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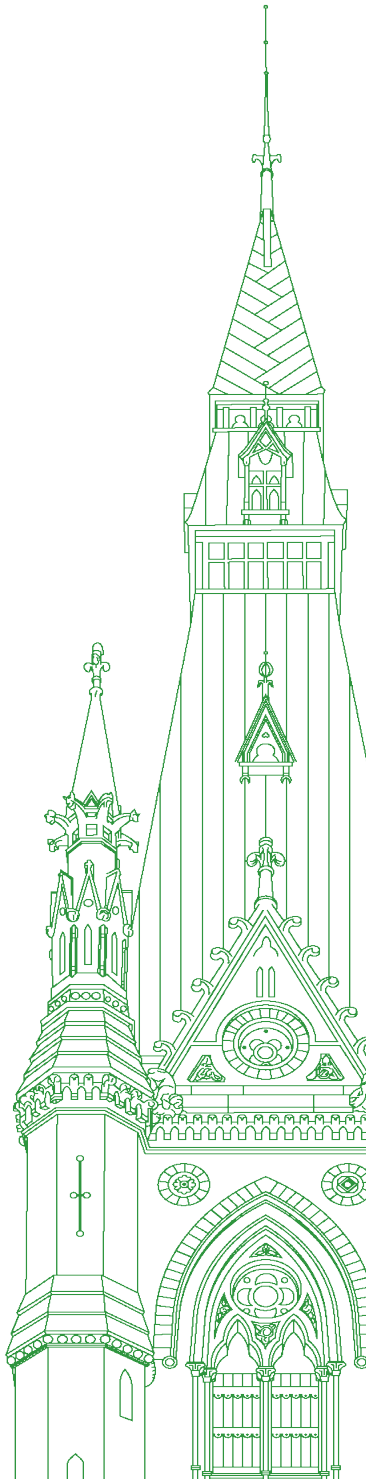

Chair: Mr. Sean Casey

Standing Committee on Health

Thursday, June 6, 2024

● (1110)

[*English*]

The Vice-Chair (Mr. Stephen Ellis (Cumberland—Colchester, CPC)): I call the meeting to order. Welcome to meeting 121 of the House of Commons Standing Committee on Health.

Before we begin, I 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 order to protect the health and safety of all participants, including the interpreters. Use only the approved, black earpiece. The former grey earpieces must no longer be used. Keep your earpiece away from the 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.

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 welcome our panel of witnesses. We have, as an individual, Guy Felicella, harm reduction and recovery expert, by video conference; Dr. David Tu, medical doctor, Kílala Lelum Health and Wellness Cooperative, by video conference; from the Government of Alberta, Dan Williams, Minister of Mental Health and Addiction; and from the Institute for Addictive Behaviours and Dependencies, Dr. João Goulão, by video conference.

Thank you all for attending.

We start with opening statements. You each have five minutes. Should you wish to look at me, I will hold up a one-minute card when you have a minute left. I like to run the committee on time, given my former military background. We'll try to stick with that.

Given that, Mr. Felicella, you have the floor for five minutes.

Mr. Guy Felicella (Harm Reduction and Recovery Expert, As an Individual): Thank you.

Good morning, honourable members.

My name is Guy Felicella. I'm here to speak to you today as someone who has struggled with drug use for more than two decades. I lived on the streets. I was a dealer. I went to jail. I survived six overdoses and severe infections before I found recovery. I now have a job helping others, a family and a life that I love.

Before I give my statement, I want to say that I was hesitant to appear at this committee. I've watched several of your meetings since February and have been disappointed by the witness testimony being taken out of context and shared on social media. This is an issue that I care deeply about, so I'm here to share my story and what I know and to ask you to treat this crisis with the integrity it needs.

Here is my key message: The cause of today's crisis is contaminated street drugs provided to Canadians by organized crime, full stop.

Luckily for me, when I started using substances in 1981 to deal with depression and suicidal thoughts at the age of 12, street drugs were not yet contaminated with unknown quantities of fentanyl, benzos and xylazine.

By my twenties, I was addicted to heroin. I was navigating the hierarchies of prison and gangs, seeing death and violence, facing threats to my safety and my life, and dealing with the extreme challenges of living on the street. I was able to survive all this, in part, because even though they were illicit, I knew the drugs I was consuming.

When North America's first supervised consumption site opened in 2003, my life changed immediately for the better. At Insite, I received clean needles, which reduced my risk of overdose and cut my risk of dangerous infections. I got health care and support services. Every time I asked for it, I got help entering detox and treatment programs.

Insite's records show that I used this harm reduction facility more than 4,000 times in 10 years.

I know some of you think I didn't deserve that level of support and that I should have been left to die from my trauma, my addiction and my choices. However, my wife, my three kids, the people I have supported into recovery and many of the youth I've helped redirect would disagree with you. Maybe even the mayor and council of the City of Vancouver would disagree too, since last month they declared a day in my honour for all the work I do to help people.

I experienced multiple overdoses at Insite, including my last two on the same day in 2013. All overdoses were reversed with naloxone. That staff group there saved my life.

It's probably not a coincidence that fentanyl first appeared in B.C. in 2013, but I don't know if it was in the drugs that nearly killed me. That was also the year, after many attempts, that I achieved recovery and it stuck. If I hadn't, I wouldn't be here to talk to you today.

The heroin I was using, which killed 334 people in 2013, has now completely been replaced in the drug supply by an ever-changing toxic mix of fentanyl and other adulterants. This was a massive jump in potency when supply chains were interrupted during the pandemic.

Last year, in 2023, toxic drugs, sadly, killed over 2,500 British Columbians. That's more than seven times the number of deaths, and with that comes an equal increase in related physical and brain injuries; pressure on first responders, health care and recovery programs; and impacts to public safety and to our communities. That's more than seven times the impact in 10 years. That's over 600%. We don't have the resources or people to deal with such a huge increase over such a short period of time.

This deadly trend is repeating in every province across Canada and every community in North America, regardless of drug policies, which brings me back to my key message. This is a toxic drug crisis. It's not a policy crisis. It's not an addictions crisis. It's not because of wacky people or wacky ideas. It's not caused by harm reduction, safer supply or decriminalization, and every single one of you knows this.

You've heard from over 50 witnesses, and you've received 20 briefs. This must be clear acknowledgement that toxic, illicit drugs are the cause of this public health emergency, and the public must be informed and warned about where the real risks lie. You are hurting people when you say otherwise.

Different experts have different ideas and solutions, but if there is no agreement on the cause of the crisis, then your work here at this committee is absolutely pointless. Only from shared understanding can real solutions, rather than campaign slogans, be developed, debated and decided.

Thanks for your time, and thanks for listening.

● (1115)

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

Now we'll turn to Dr. Tu.

You have the floor for five minutes, sir.

Dr. David Tu (Medical Doctor, Kilala Lelum Health and Wellness Cooperative, As an Individual): Thank you, Guy.

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

Thank you, honourable members, for this opportunity to speak with you.

Allow me to begin by situating myself in the work that I do. My name is David Tu. I am a non-indigenous family physician. For the past 24 years, I have worked as a family doctor in Vancouver's Downtown Eastside with a dominantly indigenous practice. I am grateful for the last four years to have been the recipient of a Health Canada SUAP grant, which has allowed me to explore the impacts of partnering indigenous elders with primary care providers to deliver services to indigenous people living with opioid use disorder in an urban setting in a meaningful way. I currently work at the Kílala Lelum health centre in the Downtown Eastside.

As Guy just said, we are eight years deep into a public health emergency in British Columbia, resulting in the deaths of seven individuals per day due to an increasingly toxic and unregulated drug supply. Indigenous people living in the Downtown Eastside are at the epicentre of this crisis. To illustrate this, I want to share a story that highlights some of the complexities of the situation.

Ms. M is 38-year-old indigenous woman of Métis and first nations ancestry. I've known her and she's been a part of my family practice for the past 14 years. She's the mother of a three-year-old son. She's incredibly witty and a fiercely loyal human being. She's also endured extreme levels of trauma in her life, and she lives with a long-term, severe substance use, opioid and stimulant use disorder.

For the two years after her infant son was taken from her and removed to care, Ms. M expressed no interest in controlling her substance use. Despite the support of her family and a dedicated care team, there was minimal engagement in opioid agonist treatments and only sporadic engagement with prescription alternatives.

During this two-year period, she experienced multiple overdose events. She could easily have died and been just a statistic in the sheer volume of indigenous people dying each day in B.C., yet with an increased sense of hope for reclaiming her role as mother to her son, I am pleased to say that Ms. M is now engaging in care and is on a fentanyl patch-based OAT program that has allowed her to significantly reduce her illicit opiate and stimulant use.

She is currently motivated to attend an indigenous family-centred residential treatment program with both of her parents, her sister, her partner and their son. Sadly, the only two indigenous-specific treatment centres in B.C. that accept families will likely reject this family, one, because they exclude people who are receiving OAT and, two, because they do not allow children under age eight.

We are hoping for an exception, but both centres have a six- to 12-month wait-list, and this is a harsh reality for this family. Eight days ago, Ms. M was discovered unconscious in a bathroom in her mother's apartment building. Thankfully, she was resuscitated, and she recovered in the emergency room.

Let me make a statement of fact. The unregulated drug supply is killing people, and first nations people are at six times the risk of death compared with non-indigenous people in B.C. To paraphrase elder Bruce Robinson of the Nisga'a people—you can't help people if they are dead.

Many individuals with a substance use disorder are not ready to address their addiction for a variety of reasons. This means that oftentimes treatment services are unlikely to bring about a recovery for them, similar to Ms. M in the two years following the removal of her child.

Alongside other harm reduction initiatives, prescribed alternatives and opioid agonist treatments can help reduce the risk of overdose; however, it is widely agreed among medical professionals like me that we can't prescribe our way out of this public health emergency. There are several things that we collectively need to do to change course.

The first is a fully functional continuum of care from harm reduction to recovery-oriented treatments.

The second is a pathway we can all be on to a regulated drug supply. We must also acknowledge that culture saves lives. For indigenous people specifically, whose route to addiction was often paved by the trauma resultant from colonialism, traditional medicines and cultural practices offer a meaningful means for many to gain control over their substance use and address the underlying causes of their addiction.

The third need is for more investment in programming focused on culture, traditional medicines and land-based healing. To be clear, we need investment in treatment programs. For indigenous individuals such as Ms. M, who are prepared to address their substance use, there is a need for increased access to culturally appropriate residential and community treatment.

