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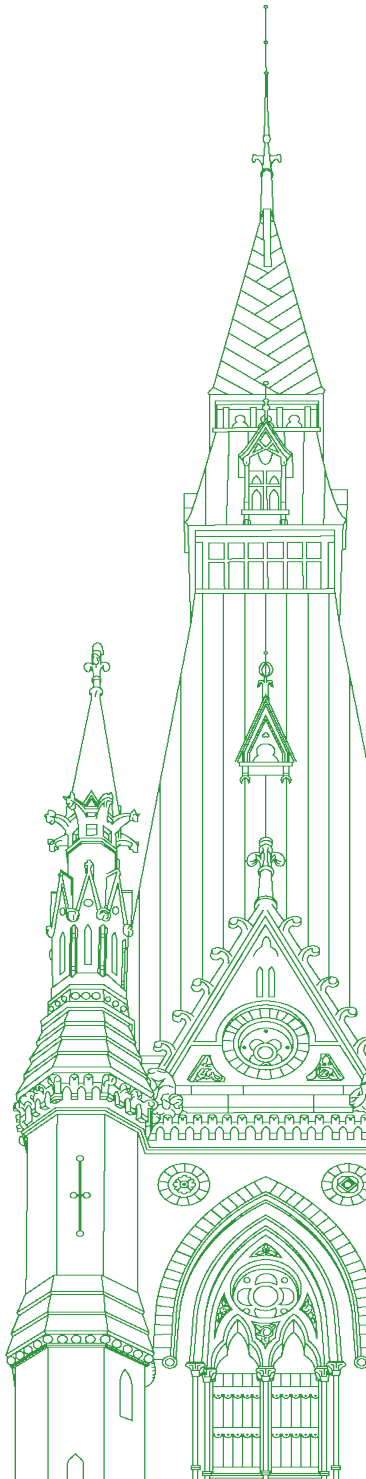

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, June 3, 2024

● (1545)

[*English*]

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

Welcome to meeting number 120 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 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 the black approved earpiece. The former grey earpieces must no longer be used. Please 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 for your co-operation.

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

We have a challenge with Dr. Powlowski that we're trying to resolve. We will not hold up the meeting, if at all possible, while that's being done.

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

I'd like to welcome our panel of witnesses. Appearing as individuals are Dr. Bohdan Nosyk, professor and St. Paul's Hospital CANFAR chair in HIV/AIDS research, Faculty of Health Sciences, Simon Fraser University; Mr. Benjamin Perrin, professor, Peter A. Allard School of Law, University of British Columbia; and Dr. Julian Somers, clinical psychologist and distinguished professor, Faculty of Health Sciences, Simon Fraser University.

[*Translation*]

Finally, we welcome Catherine Jutras, an overdose prevention consultant. She is representing Arrimage Jeunesse and Mouvement de la relève d'Amos-région.

[*English*]

All of our witnesses today are appearing by video conference. We will ask them to provide opening statements of five minutes in length in the order in which they appear on the notice of meeting.

We will start with Dr. Nosyk.

Welcome to the committee. You have the floor.

Dr. Bohdan Nosyk (Professor and St. Paul's Hospital CANFAR Chair in HIV/AIDS Research, Faculty of Health Sciences, Simon Fraser University, As an Individual): Thank you.

Good afternoon.

I'm calling in today from the unceded territories of the Musqueam, Squamish and Tsleil-Waututh nations.

Much of my work has focused on evaluating treatment for opioid use disorders, and I'd like to share some up-to-date evidence and perspectives on this topic, focusing on opioids specifically.

Broadly speaking, there are three options to choose from: outpatient pharmacological treatment, or OAT, short-term detoxification and longer-term residential care. The latter two may also include pharmacological treatment. Only one of these three options is systematically reported and available for independent researchers like me to analyze: OAT. That includes methadone, buprenorphine, slow-release oral morphine and others, prescribed in outpatient clinics and dispensed from community-based pharmacies.

As of March 2024, we had just over 24,000 people accessing some form of OAT in B.C. Unfortunately, retention in treatment has declined over the past 12 years. Although it's a complex story, most fundamentally, we haven't increased our daily dosing to match the elevated tolerance of our clients, who are now using fentanyl as opposed to heroin. More recently, doctors are now having to manage benzodiazepine tapers alongside OAT. Eliminating copayments for treatment and combining prescribed hydromorphone with OAT, as we learned serendipitously through the prescribed safer supply program, have improved OAT retention, although much more needs to be done to improve this form of treatment.

Short-term detoxification treatment in and of itself is not evidence-based care but rather a means of stabilizing and linking individuals to ongoing care after discharge. These data are held by health authorities and are not systematically linked to other provincial datasets. I was involved in a project where we were able to link these data in 2017, and the outcomes for people with OUD were poor. There were high rates of readmission to detox or ED admission, and only about 40% of people with OUD were dispensed OAT after discharge. I believe this is the only published evidence out there on detox outcomes in Canada. I urge you all to verify.

Data on specialized residential treatment facilities in B.C. are also siloed, held either by health authorities or by private for-profit clinics. We know that we have over 3,600 publicly funded treatment beds in B.C., although these are not exclusive to OUD. We know very little about the outcomes of individuals accessing this form of care in B.C. either at the point of discharge or after discharge. Tracking outcomes after discharge is important because what we've found is that transitions back into community are difficult, and it's likely that we need multiple tiers of support, including housing and other social supports, once these individuals are discharged.

What do we know about outcomes for people with OUD served by residential care facilities? Two systematic reviews were published in 2019, one by CADTH and one in the journal Drug and Alcohol Dependence. Though both demonstrated some positive outcomes, few of the component studies focused on people with OUD. The outcomes were mixed for this population, and none included people using fentanyl.

This leaves us with more questions than answers. We need to know the short-term and long-term outcomes for people who received residential care for OUD, including measurable definitions of recovery. We need to build the evidence on who benefits from these services, understand what percentage of that population is accessing services and ensure that this access is equitable, at least on geographic, ethnic and economic strata. We need to know about the staffing requirements and the level of financing needed to reach our target population. Can we hit scale? Finally, we need to continuously evaluate and adapt our approach as the needs of our clients change.

I want to emphasize here that these are not one-size-fits-all services. Through a Health Canada SUAP-funded grant, we found that perhaps the greatest unmet need was care for pregnant people with OUD. Until St. Paul's opened up a perinatal SUD ward earlier this year, there were only 13 perinatal SUD beds in B.C., and that's not just OUD but all forms of SUD. Twelve of them were in Vancouver, and there were none in the north, where OUD prevalence amongst pregnant women is 2.7 times higher than it is in Vancouver. That's coming out of a paper that's currently under review.

To be clear, no jurisdiction in North America has thus far successfully responded to the introduction of fentanyl into the illicit drug supply. Neither B.C. nor Alberta, the provinces with the highest prevalence of fentanyl in Canada, has done so. I'm a believer in evidence-based decision-making, a learning health system. That means learning from both our successes and our failures.

For the sake of the seven more people who will die of an overdose today just in B.C., I urge you to set aside your ideologies, political beliefs, and aspirations and focus on the true scope of this problem and the needs of these people. One of the constructive actions that this committee can take is to recommend—ideally, mandate—the systematic reporting of outcomes across all forms of SUD treatment, recognizing, of course, the legal complexities of doing so. We need to learn from each other to adequately respond to this persistent and evolving crisis.

● (1550)

I've made available to the committee each of the references used within this statement.

Thank you very much.

The Chair: Thank you, Dr. Nosyk.

Next, we have Benjamin Perrin from the University of British Columbia.

Welcome to the committee, Mr. Perrin. You have the floor.

Professor Benjamin Perrin (Peter A. Allard School of Law, University of British Columbia, As an Individual): Thank you, Mr. Chair.

Greetings. My name is Benjamin Perrin. I'm a law professor at the University of British Columbia.

A decade ago, I was the lead criminal justice and public safety adviser to Conservative Prime Minister Stephen Harper. I supported the tough on crime agenda and the war on drugs. I've come to realize those views were a toxic blend of ignorance and ideology. My heart was hard. My mind was closed.

What changed? I met with people deeply impacted by this unparalleled, unregulated drug crisis. I met people who use drugs and the family members of those who have lost loved ones. I met groups like Moms Stop the Harm, which have repeatedly asked to meet with people like Pierre Poilievre, the leader of the official opposition, yet he refuses to even listen to those courageous parents. I visited overdose prevention sites and clinics that provide regulated drugs as a substitute for those made by organized crime, places that I understand some members of this committee have refused to even visit. I read the studies and peer-reviewed evidence for myself. I interviewed police, prosecutors, defence lawyers, judges, border officials, indigenous leaders, public health experts, non-profits, peers and addiction medicine physicians.

My faith in Jesus Christ opened my heart to people who are suffering in our society, the marginalized, the downtrodden, the stigmatized and the outcast. I would remind others who share my faith, or profess to, that Jesus came to seek and save the lost, not to condemn and not to punish. He said to let those without sin throw the first stone.

This incredible transformation and journey led to a complete change of heart on these issues. I now have been recommending for many years a compassionate and evidence-based approach. I'll highlight the five urgent needs. There are many mid- and long-term recommendations, as well, but I'll focus on these in the short time I have.

First, naloxone, the temporary antidote to opioid drug poisoning, needs to be widely available and people need to be trained to respond. Naloxone saves lives.

Second, we must ensure every Canadian has access to a safe place to use substances, where they can receive emergency medical support free of fear of criminal prosecution. From January 2017 to January 2024, over 400,000 Canadians used these life-saving supervised consumption services, with staff responding to over 55,000 overdoses. Not a single person died. Over 470,000 referrals were made at these sites to health and social supports. As the Supreme Court of Canada said in a unanimous ruling in 2011, supervised consumption sites save lives, and their benefits have been proven.

