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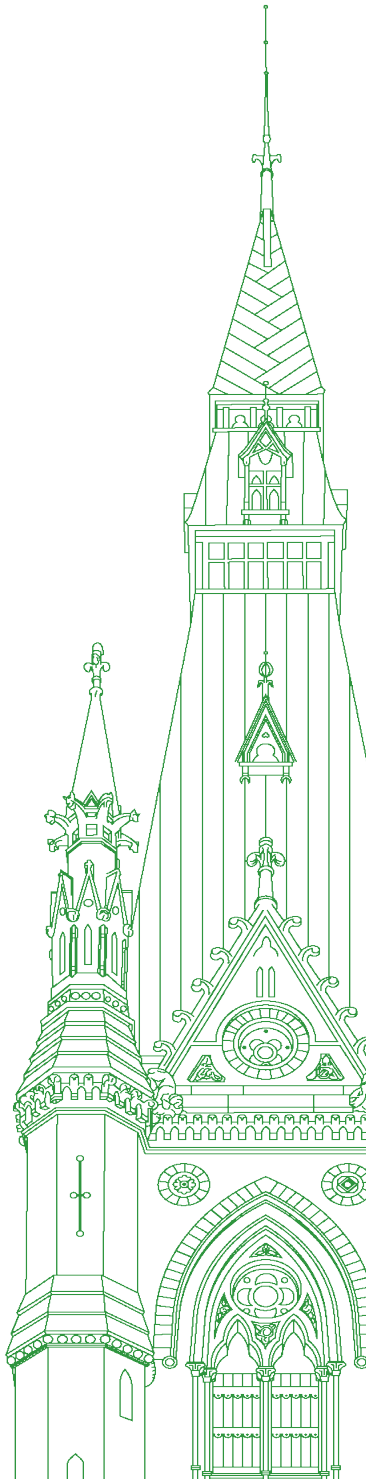

Chair: Mr. Sean Casey

# Standing Committee on Health

**Tuesday, October 8, 2024**

● (1100)

[*English*]

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

Welcome to meeting number 131 of the House of Commons Standing Committee on Health.

Before we begin, I'll ask everyone in the room to read the guidelines printed on the cards on the table. The measures are in place to help prevent audio and feedback incidents to protect the health and safety of all participants, including the interpreters.

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'd like to welcome our panel of witnesses.

We have Dr. Sarah Larney, associate professor, University of Montreal, who is online. Sarah MacDonald and Lance Charles are with us in the room. Representing the First Nations Health Authority, we have Dr. Cornelia Wieman, chief medical officer, who is online. Representing the Vancouver Island Construction Association, we have Rory Kulmala, chief executive officer, also by video conference.

Thank you all for taking the time to be with us today. As I'm sure you have been informed, you will have up to five minutes for your opening statements. Then we'll proceed with rounds of questions. We're going to begin with Dr. Larney.

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

**Dr. Sarah Larney (Associate Professor, Université de Montréal, As an Individual):** Thank you, committee members, for this opportunity to speak with you today.

My name is Sarah Larney. I have a Ph.D. in public health, and I'm an associate professor at the Université de Montréal. My research focuses on the health and well-being of people who use and inject drugs.

I have conducted several projects that are relevant to the committee's remit. The most recent of these was an analysis of toxicological findings from people who died of overdose over the past decade in Quebec. These data showed that while Quebec was shielded from the worst of the toxic drug supply and overdose epidemic prior to 2020, this is no longer the case. In recent years, fentanyl is increasingly present in people who died of overdose, alongside a growing variety of highly potent and toxic compounds, including non-medical benzodiazepines, nitazenes and xylazine.

The number of opioid overdose deaths in Quebec increased dramatically in 2020 and has remained high. There were 319 opioid overdose deaths in Quebec in the first six months of the year compared with 236 in the same period last year—a 35% increase. The rate of overdose mortality is low relative to provinces in the west of Canada, but it is probable that the situation will continue to worsen as a result of the toxicity of the drug supply.

We have also studied use of supervised consumption sites in Montreal since 2018. In this work, we found that the proportion of visits to supervised consumption sites requiring an overdose intervention increased markedly in 2020 and has remained high since. However, these overdoses were not fatal because staff were able to quickly respond, providing oxygen, naloxone and further care as necessary. Supervised consumption sites must be a central part of the response to the overdose epidemic. The number of deaths that would occur without them in major cities, regional areas and across the country is unthinkable.

The current overdose epidemic is often dated to 2014 or thereabouts. Recent work in the United States, however, has shown that overdose deaths have in fact followed an exponential growth pattern for nearly 40 years. Using publicly available data from Statistics Canada, we have identified a similar growth pattern in Canada, with an average increase in the overdose mortality rate of 9% per year, every year, since the year 2000. There is no sign of this trend slowing down.

I want to emphasize that exponential growth does not just mean rapid; it means a specific pattern that is underpinned by a process or processes that continually catalyse further growth. While the toxic nature of the drug supply is the immediate cause of the overdose epidemic, these underlying processes contribute to the sustainment and growth of the epidemic. These are most likely socio-economic trends such as increasing housing costs, increasing income inequality and declining income mobility. These trends intersect with and influence each other. It is not a coincidence that overdose deaths have increased in Montreal at the same time that housing costs have increased dramatically and income inequality has also increased.

My point here is that well-funded, low-threshold harm reduction services are essential to manage the acute overdose crisis. These services, however, are hamstrung by a policy environment that permits growth in overdose deaths to continue. Interrupting this growth requires social policy reform, attending to the housing crisis, income stagnation and other issues including overburdened health systems, particularly mental health systems, across the country. Drug policy reform is also essential to address the perverse incentives that drive drug traffickers to produce ever more potent substances.

No single one of these issues that I have mentioned is the sole cause of the overdose epidemic, and no single policy will bring an end to this epidemic. Rather, it is likely that all of these will need to be addressed in some way and the social safety net strengthened if we are to successfully interrupt the epidemic curve.

Thank you.

● (1105)

**The Chair:** Thank you, Dr. Larney.

Next, I'm pleased to welcome Sarah MacDonald and Lance Charles, who are here with us in the room.

You have five minutes for your opening statement. I understand that you're going to be sharing the five minutes, if I'm not mistaken.

You have the floor. Welcome.

**Mr. Lance Charles (As an Individual):** Thank you for having us.

My name is Lance Charles. This is my wife Sarah MacDonald. She is the mother of Brianna MacDonald. Brianna passed away on August 23 from an overdose. She struggled with mental health. It dragged her down a dark path. She was an amazing little girl. She had a laugh like no other child. She was there for you when you needed her.

Around the time I came into Brianna's life, she started to experience issues with her mental health. She started experimenting with drugs, as well. Her drug of choice was Molly, but she would try anything she could get her hands on. Brianna had over 20 recorded suicide attempts. She tried to overdose on prescription drugs she would steal. Over time, you could see she was going down a very dark path.

We, as parents, started to discuss what we could do and tried to get her help. We looked into treatment centres, mental health centres, doctors and counsellors. None of it helped. The treatment centres told us she was too young. The doctors told us she had behavioural issues. Others told us she's too young to diagnose. Brianna's father and I begged doctors to keep her in hospital. The doctors overlooked what we said and released her, sending us home with Narcan kits. This was starting to get very alarming. It seemed we spent every other week with Brianna at the hospital. She was prescribed many different medications. Some worked for a bit, while others didn't work at all.