● (1120)

Lastly and importantly, we must put an end to false dichotomies and divisive politics. I couldn't say it better than Guy did. We are a country of abundant resources, and the COVID-19 pandemic revealed our capacity to mobilize resources in response to public health needs. We need harm reduction services, including prescribed alternatives to keep people alive when they are not prepared to—

The Vice-Chair (Mr. Stephen Ellis): Dr. Tu, I have to interrupt you. You'll have lots of time to expand on your ideas as people ask you questions, but your five minutes are over, sir. Thank you.

Next we turn to Mr. Williams.

You have the floor, sir, for five minutes.

Mr. Dan Williams (Minister of Mental Health and Addiction, Government of Alberta): Thank you.

[*Translation*]

Thank you for your warm welcome here, in Ottawa.

[*English*]

My name is Dan Williams. I am the Minister of Mental Health and Addiction for the Province of Alberta. I'm a policy-maker. I don't have lived experience. I haven't worked on the front lines. I am someone who gets to decide, with my cabinet and my colleagues in Alberta, how to respond to what is an addiction crisis that is ravaging Alberta, in our families and communities—and across the entire country, we see the same direction happening.

For you, as the opioid epidemic and drug crisis committee appointed to investigate this, I think it's important that we frame it in the appropriate way. The reason we have overdoses as we do and see this tragedy unfolding with our families and on our streets is that there is a disease. It's the deadly disease of addiction. It doesn't discriminate based on who you are, and it could affect anyone.

The reality is that addiction has one of two paths, only one of two ends—and anyone who tells you otherwise is lying to you and they could be lying to themselves. There are only two ends to addiction. As a policy-maker, as a province and as a country we need to accept this reality. It either ends in pain, misery and, tragically, given enough time, death, or it ends in treatment, recovery and a second lease on life.

That is why Alberta cares so passionately and believes we have this obligation to care for those who are in a vulnerable position, those who are suffering from this disease of addiction, which could end deadly or in hope and renewal, so that they can be family members again—brothers, sisters, fathers and mothers—and allow us to have a vibrant community with these individuals recovered and fully contributing again to those wonderful parts of our community that we love so much.

Therefore, Alberta has invested a huge number of resources to build this out. We understand that we have a choice as a province, just as we do as a country, between continuing down the path that we've seen for, let's say, the last 25 years in Canada in terms of a policy setting that is not producing the results that we need.... Our communities are increasingly unsafe. Individuals who are suffering from addiction do not get the dignity and care that every one of them deserves with the opportunity for recovery.

I think we, all of us—and especially you in this committee and those responsible for making the federal policy—have and share that same moral obligation that I have, as a minister in the Province of Alberta, and that each citizen of our country has, in wanting to see our communities improve and the dignity of everyone respected and cared for.

To give you some idea of the work we've done, we'll have invested, by the end of it, probably close to a billion dollars in capital. We're working towards that end when it comes to building the infrastructure. Alberta, along with the rest of the country, for many years did not built out the treatment capacity needed. We need to have an off-ramp out of addiction. If we see an increase in addiction happening, whether we talk about the oxycodone crisis—which propagated much of the opioid pandemic that we saw and still are in the midst of—or about meth, cocaine or any other substance, even alcohol, we need to have a path for people to leave addiction and end up not dead but in recovery.

That is why we invested in 11 recovery communities across the province, five of which are partnered with indigenous communities. Four are on the reserve of the indigenous community, knowing that they're disproportionately affected by this deadly crisis of addiction. We need to step into that space, not waiting but rushing in to support them in how they see.... As we heard previously, culture is an important part of that land-based healing, so it's culturally appropriate healing that goes along with the indigenous communities in Alberta.

We obviously invested not just in those 11 recovery communities for a full continuum of care, but we meet people where they're at. Our system funds millions of dollars for drug consumption sites and naloxone kits. We have therapeutic living units in our corrections facilities. We have access to treatment, which I know many of you got to see when you generously came to Alberta to see our program.

When it comes to the path forward for Alberta and for Canada, my request to each of you is to take, as we heard from earlier testimony, very seriously this crisis. We cannot continue with experimentation like decriminalization, which, happily, we saw walked back in Alberta. We in Alberta are opposed fundamentally to a policy, like safe supply, which hands out drugs to drug addicts in an attempt to deal with an addiction crisis.

We believe in hope and opportunity. We care about the compassion you need to care for those individuals who are struggling. We ask as well, as a federal body responsible for first nations, that you come to the table, do not avoid your obligations with first nations and partner with us and the first nations to provide hopeful solutions.

● (1125)

Thank you for your time, and I look forward to answering your questions.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Minister.

Now we will hear from Dr. Goulão.

Dr. Goulão, you have the floor for five minutes.

Dr. João Goulão (Institute on Addictive Behaviours and Dependencies): Thank you, Chair. It is an honour to join you and this committee

I will use my five minutes, first of all, to try to destroy some myths around the so-called Portuguese model. I'm aware that the way Portugal used to address the heroin epidemic in the eighties and nineties is quite often described as mere decriminalization or, more than that, a liberalization of drug use. However, it is far more than that.

On one side, we did not liberalize the use of substances in Portugal. Drug use is still prohibited. It is not a crime. People do not undergo imprisonment penalties, but there is a set of administrative sanctions that are used to deter people from using drugs.

On the other side, decriminalization is only one part of the system, which constitutes a continuum from prevention to treatment that includes harm reduction policies and reintegration. Even if I consider decriminalization to be a very important part of that, it is mostly a way to get in touch with people who otherwise do not approach the health system or search for any kind of support to change their lifestyles.

With the complete set of policies that we have put in place—and I was happy to have the opportunity to share what we do here with Minister Dan Williams and his staff a couple of weeks ago—we managed to stop an epidemic that I compare to the one you are living through in North America related to fentanyl. It cuts across all layers of society and affects all families. I believe that it's almost impossible to find a Canadian or American family that has not been affected by this epidemic.

I think the way to completely change how we address those problems is to consider drug-related disease, or drug use disorder, as a disease with the same dignity as other diseases, and think of the people who suffer from it as having the same dignity as patients who suffer from other kinds of diseases. I think it's key to consider and to approach those problems from the health and social side, rather than prosecution or any kind of coercion of people who have these kinds of problems.

I'm very happy to address this, and I'm completely at your disposal to reply to questions you may have about the Portuguese way to address these problems. Thank you for having me here.

● (1130)

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

We will now turn to rounds of questions. We will start with the Conservatives.

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

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

To start out, I want to thank you, Mr. Felicella, for being here and sharing your story so bravely. I'm glad that you are here to tell your story, and I'm glad that you are alive. It proves that recovery is in fact possible.

I'm going to start my questions to Dr. Goulão. In your opening statement, you said that in Portugal, under the Portuguese model, you didn't liberalize drug use, and that decriminalization was just one aspect. In Portugal, if someone were to be smoking crack on a beach, what would happen to them if a police officer were to come around?

Dr. João Goulão: Thank you for the question. I don't know if I must reply immediately, Mr. Chair?

Mrs. Laila Goodridge: Yes.

The Vice-Chair (Mr. Stephen Ellis): Yes, please, sir. We do a back and forth here, and the total amount of time for each party at this time is six minutes.

Dr. João Goulão: Okay.

If someone is using an illicit substance in a public place, the police authorities may intervene, might take this person to the police station, apprehend the substance or substances that he or she has and weigh it. If the amount of the illicit drug that the person has with him is more than what's considered adequate for personal use for 10 days, there's the presumption that this person is smuggling drugs, trafficking drugs, so he or she will be sent into the criminal system as before.

If the person has less than that amount, adequate for personal use for 10 days, they are just sent to present before an administrative body called the Commissions for the Dissuasion of Drug Addiction, which is a body under the Ministry of Health that has the power to apply administrative sanctions, similar to those that are used for traffic problems such as not using a safety belt or things like that.

The main task of that commission, which is composed of health personnel, is to assess what kinds of needs this person has related to drug use. If he or she is an addicted person, they are invited to join the treatment facility and the commission has the possibility to facilitate the affair and to make it very simple.

● (1135)

Mrs. Laila Goodridge: In British Columbia, they embarked on a very radical drug legalization project where they effectively removed all tools from the police to be able to do anything with public drug use. They've recently rolled some of that back because it was an abject failure, leading to skyrocketing addictions.

I noted that in a 2018 Vancouver Sun article, you said, “Decriminalization is not a silver bullet,” and “If you decriminalize and do nothing else, the problem will get worse.” That's exactly what we saw happen in British Columbia.

You talked about the dissuasion committee. How exactly does that work?

Dr. João Goulão: When the person comes to that commission, there's a technical staff with psychologists and social workers, who collect a history for the person, trying to identify the needs and to understand if the person is in fact addicted to substances or is a mere recreational, occasional user. In any case, if the person has an addictive disorder, they are invited to join a treatment facility, but it's not compulsory. There's some work of motivation to address people to treatment.

Most of the people who are present at those commissions are not addicted, in fact. Most of them are users who are not really problematic, but the aim is to intervene before they become problematic, so to act on any factor in their lives that may lead to a more problematic way, to more problematic use, later on.

Mrs. Laila Goodridge: In Canada, they have a program that's called a so-called safe supply program, and they give out sometimes upwards of 30 hydromorphone pills per day to people who are struggling with addiction. Is this something that is happening in the Portuguese model?

Dr. João Goulão: No, madam.

Mrs. Laila Goodridge: Do you think that it is a smart idea?

Dr. João Goulão: I don't dare to.... Our realities are quite different, but in any case, we use plenty of substitution opioid treatment with methadone and buprenorphine. However, we do not have this kind of safe supply policy that you are experimenting with there.

Mrs. Laila Goodridge: What is the breakdown—

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mrs. Goodridge. That's the end of your round.

Thank you, Dr. Goulão.

Next we turn to Dr. Powlowski.

Dr. Powlowski, you have the floor for six minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Dr. Tu, you mentioned land-based treatment in your testimony. One purpose of what we do is to eventually come up with a report and recommendations to the government, so I want to hear more about land-based treatment. Are you using it? How successful is it? What evidence is there that it's successful, and do you think we need to put more resources into it?

Certainly my impression is that, for indigenous people, this holds a lot more promise than a lot of other forms of treatment.

Dr. David Tu: Thank you very much for that question.