All of the sources I'm mentioning have been given to the committee clerk.

Third, regulated substances are needed to replace the toxic, contaminated, unregulated drugs that are killing Canadians. Over 42,000 people died in our country between 2016 and September 2023 during this crisis. Now, misinformation and lies cannot conceal the true reason for these deaths. Illicit fentanyl made by organized crime, including right here in Canada, is the primary cause, detected in 82% of post-mortem toxicology reports. A regulated supply could include prescribed alternatives, compassion clubs or witnessed use for no-cost, regulated alternatives, but with payment required for carries and other options. Those who oppose regulated alternatives condemn Canadians to risk their lives with unregulated drugs made by organized crime. Regulated alternatives save lives.

Fourth, we need to address this as a public health emergency. It's not a criminal justice problem. Criminalizing people who use drugs is cruel, ineffective and deadly. Incarcerating someone with opioid use disorder increases their risk of death by 50 times. For many, it's therefore equivalent to a death sentence.

Fifth, Canadians need treatment and recovery options that reflect five key requirements: evidence-based, rapid access, publicly funded, regulated and, finally, trauma-informed and culturally appropriate. Abstinence-based treatment alone is not medically recommended. Studies, including those in the British Medical Journal, show that those who complete a 28-day detox program have an increased risk of death because this is, again, a chronic relapsing condition and their tolerance goes down rapidly during periods of forced or voluntary detox, making a relapse potentially deadly.

● (1555)

This false debate between harm reduction versus treatment is a distraction. We need both. People need to be alive to enter treatment.

In closing, I agree that no jurisdiction in Canada has fully implemented all of these evidence-based recommendations.

I would implore you, if your goal is to get re-elected and secure power, to read the polling data. If your goal is to save lives, I urge you to read the research and listen to those most deeply impacted by this crisis.

Thank you.

The Chair: Thank you, Mr. Perrin.

Next we have Dr. Somers from the Faculty of Health Sciences at Simon Fraser University.

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

Dr. Julian M. Somers (Clinical Psychologist and Distinguished Professor, Faculty of Health Sciences, Simon Fraser University, As an Individual): Thank you.

I am Dr. Julian Somers, a person in long-term recovery, a licensed clinical psychologist and a distinguished full professor at Simon Fraser University. I began my clinical career working at B.C.'s Riverview Hospital in 1987, and was trained in addiction research and clinical practices by Dr. Bruce Alexander and Dr. Alan Marlatt.

I've directed clinical training in departments of psychology and medicine, and led three university-based centres focused on clinical and applied research. My body of research addresses harm reduction and recovery from addictions, often concurrent with additional mental illness among youth and among people who experience homelessness and frequent involvement with our justice system. I have also led primary care and telehealth programs spanning B.C., Alberta and the north.

I'm here today to testify to B.C.'s dangerous and imbalanced approach to addiction policy that prioritizes drug liberalization and legalization and largely ignores addiction prevention and recovery. This approach has been driven by an influential group of current and former health officials whose financial interests overlap with their advocacy.

As has been reported by several journalists, B.C.'s drug policies have been shaped for many years by a network of public servants and university-based researchers who previously focused on pharmaceutical interventions for HIV/AIDS.

The key players include former provincial health officer Dr. Perry Kendall and the Michael Smith foundation's scientific director, Dr. Martin Schechter, who co-created Fair Price Pharma to provide heroin. Former deputy PHO Dr. Mark Tyndall created the MySafe Society, which dispenses opioids from vending machines. Dr. Evan Wood created a pharmaceutical company and directed the B.C. Centre on Substance Use, or BCCSU, which was formed from the HIV/AIDS centre for excellence. The current BCCSU director, Dr. Thomas Kerr, was recently involved in a scheme to disrupt and silence speakers at a conference I spoke at. The BCCSU provides significant annual funding to the Vancouver Area Network of Drug Users, VANDU, and other allied groups. He was also involved in research for the Drug User Liberation Front's activities purchasing, testing and selling illegal drugs. DULF and VANDU have a pending court decision versus the federal government, where they argued for a section 56 exemption to be able to legally buy and distribute drugs, including heroin, cocaine and meth. DULF was raided and shut down by Vancouver police last year. Reports state that Dr. Kendall met with DULF about providing them with heroin. B.C.'s current PHO, Dr. Bonnie Henry, is a protege of Dr. Kendall's and a collaborator in these misguided actions. In her report advocating for decriminalization, she wrote, “As overdoses become more pervasive both domestically and worldwide, jurisdictions are looking to B.C. for leadership and guidance. The stage is set for the province to meet this call.”

The BCCSU has substantial influence on public policies that focus in a dangerous and imbalanced way on pharmaceuticals. Drugs are a relatively small component of policies and services that reduce harms associated with addiction. Furthermore, the BCCSU appears to be focused on advancing drug legalization. Dr. Kendall served as co-executive director of the BCCSU after retiring as PHO. Despite public reporting of apparent conflicts of interest, I'm not aware of any actions to investigate how our current policies may be related to incentives among those involved.

My efforts to advance relevant evidence have garnered a severe backlash in my home province of B.C. In 2022 I co-authored a rapid review on safe supply that highlighted the weak status of evidence, the likely risks, including drug diversion, and the alternative interventions that are well supported by evidence. The BCCSU responded by holding press conferences and producing an open letter accusing us of conducting low-quality research, which was a grossly inaccurate statement. They also attacked my character and have sponsored plans to disrupt events that I am speaking at and have me removed as speaker. These are the methods of activists, not scientists.

In March 2021, I briefed B.C. deputy ministers on evidence related to addiction. One week after the briefing, I received a letter ordering the immediate destruction of our entire database spanning over 20 years of research and involving hundreds of thousands of British Columbians. Remarkably, the B.C. government subsequently lied about these actions.

● (1600)

I continue to speak out because I have a responsibility. The suffering in some parts of our country is exacerbated rather than ameliorated by public programs. We need to redirect our actions to address addiction prevention and recovery.

I’m grateful for the opportunity to appear.

Thank you.

The Chair: Thank you, Dr. Somers.

[*Translation*]

We will now turn to the representative from Arrimage Jeunesse and Mouvement de la relève d'Amos-région.

Please go ahead, Ms. Jutras.

● (1605)

Ms. Catherine Jutras (Consultant, Overdose Prevention, Arrimage Jeunesse and Mouvement de la relève d'Amos-région): Hello, everyone.

First of all, thank you for inviting me to appear before you. I am not used to having this kind of platform. I have been working on the front lines for about 20 years and I was a street worker for 12 years, working every day with people experiencing the kinds of problems we are talking about today. I am not used to making this kind of presentation and I am a bit nervous, but I will do my best.

I was invited here today because I conducted research for a year and a half. I began the research at the end of 2021 and finished it in 2023. During that research, I was on the front lines documenting the real-life experiences of people who use drugs in an effort to highlight the human element behind this problem. People often refer to data and facts, but the human element often seems to be overlooked. This whole problem is extremely complex. I wanted to highlight that fact. Since I had the opportunity to work with people in order to bring attention to this problem, I had access to their personal histories and was able to develop trusting relationships with them.

In the studies that are conducted, it really seems to me that we will never get the real numbers as long as there are so many taboos in this area. These taboos and stigmatization are major factors that obscure the real things that we see, do not see, or experience at the same time.

I have forwarded my study findings to the clerk so you can review them. I say a study and research, but it was really very simple. I did my research in the community, not with a university.

What led me to conduct my study? I started my study by reaching out to people on the front line. I took part in 29 directed discussions, not really interviews, with people who use drugs. I met all kinds of people, both homeless people and ordinary people who use drugs. I talked to a municipal councillor, to single-parent families and to people working in the mines. People from all walks of life use drugs. Someone said something that struck me, and that was how I began my study. That person said they did not want to become a statistic, the number you become if you die of an overdose. That was really the comment that sparked my study.

What were the findings of my study? I met directly with 29 individuals. I spoke with 14 workers from 11 different services in Abitibi—Témiscamingue, the region I am from. I also reached more than a hundred people through various surveys. What this study shows is the real complexity of the problem.

I would like to ask you to consider the problem from another point of view. Drug use can be seen as problematic in itself. In many cases, however, we see a lot of people who use those drugs to deal with another problem. When I say the complexity of the problem, I mean we have to look at the problem as a whole. Rather than focusing on the fact that a drug causes a specific problem, we have to ask and try to understand why people use those drugs. They are the ones who could tell us why they use them. We cannot generalize because every person has their own reason for using them.

● (1610)

The problem has to be addressed proactively. In my opinion, there are two aspects: prevention, which people talk about a lot, and harm reduction. They have to be considered together because they do not have the same objective. That said, the vision and goals are ultimately the same, but we need to work on both aspects at the same time.

The Chair: Ms. Jutras, I would invite you to finish your opening remarks. The committee members are eager to ask you some questions, and you will have the opportunity to comment further in answering them.

Ms. Catherine Jutras: Time flies, Mr. Chair. I will conclude my remarks, but I will be pleased to provide additional details in answering questions from members.

My message is to ask you to consider the complexity of the issue and to respect each individual's journey. It often seems that people want to solve a problem by giving individuals a predetermined timeframe, but it is very important to respect each person's path to rehabilitation. We have to remember that not everyone who uses drugs has problems.

It is fairly simple to work towards harm reduction by facilitating access to substance analysis. In my view, the problem is that people don't know what they are taking, and they experience the effects of toxicity and contamination, which increase the risk of overdose. Facilitating access to substance analysis could be a step in the right direction.

I will stop here, but I look forward to the members' questions.

The Chair: Thank you very much, Ms. Jutras.

[*English*]

We will now begin with rounds of questions starting with the Conservatives.

Mrs. Goodridge, you have six minutes, please.

