undertake next. Because we have quite a few new members here, what we have done, historically....

I know the waters have become a bit muddied because of some of the studies we've undertaken, but that being said, we had a tradition. I'll use the word “tradition” here, even though it would make us think it's been this way for decades. The tradition here has been for a short time. Some are long and some are short. We have had a tradition whereby a study is proposed by each of the different parties, perhaps in proportionality to their representation here, and then we move around in a circular direction.

We should have a planning meeting to get back to that and really have a more fulsome look at the proposed studies that are before the committee. Obviously, if there are studies that are more urgent than others, we would certainly talk about that as a larger group to understand, on behalf of Canadians, what we should do in sequential order.

The other thing that's really important is that my colleague Mrs. Goodridge has put forward a study on breast cancer, which is, of course, somewhat mentioned in the women's health study, but there's more evidence that came out today.

If you'll indulge me, in a recent news article put out by Global News, it says:

> Canada’s guidelines for routine breast cancer screenings will remain unchanged, despite mounting pressure from medical experts who have labelled them as “dangerous.”
>
> The Canadian Task Force on Preventive Health Care released its updated guidelines Thursday recommending that people in their 40s should not get routine mammograms but can request one if they want.
>
> The current guidelines set by the task force are to begin routine breast cancer screening at age 50.
>
> “The first and most important recommendation coming out of this guideline is that breast cancer [screening] is a personal choice, and that people deserve information so that they can make the right choice for them,”....
>
> “We recommend that women between the ages of 40 and 74 are provided with information about the benefits and harms of screening to make a decision that aligns with their values and preferences,” she said during a media briefing on Thursday.
>
> She added that this information should cover factors like family history, race or ethnicity, and breast density. If someone is aware of these factors and wishes to be screened, they should be offered mammography every two to three years.
>
> The task force said it holds firm on its position not to lower the recommended [age] due to concerns of over-diagnosis and unnecessary biopsies.
>
> The new breast screening guidelines released today by the Canadian Task Force on Preventive Health Care are “dangerous and harmful to Canadians,” Dense Breasts Canada executive director Jennie Dale, said Thursday....
>
> “We are beyond disappointed in the recommendations,” Dale said. “The guidelines should reflect the latest evidence and prioritize the lives of Canadians. The Task Force has failed us and we ask Canadians to tell Minister Holland to suspend these guidelines and use modern science to save lives.”

It goes on. People talk about how they're deeply concerned, there's good evidence and the guidelines are outdated and flawed. I'm just paraphrasing to try to speed things up here a bit.

● (1310)

Mr. Brendan Hanley: I have a point of order, Mr. Chair.

I don't see how Dr. Ellis's speech is relevant to the motion on the table.

The Chair: Thank you, Dr. Hanley.

As I was listening to Dr. Ellis, it seemed to me that he was pointing out that there are other studies that should take precedence over this one. He got into an unnecessary amount of detail with respect to his choice, but I don't think he's that far removed from the point for it to be entirely irrelevant.

If you could bring it back a little bit, Dr. Ellis, go ahead.

Mr. Stephen Ellis: Absolutely, Chair.

That's why, as I began down this road, I started.... The article goes on and on. I didn't realize it was quite so long.

The point is, of course, that this is information. I think there are two really important things. First, this happened today. The second thing is that this article points out and underlines that, if there is any avenue in this country to get this incredibly important issue into the mind of the Minister of Health, Mark Holland, we are the closest people physically and from a "loudness of voice" perspective to get that information to him.

That being said, this is an urgent issue that we already had on the docket previously, which does relate specifically to the drafting instructions that we were to get to today.

I just can't understand it. We got into this problem before in this committee, where we, first of all, had a health human resources study that got backed up for, I want to say, over a year. That's a disservice to Canadians.

Then we had a children's health study for which we had so many different members here that, in the end, I think there were probably three, four or five of us here for the majority of the testimony related to that. Trying to create a report that is in any way, shape or form useful on behalf of Canadians when the majority of people were not even here during the report to hear the testimony becomes very difficult.