I acknowledge that I am partnered with and work alongside many experts in indigenous medicine practice, cultural practice and land-based therapies, but I myself am not an expert in those modalities and therapies. However, I have witnessed their impact. In terms of evidence....

● (1140)

Mr. Marcus Powlowski: Dr. Tu, can you tell us what exactly it is? If somebody goes into land-based treatment—I think I know—do you go out to the land for a couple of days or weeks, or how does it work?

Dr. David Tu: To be honest, there's a lot more complexity than giving a simple answer that it is just this one thing, but it is fundamentally about connection. It's about relationships, and one of those relationships is to the land. Conceptually, from the teachers I've had, from indigenous elders and providers, the solution to addictions focuses around relationships more than substituting other therapies or modalities, and the relationship to the land is a really important relationship for many indigenous peoples and cultures.

Establishing those reconnections, along with the reconnections to who you are as an indigenous person, to your family and to your ancestors.... These are the connections that actually draw people into a positive state of identity as a human being. People who acquire that state—a good relationship with themselves, a positive outlook—tend to make affirming, positive choices for themselves. It's those relationships that support them to make choices such as decreasing the use of harmful substances on their bodies.

I've seen it play out as people going on a canoe journey or, actually, people just taking daily walks to the beach in our neighbourhood to connect with the ocean. There are many ways to re-establish those relationships, and there are many very sophisticated indigenous modalities, from indigenous medicine providers, to actually bring about those reconnections to the land and that meaning. I don't want to belittle the sophistication of indigenous medicine practice because it is sophisticated, but there's a lot of evidence that this is a pathway for many to change their substance use.

To your question, yes, I definitely, wholeheartedly endorse greater investment both in developing the protocols and in developing the resources.

Mr. Marcus Powlowski: Mr. Williams, perhaps you might comment on it too. Would it be your recommendation to put more resources into land-based treatment?

Mr. Dan Williams: Thank you for the question.

I think that land-based treatment, especially through an indigenous lens, is a central pillar to how we look at recovery as an opportunity. We believe every single Albertan who suffers from addiction deserves an opportunity at recovery. We see really great outcomes. When you look at therapeutic living communities or recovery centres, which land-based treatment would be specifically within, when that's paired with opioid agonist therapy, the data is clear on that in terms of research. Also, our outcomes point to that as well. I understand you had Dr. Day present as well to this committee, our head of addiction medicine.

We partnered with five indigenous communities, four on reserve, where it really is not an imposition of, "This is what you're doing," but a proposition: "How do we partner together for nation-to-nation conversation around...?" Every single first nation chief I speak to, every time I go on to a reserve, they're asking for recovery treatment capacity. They are asking for that. They are saying please. They understand that there are marketing terms around safe supply, etc., but they see past that because they see the carnage in their communities. They are saying, "Please help us with this," so the Province of Alberta said that, even if it is federal jurisdiction, this is a community problem that we need to step into to work on with them.

We invested approximately $35 million in each of these recovery centres, plus the operation costs, where it will be owned and run on reserve by first nations, culturally integrated. We think it's a central piece in how we look at addressing the crisis.

Mr. Marcus Powlowski: Thank you.

Dr. Goulão, you talked about the commission that people have to appear before if they're caught with drugs. What happens with the problematic users who don't agree to any sort of treatment, who don't agree to use opioid agonist treatment or to attend some sort of therapy? What's the next step, or is there a next step?

Dr. João Goulão: The attempt is to motivate people with problematic use to attend or to join a treatment program, but they are free to refuse. Then, in the first contact with users, the only recommendation given is, "Please do not come here for the same reason in the next"—let's say—"six months because otherwise we'll have some kind of penalties."

● (1145)

Mr. Marcus Powlowski: Okay, so there are penalties. What are those penalties?

The Vice-Chair (Mr. Stephen Ellis): Dr. Powlowski, maybe you'll hold that question.

I'm sorry, Dr. Goulão. The time for this round is over, but we have lots more time left. Thank you for that.

Witnesses, before we go on, if you struggle with Canada's other official language, French, there is a button on your computer screen. If you weren't made aware, it looks like a world, and you can pick the language you wish to hear this in.

[*Translation*]

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

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

Dr. Goulão, thank you for accepting our invitation. Many praise your model or refer to it. Everyone, whether on the right or the left, draws from it, and I want to highlight the key elements.

Some claim that there needs to be criminal consequences to encourage people to go through treatment, and that decriminalizing drugs lets people off the hook and leads straight to chaos. How do you see it?

[*English*]

Dr. João Goulão: Thank you for the question. In fact, I do not agree. We are much more effective in reaching and helping people in this framework of decriminalization than before.

I must tell you that we lived for a long time under a dictatorship here in Portugal, during which people did not even approach treatment facilities because they were afraid to be referred to the police. In fact, decriminalization facilitated and made everything much smoother, with more dignity and a drop in stigma towards people who use drugs, so I consider that it was a very good step forward.

[*Translation*]

Mr. Luc Thériault: Before decriminalizing drugs, should we not make sure that we have well-coordinated wraparound services? Earlier you mentioned a continuum of care, and I'd like to hear more about that.

Also, the Minister of Health tells us that people have a choice between misery and treatment. The province is building treatment centres and putting people in them. Is there another way, aside from this binary approach? Are there people who go on taking drugs for 20 years without putting their lives at risk and while continuing to function?

[*English*]

Dr. João Goulão: I believe that the first thing to do is to assess and get an understanding of the needs of the person we have in front of us, and the motivations of their drug-related problems. I also believe that we need to provide to people who use drugs the minimum level of dignity before we can demand that they struggle for a change in their lifestyle.

Does this person have a house? Does this person have access to health care? In general, does this person have their basic needs fulfilled? Only then can we work on motivation to change. That's why I'm talking about a continuum, and the continuum from harm reduction policies that are not an incentive to continue using substances but a way to contribute to a better and longer life in any circumstance.

[*Translation*]

Mr. Luc Thériault: Some think that harm reduction puts in place conditions that can lead to disorder and indulgence on the part of police and stakeholders, allowing people to wallow in misery. How important is harm reduction in your continuum of care to achieve betterment?

● (1150)

[*English*]

Dr. João Goulão: This is the first step to approaching people who are the most disorganized and to gaining their confidence in the health personnel, so that we can establish a relationship because this is the basis for the therapeutic work. I think harm reduction is in fact key to approaching people we otherwise do not manage to reach.

[*Translation*]

Mr. Luc Thériault: Did you experience cohabitation problems, and if so, how did you manage them?

[*English*]

Dr. João Goulão: I do not understand the meaning of “cohabitation”.

[*Translation*]

Mr. Luc Thériault: In Canada, harm reduction strategies include supervised consumption sites, as well as supportive housing, which can give rise to problems between those sharing spaces in a community.

Did you experience those problems in Portugal, and if so, how did you overcome them?

[*English*]

Dr. João Goulão: On the contrary, I think this is the continuum I was talking about. We try to establish continuity in the levels of care that we can provide in any circumstances, and we do not give up on people in any circumstances.

I am not able, as a medical doctor, to motivate someone to step into a treatment centre. However, in a therapeutic community, at least I can contribute to that person having the conditions to use with lower risk and to continue working on other areas of his life.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Monsieur Thériault.

Dr. Goulão, thank you.

Dr. Johns, you.... I've promoted you to a doctor, Gord. I hope you welcome that promotion.

That being said, Mr. Johns, you have the floor for six minutes.

Mr. Gord Johns (Courtenay—Alberni, NDP): Thank you, Mr. Chair.

Thank you to all the important witnesses for your incredible testimony and all of your work.

Minister Williams, your government has had a significant growth in toxic drug deaths per capita, from 800 in 2019 to over 2,000 last year, the worst year on record, and now has a per capita rate that's almost on par with British Columbia.

Paul Wells just wrote in Substack the other day that the scale of the crisis in Edmonton and across Alberta makes it hard to be sure of success. He cited Deputy Chief Driechel. He has been in the Edmonton Police Service for 27 years, and he said, “It's worse than I've ever seen it.”

We've also seen your government close safe consumption sites. You've opened one new one since you formed government. You've cancelled five. You've closed two, and you plan to close three. The previous government had opened eight new ones and planned for two.

Do you support safe consumption sites and recognize the importance they have to save lives?

Mr. Dan Williams: Thank you so much for the question.

Alberta's government continues to fund drug consumption sites, but our position is fundamentally that without an off-ramp out of addiction and treatment capacity being built, which is seriously and chronically underfunded and under-built across the country, how do you expect somebody to ever get healthy?

The purpose of a health care system should be about getting people care, treatment and into recovery and healthy, so we fund them. However, I don't think a drug consumption site on every corner is going to solve this problem. We need a serious adult conversation as a country about what that off-ramp looks like. Alberta is putting a policy option forward that has largely been ignored by the rest of the country for the last 25 years.

Mr. Gord Johns: Nobody is saying that we don't need more treatment and recovery, Minister. I think all of us agree that we need to scale that up. That is something we're all unified on.

Regarding the importance of safe consumption sites, I'm going to ask Guy Felicella to perhaps comment about those.

Mr. Felicella, you advocate for both harm reduction and recovery. Can you talk about why that is so important?

Mr. Guy Felicella: Yes, most definitely.

I mean, obviously, dead people don't recover. You also have a lot of people who use substances who don't struggle with an addiction. With the risk of the contaminated drug supply that's on our streets today, first-time substance users, intermittent substance users, casual substance users and people who struggle with addiction—people from all walks of life who use substances—are at severe risk of death.

The unfortunate part is that it's like we wait for people to have this addiction before we actually help them. Treatment and recovery won't help people who just use these substances. Harm reduction services will, and a lot of them build the connections and services to build out other health care services.

Look at the 20-year impact of Insite in the Downtown Eastside of Vancouver, which has referred 71,000 people to offsite services. Many of those could be detox, treatment, recovery, health or hospitalization. Harm reduction is really a big connection piece, similar to what Dr. Goulão was speaking to, to build support, build the trust, build the non-judgmental, compassionate relationship that's needed when somebody does make the leap. If you look at Insite, on the second floor, it has a detox floor. On the third floor, it has a transition floor.

I will say this. It wasn't recovery services that came to the Downtown Eastside to get me out of there. It was harm reduction services that were giving me bus tickets and cab fares to treatment facilities, and every time I left treatment—because it's a chronic relapsing condition—harm reduction welcomed me back. I wouldn't be alive today without it, so I'm a fierce advocate for understanding that we need a full pathway, a full continuum of care in this country that supports both harm reduction and recovery. Gone are the days where it's either-or. It has to be both. This drug supply is killing people.