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

Thank you to all the witnesses for testifying here today.

My questions are going to be primarily directed to Dr. Somers.

Dr. Somers, you mentioned Dr. Perry Kendall. What was his role when he was a public servant with the Government of British Columbia?

Dr. Julian M. Somers: Perry served as our inaugural provincial health officer, our head medical health person advising the provincial government.

Mrs. Laila Goodridge: What about Dr. Mark Tyndall?

Dr. Julian M. Somers: Mark served as Perry's deputy and overlapped in that role with Dr. Bonnie Henry, also serving as deputy provincial health officer.

Mrs. Laila Goodridge: What about Martin Schechter?

Dr. Julian M. Somers: Marty—I'm sorry; before our most recent disagreements, I was on a first-name basis with all these individuals.

Marty worked in HIV/AIDS in the centre.

They all had very important roles and worked collaboratively in truly groundbreaking HIV/AIDS-related work. Marty, most recently, is the scientific director of the Michael Smith foundation, which is B.C.'s largest health research funder. He also has a role at the University of British Columbia.

Mrs. Laila Goodridge: In your opening statement, you made reference to the fact that some of them are now working for pharmaceutical companies. I think that's quite concerning. I was wondering if you could lay that out a little bit. I know that you have a lot of experience when it comes to this, so I was wondering if you could share with us where they are now.

● (1615)

Dr. Julian M. Somers: I've observed that they turned attention from HIV/AIDS to addiction as a group. They appear to have preserved the same focus on pharmaceutical interventions that made a lot of sense in relation to reducing infectious diseases, but it's not a good fit for addiction. As I said in my remarks, pharmaceuticals play a relatively limited role.

It's clear now that they worked together in advancing a larger agenda to prioritize the role of pharmaceuticals. They each laid claim to various corporate methods of following through on their advocacy. Unfortunately, they also took the step of stymying criticism and had a strong influence on shaping an overall narrative that, in some cases, was really inaccurate—an example being, as was said with respect to HIV, that everyone is at risk. They tried to promote that same narrative with respect to addiction, where it is simply not true.

Looking at B.C. to give some fairly stark examples—

Mrs. Laila Goodridge: Sorry, we have very limited time, so I just want to summarize.

You said that top public health officials, who made decisions about whether safe supply would go forward in British Columbia, then went on to found pharmaceutical companies that would stand to benefit financially by supplying safe supply in British Columbia.

Dr. Julian M. Somers: Yes, and elsewhere.

Mrs. Laila Goodridge: In your opinion, is this a conflict of interest?

Dr. Julian M. Somers: I wouldn't be the first to say there is the appearance of conflict. I believe there is that.

Mrs. Laila Goodridge: It's generally accepted that the appearance of conflict is in and of itself a conflict.

You just said that they wanted to benefit from safe supply elsewhere. Could you expand on that a bit? Where else were they trying to expand their grasp?

Dr. Julian M. Somers: For instance, it would be through the so-called compassion club model, which also harkens back to HIV/AIDS. Essentially groups and networks of people would procure drugs and make them available to others. Those are now across the country. The vending machines that are part of Dr. Tyndall's company are in multiple provinces.

The effort to advance so-called safe supply also had national aspirations and is of course implemented in provinces other than B.C. The origin of this is with this group. They had their sights on having both a national and international impact, as Dr. Henry noted in her report on decriminalization.

Mrs. Laila Goodridge: You wrote a report in 2022 that was really critical of safe supply. Can you expand on that report for us?

Dr. Julian M. Somers: It was only critical insofar as.... We did this for the Alberta Ministry of Health. We've done systematic reviews, rapid reviews. Rapid reviews are done as they sound, very quickly on a focused question, usually before Parliament or the House.

We were given a series of linked questions. We conducted our analysis. We reported our methods. We reported the questions that we were addressing. We found, as others had found, that there was no evidence directly addressing the practice that we're referring to as safe supply. We highlighted some risks and some alternative interventions that have far greater track records and empirical support in reducing severe addictions. That's what we produced.

The Chair: Thank you, Dr. Somers.

Thank you, Mrs. Goodridge.

Next is Dr. Hanley for six minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you to all the witnesses for appearing today.

I want to start with Dr. Nosyk.

Thanks for coming. You previously submitted to this committee a presentation that was based on the risk mitigation study. It's quite a long presentation. There are lots of interesting conclusions. Can you briefly recap that study and its findings?

● (1620)

Dr. Bohdan Nosyk: At a high level, people who received risk mitigation dispensations, particularly opioids, in the week after receipt had a much lower risk of death. We saw a biological gradient in that effect. More dispensations led to a lower risk of death. That was controlling for access to OAT, so it was independent of access to OAT.

We've since come up with a separate study looking at coprescription, because doctors often coprescribe hydromorphone tablets alongside OAT. We actually saw some really positive benefits in terms of improving retention in treatment.

Mr. Brendan Hanley: Thank you very much.

Can you see these results applying to other settings? What are the conclusions that we could derive in terms of harm reduction and safe supply being applied to other settings?

Dr. Bohdan Nosyk: I think this is one tool in our tool box. It's one step and one part of a continuum of care.

As others have mentioned, I don't think this is a debate of harm reduction versus recovery-oriented models. I think we need a full spectrum of different options. In a time when we're dealing with a progressively more toxic and unpredictable drug supply, we need more options to deal with these challenges, not fewer.

Mr. Brendan Hanley: Are you familiar with the research of Dr. Somers and specifically some of the criticism of his research quality by leading addiction experts?

Dr. Bohdan Nosyk: I am.

Mr. Brendan Hanley: Could you elaborate on that for the committee?

Dr. Bohdan Nosyk: Would you like me to comment on that?

Mr. Brendan Hanley: Yes, please.

Dr. Bohdan Nosyk: When the report came out, I hadn't seen it. I had only seen the review and the critique. I reviewed both the report and the critique, and I came to the same conclusions as those who wrote the critique. I thought the conclusions didn't match the underlying data. I think they were premature.

At that time, colleagues across the other institutions I was working with and I were designing the evaluation of the RMG program. It took us time to collect that data and report it out to the public. I was a signatory to that critique.

Mr. Brendan Hanley: Mr. Perrin, thank you for your testimony.

I read your book, *Overdose*, which you wrote in 2020. I was going to bring it for you to sign, but I realized you were on the video conference today.

Prof. Benjamin Perrin: I'm sorry about that.

Mr. Brendan Hanley: When you wrote that book four years ago, it was during the pandemic.

Has anything changed, apart from things getting worse in most jurisdictions and the contaminated toxic drug supply getting worse and more complicated? In terms of your overall observations, your approach and your recommendations, has anything changed since you wrote that amazing book?

Prof. Benjamin Perrin: The core problem remains the same. It has become worse. Particularly here in B.C., as you alluded to, if you look at the graphs in the B.C. coroner's reports, we see that not only do we continue to have these persistently high levels of illicit fentanyl in these post-mortem toxicology reports, but benzodiazepines have continued to steadily rise and increase.

When we're looking at reasons for why deaths are continuing unabated, relatively speaking, despite some measures being taken, that is something big to contend with.

I think the big thing that has changed, though, since 2020-21 is that we're in the midst of a major backlash against measures that are evidence-based and that we know save lives. Specifically, these are supervised consumption sites, regulated safer supply and treating people who have substance use disorder as people rather than as criminals.

When I wrote *Overdose*, to be quite honest, I actually thought I was wasting my time on a few chapters in the book in which I was arguing why we need to have supervised consumption sites and why we need to have alternatives to toxic drugs. At the time I wrote it, I thought it was so self-evident and that was where things were going. Now we see it going in completely the opposite way.

The biggest concern I have right now is the misinformation and the lies that are blocking life-saving interventions.

● (1625)

Mr. Brendan Hanley: Thank you.

Can you give an example of a lie or two that are being propagated and preventing evidence-based policy from being implemented?

Prof. Benjamin Perrin: Yes. Here's one that I called out: This is from Conservative MP Glen Motz. Some of you will have seen this. It is a tweet he put out on X on April 30 of this year. He wrote, “Trudeau decriminalized public use of crack, heroin & other hard drugs, resulting in a 380% increase in BC deaths”. That's a lie. I responded to him directly in my own post, citing BC Coroners Service data. I wrote, “This is a lie you are spreading. There has been no such increase”. In fact, the most recent data at that point was from February 2024, comparing February 2023 to February 2024. In those months, there was actually an 11% decrease in people who had died.

Those are the kinds of lies and misinformation we're talking about.

A second example I would give you is the lie that it's safer supply that is killing Canadians. That's a lie that has been perpetuated by the current leader of the Conservative Party Mr. Poilievre.

The Chair: Thank you, Mr. Perrin.

[*Translation*]

We will continue with the Bloc Québécois.

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

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

Ms. Jutras, no need to blush or apologize for being shy. It is important for us to get the facts from the front lines, in addition to the expert testimony we have heard, beyond the toxic mixture of ignorance and ideology that Mr. Perrin referred to. That truth is subjective of course, but it is important for us, through your voice and your work, to listen and hear what these human beings have to say to us so we can learn lessons and adjust our approach to their suffering.

Mr. Chair, if Ms. Jutras would be so kind, I would like her to submit her qualitative study to the committee so we may refer to it. If she agrees, I would like it to serve as a reference document for the committee.

Ms. Catherine Jutras: Yes, of course.

Mr. Luc Thériault: Thank you.

So you had access to a sample of 29 individuals who opened their hearts and agreed to trust you and tell you their story.

Stigmatization is one of the greatest dangers faced by people with an addiction. We heard about that when we visited major Canadian cities. I would like you to tell us more about that. What harm does stigmatization cause? What do those people say about it?