I think, too, when we talked about this previously, we had talked about trying to clear some of the backlog of issues that we had. Using the half an hour that we had today would have made perfect sense to do that, and then, as I said, to have some planning meetings around looking at the other topics that are of critical importance to Canadians.

I'm not saying, Ms. Sidhu, that your motion is not of critical importance—perhaps it is. I think perhaps hearing it again would be useful. Our minds were significantly turned to another issue that's of critical importance to Canadians right now and unbelievably topical since the federal government was involved in a partnership with the B.C. government for an experimental decriminalization project with respect to opioids, which are killing more than 22 people a day on average. You all know that.

We were focused on that particular study, and that study wanted to be interrupted.... I can't understand why when we had significant witnesses here—

● (1315)

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

There are not 22 people a day in British Columbia dying from toxic drugs, just to clarify.

The Chair: Mr. Johns, it isn't a point of order.

Mr. Gord Johns: It's a point of clarification.

The Chair: It's a matter of debate on something that isn't particularly relevant to the motion.

Go ahead, Dr. Ellis.

Mr. Stephen Ellis: Thanks, Chair.

To be clear, if I said "in B.C.", I misspoke. I meant in Canada.

You're very welcome, Mr. Johns. It's six a day in B.C.

That being said, the point here is that we're not making a useful and judicious use of the limited time we have. We also have another motion and I'll take my hat off to Mr. Johns. He presented his motion, which was germane. He presented it quickly. We agreed on it quickly, and we moved forward with it because it is incredibly important that, before the end of this session, we be in a position to have the ministers respond to the estimates again.

My plea to this committee is that we have work before us, some of it perhaps is more important than others. Some of it—and this is my summary, Chair, just to give you a heads-up—is incredibly important on behalf of Canadians and perhaps some of it is less so. I'm not going to tell you that I think I'm the arbiter on that.

There is the fact that we have a bit of a backlog of things that we need to get to and we are coming toward the end of the session. If members have the desire to sit all summer and have Standing Committee on Health meetings all summer, I think the Conservative side is quite happy to do that.

If that's your plea, Ms. Sidhu, I'm happy to be here to do that and to be of service to Canadians. I think that's incredibly important.

Specifically with the study on opioids.... Again, this is my own prioritization. The study on opioids and the study on breast cancer and screening guidelines specifically, for me, would be at the top of my list of things that we need to do on behalf of Canadians.

Because of the dire straits and the difficulties we got into with respect to other studies in the past.... This is not the fault of the analysts. That's not what I'm meaning to say in that direction. In the past, we've gotten into some difficulties with the studies because they've been so prolonged and drawn out. That causes extreme difficulties and makes reports—with all of our names on them—perhaps not as good as they could have been if we had done them in a more timely fashion.

That's my plea. For that reason I move to adjourn debate on Ms. Sidhu's motion.

● (1320)

The Chair: A motion to adjourn debate is a dilatory motion. It is not debatable. We must go directly to a vote.

Mr. Stephen Ellis: Chair, I'd like to request a recorded division. There are too many people online for me to process that.

Could we ask the clerk to do it?

The Chair: You don't need a reason; you can have it as a right.

We will have a recorded division.

(Motion negatived: nays 6; yeas 5)

The Chair: Mrs. Goodridge, you have the floor.

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

It's really frustrating. It's just one of those things....

To go a little bit further, I appreciate Ms. Sidhu bringing this motion forward, but it's really frustrating. We had possibly some of the most powerful testimony I've heard on this opioid study come from Mr. Earl Thiessen when it comes to his own personal, lived experience with addiction. The fact that we decided, because a motion was moved, to not continue having questions with him and the other witnesses who were here is extremely difficult.

Mr. Chair, there's a lot of conversation happening in the room. I'm having a hard time hearing myself think.

The Chair: Thank you, Mrs. Goodridge.

Could I ask everyone just to extend the courtesy to Mrs. Goodridge and to your colleagues that, when they have the floor, you keep your side conversations outside?

Go ahead, Mrs. Goodridge.