We noticed things were getting darker. She became a ball of rage. She was up all night sneaking around and doing drugs. She started to come and go as she pleased. Sarah and I would often get woken up by the police bringing her home because she was found extremely intoxicated. Police would also be needed when she had her violent episodes and threatened to kill herself. An officer asked me once what I would like him to do. I told the officer, “She's threatening to harm herself. Please invoke the Mental Health Act and force her into a hospital.” The officer told me he couldn't because it's against her will.

This is when I discovered the Infants Act. This little girl had more rights to her medical decisions than her own parents. She could tell doctors anything they wanted to hear, and they would release her. Back in February this year, Brianna was found in the kitchen overdosing. Sarah called 911. An ambulance came a short time later to take her to Abbotsford general. Sarah got very mad when she was at the hospital. She stood up to the doctors, who were just going to pump Brianna's stomach and send her on home. Sarah directly told the doctors that we were tired of this. Brianna needed help with her mental health.

This time they sent her to the children's hospital in Vancouver. Brianna didn't do well there. She was lashing out at staff, and screaming. They really couldn't handle her. They weren't fit to handle her. They transferred her to a place called CAPSU. It's at Surrey Memorial. They held her for about 10 days. While there, she had her good days and she had her bad days. Sarah had a meeting with the doctors. They told her Brianna was clear to be released when, realistically, she wasn't. She had just finished putting a pencil through her hand. Once again, Sarah fought to keep her there. Of course, all they did was send us home with a Narcan kit.

This is when we started to see the real dark side of Brianna. We noticed she started using drugs like Molly on a regular basis. We were astounded that she could actually get these drugs. One evening, a car randomly pulled up in front of our house. I went outside after asking my wife who this person was showing up in front of our house. It turns out that we didn't have a clue. I went out to check and make sure. I asked what this person's business was in front of our place. These were two 16-year-old children who were there to sell our daughter Molly. We took pictures of the licence plate and reported it to the police. The police never did anything. They didn't even report back to us.

● (1110)

Now I was really getting worried. It was shortly after this that Sarah started wondering what else was she up to, so she started following Brianna around.

Brianna would actually go to a harm reduction site. She would acquire these zip-lock bags full of needles, cooking kits and pamphlets on how to cook the drugs and safely use them. We were astounded by the fact that these were available to a child. How can a 12-year-old, as she was at that time, acquire these? She can't buy marijuana at a dispensary and she can't buy booze at a liquor store, but she's able to pick up these kits from a harm reduction site to use drugs—a site that is meant for people who are not children. It didn't make any sense

Now we have reached the darkest times, just before she passed. Around the end of July 2024, Brianna became so violent towards her mom and I. This was a direct result of not just the drugs, but her mental health, which had gone so far down a deep path.

Sarah was destroyed seeing her daughter do this. We talked about it every night, trying to figure out what to do. Days later, Brianna became so violent with us that she caused some serious damage to her mom, who ended up in hospital with a severe concussion and some serious brain trauma. I ended up with a black eye and a cracked orbital socket.

Now her mental health was in a really dark spot and we didn't feel safe having her at our house when we have other children. The police removed her from our house and advised that it was not safe for her to be around our other children because she had become so violent. They ended up taking her to a place called Cyrus house. Cyrus house tried to hold her and keep her there. She stayed one night. The next night she didn't return.

When she didn't return, Cyrus Centre put out a missing persons report. This is when we found out she now wanted to be at a homeless camp. The police found her there. They didn't directly tell us that she was at a homeless camp. We found that out days later, by ourselves.

All they said to us was that is safe and that she's with another adult—who was nobody to us. We didn't know her; we didn't even know her name. Since when is it okay for a 13-year-old to be at a homeless camp? Why didn't the police bring her back to Cyrus Centre? Why was she just left there with another adult who doesn't associate with us?

We did keep in contact with Brianna every day. We brought her food and we brought her clothes, but she didn't want to return home. We tried to inflict rules and tried give her more stability; we told her that if she comes home, she needs to follow these. She said, “Why? I can do whatever I want out here”. It didn't make any sense. If she needed clothes or if she needed anything, she could always reach out to us and we were there for her.

Now we come to August 22 and August 23, 2024.

I went to work on August 22, thinking this wasn't going to be a change in my life. I was at work. I work night shifts at Seaspan international. I received a phone call from my wife, who never calls me at three in the morning. It was the one that a parent dreads.

She started the conversation off with, “I love you very much”. This is when she proceeded to tell me that our daughter had passed. This is every parent's nightmare.

This is when we realized that the system we have in place had failed her massively. The people she could go to for help failed her.

● (1115)

My question is, and always will be, why are harm reduction places considered safe? Why are children allowed...I shouldn't say “allowed”. Why are there no programs, really, in place for our children and their mental health? These drug addictions would have never become what they were had she been able to, honestly, get the mental help.

She used to tell us she would have demons and voices in her head, and the only way she could drown them out was through the drug use. I don't know about you guys here, but when you stand back and think about that, it is very alarming that a child is using drugs to drown out voices in her head. The mental health problems were there, but anybody we reached out to weren't. They would send us home with Narcan kits. They would tell us, “We can't force her into anything against her will.”

On September 19, Brianna's friend Chayton, a very lovely little boy...they were best friends.... They started experimenting with drugs because they both struggled with mental health. He had a very hard time dealing with the fact that Brianna was gone, to the point where he made a suicide attempt shortly before Brianna's funeral and, days later, after her funeral, succeeded. He is no longer with us. These were two 13-year-olds who have passed now, not only because of drugs but struggles with mental health. We need things to change because our children are dying, and we can't afford to lose any more children.

I thank you for bringing us here to speak. I hope Brianna's story, as well as Chayton's story, can bring awareness to the struggles that our children are having and awareness to the parents who are struggling with children who are struggling.

It hurts every day thinking about this situation, because I think that, if Brianna had access to the proper mental help, she'd still be here today and able to tell you this herself. Instead we have to speak on her behalf because she's no longer with us. It breaks my heart, having to speak about a child who's no longer here. We do need change, and it needs to be now. Our children are dying, and no other parents should be going through this pain. I hope that, today, we can bring some answers and enlightenment to this subject.

● (1120)

**The Chair:** Thank you, Mr. Charles. Please accept my condolences, and those of my colleagues, for the passing of your dear Brianna, and also our respect for your courage to tell such a personal story in a public forum.

Next we go to the First Nations Health Authority, and Dr. Cornelia Wieman. For the next five minutes, Dr. Wieman, you have the floor.

**Dr. Cornelia Wieman (Chief Medical Officer, First Nations Health Authority):** Thank you.

Good morning, *boozhoo*, *aniin*.

I'm Dr. Nel Wieman. I'm originally from Mishi-baawitigong First Nation in Treaty 5 territory, which is part of the Anishinabe Nation. I serve as the chief medical officer at the First Nations Health Authority here in British Columbia.

I want to acknowledge that I'm speaking today from the traditional, ancestral and unceded territories of the Musqueam, the Squamish and the Tsleil-Waututh nations.

The FNHA is the first organization of its kind in Canada, created by and for first nations people in B.C. to support their health and wellness. Since before the toxic drug crisis was declared a public health emergency in 2016, we have been on the front lines, addressing the disproportionate impacts on first nations individuals and communities who have worsened historical and systemic inequities and intergenerational trauma.

Our role is to engage with communities, and we continue to expand our public health response to this emergency in collaboration with our health governance partners.