Again, as I said, not everybody who uses substances struggles with an addiction.

● (1155)

Mr. Gord Johns: I'm just going to add to that. You said not everybody has an addiction. Can you speak about that?

Minister Williams talked about it being an addictions crisis. Do you want to comment on what you heard there?

Mr. Guy Felicella: Yes, if it were an addictions crisis, you could look back to decades past where alcohol consumption had the highest rate of addiction in the country forever. It was the number one drug, so if that was an addictions crisis, why didn't we call it an addictions crisis 20 years ago?

It's really a toxic drug crisis because the drug supply has just shifted and changed. Yes, sure, there are people who are struggling with addiction who are using substances. I'm not denying that, but let's get real. What's killing people is the contaminated toxic drug supply. Some people, yes, may struggle with an addiction, but again, it being a chronic relapsing condition.... I went to treatment over a dozen times, and the majority of people who go into treatment don't walk in the front door and out the back door and their lives change. This is a process. Recovery is a long journey for a lot of us, for the majority of us.

I think one of the things we have to look at and be real with is how we treat death and prevent people from dying, and how we support people and treat addiction. You can't treat addiction if people are dead.

Mr. Gord Johns: Thank you.

How much time do I have left, Mr. Chair?

The Vice-Chair (Mr. Stephen Ellis): You have 10 seconds.

Mr. Gord Johns: Can you speak about the importance of safe consumption sites?

Mr. Guy Felicella: When you overdose, there multiple times...and you wouldn't have a beautiful family and the life you live today, three kids, a career. You know, it just speaks to their importance. Harm reduction kept me alive until I was able to find my recovery, so I'm really grateful.

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

Now, for the benefit of witnesses, the amount of time in the rounds will change, so I just ask you to be mindful as I tell you how long they will be.

We will now turn back to the Conservatives.

Mr. Doherty, you have the floor for five minutes.

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

Dr. Goulão, it's nice to see you again.

Mr. Felicella, I want to say, as somebody who's from B.C., that I've followed your life and story in the media and also through some of the talks that you've done in schools and publicly as well. I greatly respect you and appreciate your point of view and appreciate your appearance on this panel today.

Minister Williams, you wrote an open letter to the federal government calling for a common-sense solution of traceability measures on so-called safe supply. You said your recommendation mostly fell on deaf ears. It went nowhere. It seems that this government is deliberately ignoring that diversion is in fact a problem and that it might possibly be actively enabling it.

Is that an accurate statement?

● (1200)

Mr. Dan Williams: Yes, that's an accurate statement.

Mr. Todd Doherty: You described the diversion of so-called safe supply as a human catastrophe unfolding before our eyes. Can you elaborate on this?

Mr. Dan Williams: Yes.

Fundamentally, the addiction crisis that we're in...and it is an addiction crisis. I need to point that out. Nobody walks down to the Downtown Eastside in Vancouver or Whyte Avenue in Edmonton, or wanders the streets in our beautiful city capital, as I have, and thinks that these individuals who are struggling and are intermittently homeless are not in active addiction.

Speedballing methamphetamine with fentanyl in this crisis situation is an addiction. We need to address that seriously, and if we're not adult enough to have that conversation, we're not going to find the right policies and solutions to it.

When it comes to safe supply, what that does is fundamentally increase the supply of opioids available to the public. If you look at the Stanford-Lancet commission from the world's pre-eminent scientific journal published with Stanford University, which is academically the authority on the North America opioid overdose crisis, the axiomatic rule that comes out of that report is effectively that if you increase supply, you increase harms. It does not matter if the producer of the supply is a drug dealer trafficking fentanyl from China or Prime Minister Justin Trudeau providing it through SUAP grants. The same biological fact of consuming the opioid will drive new addiction. You will have more supply. You will reduce costs. You will reduce barriers. You will increase access and, therefore, increase harm.

We saw this because the fundamental crisis we're facing was due to an opioid crisis that was proliferated in the 1990s with Purdue Pharmaceuticals and oxycodone, cynically propagated by them and by the industry that moved it forward.

We now see the Government of Canada repeating this again, and if they deny the diversion claims that Alberta believes are true, if they deny the diversion claims that the RCMP and Prince George and others have said are happening en masse with mass seizures of 10,000-plus pills, they can use evidence of a chemical tracker, which is approved as per guidelines with the FDA in the United States to protect intellectual property for for-profit pharmaceuticals.

Surely we can do that here in Canada. Surely if we have the ability to protect profits in the United States for pharmaceutical companies, why not protect lives and use the evidence that it is being diverted. Otherwise, I don't understand what they're afraid of beyond the moral and legal liability that they have for propagating it.

Mr. Todd Doherty: Thank you, Minister Williams.

Dr. Goulão, Portugal is always used as a gold standard in terms of dealing with a nationwide addictions crisis. Was Portugal facing a fentanyl epidemic when they implemented decriminalization?

Dr. João Goulão: No, sir—

Mr. Todd Doherty: What resources...?

I'm sorry. Go ahead.

Dr. João Goulão: When we developed our policies, we were addressing a heroin epidemic. It was the biggest problem that we were facing at the time.

Mr. Todd Doherty: Dr. Goulão, what resources and infrastructure were put into place prior to the Portuguese project.

Dr. João Goulão: They were quite modest, sir. We are a country with limited resources, but we have been steadily stepping up the investment in the health service addressed to drug-related addiction problems. Nowadays, we have a mandate that encompasses not only the problems related to illicit substances but also to alcohol, for instance.

Mr. Todd Doherty: I just have one last question. You've mentioned the serious lack of wraparound supports and how important those are.

Can you describe in detail the wraparound supports Portugal implemented?

The Vice-Chair (Mr. Stephen Ellis): Dr. Goulão, I'll have to interrupt you there. I'm sorry. Mr. Doherty's time is up, but perhaps we'll have time to come back to that question.

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

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

Mr. Chair, I want to thank all the witnesses for being with us and offer a special thanks to Mr. Felicella.

Mr. Felicella, thank you for giving back to the community. I'm posing my first questions to you.

Very soon you will be celebrating Father's Day. You have a beautiful family. What message do you have for the people who claim harm reduction has failed?

● (1205)

Mr. Guy Felicella: Well, ma'am, it's pretty simple: My kids wouldn't be on the planet. They came after 2013.

The real big picture of it is that it's truly humbling. What I was struggling with was a lot of childhood trauma throughout my life and how I viewed myself as a person in society. Having the people in the supervised consumption site...it was overwhelming. They were always the ones constantly giving me options, talking to me about detox and talking to me about recovery. I really built a relationship with those nurses there. They cared. They cared more than I cared. That's why I kept coming back.

I was good at getting sober. I was just never good at staying sober. It took me a long time, but without the support of that supervised consumption site, I wouldn't be celebrating Father's Day. I wouldn't be celebrating anything I do. There are the impacts I've also had from the school talks and the wisdom that I can pass on to these kids so that they don't fall down the same path as mine and so that, if they are struggling, they do reach out.

It's been absolutely a very humbling experience, but I accept my past for what it was. I try to really have a balance of understanding. You know, there are a lot of people who just use drugs and don't have an addiction, and I don't want them to die. Having facilities that support all pathways and all people as individuals is vital.

Ms. Sonia Sidhu: Thank you.

What can provincial and federal governments do to stop the flow of the toxic drug supply? When you're going to schools and you're talking to the kids, what resources need to be provided?

Mr. Guy Felicella: First off, I think a lot of it has to deal with all the aspects of the four pillars, which are harm reduction, prevention, enforcement and treatment, and having those flow right right across the country. Obviously, with the toxic drug supply, it's really changed the dynamic of the things that we struggle with.

In our sense, the education piece is just vital for kids to understand how dangerous it is to use substances in today's day and age. It's not a question of.... Me telling somebody not to do something doesn't stop them from doing it. You also have to consider that when you're educating people. If you are using these substances, please don't use alone. Please get naloxone trained. Please reach out for support if you need it.

You just have to have the full continuum of care. We can't keep going back and forth. Just like we're not going to prescribe our way out of this, we're not going to treat our way out of this by sending people to treatment and recovery, because there's a back end to that as well. People need employment. People need purpose. I didn't need somebody to tell me how to live. I really needed people to show me how to live. That was the continuum of care with both harm reduction and recovery.

Ms. Sonia Sidhu: Thank you.

My next question is for Dr. Goulão, quickly.

Thank you for joining us today, Dr. Goulão.

I'm a member of the interparliamentary group UNITE, founded in Portugal by your former colleague, MP Ricardo Baptista Leite.

Could you talk to this committee about the debate you had in Portugal in Parliament and in society?

Dr. João Goulão: The debate around decriminalization, is this what you mean?

Ms. Sonia Sidhu: Yes.

Dr. João Goulão: It was held in or around 2000. It was a proposal of the committee that drew up the first national strategy. That included decriminalization and, in fact, it was quite easy to have the social support of the population around this idea. At the time, it was almost impossible to find a Portuguese family that had no problems related to drugs. It was crosscutting all groups of society. Of course, it affected mostly the most disorganized marginalized groups, but it affected the medium class, the upper classes, the political class—everyone. It was—

The Vice-Chair (Mr. Stephen Ellis): I'm sorry, Dr. Goulão. I'll have to interrupt you there, sir. Thank you for that.

[*Translation*]

We now go to Mr. Thériault for two and a half minutes.

Mr. Luc Thériault: Dr. Goulão, please finish what you were saying.

● (1210)

[*English*]

Dr. João Goulão: Thank you.

I was trying to explain that everybody had someone at home with drug-related problems. People tended to say that “my daughter” or “my boy” is not a criminal, they're someone in need of help, in need of treatment and in need of support. The social support for the idea of decriminalization was quite strong.

At the Parliament, things were a bit more complicated with a bipolarization between left-wing parties and with more conservatives opposing the idea. In any case, the win for the proposal of decriminalization back in 2000 was comfortable.

[*Translation*]

Mr. Luc Thériault: Can you tell us more about the stigma and the extent to which it's harder for people to get off drugs as a result?

[*English*]

Dr. João Goulão: In fact, if we are dealing with a criminal, the way that society looks at the person is different from the way society looks towards people who suffer from an illness. The respect that is devoted to that person is different under a criminalization framework than it is when you consider that you are dealing with a chronic relapsing condition, as Mr. Felicella already told us.