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

To just follow up on some of what my colleague, Dr. Ellis, stated, the motion I moved on looking at the breast cancer guidelines isn't just politics for me. This is something that is incredibly important to me. I was 21 years old when I lost my mom to cancer, and my mom was 49 years old. She was younger than what she would currently be able to get a mammogram for. In the time since I've lost my mom.... That shook our entire family. That created trauma, heartache and so much challenge for my entire family.

I remember watching my dad, who was the strongest person I ever knew, turn into a very broken man for a while after my mom died. She was the love of his life. It was breast cancer. It was something that should have been completely preventable had she simply been able to have adequate diagnostic testing available to her at an earlier age.

The Canadian Cancer Society, in fact, today put out a statement:

> The Canadian Cancer Society is disappointed by the new breast [cancer] screening guidelines released today by the Canadian Task Force on Preventive Health Care (CTFPHC) and specifically the lack of a recommendation to lower the start age to systematically screen for breast cancer nationwide.

These conversations happened as we were studying women's health. We heard from multiple witnesses about the importance of breast cancer screening earlier and about the difference between breast cancer screening when it comes to dense breasts and different breast compositions. We heard a lot about women's health, and it was something that hit me, as someone who is the daughter of a breast cancer person. It hit me that we could make an actual immediate difference in the lives of people like my mom and our family, as well as all the other families in similar situations.

Also, women's health is so understudied at the best of times. There's the fact that most people don't even want to talk about women's health and the fact that in this health committee, when we decided to study women's health, we didn't study breast cancer. We didn't study endometriosis. We literally looked at just women's health, as if somehow studying health for more than 50% of the population is an okay thing.

It really bothers me, because I can't imagine a time when we would say, you know what? Let's have a study on men's health. No, we wouldn't. We would study men's mental health. We would study prostate cancer. We would study the guidelines.

I've said this before, and I'll say it again. I'll say it right now here on Hansard. If men had to put their reproductive organs into a mammogram machine as their form of diagnostic, we would already have a different test. If that were something men were subjected to, we would already have a different test. This just speaks to the systemic challenges women's health has.

Here we have an opportunity, then, to study women's health, to have conversations with the analysts and to have this conversation. Instead—

● (1325)

Mr. Brendan Hanley: I have a point of order, Mr. Chair.

I certainly understand Mrs. Goodridge's passion on this important subject, but I don't believe this is relevant to the motion on climate change.

The Chair: I'm inclined to agree. We do extend a wide latitude, but I would ask you, Mrs. Goodridge, to bring it back around to the motion, please.

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

I think it is deeply relevant, because in this committee, we have had a precedent of having different studies come forward.

My question is what the motivation was for Ms. Sidhu to bring this up. She mentioned my home community, or thereabouts, having forest fires. I will share with the committee that, as of a few days ago, the forest fires are now being held and they're actually under control because of the amazing work that's been done by Alberta Wildfire and the wonderful wildland firefighters who put themselves out there to protect our community and create all of this structural space. That work was done by Alberta Forestry.

The vast majority of the firefighting capacity is done specifically by provincial forest firefighting groups. This is something that is quite probably more provincial in scope, if we're going to be looking at forest fires specifically, but that's a whole other space.

Going back to the breast cancer motion, which is deeply relevant, we are effectively saying that getting further in our women's health study and getting to a space where we can actually release this report isn't important. That is what has happened here today. That is what is happening right now.

While I appreciate this, and I would appreciate our continuing this conversation another day and at another time, I would—

● (1330)

Mr. Brendan Hanley: On a point of order, I would submit that moving a motion has nothing to do with planning and prioritization. I don't think this is relevant.

The Chair: I think it is absolutely relevant, Dr. Hanley. She's talking about what's being bumped because of what's proposed in the motion. I don't think that's off base at all.

Go ahead, Mrs. Goodridge.

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

With that said, I have other commitments, so I would move that we adjourn the meeting.

The Chair: Is it the will of the committee to adjourn the meeting?

(Motion agreed to)

The Chair: The meeting is adjourned.