Our data for B.C. first nations people is alarming. In 2023, we lost 448 first nations people to toxic drug poisonings. This was a 10.3% increase from 2022. First nations people died at 6.1 times the rate of other B.C. residents. Women and young people are particularly overrepresented. Since 2016, we have lost 2,356 lives. These data are not just numbers. They represent our family members, our aunties, our youth, our elders. They are loved and missed. This is only the tip of the iceberg. There are vast numbers of other substance use-related harms, such as acquired brain injury, disconnection, and mental, emotional and spiritual distress.

Between 2015 and 2021, life expectancy for first nations people in B.C. fell by 7.1 years, driven both by the COVID-19 pandemic and the toxic drug public health emergency. This reveals the long-term losses and harms to our communities, and the urgent need for critical action. FNHA's response, to date, has been rooted in cultural safety, community engagement and innovative initiatives derived from shared learnings across our five regions. Our approach is community-driven and nation-based and supports a continuum of care that meets people where they are in their wellness journey. We have developed and funded culturally safe community-based programming grounded in harm reduction, which includes expanded OAT availability, establishing peer support groups and outreach teams, funding first nations-lead overdose prevention sites, and increasing access to harm reduction supplies in communities. We have also supported public education and awareness through our Not Just Naloxone training program and communications campaigns; expanded cultural programming, including through land-based healing initiatives, and funded rapid access to treatment and healing centres that incorporate culturally safe practices.

While progress has been made, we continue to face significant barriers. These include the inaccessibility of substance use services in communities, particularly in rural and remote areas, and the lack of long-term, sustained and flexible funding, including for cultural programming. We cannot ignore the role racism and discrimination play, and the lack of recognition of the intergenerational impacts of colonialism resulting in culturally unsafe health care. This is further compounded by the stigma surrounding substance use, which prevents people from accessing care.

In closing, the toxic drug crisis of 2024 is more deadly than it was nine years ago. The major driver of deaths is the increasingly unpredictable, dangerous and potentially lethal unregulated drug supply. The politicization of this emergency threatens progress, especially the backlash against proven evidence-based harm reduction measures that can save lives, and hits first nations people the hardest, deepening existing inequalities.

● (1125)

Every loss is felt deeply by families and communities, and we call upon our system partners to implement timely solutions that are first nations-led, culturally safe, trauma-informed and appropriately funded.

I thank you for your attention today.

Thank you, *meegwetch*.

**The Chair:** Thank you, Dr. Wieman.

Next, from the Vancouver Island Construction Association, we have Rory Kulmala.

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

**Mr. Rory Kulmala (Chief Executive Officer, Vancouver Island Construction Association):** Thank you, Mr. Chair.

I'm Rory Kulmala, CEO of the Vancouver Island Construction Association, where I have the privilege to work and live in the traditional territories of the Lekwungen peoples and on the historical lands that we have a relationship with through the Songhees, Esquimalt and Saanich peoples to this day.

The year 2024 marks the eight-year anniversary of the state of emergency declared by the B.C. government in 2016 in response to a dramatic increase in overdose deaths that year. Toxic drug poisoning from illicit drugs remains the most prominent cause of unnatural death in British Columbia, greatly surpassing those of suicide, motor vehicle accidents, homicide and prescription drug overdose.

In 2022, the BC coroner's office released the report “BC Coroners Service Death Review Panel: A Review of Illicit Drug Toxicity Deaths”, which outlined some important demographic trends among a representative sample of British Columbians lost to toxic drug poisoning. An important finding of this report was a trend in employment by sector: Of those employed at their time of their death, 52% were working in construction, trades, transport and equipment operation. The high number of drug poisoning deaths represented in the construction industry has been, in part, attributed to substance use and consequences of strenuous work environments, with long shifts and pain. Stigma is pervasive in the construction industry, as is the real barrier to accessing treatment, resources and harm reduction supports, including those for mental health.

The Tailgate Toolkit project, which we have developed, was initially funded by Island Health. It was born out of an increased need for supports and services specifically created for the construction industry. The work of VICA's harm reduction team in creating a curriculum and dialogue for the industry was recognized by the B.C. government, and funding for the project was picked up in January 2022 to deliver this training throughout the province.

The project targets anyone working in construction and trades who uses substances and employers who wish to increase harm reduction awareness in their workplaces. The goal of this project is to bring awareness and increase access to harm reduction services and provide ideas to those who work in the construction industry. This project is the first of its kind in the construction industry. It's innovative, in that the project partners with indigenous knowledge keepers; lawyers; an organization that supports people living with chronic pain; people with lived and living experience; health authorities; managers; supervisors; and owners of construction and trades companies to break down stigma and provide training and education to meet the needs of our industry. It aims to reduce the number of toxic drug deaths in the province of British Columbia.

There are three components to the tool kit. Toolbox Talks is approximately 30 to 45 minutes in length and is delivered live on-site, and we can do it via Zoom, with VICA's harm reduction team. The talks highlight stats about the drug poisoning crisis; why it's an issue in the construction sector; why it's an issue for men particularly; the connection between mental health and substance use; physical and mental health resources; harm reduction and recovery resources; and any other available resources and supports that an employer may require.

The talks can also serve as an operation for the distribution of naloxone kits and training on those kits.

The second component of the tool kit is a training course directed at those in supervisory and frontline positions. They're delivered over two full days or four half days. The training covers statistics about the drug poisoning crisis; an introduction to harm reduction as an approach; construction industry discussions; substance use and mental health; components of stigma; recognizing substance use and impairment; mental health first aid; mental health and substance use literacy, with a focus on having effective and supportive conversations; naloxone injection training; indigenous perspectives; active listening; compassion; resiliency; chronic versus acute pain; pain management stigma; and more through the summary of services available.

● (1130)

In consultation with local health authorities, the third component of the tool kit is digital and print resources for both employees and employers that highlight the harm reduction and recovery services that are available to workers within and beyond their benefits packages. These resources are a mix of province-wide and regional-specific resources that will contain identity-specific supports, including indigenous-led organizations and an industry-specific support group.

VICA's current harm reduction team includes trained regional facilitators who are positioned throughout the province in construction association offices. We call them RCAs. They're all trained social workers working in collaboration with the provincial health authorities. Facilitators gather information on the programs and services available in their area and the province along with information about specific needs of individuals working and living in those regions.

Currently our B.C. construction association has reached over 12,300 construction-related companies. Facilitators offer training either virtually or in person, allowing our project to reach even more communities where travel could be a barrier.

In partnership with the Umbrella Society, which is a local substance support centre here in Victoria, B.C., the final component of VICA's project provides weekly meetings for folks in construction struggling with substance use. They are facilitated by two Umbrella Society staff who have lived experience of both substance use and working in the construction industry.

From January 2023 to the end of September 2024, VICA's harm reduction staff have had the opportunity to provide 230 talks, over 5,500 people working in the construction industry—

● (1135)

**The Chair:** Mr. Kulmala, could I get you to wrap up? You'll have lots of time to expand on your presentation in the questions and answers that follow.

**Mr. Rory Kulmala:** Sure. That summarizes our components, and I'll leave it there.

**The Chair:** Thank you, sir.

We are now going to begin rounds of questions starting with the Conservatives.

We'll go to Mr. Doherty for six minutes, please.

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

I will start off by thanking you, Mr. Chair, for allowing our witnesses the time hey deserve to tell their story.

I'm going to focus my questions on Mr. Charles and Ms. MacDonald.

I want to thank you guys for your strength. I don't know if I would have had the same strength that you have, so I thank you for that.

If you could send one message to Justin Trudeau about the failed drug policies, what would it be?