I believe this makes a lot of difference. Even among health personnel, the attitude became quite different.

[*Translation*]

Mr. Luc Thériault: It also affects how willing or able a person is to seek help or admit that they have a problem, because it could jeopardize their job or housing. It's downhill from there, and people wind up on the streets.

The Vice-Chair (Mr. Stephen Ellis): Sorry, Mr. Thériault, but the answer will have to wait until the next round. Thank you.

[*English*]

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

Mr. Gord Johns: Thank you, Dr. Goulão, for being here. It was great to meet you in Portugal. We can't thank you enough for taking the time to always help and share policies that have worked for you in Portugal.

When I was in Portugal, I learned about your response at the peak of your drug-related deaths. Your country went from 250 people on methadone to 35,000. You engaged the military to build labs for affordability and speed. You scaled up year-long treatment facilities across the country. You took a multi-faceted approach to this complex issue, and your numbers have gone from 100,000 chronic substance users to 23,000 today.

Do you see Canada responding in the way Portugal did to this health emergency? What would be the recommendations you'd make to Canada?

Dr. João Goulão: Thank you, sir.

To be honest, I don't know in depth the reality in Canada, but I think the investment and the availability to turn easily to access treatment facilities would be very important. The investment, in my view, is in treatment and harm reduction, as was already said, to gain the confidence and the trust of people. That is key to dealing with this kind of problem.

Mr. Gord Johns: Again, we constantly hear certain politicians state that Portugal has forced treatment and that the dissuasion commission is about forced treatment. You've been clear that the Portugal model is not about forced treatment.

Can you explain why the Portuguese don't believe that forced treatment is the answer?

Dr. João Goulão: In fact, we find that motivation and, once again, providing people the minimum levels of dignity and allowing them to make their choices is much more effective than forcing someone to do whatever he doesn't want to do. I believe that we are much more effective if you provide.... If we have someone who is homeless and living on the streets, with no dignity, no access to hygiene or to health care, if we provide those conditions, then we can work on motivation to change the lifestyle.

● (1215)

Mr. Gord Johns: Thank you.

The Vice-Chair (Mr. Stephen Ellis): Thank you, sir.

Thank you, Mr. Johns.

We'll now turn to Mrs. Goodridge.

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

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

Minister Williams, education and prevention are key pillars of any good strategy to address addiction. I recently met with Dr. Victoria Burns. She's at the University of Calgary with a program called Recovery on Campus. I was really excited to hear about some of the really innovative and wonderful work they're doing to promote recovery on post-secondary campuses across Alberta.

I wonder if you could expand on and share why the Government of Alberta decided to create a program like this.

Mr. Dan Williams: Thank you for the question.

It's a terrific organization, Recovery on Campus. Of course, Dr. Burns has been an important part of getting that going. It started at the University of Calgary and is now at 26 post-secondary institutions, where they focus on recovery and opportunities for people to live campus life but also to live in recovery at the same time. We provide funding of approximately $1 million per year for that program, and we want to see it continue to expand.

Interestingly, the day I was sworn in as minister was June 9 of last year. My first event was that evening at a post-secondary institution, Red Deer Polytechnic, and it was an event with Dr. Burns. The first thing that happened to me when I went to registration was that an individual came up to me and gave me this coin. It's a 24-hour coin. I've kept it with me ever since that day. This person had been sober for 24 hours.

It's important. It's important for us to be able to grasp individual instances of hope. If you have a system that doesn't provide hope, if you have a system that doesn't fund recovery, that doesn't build beds, that turns harm reduction into some sort of marketing term rather than genuinely trying to help people, to convince people that, instead of treatment, we'll put resources and funds into safe supply to continue to palliate this addiction to the highest-powered pharmaceutical-grade opioids or whatever the substance is, I think that kills hope for those who see a possible life.

All of my office is in recovery. Our chief of staff in the Province of Alberta is in recovery. These are people of immense capacity. I believe deeply that this coin I have is the start of hope for somebody every single day when they get to touch that.

We as a province and we as a country need to embrace that hope. Otherwise, we're sending a message of despair to those who suffer from this disease.

Mrs. Laila Goodridge: Thank you, Minister Williams.

I know the Government of Alberta has also made many other innovative moves, specifically investing in addiction recovery supports and recovery communities. There are 11, as you said in your opening statement, and four are on federal first nation reserves.

Why did the Government of Alberta choose to move forward with building recovery centres on first nation reserves when first nation health care is the responsibility of the federal government?

Mr. Dan Williams: It did because the Government of Alberta sees these people as humans and sees this as a question of dignity. These are Albertans like everyone else. We want to partner with our indigenous communities, and we're not waiting for the federal government to backfill the gap they've left. The first nation chiefs—I've just come from meeting with a Treaty 6 chief—all want to see recovery.

The only health care the federal government is truly responsible for is on-reserve first nation health care. That seems to be the only health care they're not willing to deliver when it comes to addiction treatment for first nations. The Government of Alberta is spending tens of millions of dollars on not just infrastructure but also programming.

Instead, we're asking the federal government to stop pushing the safe supply pouring over our border from B.C. and other places. You can't suck and blow at the same time.

Mrs. Laila Goodridge: On that point, I know you wrote a letter to the Minister of Mental Health and Addictions asking for a chemical tracer to be put on. We've now seen the Government of British Columbia step on board because they've now admitted that diversion from these so-called safe supply programs is actually a very serious problem.

I wonder if you could share why the Government of Alberta has asked for that. How concerned are you about the diversion of this so-called safe supply program?

Mr. Dan Williams: The Government of Alberta has made safe supply illegal in the province. That's our right. It's our responsibility under the Constitution and the division of powers. We will continue to do that so long as we are elected as a government.

However, what else would you have Alberta do now, other than come and plead at this committee, and write letters to the minister that go unresponded to in substance, because we see 65 million pills a year being pumped into safe supply? Each one of those eight-milligram pills are more powerful than street heroin. These are pharmaceutical-grade opioids being mass distributed unwitnessed. What would you have Alberta do beyond opposing it here and making it illegal?

We need the federal government to take action on what is the most radical policy in the world. No one is doing this anywhere else. It's a failed policy. It's devastating.

I'm all for what people call “harm reduction” if it's naloxone kits, if it's drug treatment centres, if it's a virtual opioid dependency program or a needle exchange, but it becomes harm production when you become the purveyor of the hard, powerful drugs themselves. We oppose that.

● (1220)

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

[*Translation*]

We now go to Mrs. Brière for five minutes.

[*English*]

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

Minister Williams, I'm glad to see you again, sir.

I know that Minister Saks replied to your letter and offered to have officials from Health Canada discuss with yours the practical issue with chemical markers. Can you confirm if that meeting happened?

Mr. Dan Williams: I'm happy to meet with Minister Saks at any time on this.

Mrs. Élisabeth Brière: It's not with Minister Saks, but with her officials. In her letter, she suggested a meeting with officials.

Mr. Dan Williams: I'm certainly happy to see the officials reaching out. I think that—

Mrs. Élisabeth Brière: Can you confirm whether that meeting happened?

Mr. Dan Williams: I'll ask my officials if they have had the conversation. I think there would be a sense of urgency from the minister if she understood the consequences of diverted safe supply and high-powered opioids being mass-distributed into our communities.

We now admit, from B.C., that diversion is happening. The consequence of this.... We spoke to a researcher out of the United States on the addiction crisis, and he said that he believes there are as many opioids on the street now as there were under the high point of the oxycodone crisis in Canada, because of the safe supply being distributed by this government.

Mrs. Élisabeth Brière: Thank you.

Dr. Goulão, I'm happy to meet you. Thank you for joining us.

Earlier during the meeting, a Conservative MP said wrongly that Canada is legalizing drugs. What would you say to anyone who says that decriminalization and legalization are the same thing or a wordplay?

Dr. João Goulão: Thank you, Madam.

Many times, in fact, I tried to explain that those terms do not mean the same thing. Legalization is the regulatory term that means a substance is legal, as we consider alcohol or tobacco. That's different from what we did. Using drugs is no longer a crime, but under our law it is still prohibited and it's punished under the administrative law. Our society continues to give a clear sign of disapproval of drug use, and I think this makes the difference.

[*Translation*]

Mrs. Élisabeth Brière: Dr. Goulão, what do you think of Alberta's approach of investing heavily in treatment instead of the continuum of care? Under the model, people have a choice between a life of misery, as the minister put it, and mandatory treatment.

[*English*]

Dr. João Goulão: Ideally, in the continuum of supplying the responses the person needs, I believe those responses must be built in accordance with the concrete person we have in front of us. Mass policies that offer the same thing to everybody I do not believe are really effective. We must have an individual plan for each person.

This continuum came from all these reasons. We have a new strategic plan here in Portugal and it has three pillars: empower, care and protect. We developed our policies around those three ideas in accordance with the life cycle—with the context of where the person lives and where it evolves. I think an individual plan is key to being effective for each person.

● (1225)

[*Translation*]

Mrs. Élisabeth Brière: Thank you very much.

Mr. Felicella, your story was quite moving, so thank you for sharing it. I was quite glad to hear you say you didn't need someone to tell you how to live. You needed someone to show you how to live.

In your view, can every drug user go through treatment successfully?

[*English*]

Mr. Guy Felicella: You have to look at the individual, what they're learning in treatment and their ability to look at life-changing avenues. It's easy to say to people “go to treatment”. It's just very hard to stay sober. Also, treatment or completing treatment doesn't guarantee that you're going to be sober either.

A lot of the time, people need the back-end support after treatment. They need to be shown how to get their ID back. I mean, I needed to know how to pay off past debts, and I had to get my driver's licence. I needed to know how to do a résumé.

You really have to teach. There's so much more that goes on than just getting off the drugs. You really have to create a new life where it's easier not to go back to the substances, and that is easier said than done.

The Vice-Chair (Mr. Stephen Ellis): I'll interrupt you there, Mr. Felicella.

Madame Brière, that's your time. Thank you.

Colleagues, we'll now turn to Mrs. Goodridge.

You have the floor for five minutes.

Mrs. Laila Goodridge: Thank you again.

Minister Williams, as has been put forward, people like to accuse Alberta of not supporting harm reduction, and I know that's nowhere close to the truth.

Can you speak to some of the innovative plans and programs you have in place, specifically the narcotic transition services? People seem to think that the only possible way of dealing with this is to give so-called safe supply and to flood the streets with more narcotics, rather than using a medical model.

Could you explain a little bit what you guys are doing with that?