Ms. Catherine Jutras: I can give you quite a striking example. When I was looking for people to tell me about their experiences, I met a parent whom I didn't know who said that it made no sense and they had to talk about it. It was a single parent of two children, one of whom needed a lot of attention. That parent was incredibly afraid. I say “that parent” for a reason, because they passed their fear on to me. I can't say whether it was a mother or a father, because I am too afraid of identifying them. I respect their anonymity. That parent might however be representative of a lot of parents in the same situation.

That parent has responders and police officers in their family. No one in their family or circle knows they use drugs and take 8 to 10 amphetamine tablets every day to be a good parent. But that person can't manage, isn't able, doesn't have the energy, and cannot do it under the incredible social pressure to be the best parent possible, pressure that you must be familiar with as well. That person who takes 8 to 10 amphetamine tablets every day does not seek help. That person told me that if their children were taken away, that would be the end for them. So they have an incredible fear of seeking help and are afraid to talk. I could hear the person's voice trembling when they spoke to me, a person who deprives themselves of all kinds of services out of fear.

There is also stigmatization, which is even worse than self-stigmatization. People eventually internalize those messages. I am thinking of another person who was very involved in the community, a responder who had helped many people, but whose life had changed dramatically. Now that person is injecting drugs and has been treated as human garbage on the street. They had helped the community so much, but internalized those messages: When doors are opened for them and they are invited in, they answer that they don't deserve it.

There was also another person who asked for help at a certain point. In my study, I say that there is no wrong door to knock on to ask for help. That person knew about a rehabilitation centre, but did not know about the red tape involved. One evening when they were using, they decided they couldn't go on and had to stop because it made no sense. So they went to the centre because they had friends who had gone there. They were turned away and told they would have to go through the usual process and go to the local community services centre. This person didn't criticize the system. They said instead that they didn't even deserve to be helped by an addictions organization and were worthless. Then they went and used drugs. That's an example of the internalization of stigmatization messages.

● (1630)

The Chair: Thank you, Ms. Jutras.

[*English*]

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

Mr. Gord Johns (Courtenay—Alberni, NDP): Dr. Somers, addiction is obviously a chronic relapsing condition, and it takes years for people to recover. Why would you be against safer supply to replace the unregulated, toxic and poisonous straight drug supply for people who relapse?

Dr. Julian M. Somers: It's imbalanced. The broad programs internationally that have shown the greatest success in dramatically reducing high-risk addiction have put the goal before themselves of ensuring social reintegration. That theme was also once active in North America.

In fact, that is the format in which methadone was introduced as a practice. It was not a stand-alone drug administration program but an inducement into a much more comprehensive process that ensured social reintegration.

By adding drugs and not paying attention to the necessity of supporting robust social reintegration, we are essentially, in many cases, providing into a system of poverty a fungible asset.

Mr. Gord Johns: That's not the question. I think we all understand that this is a complex issue. It requires a comprehensive, full slate of responses. I'm trying to get an answer on that.

You talked about—

Dr. Julian M. Somers: The answer is that it will make things worse.

Mr. Gord Johns: Well, that's what your viewpoint is.

● (1635)

Dr. Julian M. Somers: It's the evidence.

Mr. Gord Johns: The First Nations Health Authority, the BC First Nations Justice Council, the Canadian Association of Chiefs of Police, Dr. Henry, who you seem to not support—

Dr. Julian M. Somers: The Canadian Association of Chiefs of Police—

Mr. Gord Johns: Hold on, I'm not done yet.

All four chief medical health officers on Vancouver Island, where I live, the chief coroner of B.C. and the expert task force on substance use have all called for and supported a safer supply of substances. I guess what I'm hearing from you is you seem to know better than them.

You've talked about—

Dr. Julian M. Somers: Were any of them trained in addiction?

Mr. Gord Johns: There are many who were on the expert task force on substance use. Absolutely. We're talking about those who are trained in addictions.

As well, you've cited conflict of interest. You went after Dr. Perry Kendall, who established a non-profit called Fair Price Pharma, and also Dr. Tyndall, who created MySafe, which is a non-profit.

Can you explain? These are non-profit pharmaceutical operators trying to create a safer supply of substances, but you've talked about them being for profit.

Also, we heard about 50 esteemed experts who wrote a letter that disagreed with your paper on housing.

What do you say to those experts who wrote the letter, including Dr. Nosyk, who's on this panel right now?

Dr. Julian M. Somers: There are a number of allegations in your preamble. I'll focus on the question you concluded with.

We wrote a review. It did not, as Bohdan suggests, veer away from discussing the facts of what we found. Other reviewers at the same time had reached the same conclusion, which was that there is no evidence to support the safety or effectiveness of these practices.

In fact, if you search the BCCSU's website and the materials they're providing, you will see that exact disclaimer today. There is no evidence to support the safety or effectiveness of—and there are a variety of practices; fill in the blank—in order to reduce risks associated with fentanyl and other street drugs

That was the main conclusion. How did they assess it? They used the AMSTAR rating system. Bear with me. AMSTAR is a rating system for—

Mr. Gord Johns: You have to be very quick because I have other people I want to ask questions of.

Dr. Julian M. Somers: Well, you asked. I'm answering.

Mr. Gord Johns: Okay. Go ahead.

Dr. Julian M. Somers: They used the AMSTAR rating system, which is a rating system for systematic reviews. I've published systematic reviews on substance use and mental illness over the years. It's important they be standardized. Rapid reviews are not systematic reviews.

What you're pointing out is that 50 people signed on, in an emotional reaction, to a critique of a rapid review using an entirely inappropriate tool, which is basically—

Mr. Gord Johns: Thank you. I have a minute left.

Dr. Nosyk, would you like to give some comments on what you just heard?

Dr. Bohdan Nosyk: Again, this was a review that was done very early in the stages of implementation. I would just urge the panellists to read the review, read the critique and come to your own conclusions. I'll leave it at that.

Mr. Gord Johns: I'll go back to you, Dr. Nosyk.

You've heard me talk about all of the different organizations. Now their credibility is being undermined by saying they're not experts in substance use.

What are your thoughts on that when you hear about the long list of different qualified experts that I just talked about and the organizations they represent?

Dr. Bohdan Nosyk: I would argue that their credibility is very much intact.

Mr. Gord Johns: When you hear their credibility being attacked and you produce peer-reviewed research.... Your peer-reviewed research is being undermined when you hear comments that counter what Dr. Somers said.

Dr. Bohdan Nosyk: I don't take it personally. I think it's good to have dialogue. I think it's good to have alternative positions on matters. We need to discuss. This isn't a simple issue.

We had plenty of critiques on our work when it came out and we responded thoroughly as best we could through public presentations. We tried to deal with it as scientifically as we could. I'm all for debate.

The Chair: Thank you, Dr. Nosyk.

Thank you, Mr. Johns.

Next is Mr. Genuis for five minutes, please.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Thank you, Chair.

My questions will be for Dr. Somers, but I do have a quick comment for Professor Perrin.

I want to say, sir, that I respect your sincerity and your conviction. I've read your book. I do think your comments demonstrate the risk of combining good theology with bad science. I agree with you that love and compassion should define the character of our approach, including love expressed through effective dissuasion from danger and support for recovery but, as Dr. Somers has demonstrated, the NDP-Liberal approach to drug policy is wreaking havoc in our communities. It's causing diversion, and it's supported without credible evidence and pushed to the extreme by self-interested industry groups.

My first question is for Dr. Somers.

Many people are hurting as a result of the ongoing and escalating drug crisis, but there are some who benefit from it. Those who produce and sell the products driving this opioid crisis are making money off the suffering of others. Whether they wear hoodies in dark alleys or suits and ties in the halls of power, these drug dealers are benefiting from the pain of the most vulnerable.

You've talked about public health officials like Dr. Perry Kendall, who have gone from health policy roles where they advocate for decriminalization and so-called safe supply directly into business selling pharmaceutical-grade hard drugs.

Do you think that there should be rules in place to prevent former public health officials from going on to financially benefit from their previous positions?

● (1640)

Dr. Julian M. Somers: Yes, there absolutely should be rules. These types of relationships should be transparent. The Stanford-Lancet Commission urged the same thing.

In fact, when they assessed the roots of the North American opioid crisis in Canada and the U.S., the first area they highlighted was conflicts of interest and the movement—and Dr. Kendall, unfortunately, illustrates this—of people from roles in senior public health and governance roles into, in his case, the BCCSU, and then also into roles with other organizations like the BC Centre for Disease Control, which has been flagged as a source of funding for the very company that he and Dr. Schechter started.

It's one thing to consider whether the action of moving into pharmaceutical provision of drugs is a sensible thing. It's quite another to be advocating for that and setting oneself up to be the provider, so yes, there should be transparency.

Mr. Garnett Genuis: Thank you.

You alluded to this. The original cause of the opioid crisis was Purdue Pharma. They advanced drug liberalization in order to aggressively market their own new opioid product, OxyContin, in the 1990s and early 2000s. This is how the first opioid crisis began, and certainly there was conflict of interest rampant at that time with people moving back and forth between companies and regulators, etc.

Today, Purdue is at it again. Their own branded hydromorphone product, Dilaudid, seems to be the preferred option for this program of state-subsidized hard drug distribution.

It seems bizarre to me that the people responsible for the opioid crisis at Purdue are now making even more money selling drugs, marketing easier access and drug liberalization as a solution to the problem.

Do you have any insight into why a Purdue product specifically has become the go-to and what Purdue has done to engage government and civil society to be able to bring about this outcome that's very financially beneficial to them?

Dr. Julian M. Somers: Unfortunately, no, I don't, but I share your observation that it is a perverse irony.

Mr. Garnett Genuis: We know that Fair Price Pharma has met extensively with this government, meeting multiple times with the previous minister of mental health and addictions in person and having, I think, 12 meetings over the course of two years with officials.