**Mr. Lance Charles:** How can you put “safe” and “drugs” in the same sentence? It doesn't make any sense. Those two contradict each other deeply.

On the policy, you should just look at those two words, and they should tell you and give you an answer right there. “Safe” and “drugs” don't mix.

**Mr. Todd Doherty:** The system failed Brianna. We just needed one adult to stand up in the room to fight for you.

You begged doctors and those people who should have been there to do no harm and to help your daughter. What was the message you received?

**Mr. Lance Charles:** The help wasn't there. The doctors kept sending us away, and it kind of sent a message that really....

**Ms. Sarah MacDonald (As an Individual):** It didn't matter.

**Mr. Lance Charles:** —it didn't matter at all, that she didn't matter and that her mental health didn't matter.

**Mr. Todd Doherty:** I think I read somewhere that you were essentially told that, if she wanted to kill herself, that's her choice. Is that true?

**Ms. Sarah MacDonald:** Yes.

**Mr. Lance Charles:** It's very true.

**Mr. Todd Doherty:** Do you believe that Brianna would be alive today if she got the help that she needed, the mental health help?

**Mr. Lance Charles:** I believe that not only would she be here today, but she'd be able to speak out on her own situation and what she'd gone through. I believe that, if the help were there and available, her beautiful smile would still be here.

**Mr. Todd Doherty:** Just to be clear, Brianna had just turned 13, correct?

**Ms. Sarah MacDonald:** Yes—just in July, on July 15.

**Mr. Todd Doherty:** So she was just a month into her 13th year.

July 15, did you say? It's the same day as my son's birthday. I should note that she passed away on my daughter's birthday.

What does Brianna's story say about the state of mental health care in Canada?

● (1140)

**Mr. Lance Charles:** It's pretty much broken. The system that is designed to be there to help her and guide her through life, especially when it comes to struggling with mental health, just isn't there.

Whenever we did approach doctors about change and about how to get her help, she was either too young for programs or there were no programs at all.

**Mr. Todd Doherty:** They allowed a 13-year-old to write her own safety release plans. Is that correct?

**Ms. Sarah MacDonald:** That's correct.

**Mr. Lance Charles:** She wrote on that plan, and was a very manipulative little girl.

My question is, why was a child allowed to write her own safety release plan when doctors are supposed to be doing that? They are the adults. They are the ones deciding on how her safety is supposed to be—not a child, and not a child who's unwell.

**Mr. Todd Doherty:** You were powerless.

**Mr. Lance Charles:** Absolutely.

**Mr. Todd Doherty:** From the time she ended up on the streets to her death, how long was that?

**Ms. Sarah MacDonald:** It was almost four weeks.

**Mr. Todd Doherty:** Her drugs of choice were Molly and fentanyl, correct?

**Mr. Lance Charles:** They were Molly, fentanyl or anything she could get her hands on, really.

**Ms. Sarah MacDonald:** Molly was her DOC.

**Mr. Lance Charles:** It was her drug of choice, yes.

**Mr. Todd Doherty:** Are safe injection and safe consumption sites working?

**Mr. Lance Charles:** No.

**Ms. Sarah MacDonald:** Absolutely not.

**Mr. Lance Charles:** No. They don't discriminate against age and they keep providing kits to these children. It's very easy access.

**Ms. Sarah MacDonald:** It's everywhere. You can't go anywhere without seeing it now. It used to be taboo to see a joint being smoked on the street. Now you can walk by people smoking crack. It's disgusting.

**Mr. Lance Charles:** We once sat at an A&W having lunch. This was at 12 o'clock in the afternoon, in broad daylight. I had to tell my stepson to literally not look out the window, because six people were sitting there cooking down their heroin to be able to inject it. It was right outside the window where we were having lunch.

That's not acceptable. That's not what I call safe.

**Mr. Todd Doherty:** Have our communities become less safe in recent years?

**Mr. Lance Charles:** Absolutely. I believe they're getting even more unsafe as the days pass.

**The Chair:** Thank you, Mr. Doherty, and thank you, Mr. Charles.

Next is Ms. Brière for six minutes.

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

Ms. MacDonald and Mr. Charles, you have my deepest sympathy. I share your pain. I salute your courage in sharing this heartbreaking story.

What do you think should be done to involve parents in prevention work to protect our Canadian youth?

**Ms. Sarah MacDonald:** We need more rights over our children. We need to be able to stand up for them and advocate for them—not for them to advocate for themselves when they're too young. We're supposed to be their legal guardians. We're supposed to take care of them. We need to do so. We need that authority back.

**Mr. Lance Charles:** As it sits right now, we're just guardians of the government's children. They're not even ours.

**Mrs. Élisabeth Brière:** Did you know where to go to seek help or to seek services?

**Ms. Sarah MacDonald:** Absolutely. I exercised every option I had. I went to hospitals. I went to mental health places. We went everywhere. We were basically told, “We have exercised all our options. We are sorry. We condole you. We're happy for your best efforts. Thank you.”

**Mr. Lance Charles:** The only gift they gave us, really, was a Narcan kit. It's pretty alarming as a parent to receive a Narcan kit instead of, “Hey, here's a doctor's number. Maybe these people can help.”

Social workers didn't have a clue. Their answer to us was that their resources were so limited. Especially because of her age, there wasn't much they could do.

**Mrs. Élisabeth Brière:** Do you think the services are more targeted towards adults than youth?

**Mr. Lance Charles:** I believe that when the harm reduction stuff was brought in, children weren't really thought about at that point. Really, recreational drugs and stuff like that.... It was more of an adult thing. Now, however—I hate to say it—it's reaching our children at a very alarming rate, and the children are suffering. I don't think it's because they choose to do drugs; I think it's because their mental health is in the dumps.

Things need to change. Mental health needs to be changed, and so do these policies.

● (1145)

**Mrs. Élisabeth Brière:** Thank you.

Mr. Kulmala, can you talk a bit more about the tool kit?

**Mr. Rory Kulmala:** Sure.

The tool kit was generated at a time when we were trying to do outreach to the construction sector. As I mentioned, about 52% of those workers who were employed came from our sector. When we started this back in 2017, the statistic was, effectively, that one in four of those dying were in construction. We generalize “construction”—it's the trades, and commercial and blue-collar workers.

Again, I'm not professing to have a health care background, but the idea was this: How can we convey information that allows people who would otherwise avoid it or not seek help to find information, or seek out attention and treatment? I initially had a harm reduction coordinator come in from the Island Health authority. We would do a lunch and learn—a one-hour session. You can imagine how, when we invited workers to come to us, we had zero people showing up. We found that a bit concerning, considering the statistics that were out there. There was also a perspective that this wasn't happening in our industry. There was denial. It's taken eight years for us to somewhat acknowledge that this crisis affects the construction sector. More than that, it's a social impact.

We're trying to do our part to reach out to construction workers. Through our strategy of outreach to companies, we also work with local community colleges that provide first- and second-year apprenticeship training. Our effort is in creating awareness. What's happened, Madame, is that we've had workers who would otherwise stand there with their arms crossed at a meeting in the morning.... For your information and for general awareness, a “tailgate talk” is something that happens all the time on a construction site. It's how they start their day. It's typically around the tailgate of a pickup. We say, “We're going to be doing this work. Stay away from this area. These deliveries are happening.”