Mr. Dan Williams: Thank you for the question.

I'll be honest. I'm disappointed in the national dialogue around language like “harm reduction” and “safe supply”. It's unfortunate that they've effectively become marketing terms meant to convince Canadians of something that they intuitively know doesn't work, when it comes to safe supply, for example.

I don't care about the label anymore. If you have a policy, internationally or anywhere, that wants to get people healthy, then I will adopt that within my program. We have the narcotic transition services, as you mentioned, MP Goodridge. We have the drug consumption sites. We have the digital overdose response app.

We have the virtual opioid dependency program, which provides the world's first and most innovative immediate same-day access to evidence-based opioid therapy for buprenorphine products like Suboxone and Sublocade and products like methadone. Every day 8,000 Albertans get access to that. We have mass distribution of naloxone kits. Some people call all of that harm reduction and some people don't. That's fine.

However, if you call harm reduction mass distributing high-powered pharmaceutical-grade opioids unwitnessed into our communities, when those are diverted and end up on Alberta's high school and college campuses, furthering addiction, starting new addiction and massively introducing thousands of new people into addiction, then I no longer think it's fair to let Canadians believe that's harm reduction. It's clear that's harm production. It's clear that, if you're distributing the drugs, if you're the one purveying them into the community en masse, then that will produce more harm. That is my issue with it.

I am not being idealistic as I come at this beyond wanting to help individuals heal and recover. My big concern is that it's being torqued way out of context for political purposes. I'm not going to allow the marketing terms and the branding to get in the way of actually helping thousands of Albertans who are struggling.

Alberta is defiantly against and will continue to make illegal safe supply for obvious reasons. Applying addictive drugs into a community struggling with addiction will not help the addiction crisis, but I will get them help and meet them where they are. I will meet them and bring them to a spot where they can have an opportunity to recover.

Mrs. Laila Goodridge: Minister Williams, frequently I end up having people reach out to me from all across the country and explain to me how they are contemplating mortgaging their house in order to send their child to addiction treatment or how their child has a two-year wait or their sibling has a six-month wait to get into a treatment service.

The Government of Alberta has removed all user fees for treatment. Why did you do that?

● (1230)

Mr. Dan Williams: Previously, there was a $1,240 a month fee for someone suffering from addiction if they wanted to access government resources for addiction. Where do you think someone suffering from a fentanyl addiction is going to find $1,200 a month? It's very clear that's not a serious government policy around addiction.

We have increased capacity by over 10,000 beds from 2019 to now. We're building 11 recovery treatment centres, four of them on reserve in indigenous communities, for up to one year of treatment, very serious treatment. We do all this to reduce all possible barriers to getting people into treatment, understanding that addiction ends in one of two ways—with either pain, misery and, tragically, untimely death or treatment, recovery and a second lease on life. There's no third option.

How could we not, as a society, invest in treatment? I'm not saying not to do everything else. Of course we need to have a full continuum of care, and I agree with every presenter's comments on that today. With compassion in our hearts, it's deeply un-Canadian to just let people be palliated in their addiction without making them a serious offer for recovery. We need to expand treatment capacity. We need to reduce barriers, eliminate costs and blow it wide open.

People who oppose me say, yes, that's fine, but we need to build treatment and recovery. Who's doing that other than Alberta? We're putting our money where our mouth is.

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

Dr. Goulão, in the province of British Columbia, they've developed protocols to allow for the prescription of recreational fentanyl to youth under 18 years old who are struggling with addiction.

Is that something that Portugal would move towards or would support?

Dr. João Goulão: No, ma'am, I don't believe so. Hopefully, we are not dealing with the same kind of reality that you have, but I don't believe this would be a step Portugal would take.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mrs. Goodridge. That's your time.

Dr. Hanley, you have the floor for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): I want to thank all the witnesses for some incredible testimony today.

Minister Williams, thanks for coming in person, and thank you again for hosting us on our communities tour. I'll try to be brief with you, because I want to move to other witnesses, but my colleague did bring up some of the alarming increases recently in overdose death rates in Alberta, and I'm not sure you had a chance to specifically respond to that.

Can you briefly tell me your thoughts on how you're addressing that?

Mr. Dan Williams: Yes. Thank you. I'll try to be brief. I understand you have others you want to address.

Alberta has an integrated illegal drug market with British Columbia. We suffer, obviously, from the mass distribution of all sorts of drugs, including fentanyl, etc., and illegally diverted hydromorphone. We have a similar starting position. Happily, Alberta has continued to stay below B.C. on per capita and total overdose rates—an important metric for us.

If we look at last year, we were 14% lower than B.C. on a per capita rate for overdoses and, of course, 25% lower in the first two months. If you look at just February in Alberta versus B.C., year over year, we're at 33% fewer overdoses than B.C.

We're cautiously optimistic that the recovery model and its culture are having a positive impact. We've seen, since April last year, a continuous decline in overdose rates. The pandemic was brutal on every jurisdiction when it comes to this. Alberta, we believe, is starting to see some of the fruits of this, with only two out of 11 of our recovery communities coming online.

Mr. Brendan Hanley: Thank you.

I was incredibly impressed by the recovery centre in Red Deer, and by your help in hosting us there. At the same time, afterward, when we visited a harm reduction and health promotion site in the same city, it seemed a bit opposite. We saw an organization very strapped for resources and feeling that their daily work with the street-involved and drug-using community was at risk. They were even hesitating to talk about harm reduction. I have to say that the contrast was rather striking.

Putting safe supply and diversion aside, can you clarify? I think you just did, but I want to have, on the record, your position on harm reduction as one of the pillars of care and part of the continuum of care. How are you supporting that in Alberta?

Mr. Dan Williams: Sure. There are many different programs. Obviously, there is naloxone distribution, and that program in Red Deer distributes much of it. We have a drug consumption site for now, in Red Deer. The municipality has recently asked us to review what that looks like, so we're going to take a serious look at partnering with them on that. Of course, we have narcotic transition services.

Any one of those items could very easily be described as harm reduction. I have no problem with that. I need to meet people where they're at, but I need an off-ramp out of addiction, as well—not just for society but also for these individuals. Where do they go? I can't have them in hospital waiting rooms, enduring this tragic cycle or turnstile of in and out and not getting the care.

I need to build that recovery model. I need the Alberta model to be an example that shows everyone that there is hope. You're not destined to die.

● (1235)

Mr. Brendan Hanley: Minister, I'm going to stop you there, if I can. Thank you very much for that.

Dr. Goulão, I'll echo what Mr. Johns said about how important the visit to Portugal was that we were able to have and was hosted by you last year. I have so many questions for you.

I'll focus on how you think the system you've established in Portugal over the last 20 years would address a toxic drug crisis such as we have here—not just fentanyl but also a contaminated drug supply. You must be watching us and watching to see if fentanyl arrives in Portugal.

Do you have a system in place to address what could be a change in drug supply in Portugal?

Dr. João Goulão: Thank you, sir, for your question.

We try to track what kind of supply happens in our market. One of the key responses is pill testing—testing the substances that circulate and are used by the users. I think it's very important to have that in place in order to identify early what is circulating.

Apart from that, we are working on the education of people, on the availability of naloxone and on preparing people for something we expect will come to the European market with the same kind of availability you notice in your country.

[*Translation*]

The Vice-Chair (Mr. Stephen Ellis): Thank you, Dr. Hanley.

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

Mr. Luc Thériault: Minister, how many overdose deaths were there in Alberta in 2022 and 2023?

[*English*]

Mr. Dan Williams: We have ASUS, which is the Alberta mechanism we use for publicizing. It's the most integrated and transparent that I know of in the country. I have the 2023—

[*Translation*]

Mr. Luc Thériault: All I have is two and a half minutes. Can you give me the numbers?

Mr. Dan Williams: I understand. Thank you for your question.

[*English*]

I have the 2023 and 2024 numbers in front of me. I don't want to misquote. I am happy to get you the resources for the 2022 numbers.

[*Translation*]

Mr. Luc Thériault: What's the number for 2022?

[*English*]

Mr. Dan Williams: As I said, I don't want to misquote. The 2023 numbers, as we saw, are a 14% lower number than we saw in British Columbia, as a comparison. The first two months of 2024—

[*Translation*]

Mr. Luc Thériault: No, that's not what I want to know.

I can see here that, in 2022, Ontario had 2,531 cases, British Columbia had 2,410 cases and Quebec had 540. I want a number, not a percentage. What are your numbers?

[*English*]

Mr. Dan Williams: I'm very happy to have that provided to you. I don't have all the numbers in front of me for all the data.

[*Translation*]

Mr. Luc Thériault: I'd appreciate it if you would provide them to the committee.

[*English*]

Mr. Dan Williams: I'm happy to oblige.

[*Translation*]

Mr. Luc Thériault: Moving on, I heard you often mention ideology. What do you mean by that? I could take it to mean that your approach is ideological.

[*English*]

Mr. Dan Williams: I would say that of course all of us come to the public space with a desire that is going to be informed by our beliefs, but fundamentally I'm not going to throw out evidence-based data and evidence-based policy-making because of a pre-existing ideological commitment.

I see that happening in other policies like safe supply. The data shows it's devastating. Common sense shows it's not working. Nonetheless, it has continued, in spite of all.... There seems to be an allergy to the evidence that shows that. I'm about anything that brings health—

[*Translation*]

Mr. Luc Thériault: That's not what I'm talking about. You said that harm reduction leads to a life of misery and that treatment is the only hope.

If I say to you that harm reduction is the start of treatment, would you tell me that my approach is ideological?

● (1240)

[*English*]

Mr. Dan Williams: I would agree that it is the start of treatment, but in the end, with enough time, if you only facilitate the addiction, you're not—

[*Translation*]

Mr. Luc Thériault: Do you give your people on the ground, those on the front line, the tools they need to be effective during that start of treatment phase? Are you instead going to tell people on the streets that they have to choose between their misery and death and completing your supervised treatment program?

The Vice-Chair (Mr. Stephen Ellis): Sorry, Mr. Thériault, but your time is up.

[*English*]

Minister, a very brief response, if you would, please.

Mr. Dan Williams: I will meet Albertans wherever they are to get them the care they need, but certain programs like safe supply I oppose. However, that does not include a wide variety, as I mentioned, such as NTS or consumption sites. You talk about the digital overdose prevention app. I could go on and on. Virtual opioid dependency program—many people consider that harm reduction. I'm not ideological about that.