Dr. Somers, I have moved a motion at the government operations committee asking for the release of these so-called safe supply contracts. I believe that parliamentarians and the public should know about the kinds of deals that these high-priced companies like Purdue Pharma have signed with the federal government.

The Liberals have been filibustering that motion of the government operations committee in order to prevent the release of those contracts. They've said on the one hand that they don't think any such contracts exist directly between the federal government and these companies, but, on the other hand, they've filibustered to prevent the release of those contracts

Do you think those contracts should be released? If you do, why do you think so?

Dr. Julian M. Somers: They absolutely should be released because they represent public expenditures that are directly related to a highly controversial set of drug policies that are really only active in Canada, so we absolutely need greater transparency.

I would add that we need greater transparency on the flow of public and private funds into organizations like the BCCSU. Our standards for reporting in comparison to the U.S. Sunshine Act are relatively lax. We need to understand better how funds are flowing through organizations like the BCCSU into community groups that are allied with their advocacy like VANDU, DULF and many others and how pharmaceutical funds are augmenting those monies in order to pursue what appears to be a concerted agenda.

● (1645)

The Chair: Thank you, Dr. Somers.

Next is Dr. Powlowski for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I'd like to start off with a question for Dr. Somers.

You said that at some point you were ordered to destroy your database. Who ordered you to destroy the database? Why?

Did you actually destroy the database?

Dr. Julian M. Somers: I did my best to protest, but we were forced to destroy the database, and that has been done. I provided a briefing to deputy ministers—all the non-dirt deputy ministers.

Mr. Marcus Powlowski: Who ordered you?

Dr. Julian M. Somers: The Government of British Columbia.

Mr. Marcus Powlowski: Your database was as a professor at UBC?

Dr. Julian M. Somers: I started it at UBC. I subsequently moved it to my position at Simon Fraser University.

This is data that we obtained from multiple government ministries, in some cases with the consent of people we were aiming to assist, people with profound addictions who were living homeless in Vancouver and who were participating in some of our intervention efforts.

We had a large raft of information spanning more than 20 years. We had been doing this work for two decades, and we received that instruction one week after I provided the briefing.

Mr. Marcus Powlowski: What was the reasoning for that? Was it that there was confidential information in there that you weren't supposed to have, or was there no rationalization?

Dr. Julian M. Somers: There was no question of propriety.

In fact, we had agreed with the government to renew the database for another period. That had been formally completed with the Ministry of Health, and we were rebuilding it around an additional study looking at addiction and death in COVID. There was no rationale.

The government lied by saying that they were planning to do this anyway, which clearly was not true. If it were, there would certainly have been some prior communication about that. They said things that really didn't make any sense—that we could get the data from other sources, which is clearly false. There is no other way to get these data.

The only rationale that makes sense to me, and I've had this confirmed from one of the deputies that was in the room, was that my remarks antagonized some of the deputy ministers because they got the impression that I was saying their policies addressing addiction and homelessness were not effective.

Mr. Marcus Powlowski: Why did you comply with that? It seems like an administrative order by someone in government. It wasn't a legal authority. Why did you do it?

Dr. Julian M. Somers: No one at the university was coming to my defence. They persisted in ordering it done. I didn't see any recourse. Maybe I should have spoken with you earlier.

Mr. Marcus Powlowski: Maybe.

Mr. Perrin, you talked about your Christian faith, and I agree with a lot of your positions on harm reduction.

What do you say to people who are concerned about somebody smoking crack next to them on the beach when they're there with their kids? What do you say to the little old ladies or your parents who want to go downtown in Ottawa or B.C. but are afraid to because of open drug use?

People are using drugs, and we've heard that with methamphetamines they sometimes become psychotic. The fact that a lot of downtown cores have become, a little bit, hellholes...and it's revolving around things like safe injection sites. I'm sure—or I would think—that you have some sympathy for these people, while still believing in harm reduction. How do you get that balance right? Have we got the balance right?

Prof. Benjamin Perrin: Thank you for the question.

First of all, we've had public drug use in Canada prior to the now largely rescinded decriminalization pilot in B.C. and in other cities. As I travel throughout the country, I see the types of things you're talking about. It's not limited to B.C. or Vancouver. I want to talk briefly about B.C., though.

The Vancouver Police Department, and this is a quote from Inspector Phil Heard, who oversees the VPD drug unit, stated on March 3, 2024, “We've actually seen a decrease in public complaints around public consumption”. That's a direct quote from him.

Chief Constable Adam Palmer was asked about any sorts of statistics that were kept around the police claims that they didn't have recourse for the types of situations you're talking about. This is a quote from the article I'm referring to: “Palmer said the VPD has not kept statistics on number of incidents where a person was using drugs in a public place, where police were unable to intervene.”

Really, what we're seeing is quite a large upspring in concern, but the data is not backing it up. How do we get it right?

● (1650)

The Chair: Thank you, Professor Perrin.

Thank you, Dr. Powlowski.

[*Translation*]

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

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

Ms. Jutras, we know that we need to take more than just one approach. We can't force people living on the street to go to detox treatment. Harm reduction also has an important role to play. From what the people who opened up to you said, has a safe supply had a positive or stabilizing effect on their path to healing or to a more humane existence?

Ms. Catherine Jutras: Yes, absolutely.

It is a complex problem and that approach will not necessarily work for everyone. That said, there are some great success stories. I asked one person what access to a safe supply had changed for her, and she said jokingly that she's much fatter now. Since that person was constantly searching for drugs, she was not eating well. So her health has improved and she has started working again. She even said she can afford to go to the movies now. So this approach has made a huge difference in her life.

Mr. Luc Thériault: Have you also heard that drug use stabilizes?

Ms. Catherine Jutras: Yes. Safe supply allows for dosing, which gives the person some balance not available to a street person. A person can say they take a certain number of doses, but those doses can vary. So it is not the same stability as when a person consults a medical specialist. If this approach works for someone, it can certainly offer stability.

Mr. Luc Thériault: Some people focus a lot on the diversion of safe supply. In Abitibi—Témiscamingue, does that do justice to the benefits of this approach, in your opinion?

Ms. Catherine Jutras: Not necessarily. If a person is using drugs, it is because it is meeting a need. I don't know many people who will divert the drugs they use and go through withdrawal.

The Chair: Thank you very much.

[*English*]

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

Mr. Gord Johns: Mr. Perrin, you are the former senior criminal justice policy adviser for the Conservatives under Prime Minister Stephen Harper. You've heard the Conservatives of today talking about opposition to safe consumption sites, to safer supply, to decriminalization, actually blaming all of the deaths on these policies from the NDP in British Columbia. Can you talk about your concerns about this rhetoric and also what policies you would not recommend be adopted by the Conservatives and why?

Prof. Benjamin Perrin: I'll be honest. I'm feeling pretty frustrated with the distractions that I've been hearing talked about today in the committee. I was checking on social media right now, and one of the committee members is already posting gotcha clips from this committee hearing in the process of the hearing happening. Is this about hearing evidence about how to save lives, or is it about your social media channels? Is it about getting hits, or is it about saving lives? I'm disgusted by that, actually; I'm disgusted.

The lives that are going to be lost.... We know the opposition to supervised consumption sites kills people, and the federal special advisory committee on the epidemic of opiate overdoses had projections from December 2023. They projected that hundreds more would die if these harm reduction measures were not scaled up across the country, and their forecasts have been proven correct. This will only worsen if we have a federal Conservative government that suppresses, shuts down and fails to fund and support these life-saving medical interventions.

● (1655)

In terms of policies that I would recommend not be pursued, to start with, we're being told that our goal should be to bring people home drug-free. One of my co-panellists frequently talks about addictions. He's not talking about actually saving lives. He's repeatedly referred to evidence about addictions, not saving lives.

We don't have an addiction crisis. We have a toxic, unregulated drug crisis. Again, the research shows that if our focus is on simply detoxing people and getting them off drugs, if that's the main goal, that has an elevated risk of death. When your treatment is all about detox alone, it's not medically recommended. I would not recommend that kind of treatment and recovery.

Second, the idea that we can stop fentanyl at the border has backfired. Fentanyl is now being made here in Canada. We know that from the RCMP. Additionally, we've been told “jail, not bail”. In the context of this crisis, a better slogan would be “jail means death, without fail”. That's for people with opioid use disorder.

When we look at the data, who is dying? In Alberta, former premier Jason Kenney said that for every Albertan who died of unregulated drugs, half had been in custody in Alberta within the last two years. In B.C. it's two-thirds of all people. We need to stop locking people up and perpetuating this failed war on drugs that is only making things worse.

The Chair: Thank you, Professor Perrin.

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

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

My first comment will be a comment for Mr. Perrin and not a question, so there's no need to reply.

Actually, I do have a question.

Mr. Perrin, do you have a medical degree?

Prof. Benjamin Perrin: No.

Mr. Todd Doherty: Thank you.

Next is my comment. Not one person from the Conservatives, whether it's our leader or ourselves—not one of us—has said anything about safe consumption sites. In any policy, any conversation, there are many tools in the tool box. You're conflating the issue with your anger or frustration towards the Conservative team, and—

Prof. Benjamin Perrin: So you publicly support supervised consumption sites today? Do you publicly support them? Are you willing to say that on the record?

Mr. Todd Doherty: Mr. Perrin, I'll ask the questions.

Prof. Benjamin Perrin: Yes or no, sir? Yes or no, sir?

Mr. Todd Doherty: Mr. Perrin, I'll ask the questions. Thank you very much.

I've been on the record as saying there are many tools in the tool box.

Dr. Somers, I appreciate Dr. Powlowski asking the questions regarding the database and the destruction of the database, but you've also said that there have been activists who have waged war against you in terms of defaming you and discrediting you. Can you elaborate a little more on that, please?

They were paid activists—sorry.