Well, since we introduced this component, we've had workers who are clearly uncomfortable with the conversation but who, by the end of it, are saying they know somebody who needs to get this pamphlet, or who needs to come to that support group. We have a spectrum of care. It's even for people who have a heavy dependency on alcohol. We don't discriminate. It's not necessarily toxic drugs; we don't focus solely on toxic drugs. We focus on elements that would compel somebody to, you know, go out and party one night and start with a couple of beers. The next thing they know, they're having a hit of heroin.

You know, we find that the circumstances are there to suggest that there are ways to inform them about what they should be looking for, and also to coach employers to say, “Don't let people struggle in vain. If you see somebody who's clearly having challenges...." They may be sober or clear-eyed during the day, but at night, they go home and turn to a very dark place. They use drugs to cope, only to get up and do the whole thing over the next day.

**The Chair:** Thank you, Mr. Kulmala.

Monsieur Thériault, go ahead for six minutes, please.

[*Translation*]

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

Ms. Macdonald, Mr. Charles, I join the committee chair in offering you my most sincere thoughts and my compassion. We are here to try to find solutions to situations that are extremely difficult in human terms. I have the impression that the further we get into this study, the more resources we may need ourselves. Indeed, the subject affects us enormously. People are dying on the streets every day as a result of the toxic drug crisis, leaving behind brothers, sisters and parents who are living through this tragedy. To date, there have been more than 45,000 deaths due to overdoses, and we are looking for solutions.

Because solutions must be evidence-based, I'd like to talk about some research I came across, Professor Larney. At the same time, I'd like to ask you to submit to the committee your study on trends in toxicological findings on deaths from involuntary intoxication by opioids and stimulants in Quebec. I want you to do this so that we can officially have this document in our hands when we try to make a report.

At the end, you say that there are a series of interventions to prevent and respond to acute overdoses, including supervised consumption, overdose prevention sites, prescribing a safer supply, medication verification—I imagine you're talking about drug verification here—the distribution of Naloxol, and opioid antagonist treatments as well. You go on to say that further research is also needed to establish, particularly with regard to drug verification and safe supply, whether there are results that can be considered conclusive, and to determine the effectiveness of these measures.

There is currently a marked tendency in Canadian politics to go backwards, to be skittish and, for purely electoral considerations, to say that we are going to put an end to certain measures. I'd like you to tell us more about that.

● (1150)

[*English*]

**Dr. Sarah Larney:** Thank you for the question. I'm happy to share the paper you referred to with the committee.

One of the interventions that is being implemented across the country is safer supply. We are currently engaged in some work on reviewing the literature on safer supply.

There is evidence, particularly from Dr. Bohdan Nosyk's team, who I believe the committee has heard from, that safer supply prescribing or risk mitigation prescribing during the COVID-19 pandemic was associated with a reduced risk of death. This is very promising. More work—quantitative research in particular—on the impacts of safer supply is needed.

I think it's very important to say that lack of evidence around an intervention is not evidence of a lack of effectiveness. Where we are at with safer supply at the moment is a lack of evidence in many cases. We do need to see more quantitative work such as that done by Dr. Nosyk, which is very carefully designed quantitative studies evaluating safer supply programs across the country, the same way we would with any new medical intervention.

I think withdrawing those programs would have devastating consequences for people who are currently part of safer supply programs. We know that safer supply programs are helping people to regain some measure of control over their lives.

At the same time, though, I do believe that we need more studies of what the effective components of safer supply programs are and also consider the range of programs. At the moment, there are a lot of different models, so it's understanding these different models, coming to a clearer understanding of what we actually mean when we say safer supply, and understanding what the effective components of these models are.

● (1155)

[*Translation*]

**Mr. Luc Thériault:** Some think that if we force people to undergo treatment, we'll be able to solve the problem expeditiously.

Based on what you know, do you think compulsory treatment would be effective? When you talk about in-depth reform of social policy, what exactly do you have in mind?

[*English*]

**The Chair:** Give a brief response, if you could, please, Dr. Larney. We're out of time.

**Dr. Sarah Larney:** Compulsory treatment has been studied in a number of settings and is very ineffective because treatment for a substance use disorder is not a one-off process. It is an ongoing and often relapsing condition that needs a more nuanced approach than a compulsory setting, which is typically one-size-fits-all.

In terms of social policies, I would argue that we need to look at the housing crisis. We need to look at income stagnation and income mobility, intergenerational income mobility, unemployment, all of these things that contribute to a strong social safety net, which Quebec had famously in a way that other provinces were often quite jealous of, but which has been somewhat—

**The Chair:** Thank you.

**Dr. Sarah Larney:** —damaged in recent years.

**The Chair:** Thank you, Dr Larney.

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

**Mr. Gord Johns (Courtenay—Alberni, NDP):** First, I want to thank all of the witnesses for their testimony, especially you, Ms. MacDonald and Mr. Charles, for having the courage to come all the way here and share your story. Hopefully it will help prevent deaths of young people that shouldn't be happening.

If a child broke their leg and they went to the hospital, they wouldn't be denied care because we don't have certain types of care for their broken leg. They would get the care. We don't have parity when it comes to mental and physical health, largely because of the stigma, I believe. Do you believe that we don't have parity because of the stigma in mental and physical health?

**Mr. Lance Charles:** In my honest opinion, yes. I believe there's a big stigmatism against mental health, especially among youth. I believe it's been overlooked, and I believe it's been put on the back burner compared to, again, the safer supply and the harm reductions. It's almost like it's gotten lost in the wind.

**Mr. Gord Johns:** You mentioned that she was held for 10 days and then released. What type of care were you hoping she could receive instead of being discharged? What type of care do you think would have helped Brianna stabilize and recover?

**Ms. Sarah MacDonald:** I think if the doctors had taken the time to look into her mental health and actually assess her properly, they would have seen how many problems she actually had.

**Mr. Gord Johns:** You mentioned the lack of availability of mental health programs for youth. This is pretty clear. Do you think the government needs to increase funding for youth mental health supports? Do we need more education for health care professionals on youth mental health? I ask because, clearly, it sounds like the professionals demonstrated they weren't equipped.

**Mr. Lance Charles:** I do agree, yes. There needs to be more education; there needs to be more training for doctors and nurses.

There was one time that a doctor actually told us that she's too young to diagnose, which I think is completely wrong, because in the States they are diagnosing children at very young ages, and the process is actually working.

There must be some kind of separation between the two, and I believe that lack of education and lack of.... There should be more funding towards treatments and education for health care providers.

● (1200)

**Mr. Gord Johns:** Having a child struggling with mental health and substance use issues is extremely difficult on your family and on you, as parents. Did you receive any support while you were dealing with these issues with your daughter? Are there supports that would have helped you and your children as you navigated the broken system when it came to dealing with Brianna?

**Mr. Lance Charles:** We did receive a little bit of help, mostly from a few social workers here and there. They literally exercised all their resources. They even tried to pull some strings to make things happen outside the box. Their hands were tied because everything was so limited.

The few treatment centres that we would have had to pay out of pocket for wouldn't accept her because she wasn't of a certain age.

Yes, we did receive a little bit of help, but again, there were no programs or anything that were actually available for her and her situation.

**Mr. Gord Johns:** I'm sorry for your loss and for Chayton and his family, as well.

**Mr. Lance Charles:** Thank you.

**Mr. Gord Johns:** Dr. Wieman, I really appreciate your being here and joining us remotely today.

From your perspective, is the federal government doing enough to address the intergenerational trauma arising from colonialism and residential schools?

Do you believe first nations are getting enough resources from the federal government to meet the demand for culturally safe mental health and substance use care?