[*Translation*]

Mr. Luc Thériault: Do you talk about supportive housing?

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. Thériault.

[*English*]

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

Mr. Gord Johns: Minister Williams, the numbers are clear: 1,732 people died of the toxic, poisoned drug supply in 2022, and 2,050 people died in 2023 in Alberta. We had the deputy commissioner of the RCMP testify at committee, and he was unequivocally clear that police aren't seeing diversion of safer supply across B.C.'s borders. Police also disagreed about the widespread diversion, beyond a few high-profile cases. In fact, the coroners in both British Columbia and Alberta cited that only 3% of people who died in B.C. had any traces of hydromorphone and died from fentanyl, and 2% in Alberta.

You talked about not enough data or research when it comes to safer supply, but the peer-reviewed research is showing that it's actually working. You haven't provided any evidence of what your claims are. These are outrageous claims. Can you show me or produce evidence to this committee that diverted safer supply from British Columbia is flooding Alberta?

Mr. Dan Williams: Yes. I'm happy to provide two answers directly to that and address your other questions, Mr. Johns.

Number one, we have the RCMP—

Mr. Gord Johns: I'm asking if you can table that to this committee. Can you produce—

Mr. Dan Williams: I will table the RCMP statement that they made in Prince George, that they believe it's being diverted out of province.

Mr. Gord Johns: That's not enough. I want data—

Mr. Dan Williams: I'm sorry. You asked for—

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

Mr. Gord Johns: I'm asking—

The Vice-Chair (Mr. Stephen Ellis): Mr. Johns, please, you know our notion here: that when you ask a question we allow the witnesses to answer that question. I would suggest to you that the witness has about 45 seconds to answer your original question.

Minister, if you would, please.

Mr. Gord Johns: Mr. Chair—

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. Johns.

Mr. Dan Williams: You asked for evidence. I'll happily table that.

Second, I have asked for a unique chemically identifying tracer in the production of safe supply from your government, which seems to refuse for technical reasons—pushing the cart down the road without doing it. That would provide everyone with the evidence. I don't know why there's a concern over providing this. Is there an allergy to evidence in policy-making in this government? It concerns me deeply.

When it comes to evidence around what safe supply is and isn't, the peer study you're referring to is what Canadian academics refer to as “junk science” because of the way it was produced.

Mr. Gord Johns: Is the British Medical Journal junk science?

Mr. Dan Williams: It is because of the outcomes they looked at—two weeks down the road. They also didn't aggregate opioid agonist therapy out of that. It's very clear. You don't need a Ph.D. to understand that giving drugs to drug addicts to address an addiction crisis will make it worse.

Mr. Gord Johns: How is that going in Alberta, Minister?

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

Mr. Dan Williams: We see improvement.

The Vice-Chair (Mr. Stephen Ellis): Minister, thank you.

Mr. Doherty, you have the floor for five minutes.

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

I'm going to move away from the hot topic of safe supply.

I'd like to ask our witnesses this: As a country, we seem weak and unable to stop these harmful drugs from flowing across our borders, whether it's fentanyl, carfentanyl or the precursors to these. I'm wondering if the witnesses have an idea or a suggestion.

Mr. Felicella, you've been on the street. You said that you've dealt with that. I'm interested to hear your side on how we, as a nation, can stop these harmful drugs from flowing across our borders into our country.

● (1245)

Mr. Guy Felicella: That's the million-dollar question.

Honestly, it's been an absolute debacle, because you just can't stop drugs from getting into the country, unfortunately. The thing you can consistently look at is trying to reduce it.

I've seen more drugs in prison than I've seen on the street, in some circumstances. The reality is, unfortunately, that you're not going to stop the flow of drugs into the country, or the precursors. You may get the low-level street dealers, but you don't get the big guns. You never get them. They're not even in British Columbia. They're in countries like Fiji and Vietnam, running an operation globally. This global war on drugs has just provided an avenue for drugs to go everywhere. These people are effective and efficient, and they understand what needs to be done. They understand there's also no shortage of people in the world who use those substances.

Unfortunately—

Mr. Todd Doherty: I'm sorry to interrupt.

In your view, should Canada ban those precursor drugs?

Mr. Guy Felicella: I don't know what drugs these are. They are probably already banned, but they still get in. Drugs are banned in the country of Canada. You're not allowed to have fentanyl, or produce it or sell it, but it still comes into the country.

Mr. Todd Doherty: Thank you for that.

Dr. Goulão, our provincial director of health Dr. Bonnie Henry testified at our committee last week that she's in favour of legalizing deadly drugs like cocaine, heroin, meth and fentanyl.

Do you support that?

Dr. João Goulão: I quote Mr. Felicella: It's a million-dollar question.

I'm not sure. I believe everybody wants to lower the impact of the use of substances in our societies. I'm not sure which is the best way to do it or deal with them. In a regulated market, it's probably easier to track them and have good-quality products circulating.

Will people tend to use more? Will deaths grow? I'm not sure about the consequences of these types of substances. Even with cannabis, it's not completely clear what the impact is of legalization or regulation of the market. I'm not sure.

Mr. Todd Doherty: In 2023, overdose rates in Portugal were reported to have hit a 12-year high. What was the nature of that? Why was that?

Dr. João Goulão: In 2023, we had 74 overdose deaths. Most of them were related to opiates, mainly to heroin, and also crack cocaine. Those were the main causes of it.

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

Dr. Powlowski, you have the floor for five minutes.

Mr. Marcus Powlowski: Dr. Goulão, I am still curious as to how the Portuguese system works. Unfortunately, we weren't able to go there and see for ourselves. I think you either said or implied that the Portuguese system was non-coercive, although I would suggest that it is a little bit coercive in that, yes, it's not a crime, but drug use is not permitted.

Am I right that you kind of equated the possession of drugs to being like a traffic offence, like not wearing a seat belt? Is that kind of the equivalent? As well, am I right that everybody who is caught has to go before the commission for drug addiction? When does that happen? Does it happen right away?

● (1250)

Dr. João Goulão: People who are intercepted by the police authorities using drugs or possessing small amounts of drugs are addressed to those commissions. I would not say that all the people who use drugs are presented at any time in their lives to those commissions, but in any case, on average, 10,000 people a year are presented to those commissions.

Mr. Marcus Powlowski: How soon after you're picked up by the police do you go before the commission?

Dr. João Goulão: In three days people must present themselves before the commission. There is a maximum delay of three days.

Mr. Marcus Powlowski: Mrs. Goodridge asked you early on what would happen if somebody was using crack on the beach. You said that the police would pick them up and would refer them to the commission. What happens if they go right back to the beach again?

Dr. João Goulão: The police pick up the person again and somehow enforce their presence before the commission.

Mr. Marcus Powlowski: You also said—

Dr. João Goulão: If you disobey and you do not go, you are incurring a disobedience felony, which is a crime. We are not charging them for the use of a substance but for disobeying a police intervention.

Mr. Marcus Powlowski: I started to ask you this before, and you didn't get to answer. If there is no penalty and you appear before the commission, they're not going to force you if you don't want treatment. However, if it's repetitive, then you can and you will fine people.

How much is that fine? If you go for treatment, does that mean you don't get fined? How does that work?

Dr. João Goulão: I must say that for people who are addicted, who are really problematic users and who have a drug use disorder, fines are never applied. There's a long list of penalties that may be applied, such as being forbidden to attend certain places or to join certain people, or the obligation to attend, for instance, the health centre.

For instance, if I have someone who is HIV-positive and they are missing the consultations, the commission may impose that the person attend the consultations and bring a piece of paper showing that they have been there and they are complying with their treatment for HIV.

Mr. Marcus Powlowski: The commission can require people to get treatment then, you said, if they're chronic users.

Dr. João Goulão: Yes...to follow the obligations.

Mr. Marcus Powlowski: This is my last question. In many cities in Canada, like the Downtown Eastside in Vancouver, you see a lot of people with what's termed “the nod”. They are basically stoned in a public place. Do you see that in Portugal?

Dr. João Goulão: Yes, we see it. We tend to have fewer of these situations, but of course, it occurs.

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

Colleagues, we have two rounds of questions left of five minutes each.

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

Mrs. Laila Goodridge: Thank you again.

I really appreciate all the witnesses for being here. Each time we have one of these meetings, I think we get further into this, which then necessitates a space where I believe we should continue studying, have more questions and have more witnesses come, because this is clearly something that is much larger than I think we initially grasped when we looked at this.

My question is for Minister Williams. Are you aware of any jurisdictions in the world that have had success when they focused on recovery? If so, can you provide details on them?

● (1255)

Mr. Dan Williams: Obviously, Canada is a unique country with its own jurisdictional and cultural context and milieu, so whatever we do, it's going to have to be unique to us. Even the province of Alberta has a principle of subsidiarity in the Constitution, with provinces responsible for health care for a reason. The Alberta solution might look different from others, and we see two different policies happening in B.C. and Alberta that contrast. We're happy to see that we're going to have a policy outcome for both that we can use for analysis.

We have looked at Australia. We have looked at Massachusetts. We have looked at Portugal. Happily, as Dr. Goulão mentioned, we were there recently, spending time understanding their system in-depth. Recovery is a terrific opportunity. Most recovery, when it comes to therapeutic living communities, for example, as a model, isn't instigated just by governments.

Look at the world's largest. San Patrignano in Italy started in 1978. I believe it's a 1,200-person community. It has great outcomes. I think the last study I saw from the University of Bologna had a 72% rate of success, and recidivism was relatively low there, measuring longitudinally, multiple years out.

There's a lot of good information around therapeutic living communities and around recovery as a model. Recovery capital with Dr. Best, out of Scotland, is incredibly informative, along with a number of researchers like Dr. Humphreys, whom I know you heard from here at the committee. There's a lot of good evidence internationally, both locally and increasingly more at a government state level.

Mrs. Laila Goodridge: What could the federal government be doing differently to help Alberta, and Canadians more generally, with addictions?

Mr. Dan Williams: I'll speak for the Alberta context, not for other provinces. As you well know, and as I've made it abundantly clear, safe supply is illegal in Alberta. Unfortunately, we still have the policy consequences of safe supply coming into our province from reckless, unwitnessed safe supply programs in British Columbia, for example. It is the world's most radical drug policy. No other jurisdiction does it, and it is deeply devastating to the next generation of new addicts coming online.

However, beyond stopping that, or at the very least, if you refuse to stop it federally, employing the chemical tracer so we know the diversion....