Dr. Julian M. Somers: Thank you.

It started some time ago. We were stymied in gaining access to additional data to link with the databases that we already had. Those were actions by the province and the BCCDC. It really became most clear when we published the rapid review.

I don't understand Professor Nosyk's remark. He clearly is not interested in dialogue. He signed a letter that maligned, publicly, our work. The only time I've spoken to him, he told me that he was emotionally angered by it, because at the time he had responsibilities to conduct research on safe supply. Almost all the signatories—well, all the signatories of that letter that I know—have financial interests in the very topic we were reviewing. We didn't conclude anything that was unusual at the time. It was that there was an absence of evidence. Professor Nosyk has even confirmed that today, saying that things were just getting started.

What we did was point out an awkward thing, which was that the standards for introducing a pharmaceutical in any form of practice in our country and around the world typically follow rigorous assessments of their safety and their effectiveness. In this case, we decided that we were going to implement a measure without any of the controls we used for COVID vaccines—looking for positive effects, if there were any, and for harms, if there were any. We simply launched into it.

As we now know, the studies that were produced were fashioned on the fly. There was no traceable component in the drugs that we introduced in order to enable, in a fairly obvious way, the ability to detect diversion if it was occurring. Not only do we have this odd mashup of evidence today, but more importantly, we clearly adopted a double standard in proceeding with this very experiment. Is that because of the people we're discussing?

● (1700)

Mr. Todd Doherty: Are there documents you feel this committee would benefit from being able to read that might support us in going down the path you suggest we should petition to try to get?

Dr. Julian M. Somers: There are a few that come to mind immediately.

One is the safe supply review, which we call "A Public Supply of Addictive Drugs". I think it's premature to be using the word "safe" in the label.

The second is a review we conducted on decriminalization. It will correct some of the misunderstandings that have been stated even here today. Police chiefs in Canada and in B.C. both wrote reports on decriminalization, stating they were supportive only if robust measures were put in place to help people who police officers encounter, and that has not been done.

The third document I'd recommend is the Stanford-Lancet Commission report.

The fourth is the Portuguese national drug strategy, which is a document rich in its complexity and in its direction, and which, I think, illustrates for other nations how we can get our heads collectively around a concerted approach that isn't referring vaguely to tools and tool boxes and making things hyper political but is actually integrated and purposeful.

The Chair: Thank you.

Mr. Todd Doherty: Thank you, Dr. Somers.

Can I ask just one question?

Those are four public documents, I believe.

Dr. Julian M. Somers: That's correct.

Mr. Todd Doherty: Would you be able to provide the committee with those this week by any chance?

Dr. Julian M. Somers: I would, happily.

Mr. Todd Doherty: Thank you so much.

The Chair: Thank you both.

[*Translation*]

Ms. Brière now has the floor for five minutes.

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

Dr. Somers, do you have any evidence that Fair Price Pharma has made any profit from the sale of a safer supply?

[*English*]

Dr. Julian M. Somers: I haven't seen their financial documents, even though, as we're aware, not-for-profits can still pay people. I'm not aware of the flow-through of funding or their success in obtaining funds in the first place.

[*Translation*]

Mrs. Élisabeth Brière: Has the B.C. government offered you access to a new database to continue your research?

[*English*]

Dr. Julian M. Somers: No, unfortunately, they have not. It's my belief their intention was to ensure that there was no capability to assess the performance of the programs they have grown over these last few years.

Mrs. Élisabeth Brière: Thank you.

[*Translation*]

Dr. Nosyk, we all know that the opioid crisis is complex, with various facts. We also know that one of the challenges for opioid users is their long-term retention once they have started opioid agonist treatment. Would you agree that the difficulty keeping people on that kind of treatment is the result of stigmatization as well as a lack of options?

[*English*]

Dr. Bohdan Nosyk: I think those things contribute to the problem. We have had a lot of experience with opioid agonist treatment over a very long time. It has been accepted that this is a chronic recurrent disease and that people typically go through stages of remission and relapse. That process has continued, but as people relapse they're now being faced with a far more toxic illicit drug supply. It's far more dangerous to relapse off opioid agonist treatment nowadays, and so we need more options to keep people safe.

Treatment is one part of a continuum of services that we need. I think we need to adjust our expectations and adjust our knowledge, based on the introduction of new contaminants into the drug supply, which is still happening. The ground is still shifting beneath our feet here. We're trying hard to keep up. It's painful to watch our outcomes continue to deteriorate and it's painful to hear from physicians who are trying their best to keep their patients alive. It's difficult.

● (1705)

[*Translation*]

Mrs. Élisabeth Brière: Thank you.

We have just returned from visiting various Canadian cities. We met with front line organizations, such as the one represented here today by Ms. Jutras. We found that people are suffering, and people are looking for solutions, both for the people who help drug users and save lives, and for drug users.

You talked about finding options. We are gathered around this table and we have to find a solution to overcome this crisis. What can you recommend to us?

[*English*]

The question is for you, Dr. Nosyk.

Dr. Bohdan Nosyk: I'm sorry.

We need to recognize that there is a place for recovery, a place for outpatient treatment and definitely a place for harm reduction. All of these need to work together. Again, it's painful to see continuing deteriorated outcomes. It's also frustrating to see that, more and more, this has become a public discussion about finding culprits and throwing stones, rather than finding solutions. I came here to provide the expertise and evidence I have generated or come across. I hope I'm coming across as a constructive member of this panel and giving you evidence to build on.

We need more information. That was the bottom-line statement in my introductory speech. We don't know very much of anything about recovery-oriented models of care. We don't know very much of anything about the outcomes of short-term detoxification. That's the sort of thing that needs to be reported systematically across the country.

The Chair: Thank you, Dr. Nosyk.

Next, we have Mrs. Goodridge for five minutes.

Mrs. Laila Goodridge: Thank you.

Mr. Somers, you started out your opening statement by referring to the fact that you're in recovery. I was wondering if you could share a little of that with us, because I think it probably shapes how you approach your work here.

Dr. Julian M. Somers: Honestly, I'm not sure, but you can decide.

I was adopted. I grew up with and was exposed to traumatic experiences at an early age and developed mental illness symptoms and addiction symptoms. Those persisted for a number of years, starting around age nine. I left school and was out on my own as an early teen. I was relocated to another family, where I found the beginnings of some stability.

When we look at how people identify recovery, it includes several components: connection, hope, an improved sense of identity, motivation for the future and a feeling of empowerment—recognizing that one of the core features of addiction is the experience of loss of control over one's behaviour while one is aware of the harms that are resulting. Those components spell the acronym CHIME. CHIME was produced through meta-analyses and systematic reviews. It's been replicated. This is how people describe their experience of recovery.

That was certainly true for me. I was fortunate to find it through study, mountaineering and pouring my energies into those types of activities. I never went to 12-step meetings, but I know many people, of course, who benefit from other methods of transcending their loss of control and finding those qualities summarized in the CHIME acronym.

● (1710)

Mrs. Laila Goodridge: Thank you for sharing that. I think it's important for people to understand what exactly recovery is and how it can look and play out in different spaces and aspects.

When it comes to Fair Price Pharma and their heroin.... Do you believe there should be a move towards a retail heroin business in Canada, as is being purported by Fair Price Pharma?

Dr. Julian M. Somers: No. I think that would be a very ill-advised step.

Mrs. Laila Goodridge: Regarding the vending machines for so-called safe supply that Dr. Mark Tyndall has put forward, do you think that is a responsible use of taxpayer dollars?

Dr. Julian M. Somers: Not at all.

The familiar refrain, which has some truth to it, is that addictions are problems of loss of connection. Therefore it is bewildering to put a vending machine between the government and a person who is suffering, rather than an opportunity to interact with a human who can accompany them on some constructive steps along the healing path.

Mrs. Laila Goodridge: I heard you a while back at a conference in Calgary talking about the housing market. One of the studies you did was on who were most successful post-recovery in housing, and housing models.

I wonder if you could expand on that a little.

Dr. Julian M. Somers: Canada has a major tradition of following deinstitutionalization, along with many other places. It's a tradition predicated on closing large institutions on a commitment to institute community-based, recovery-oriented services. This is a decades-old refrain we were reminded of when Senator Kirby crossed the country and summarized his findings in “Out of the Shadows at Last”. Once again, we were told we have not closed that gap.

Canadians funded the world's largest randomized control trials to evaluate recovery-oriented housing in comparison with usual care. The results were dramatic. I led the trials in Vancouver, where our focus was on addiction. We found dramatic reductions in crime and medical emergencies, and improvements in health—

Mrs. Laila Goodridge: Are there any documents on that?

Dr. Julian M. Somers: There is a large number of peer-reviewed publications.

Mrs. Laila Goodridge: If you could table those with the committee, that would be spectacular.

Dr. Julian M. Somers: I will.

Mrs. Laila Goodridge: To follow up on some of these points, I wonder if we could get agreement around the room to have documents produced, specifically financial documents, donor information and contracts with the government for Fair Price Pharma and MySafe, and add them to our committee.

I'm wondering, Chair, if we could have—

The Chair: You're out of time, Mrs. Goodridge.

That's a request for unanimous consent for the production of some documents.

Is everyone clear on what's being asked for?

Mr. Todd Doherty: Yes.

The Chair: Okay.

Do we have unanimous consent to request those documents?

Mr. Brendan Hanley: No, not right now.

The Chair: Okay. There is no unanimous consent.

● (1715)

Mr. Gord Johns: Mr. Chair....

The Chair: Do you have a point of order, Mr. Johns?

Mr. Gord Johns: Yes.

I'm happy if my colleague wants to bring this back at another time so we can revisit it.

The Chair: Thank you.

Next we have Ms. Sidhu for five minutes.

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

My first question is for Mr. Perrin about misinformation.