I think you know that a mental health emergency has been declared by the Nuu-chah-nulth Tribal Council in my riding.

Can you also speak about the barriers to accessing federal funding, including the SUAP applications, which have been rejected across British Columbia?

**Dr. Cornelia Wieman:** Thank you for the questions.

To start, I just want to express my deepest condolences to Mr. Charles and Ms. MacDonald for sharing their testimony.

I'll start with saying that for first nations people, most often the underlying reason why people choose to use substances is trauma—the state of their mental health—whether that's from historical experiences, contemporary experiences of trauma or intergenerational experience of trauma. People use substances because they want to change how they feel. That's probably very similar for people other than first nations people.

Here in British Columbia, of course, we are quite concerned, as I shared the data for first nations people in B.C., particularly about the decrease in life expectancy, which is mainly driven by the toxic drug crisis public health emergency. As you've mentioned, there are the various states of declarations of emergency regarding the toxic drug crisis in different areas across the province by first nations communities or tribal councils, etc.

In answer to your question, we feel that the level of funding that we could leverage against the toxic drug crisis broadly probably isn't there. For example, I've said before that the amount of funding that was directed to the COVID-19 pandemic compared with what has been allocated for addressing a public health emergency that's now into its ninth year, where we have lost many more people due to toxic drugs than we did to the COVID-19 pandemic, sort of says something.

I think we've already spoken at this committee about stigma.

**The Chair:** Thank you, Dr. Wieman.

We'll go to Mr. Doherty for five minutes, please.

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

Mr. Charles and Ms. MacDonald, why did Brianna start using drugs and at what age did she start?

**Ms. Sarah MacDonald:** She started using drugs at about ten and a half, shortly after her stepfather and I broke up. She just wasn't handling it very well.

● (1205)

**Mr. Lance Charles:** She also wanted to drown out the demons and the voices that she kept hearing.

**Mr. Todd Doherty:** Is safe supply really safe?

**Ms. Sarah MacDonald:** How can you have “safe”, “supply” and “drugs” in the same sentence? There's no such thing as safe drugs, period.

**Mr. Todd Doherty:** Would safe supply have saved Brianna?

**Ms. Sarah MacDonald:** No.

**Mr. Todd Doherty:** Do you feel that Brianna was a victim of failed drug policy?

**Mr. Lance Charles:** I feel it isn't just that she was failed by the drug policy; I feel that she was failed by the public health system as a whole. There were many different layers of failure. That was just one of them.

**Mr. Todd Doherty:** Can you tell us a little bit more about Chayton?

**Mr. Lance Charles:** He was a loving little boy and very gentlemanly.

**Ms. Sarah MacDonald:** He and Brianna would sit on the phone for hours conversing back and forth with each other. They just absolutely adored each other. They were the best of friends. They had known each other for the last few years and fed off each other, good and bad.

**Mr. Todd Doherty:** Yes.

**Ms. Sarah MacDonald:** He really took it personally, and I really feel sorry for that.

**Mr. Todd Doherty:** What can the federal government do to make sure tragedies like Brianna's and Chayton's never happen again?

**Mr. Lance Charles:** Make changes to the public health policy. Start giving more funding and providing more educational background to these health workers who need it. For doctors, there needs to be more training. To be honest with you, it seems like mental health in children is being overlooked, and for doctors and psychologists and psychiatric care people, there's too much they don't understand.

Like I said to Mr. Johns, down in the States they are diagnosing children with mental health problems. Why can't we do that here in Canada? What's the difference?

**Mr. Todd Doherty:** You said the drugs in our community are getting worse. Are you seeing the diversion of safe supply into the hands of our kids and into the neighbourhoods in Abbotsford?

**Mr. Lance Charles:** Let's put it in this perspective, Mr. Doherty: A child can go up and get a bag of items to do a safe injection and prepare their drugs, and they literally walk out that door and there's a drug dealer standing right there. It's just like what happened in Nanaimo recently, where they were giving the self-harm safe kits in the front and out the back door the drugs were flying. I think that is enough of a statement to prove that, yes, it's becoming alarming.

**Mr. Todd Doherty:** I have about a minute left. What else would you want our nation and those in this room to know about Brianna?

**Ms. Sarah MacDonald:** She was a very loving, beautiful, caring girl. She was taken way too soon. She was so compassionate. She had so much potential. She was so smart. She loved to research everything so much. I wish she were here to share her side of the story right now.

**Mr. Lance Charles:** She was robbed of her life. I feel she had so much potential to be a powerful individual, because she always took other people's problems and made them her own. She took it seriously. It didn't matter what it was, how big or small. She was a powerful individual. I believe that with the right education and treatment, and had she been able to finish school, she would have been a perfect fit in this room with all of us; she was that intelligent.

**Mr. Todd Doherty:** Thank you for sharing that with us and for being with us today.

**Mr. Lance Charles:** Thank you.

**The Chair:** Thank you, Mr. Doherty.

Ms. Kayabaga, you have five minutes, please.

**Ms. Arielle Kayabaga (London West, Lib.):** Thank you, Chair.

I will also take this moment to thank you, Mr. Charles and Ms. MacDonald, for your courage in sharing your story with us and continuing to advocate for your daughter even though she's no longer with us. I think her siblings are probably very proud of the two of you and the courage it takes to do that.

Ms. MacDonald, you mentioned a bit about the genesis of her journey in this. What else do you think the federal government could have done to support the province in preventing her starting on this journey before we got to her use of drugs?

● (1210)

**Ms. Sarah MacDonald:** I think there needed to be more mental health support in place for her. She did talk to people and stuff, but I felt like she was very overlooked by a lot of them and they weren't actually listening to her in the bigger picture. They were just listening to what was in front of them, and not the whole story.

**Ms. Arielle Kayabaga:** Do you feel that if there had been earlier prevention in her mental health journey, the pathway for her could have been completely different?

**Ms. Sarah MacDonald:** I think it would have been completely different. I don't think she would have been drowning out those noises she had in her head. She wouldn't have been so sad inside and felt so heartbroken and so distraught that she wanted to take her own life.

**Ms. Arielle Kayabaga:** Do you think there should be more supports in schools—everywhere—for children like Brianna, especially if there is some major shift in their lives like a parental separation? Do you think these are things we could implement in our education system from the provincial level?

**Ms. Sarah MacDonald:** I think they could be implicated a bit more. I know there are some people, like counsellors and such, in the schools, but I think there could be more.

**Ms. Arielle Kayabaga:** Do you think addressing some of the stigmas around families who are going through some shifts could also help the children better navigate their mental well-being while they're witnessing that?

**Ms. Sarah MacDonald:** I think so. Yes.

**Ms. Arielle Kayabaga:** I want to thank you both for being so courageous in answering our questions.

I'm going to shift my questions to Ms. Larney.

You talked about a paper you published regarding some of the provinces, like Quebec, that have been sheltered from the overdose epidemic. Could you talk about the factors that led to this, and why it's no longer the case?

**Dr. Sarah Larney:** Certainly.

We see the increase in fentanyl and other substances entering the drug supply in Quebec. It actually began slightly before the COVID-19 pandemic, but then the pandemic created the conditions that caused chaos in the drug market, essentially. When you have that level of disruption and new players and new substances entering the market, this is when we start to see significant increases in deaths.

That's the acute cause of what happens. We have this change in the drug market away from the reliable supply that had existed beforehand, to a much more unpredictable supply, which is much more similar to what you're seeing in other provinces.