I'd say the Government of Alberta has stepped forward in a very big way by partnering with indigenous communities. Importantly and constitutionally, this is the responsibility of the federal Crown. I believe we've stepped into a space that has been left open and abandoned by the federal government. I would like to see it come to help us with what the first nations are asking for, which is treatment capacity in a land-based, culturally sensitive, integrated continuum of care, from shelter systems all the way through to post-recovery housing and everything in between, with the corollary investment to follow. This is because, right now, it's falling on us.

Happily, we are partnering, because we believe we need to. We'd like to see the feds also fulfill their responsibility.

Mrs. Laila Goodridge: Thank you.

My next question is for Dr. Goulão. What recommendations would you give to the Government of Canada to improve its addiction policy to have more people find recovery from addiction?

Dr. João Goulão: I believe you have a lot to offer people who want to change their lifestyle. I also believe it's probably possible to improve coordination among several responses and the so-called continuum of care, from harm reduction to treatment facilities and the way we can cultivate people to step in.

Mrs. Laila Goodridge: In the Canadian context, we have three northern territories. There isn't a single treatment centre in any of those territories. We have so many first nations communities from coast to coast to coast that do not have any access to treatment.

The Vice-Chair (Mr. Stephen Ellis): Be very brief, Mrs. Goodridge, please.

Mrs. Laila Goodridge: My question to Mr. Goulão is this: Do you believe Canada should be investing in creating more treatment space?

Dr. João Goulão: First of all, it's necessary to make a diagnosis of what is needed in each region. Calculate a ratio for the responses—the number of available beds in therapeutic communities—then build them accordingly. You need the diagnosis.

● (1300)

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

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

Given that we started 10 minutes late and this round will finish at five minutes past, can I ask if it's the will of the committee to give the NDP and the Bloc an extra two and a half minutes each, in order to complete the full two hours?

The Vice-Chair (Mr. Stephen Ellis): If it's the will of the committee, I'm here at your service. I'm looking around the room. That would require unanimous consent, I believe.

Are there objections?

Very well. It's a tad unusual. Usually, we end rounds of questioning with the Conservatives and then the Liberals. Again, if it's the will of the room, I'm happy to do that.

I don't see any objection, so we'll do that.

Dr. Hanley, you have the floor for five minutes.

Mr. Brendan Hanley: Thank you.

Mr. Felicella, I know you do a lot of work with youth. We may not have time to go too in depth on that, but I know you have an interest in reorienting youth at risk.

I wonder if you could briefly describe this, and perhaps submit more details to the committee about your work with youth.

Mr. Guy Felicella: Yes, most definitely.

I've spoken in over 100 schools. I talk to youth and share my story of overcoming immense challenges throughout my life, and the variety of services that helped me get to where I am today. You know, as a person who understands and talks about the struggles I had as a youth, as well.... It's very relatable to youth. I've had many testimonies from mayors, towns, school principals, liaisons, counsellors and police. It's been very overwhelming.

Recently, I did a talk at Hugh Boyd Secondary School. Youth come up to me after every talk. They're usually in tears. A few of them are really struggling. They feel so much stigma and shame because they don't have the ability or capacity to reach out. They feel judged for how they're living their life. The next day, the principal emailed me saying the whole counsellor's office was packed with students reaching out and saying that Guy Felicella has a way of making reaching out sound cool. I just try to inspire youth not to go down the same path I did. However, if they do, I want them to know there are people like me and others who are in the community. There are services. We care and want to support them.

I think it's very important for us to continue to give youth the realities of the current crisis we're dealing with today, so they can move forward with their lives.

Mr. Brendan Hanley: Thanks, Guy.

I'm going to give you a very rapid perspective.

In this committee, we've looked at Alberta a lot. We've looked at B.C. a lot. We've done a lot of comparing and sometimes finger pointing. I would like to see the best of Alberta and the best of B.C. put together.

Do you have a brief perspective on that?

Mr. Guy Felicella: I am concerned about the way Alberta has scaled back harm reduction, but I do like its approach to recovery, getting people stabilized on OAT. Unfortunately, we are seeing the results of the model through their data. Last year, B.C.'s increase in overdose deaths from 2022 was 6.9%. Alberta had a 16.6% increase, and Saskatchewan actually had a 23% increase. The lesson here from all of it across the country is that we have to do both: harm reduction and recovery together.

It's a relay race, like a baton passing back and forth as many times as possible to meet the needs of the individuals who are struggling. If you're going to meet somebody where they're at, then meet them where they're at. It's one thing to say it, but people aren't dying from safer supply. They're dying from toxic drugs. If that's a pathway to get people to move forward with OAT and into treatment and recovery, I don't see why anybody would be against that because, sadly, people are dying from toxic drugs.

Mr. Brendan Hanley: Thanks, Guy. Thank you so much. That's very helpful.

Dr. Goulão, I wonder if you can briefly talk about how you built treatment capacity in the system in preparation for decriminalizing drug use and setting up the dissuasion panels—which was some 25 years ago now—and how important that was. However, I also want you to reflect on the spectrum of treatment from in-patient to outpatient to psychotherapy. If you can give a brief résumé of that in about a minute....

Thank you.

● (1305)

Dr. João Goulão: Okay.

Well, we have a complementarity between the responses that are insured by the state and supported by the state, and the private responses that are also supported financially by the state. For instance, we have an out-patient clinic in each district capital. We have 18 districts. Each has at least one centre, which has the responsibility to ensure prevention, treatment, harm reduction and reintegration in its territory. If they do not have the capacity to offer the responses needed in this territory, they may establish a contract with NGOs acting locally.

We built quite rapidly a network of responses. I must say that in therapeutic communities, for instance, they are mostly private, NGO-run. The state has only three therapeutic communities, but we have 68 run by NGOs with different models. The state responsibility is to certificate and to support the development of those communities, and then we pay for the services they supply to our patients.

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

We now go to the final two rounds of questions.

[*Translation*]

It's now over to Mr. Thériault for two and a half minutes.

Mr. Luc Thériault: Shouldn't I have five minutes, Mr. Chair?

The Vice-Chair (Mr. Stephen Ellis): You have two and a half minutes.

Mr. Luc Thériault: Very well.

Mr. Felicella, you've been through a lot. As Mrs. Goodridge said, you're proof that recovery is possible.

No matter whether they agree or disagree on certain points, everyone who has appeared before the committee agrees on this: Relapse is part of the recovery process. Stigma looms when someone relapses. Every relapse is self-stigmatizing. Can you talk about that and the importance of harm reduction in that regard?

[*English*]

Mr. Guy Felicella: Yes, sir. Thank you.

Stigma in our society is just as deadly as the drugs themselves. It's the main reason why people use alone and don't reach out for help and support. It's the main reason why people are dying as well. It's not just the drugs, but on top of that, the shame and just how you feel like such a failure. You try to go into a program and you try your best. I don't think people in our society celebrate that there are people trying, but often they're just not getting the results that they need.

The reality is that the toxic drug supply doesn't change when you're in treatment. It gets worse and worse and worse. Then when you do relapse, it's there to ambush you and kill you. We're just not going to think we're going to have this revolving door of sending people into treatment and then back and not have a harm reduction safety net underneath that. People will die. People won't get better.

As I said, although campaign slogans like “bring your loved ones home drug-free” sound appealing, the reality is that it's not the truth. That's why we have to have all systems of care that meet and support people's needs. If we do that and really do it in a way so that we do both harm reduction and recovery equally, I promise you we will reduce the number of deaths in this country.

[*Translation*]

Mr. Luc Thériault: There's a lot of focus on prevention, but don't you think we need to do a lot more work on relapse prevention? Shouldn't we talk more about that?

[*English*]

Mr. Guy Felicella: One hundred per cent. I think you have to look at our society too as to why people are using drugs. Go way up river before people fall in, and really give them the tools that are in place. Canada has been in a health crisis for many decades, where not as much has been put into it. We're seeing the catastrophic results because the drug supply changed so dramatically.

I think you're right. We have to do more prevention. We have to do more of everything. That is the key to all of this. We really have to inform everybody in Canada. Like we've all said on this panel, I haven't been into a community where, sadly, I haven't seen toxic drugs impact somebody's life.

● (1310)

[*Translation*]

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. Thériault.

[*English*]

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

Mr. Gord Johns: First, Mr. Chair and committee, I want to thank you for giving us this extra round.

Dr. Goulão, is the treatment program your country runs for-profit or not-for-profit?

Dr. João Goulão: Most of the treatment is not-for-profit. It's free of charge in the official responses in the units run by the state. It is almost free of charge in private responses, such as therapeutic communities. The state supports 80% of the costs and the patient or his family must support 20% of it. If that is not possible, if the patient has no financial capacity, social security can support the remaining 20%. Nobody stays out of care because of a lack of financial resources.

Mr. Gord Johns: Mr. Felicella, we have about a minute and a half left.

Is there anything you heard today that you want to comment on or anything you feel left unsaid? I'm sure you have lots to say.

Mr. Guy Felicella: Yes, most definitely.

I just think people look at British Columbia and they think it's a harm reduction province. That's incorrect. It's an everything province. We have scaled up treatment here. We have over 3,600 treatment beds right now that people can access. We also have harm reduction services. I think the province has scaled up, since 2017, 607 beds with more to come. We also have the recovery community centres, which are places where people who have the desire to change their lives get group therapy. We also have the road to recovery program out of St. Paul's.

It was unfortunate that some members of this health committee didn't show up for that tour, because it really shows the importance of recovery being met at a hospital where people can go in and get access to detox and treatment through those recovery services. We have contract beds through health care services.

British Columbia is really fascinated with doing all aspects and understands that this approach needs a full continuum of care. That's what we'll continue to work on here. That's what I'll continue to fight for. That's what I'll continue to advocate for not just in British Columbia but across the world, because it's so important. I don't want to see anybody die anymore. This is just too tragic.

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

Thank you to the witnesses.

Albeit unusual, I do wish to set the record straight in the sense that members from the Conservative Party were unable to attend because of wildfires. Let's be clear.

Mr. Todd Doherty: There was also a death in the family.

The Vice-Chair (Mr. Stephen Ellis): Yes, there was also a death in the family.

That being said, colleagues, we are at the end of our round of questioning. I want to thank the witnesses for taking the time to appear and share such valuable information today.

Colleagues, we'll suspend for five to seven minutes and resume in camera for drafting instructions. Those of you online, please use the in camera link to rejoin the meeting. The meeting is suspended.

[*Proceedings continue in camera*]