Mr. Perrin, my question is about the deliberate political strategy of some post-truth populist politicians. We know some post-truth populist politicians south of the border and in our country are spreading misinformation for electoral gains and fundraising.

Do you have any evidence or numbers to share with this committee on how misinformation impacts the lives of Canadians?

Prof. Benjamin Perrin: That's not an area I specifically study, but I can comment on what I know in the context of this committee's work on the unregulated drug crisis.

First off, generally, we know misinformation spreads more rapidly than truth. Likewise, corrections or responses are also very slow in coming, if at all. What most concerns me is seeing a persistent and repeated pattern of misinformation and lies being spread by the current leader of the official opposition, who seeks to become the next leader of our country on this issue. It is deeply repugnant, during a public health emergency that is killing tens of thousands of Canadians, that there would be any dispute, let alone the deliberate spreading of misinformation about the proximate cause of that.

We know from every available source what the cause of the toxic drug crisis is. It is illicit drugs made by organized crime, full stop. There are reasons people take drugs. There are different pathways we could take with policy. However, if we can't even agree on the problem, we're never going to get to saving lives. I think that is the starting point for this committee's work: Do the members of this committee agree that's the problem? The second is: What's the objective? Is the objective to save lives, or is it to follow the polls?

There is a clear correlation between policies that are not evidence-based but which poll very well, such as cracking down on people who use drugs with forced treatment, and that result in increased deaths, according to the research.

Ms. Sonia Sidhu: Do you agree that misinformation costs lives or impacts the health of Canadians?

Prof. Benjamin Perrin: Misinformation on a pressing public health issue like this absolutely is killing Canadians. It is fomenting opposition to what we know to be life-saving medical interventions, things like supervised consumption sites.

I think it's incredibly disingenuous for one of your colleagues on the committee to claim, without being very clear, that it's part of a tool box, whether the Conservative Party supports it or not. If that's the case, I'd like to hear from Mr. Poilievre. I challenge Mr. Poilievre to stand up in the House of Commons tomorrow or at a public event and state, "I support supervised consumption sites, period." That's a simple sentence. Is that his policy or not?

We're not here to play games. Lives are at stake, and Canadians have a right to know.

Ms. Sonia Sidhu: We see many biased political pages spreading misinformation online. The Government of Canada had a similar issue during the pandemic, where we had to use advertising and work with local journalists to provide accurate information.

What approach would you recommend to this committee on combatting this type of information, which is misinformation, when it comes to addictions?

Prof. Benjamin Perrin: There's a role the media has to play. There's a role that politicians have to play.

Ultimately, we're in a climate that's unlike any I've experienced before. I remember the days when if you had facts and credible evidence to support a policy, that would persuade people. We're living in a post-truth world. It's very difficult and frustrating for those of us who are concerned about facts and truth, but I think we have to continue.

The people who are most impacted by this need to be at the table. We need to hear from them. I don't know—I've looked at it a little bit—about the committee's witness list, but I strongly encourage the committee to hear from more people with lived experience. There are 400,000 Canadians who have gone to supervised consumption sites, over 5,000 Canadians here just in B.C., who have relied on a regulated alternative to the toxic criminal drug supply. Those are the folks who the committee needs to hear from. They will give you the evidence you need to hear.

● (1720)

Ms. Sonia Sidhu: My next question is for Dr. Nosyk.

On the shared jurisdictions, such as public safety, this committee had important testimony from law enforcement agencies in B.C. about the tools they require from provinces. We know municipalities are in charge of local bylaws.

What recommendations can you give to the committee on working with provinces, like B.C., and municipalities to respond to this crisis?

Dr. Bohdan Nosyk: I think it's collaboration across jurisdictions, across different sections of government. This isn't something the public health sector can solve on its own. We need collaboration with law enforcement. We need collaboration with housing and the ministries of child and family development. This isn't something we can tackle alone in the space of public health.

The Chair: Thank you, Dr. Nosyk.

Thank you, Ms. Sidhu.

[*Translation*]

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

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

Ms. Jutras, given the toxic and lethal drug crisis, we have to be there for people who are dealing with addiction. That is a constant that we are seeing. Help has to be available when they need it. What should we focus on as an overall approach to more effectively help those people?

Ms. Catherine Jutras: We certainly have to listen to them. That is the foundation because individuals have different life stories. They are not all at the same stage in their lives, and they do not all have the same needs and goals. So we have to listen to them, consider them as experts on their own lives, but not necessarily try to place them somewhere or dictate a recovery path for them. We have to listen to the person.

There is an interesting document that we use a lot in street work, roughly translated as Street Work: From the Spoken Word to the Written. This document says that if we make arrangements for the margins, the margins will make other arrangements. There are in fact always margins. From what I have seen, people cannot be forced to live entirely in a community. The vision put forward is instead to create bridges between the margins and the rest of the community so there are channels.

Mr. Luc Thériault: We should not impose a specific approach, but rather we have to see—

Ms. Catherine Jutras: We have to offer a choice.

Mr. Luc Thériault: Okay.

We have talked a lot about safe supply, but isn't supervised housing also an approach to harm reduction? It isn't a miracle solution, but it can help stabilize use and gradually improve quality of life.

The Chair: Mr. Thériault, I understand the witness has a connection problem. In any case, your time is up.

Mr. Luc Thériault: Mr. Chair, if Ms. Jutras comes back online, we could give her—

The Chair: We have to wait for the technical issue to be fixed first.

Mr. Luc Thériault: Okay. If she comes back online, we could give her the chance to answer, if the members of the committee agree.

In the meantime, you can go to the next person. We will use the 30 seconds later on.

[*English*]

The Chair: Okay.

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

Mr. Gord Johns: Thank you.

Earlier I cited that the B.C. First Nations Health Authority, the Canadian Association of Chiefs of Police, our chief medical health officer of British Columbia, Dr. Bonnie Henry, the chief coroner of B.C., the expert task force on substance use, the former chief medical health officer, Perry Kendall, and Mark Tyndall are now being referred to as paid activists. It seems, according to the Conservatives and some witnesses they bring, like they're alluding to some sort of conspiracy.

Mr. Perrin, what do you think when you hear that all of these experts....? The question was brought earlier that they're not experts in addictions medicine.

What do you think when they're deemed to be unqualified, or that we shouldn't seek out their expert advice when it comes to addictions medicine?

● (1725)

Prof. Benjamin Perrin: It's a shocking, unethical and false allegation. When you cast aspersions in a setting like this, where you're protected from criminal and civil liability, and you don't give anyone you're making allegations against an opportunity to respond, it's a very dangerous combination. I recently watched a podcast on McCarthyism, and it reminds me of that, if you're going to start casting aspersions about people.

There's a process and a way for the committee to explore any of those concerns it wants. If it wants to go down that road, which I don't think is necessary, it should be giving those people a chance to respond.

There is a widespread consensus across different groups of people who work on this issue, including addictions experts, that we need to address the root cause, which is this unregulated drug supply.

You mentioned the BC Coroners Service. I would encourage the committee to not just take that title, but when you look at the report that is the basis for the BC Coroners Service's recommendation for regulated alternatives...I haven't even counted, but there are between 12 and 18 listed experts who all work in this field, including addictions experts and physicians.

It's one thing to say someone disagrees, but to try to suggest that there's something else there is false, misleading and unethical.

Ultimately, in closing, I would urge the committee to please focus on the main concern here. You're studying why this is the leading cause of unnatural death for Canadians, and it's going to continue to go for a long time, unless we begin to address the root causes of it, do the emergency response now and build the holistic supports around housing, addressing childhood trauma, prevention and all of that.

We need to deal with the crisis we have urgently.

Mr. Gord Johns: Do I have time for a very short question, Mr. Chair?

The Chair: Yes. Go ahead.

Mr. Gord Johns: You're the former senior criminal justice policy adviser to Stephen Harper. What would your advice be to Pierre Poilievre and the Conservative Party?

Prof. Benjamin Perrin: I would just say please look at this with fresh eyes. This is not an ideological issue. We need to follow the the best available evidence to depoliticize the issue.

Why are you in government if it's not for the benefit of Canadians? This has to be about saving lives, not about following the polls or anything else.

The Chair: Thank you, Mr. Perrin.

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

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

Mr. Perrin, you don't have a medical degree. Is that correct?

Prof. Benjamin Perrin: I already answered your question about that. Of course not. I'm a law professor, so no.

Mr. Todd Doherty: Are you an addictions specialist?

Prof. Benjamin Perrin: No. I'm a law professor.

Mr. Todd Doherty: Okay, so really, the only—

Prof. Benjamin Perrin: I interviewed those people for my research, though.

Mr. Todd Doherty: You talked about having Canadians who have lived experience appear before our committee on this. I couldn't agree with you more. I think we'd get much more benefit from that than having a pissed off ex-staffer basically defame his ex-party and potential leader, the next prime minister of Canada, at every intervention.

Dr. Nosyk, I really, truly appreciate the testimony you have given us over the last little bit. You've offered a lot of insight, as have many of our witnesses throughout this study. It's quite frustrating when you have somebody who comes on and it's very clearly a very partisan attack, when I think for the most part, we're having these discussions at committee, we have all really tried to do our very best to understand this. It is a very complex issue.

Mr. Perrin, you mentioned in previous remarks that the Conservatives, including our leader, have been spreading lies and misinformation, including that safe supply is what's killing everyone. No one is saying that.

What we are saying very clearly on record is that so-called safe supply is an unsafe and irresponsible policy and that it's making the crisis worse. We cannot—

● (1730)

Prof. Benjamin Perrin: Your leader said that. Your leader said safe supply is killing people.

Mr. Todd Doherty: Again, Mr. Perrin, it's my time and not yours.