**Ms. Arielle Kayabaga:** I come from a community in London where we have been grappling with this opioid crisis since way before the pandemic. I think it has increased, but there were times when we could look to harm reduction from these toxic drugs as proof that it saves lives. We have numbers to prove that.

What do you say to people who still need more data and information to prove that harm reduction does save lives?

**Dr. Sarah Larney:** There is an enormous amount of evidence that harm reduction is an essential part of the response.

If I can come at this from a slightly different angle, one thing that would be helpful is to consider that we don't have to have either harm reduction or other health interventions. This is about providing wraparound care that meets people where they are. That includes harm reduction when that is what people need to keep them alive, right through to various treatment options, mental health care and supportive housing. It's the whole range of services that people really need.

I think positioning harm reduction and other interventions as opposites, not actually working together, is a false dichotomy.

**Ms. Arielle Kayabaga:** For clarity for me and other people who may not have this answer, what is the age restriction for safe consumption sites? Is it the same policy across the country, or does it differ from province to province?

**Dr. Sarah Larney:** I believe it differs from province to province. I do not have the exact numbers on hand, so I would not like to speculate.

**Ms. Arielle Kayabaga:** Okay.

Could you—

● (1215)

**The Chair:** Thank you, Dr. Larney.

That is your time.

**Ms. Arielle Kayabaga:** I'm sorry, Chair. I just want to ask if she could submit that information to the committee once she has it, so that we can have it.

**Dr. Sarah Larney:** Certainly. I'd be happy to.

**Ms. Arielle Kayabaga:** Thank you.

[*Translation*]

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

**Mr. Luc Thériault:** Professor Larney, with regard to the social determinants of illness, if I say that the pandemic amplified the flaws and fragility of the health care networks and that this phenomenon was linked to chronic underfunding dating back several decades, does that make sense to you?

I bring this up because you say in your conclusions that we're going to have to intervene in terms of social policies and the social determinants of health. However, we can't restore such a situation overnight.

Because organized crime is opportunistic, it has totally adapted to the pandemic situation. Now we're suffering the consequences of what we failed to do properly, particularly in the area of mental health. This problem, in fact, dated back several decades before the pandemic.

Does what I'm saying make sense, in your opinion?

[*English*]

**Dr. Sarah Larney:** Yes. Completely. In terms of the strained mental health system and the broader physical health system and of people with chronic pain, such as people in the construction industry, I think all of the witnesses are saying there is a need for greater resourcing of health care and mental health care that can be implemented before people are in a situation where we're needing to prescribe safer supply. Absolutely.

[*Translation*]

**Mr. Luc Thériault:** I have led an unprecedented battle to ensure that the provinces and Quebec receive an increase in health transfers commensurate with the challenges they face. I have already said, in a speech in the House, that I thought it was criminal to give an increase of only $46 billion in new money over 10 years.

Do you share my point of view?

[*English*]

**Dr. Sarah Larney:** I would have to say that I am probably not as familiar with the details as you are. I think it is true that the Quebec health system is crying out for funding, as are all health services across the country.

**The Chair:** Thank you, Dr. Larney.

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

**Mr. Gord Johns:** Thank you.

I'll go back to you, Dr. Wieman. I really appreciate your talking about the comparables with COVID. I mean, the federal government spent less than 1% responding to the toxic drug crisis as compared with COVID. We've now lost more people to the toxic drug crisis than COVID, I believe.

We've seen increased death rates in neighbouring provinces and states. In Alberta they had a record number of deaths last year. Alaska, a neighbouring state, had a 45% increase in deaths and now has a higher death rate than British Columbia. Baltimore has a death rate five times that of British Columbia. All are places without harm reduction, with pretty much no safe supply and no decriminalization.

Maybe you could speak to your earlier comment about the impact that the politicization of this crisis is having. I was in Portugal last year, and they talked about the fact that it was experts who led their response, not politicians. The politicians got out of the way.

Can you talk about the role politicians should be playing and experts and how we can move forward with less politicization?

**Dr. Cornelia Wieman:** Thank you for that question.

I think as a way of responding, I will say that one thing we have observed in British Columbia is that a lot of misinformation is being spread in the public realm about the toxic drug crisis and the interventions directed at trying to save lives. That misinformation is really harmful. It has the potential to have devastating effects, should, for example, supervised consumption sites be closed, as mentioned by Dr. Larney.

We at First Nations Health Authority are in support of a full spectrum of prevention, harm reduction, detox, treatment and recovery, and aftercare. I think what happens with the spread of misinformation for purposes “other” than—you know, for politicization purposes—is that it increases stigma, for example.

When people use the term “drug dens” to describe supervised consumption sites, it's really abhorrent. The body of evidence that lives have been saved at supervised consumption sites is very strong. We've already used the broken leg analogy in this committee. We have centres that provide dialysis, for example, for people with kidney failure so that they don't have to travel long distances. We don't call those dialysis places "drug dens", but because of the stigma against mental illness and people who use substances, we do with them.

I think that has proven not to b every helpful. It has been harmful.

● (1220)

**The Chair:** Thank you, Dr. Wieman.

Next is Mr. Vis.

I understand you'll be splitting your time with Ms. Goodridge.

**Mr. Brad Vis (Mission—Matsqui—Fraser Canyon, CPC):** Perhaps.

**The Chair:** All right. You have the floor, sir.

**Mr. Brad Vis:** Thank you, Mr. Chair.

As the local MP for our community of Abbotsford, I'd like to thank you for being here. You mentioned the Cyrus Centre. I live just off George Ferguson. This is around the corner from my house. Thank you for sharing your story.

If you could send one message to the Minister of Mental Health and Addictions about some of the failed drug policies we have in Canada, what would that be?

**Mr. Lance Charles:** It would be that we need more help. The health care providers need way more help. There just isn't enough. I get that there's an opioid crisis going on and there's a lot of people dying from drugs, but the mental health aspect is a big, leading factor. We can't overlook mental health. Drug use and mental health issues go hand-in-hand. In order for it to stop, we need more funding.

**Mr. Brad Vis:** As you know, the governments of British Columbia and Canada signed a special agreement for decriminalization of hard drugs in British Columbia.

Is it your experience that it became easier for children to get drugs since decriminalization began? How did Brianna generally get her drugs?

**Mr. Lance Charles:** I believe it did, actually. The decriminalization of drug use and possession of drugs increased the drugs coming to British Columbia. It lowered the prices. It made them easier to acquire because, hey, with your mental health medication, a lot is experimental and you have to pay out of pocket and it's not always covered, but the drugs can replace that. People were replacing the mental health pills and prescriptions with the hard drugs.

As for Brianna getting her drugs, she got a lot of it through 15- and 16-year-old kids. These 15- and 16-year-old kids actually got really ballsy and showed up at our house one evening. I actually had to escort them out of my neighbourhood.

**Mr. Brad Vis:** I'm just going to ask one more brief question before I turn it over to MP Goodridge.

As a parent in the public school system in Abbotsford as well, what role does the Abbotsford School District have to play in keeping our kids safe?

**Mr. Lance Charles:** I feel there should be more police liaisons. I feel they should be checking the children before they even come to school. If found with drugs on them, they should be punished so they realize that it is wrong and they shouldn't have access to these drugs. Nobody should.

**Mr. Brad Vis:** Thank you.

**Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC):** Thank you so much for sharing your daughter's story with us and being here.

Justin Trudeau has brought forward the most radical drug policies our country has ever seen, flooded the streets with hard drugs, as you said, and made it so that it was legal for kids and adults to have crack, meth and even your daughter's drug of choice, Molly, or ecstasy.