The challenge we have is that we are perpetuating addiction without getting people either into detox or into treatment so that...recovery and we can bring people home. I know what I'm talking about, as I've shared very publicly the battle our family has had with my brother's addiction and other addictions within our family's life.

I noted that one of our colleagues had mentioned, or maybe it was in your testimony, that we haven't even bothered attending. Just because it's not public doesn't mean we haven't gone to these sites by ourselves. I don't do things just for social media likes and what have you. I go about doing my own business and visiting these sites on my own. Thank you very much.

Mr. Somers, thank you so much for sharing your story today. I appreciate the work you are in and what you're going through, long-term recovery. Recovery takes many steps.

I want to say again that if you feel there's more information that perhaps you have not had the chance to share with this committee or documents you feel we could benefit from, please mention them today and then send them to us, if at all possible.

Mr. Somers, do you have any further comments?

Dr. Julian M. Somers: I'll add one. It's a growing reading list.

It's the U.K. commitment to a recovery-oriented system of care. A recovery-oriented system of care is the most frequently used framework that governments around the world are using in order to fully integrate all government activities toward a common goal of preventing addictions, as well as actually other mental illnesses, by intervening early and promoting recovery. It runs the gamut from interdiction and international relationships to domestic activities that cut across a broad swath.

We haven't yet mentioned the role of, for example, employment and the fact that 60% of the people who are experiencing poisoning in Canada were unemployed and they're mostly young people. Employment is powerfully related as a protection against the risk of addiction and also as a component of promoting recovery.

A related observation is that not only are poisoning deaths the leading cause of death among youth in B.C., but about 60% of the kids we're losing were in government care. What I'm trying to get at is that this is a very skewed high-risk population.

I am not spreading false, misleading and unethical testimony. I resent the remark. I don't even know why someone would think to say that in this setting.

We have actionable steps that we must take that involve our psychology and our social interactions. I'm summarizing that with the phrase “social reintegration”. We ignore social reintegration at our peril and now are piling on with additional pharmaceuticals that are making things net worse.

I'll gladly forward those documents.

The Chair: Thank you, Dr. Somers.

We'll go to Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley: First of all, Dr. Somers, do you have a medical degree?

Dr. Julian M. Somers: I'm a clinical psychologist. I don't have a medical degree.

Mr. Brendan Hanley: Thanks. Do you have a law degree?

Dr. Julian M. Somers: No, fortunately.

Mr. Brendan Hanley: Okay. I just want to say I find it deeply disturbing, Dr. Somers, that you're making serious allegations based purely on speculation about public health officials in B.C. profiting from the overdose crisis—

Dr. Julian M. Somers: I'm reporting facts that have been publicly reported. I'm reporting facts.

Mr. Brendan Hanley: —when those same people have literally dedicated their lives to some of our most vulnerable and voiceless citizens.

I know why Dr. Perry Kendall and Dr. Schechter started Fair Price Pharma. It was an attempt to address a need that was not otherwise being addressed.

In addition, Dr. Kendall is one of Canada's great leaders in public health. I've been fortunate to be a former colleague of his. I'm sure he would be happy to come to committee to explain Fair Price Pharma.

I want to go back to you, Mr. Perrin.

Would you describe yourself as a pissed off partisan ex-staffer?

Prof. Benjamin Perrin: No.

● (1735)

Mr. Brendan Hanley: Perhaps you'd like to clear the record on that one.

Prof. Benjamin Perrin: Yes, I appreciate that.

My concern on this issue has grown out of the research that I've done the last several years. I spent most of that time, particularly in my last project, talking to people whose lives have been devastatingly impacted by the criminal justice system, by addictions and by substance use. All of us have people in our own lives who have experienced this.

When I wrote this book, *Overdose*, I didn't know anyone who had passed away from unregulated drugs, but now I do. The reason for the very grave concern I have and the strong comments I've made today is that I see a lack of adequate response, and it is killing people. That is what motivates me. I will continue to speak truth on that, and I'm going to continue to call it out. I'll call it out whatever the political party is.

If I'm pissed off, that's the only part.... I guess I am pissed off; I am. I think if any of us were not.... If we continue to see people dying in the numbers they are and we really care about that, that should enrage us, but it has to motivate us to action.

The Chair: Excuse me, Professor Perrin.

[*Translation*]

Are you raising a point of order, Mr. Thériault?

Mr. Luc Thériault: I'm sorry. I didn't mean to interrupt the witness because it is very interesting. I just wanted to remind you that you owe me at least 30 seconds of speaking time.

The Chair: Yes, but that was for Ms. Jutras who still—

Mr. Luc Thériault: I know, but I have more questions and there are other witnesses. I can question a witness for 30 seconds since I still had some time left.

My apologies to Mr. Perrin. I was waving my hand, but it wasn't to interrupt you.

[*English*]

The Chair: Okay.

Sorry about that, Professor Perrin. Please go ahead.

Prof. Benjamin Perrin: That was my answer.

Thank you.

Mr. Brendan Hanley: Thank you.

I hope I can have the minute back that I lost as well.

I wanted to state again for the record and go back to the Leader of the Opposition and the member for Carleton, who does say that government-funded safe supply programs are leading to more opioid deaths. However, I want to leave that for my last minute or so.

Mr. Perrin, I want to come back to you. If you were bringing back to the federal government recommendations from the committee, what would be the top three immediate actions that we could advocate for putting in place where perhaps we're not doing enough at the federal level?

Prof. Benjamin Perrin: I think we need to mainstream what I would describe as safe places for people to use drugs. Former Calgary mayor Naheed Nenshi said that his concern when he left the mayoral office was they only had one supervised consumption site. Where you have one, that's where you get a concentration of people. That's where you get concerns. These need to be more mainstream. That's the first thing. We should look at the mainstreaming of supervised consumption sites as a basic health response.

Second, we need to look at regulated substances, not just unique programs. We need to completely look at how we could replace this toxic supply. We should be looking at a number of alternatives that respond to concerns about things like diversion and look at different models that could work and be willing to do that.

The third thing is we need to have some national standards on what recovery and treatment mean. I mentioned five specific things: evidence-based, rapid access, publicly funded, regulated and, finally, trauma-informed and culturally appropriate.

Mr. Brendan Hanley: Do I have more time?

The Chair: You have about another 40 seconds.

Mr. Brendan Hanley: That's great.

Perhaps I can bring you back, then, to B.C. and the adjustment of the decriminalization approach. Again, I sense that there's a confounding of public disorder or public nuisance with decriminalization.

I wonder if you could comment briefly on the progress so far that you've seen with the approach from B.C. and what you would hope to see from now on.

Prof. Benjamin Perrin: In terms of British Columbia, one of the things the province has done really well is creating a large number, more than anywhere in Canada, of safe places for people to use at the provincial level, and that's when we've had a supportive provincial government. When we don't have that, in provinces like Alberta and Ontario, then funding is the chokehold against supervised consumption sites, so even though they get approved, if they're not funded, they are not going to be effective. That is a huge issue in terms of the federal role.

In terms of B.C., I think it has been a real mistake to recriminalize possession. It is in fact not the public drug use that has been criminalized, as was announced; it's the possession. That means someone walking to a supervised consumption site is liable to be arrested now, and that was not the case prior to this rollback.

We need some really serious thought about what needs to be criminal and what can be administrative. We need to go back and revisit that.

● (1740)

The Chair: Colleagues, we had some technical difficulties that resulted in Mr. Thériault losing a question. The witness has not been able to return, but in the interest of fairness, before we close the meeting, I think Mr. Thériault should have his question time back.

Monsieur Thériault, you have the floor for the last brief question and a brief answer.

[*Translation*]

Mr. Luc Thériault: Thank you, Mr. Chair. That is very kind.

Dr. Somers, from my notes I can see that a lot of issues have been raised but I don't see any solutions. Could you give us three solutions, as Mr. Perrin did, that could help us overcome the toxic and lethal crisis of drugs and organized crime?

[*English*]

Dr. Julian M. Somers: I would make the premise about people rather than about drugs. If we focus on individuals, on human beings, then we have people who are greatly at risk, are socially isolated, are struggling mentally, are unemployed and, on average, are young people.

There are voluntary things that we can do immediately. One would be recovery-oriented housing—I'm not going to be able to break this down—which has been demonstrated around the world and in five regions of Canada through randomized trials to be highly effective.

[*Translation*]

Mr. Luc Thériault: Do you mean supervised housing? We are talking about drug addicts.

[*English*]

Dr. Julian M. Somers: I am talking about people with addictions as well. The people we're losing are unemployed people who are disproportionately living rough and are socially isolated.

As I said earlier, more than half of the young people dying in B.C. were children in care. There is a profound link to social isolation and meaning in life, so there are voluntary interventions such as recovery-oriented housing. I'm not defining it.

For people who are encountering the criminal justice system, drug treatment courts and other specialized courts, when properly resourced, are extremely effective.

The third point I'll mention is prevention. We must do a far more effective job of preventing risk associated with substance use in the first place.

Those would be my top three priorities.

The Chair: Thank you, Dr. Somers.

[*Translation*]

Mr. Luc Thériault: Does prevention also include preventing relapses?

The Chair: Thank you, Mr. Thériault. I said one question, not a full turn.

[*English*]

Thank you to everyone for being here with us.

According to the schedule of the committee, this is the last meeting at which we will receive testimony. There seems to be a lot of interest in continuing that—

Mrs. Laila Goodridge: We have Thursday's meeting.

The Chair: I'm sorry. You're right, Mrs. Goodridge.

Yes, we have at least one more session that we've agreed upon, and there seems to be interest in prolonging it further. You can see why, with the diversity of opinion and the energy that goes into teasing out the opinions of everyone.

Witnesses, we very much appreciate your being here, and thank you so much for logging in and for helping provide us with your perspectives to add to the study.

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

Some hon. members: Agreed.

The Chair: We're adjourned.