Do you believe the policy choices that were made by this Prime Minister contributed to your daughter's death?

● (1225)

**Mr. Lance Charles:** Yes, I do. To be honest with you, I feel like this experiment—I'm going to call it an "experiment"—was directed towards our children. It was directed towards the people who were struggling with their mental health. The fact that she was able to acquire these drugs on a massive level, and very easily, at her age...yes, I do believe his policy is what really lead to her death. It's not just his policy; it's the fact that there's a lack of funding for mental health.

**Mrs. Laila Goodridge:** If you could tell him he has the ability, with the stroke of a pen, to change these policies today, do you think he should?

**Mr. Lance Charles:** Absolutely. To be honest with you, we need to protect our children, and he needs to start realizing this to protect our children and to save the lives of beautiful, innocent people who deserve this. These are our children. For me, being status first nation, it is our job to protect them and it's his job to help us protect them. Why can't he do that? Put the pen to the paper. Let's get more funding for the people and the children and let's stop this. Let's do it all together from the top right down to where we are, as parents. We need more rights.

**The Chair:** Thank you, Mr. Charles.

Next up is Ms. Sidhu.

You have five minutes, please.

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

I want to share my time with Dr. Powlowski.

Thank you to all of the witnesses for sharing your knowledgeable testimony. My sincere condolences to Ms. MacDonald and Mr. Charles. Thank you for doing this advocacy.

My first question is for Mr. Kulmala.

Mr. Kulmala, Public Health Ontario found in 2022 that almost one in every 13 opiate-related deceased person in Ontario was a construction worker. Why is that happening? Why is the opiate crisis hitting construction workers so hard?

**Mr. Rory Kulmala:** I think the biggest contribution that we see is that we have a similar demographic. Outside the tragedy that happens to children, we know that the main demographic is 19 to 52. We also know that the barriers to entry into construction are rather low, particularly in the skilled trades, but there's a continuum of labourers who are working there. It's an accessible career path for many individuals, but there are a lot of things that happen when it comes to pain management.

It can be a stressful job, but it can also be.... It's that “work hard, play hard” attitude. It's the bravado of men in particular who don't want to seek help, so they self-medicate. They look internally to try to treat their own challenges. Where there are elements of mental health, again, they don't want anybody to know. They have livelihoods to provide for. It's a good industry where there's good income. It provides access to people to get funds.

In some of the statistics, we see that the number of people in the construction sector who die from an overdose or from a toxic drug exposure.... It's happening in a place of residence, so they are with means.

Between mental health, pain management, the “work hard, play hard” attitude and the social element that can come with it, I think contributes to a disproportionate number of people in our sector falling to toxic drugs.

**Ms. Sonia Sidhu:** Thank you.

Last summer, I spoke to LIUNA members from Brampton about innovative programs to raise awareness and reduce stigma around substance use and mental health among construction workers.

You told us you were working with 12,300 organizations from B.C., with a focus on employers and employees, so that peer support is there.

Can you talk about some similar programs? Can you elaborate on that?

**Mr. Rory Kulmala:** Most of us trade industry associations are trying to find ways to connect with employees. We do try to do.... Ours is a bit nuanced in that we actually go to the job sites. We'll do this anywhere in the province of British Columbia. We've done it up in the north. We'll go to any job site at any time to do this tailgate talk.

We're also available as a resource to say, “Hey, I need some information.” Again, trade associations or industry associations are active. This is front of mind, so we're all looking for innovative ways.

I think the difference I see with other trade associations is that it tends to be web-based. You have to go online, log in, do this program, and it will help you. There's an 811 number. We have a number of resources that we give out to to people who are in crisis to say, “Here's the subscription of services in your area that you can access.”

We're finding that people are reluctant to go to a website. They're reluctant to actively seek out some supports, but we find that if we go to them, talk to them, give them a card and put it in their hand, they may not say it's about themselves. It will be, “I've got a friend that might want that”, which might in fact be themself. Because it's a very personal matter, we don't get a lot of feedback from people who say, “You saved my life,” but we do get people who say, “Look, I'm glad you gave me that because now I know, and I feel better about it.”

Similarly, our employers are saying, “Look, thank you for that information.” There's nuance in legislation around duty to accommodate. What does that mean? We explain it, and companies are now saying, “We have to take care of our workers.”

● (1230)

**Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.):** Lance and Sarah, I was a long-time emergency room doctor. I'm sure that in B.C. there are the same kind of laws as in Ontario, whereby the emergency room doctor has the ability—and I would say the obligation—if they think that someone presents a harm to themselves, a harm to others or is unable to look after themselves, to require a person to stay in the hospital for 72 hours for psychiatric evaluation.

How many times did you bring Brianna to the emergency room, and how often did they use that power to keep her, have her observed and at least enter into some sort of treatment?

**Mr. Lance Charles:** There were over 20 recorded suicide attempts and self-harm attempts in just a short time. It got to the point that her father and I actually pulled a doctor aside and said, “Don't fall for her narcissistic, manipulative ways. She will talk herself out of here. Please, take our pleas and keep her here. She needs a psychiatric evaluation.”

Of course, they kept telling us the same thing. “We will do our best.” Shortly after, they kicked all of us out of the room and talked to her. They said, “No, she's fine,” and sent her on home.

**Mr. Marcus Powlowski:** How many times did they keep her?

**Ms. Sarah MacDonald:** Twice.

**The Chair:** That's your time. Thank you.

Mrs. Goodridge has the floor for five minutes.

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

I'll follow up on the questions from Dr. Powlowski.

They only kept her twice in the 20-plus times you took her to the hospital for suicide attempts. Is that correct?

**Ms. Sarah MacDonald:** Yes.

**Mrs. Laila Goodridge:** When you were dealing with this kind of situation, I assume there were many times when you didn't have the opportunity or you chose not to take her to the hospital.

How often were you dealing with this? Do you feel like enough was being done to help you?

**Ms. Sarah MacDonald:** This was going on daily and her attempts were almost weekly at the end, if not every other week. They were pretty bad. We didn't go to the hospital quite often because we knew we would just be sent home and it was a waste of time.

**Mrs. Laila Goodridge:** I'm so sorry.

I'm going to switch gears a bit.

Mr. Kulmala, your Tailgate Toolkit includes resources for people to be able to access what you call safe supply.

Are workers permitted to use safe supply while on the work site?

**Mr. Rory Kulmala:** No, and I think there's an underlying requirement. We have zero tolerance for impairment on a job site. We haven't seen, and I can say I haven't had a report of, somebody actually dying on a job site who was actively using.

I'm sure, from a medical point of view, the levels of impairment are broad, but we don't accept that on a job site.

● (1235)

**Mrs. Laila Goodridge:** You do not allow employees to use drugs on the work site in your safety-sensitive employment location. You think this safe supply is good just for other people to use.

I'm confused.

**Mr. Rory Kulmala:** No, what we're trying to do is provide the resources that are available. We're advocating for wellness. Where there is safe supply, we're telling people that when they get home, if they're going to use it, there's a way to stay alive.

As I have said before, we're just trying to throw them a life ring. We're not teaching them how to swim. That's not our job. Our job is to provide awareness.

**Mrs. Laila Goodridge:** What funding do you receive from the federal government or the provincial government in British Columbia?

**Mr. Rory Kulmala:** We receive funding through the provincial government from the Ministry of Mental Health and Addictions to provide the Tailgate Toolkit throughout the province.

**Mrs. Laila Goodridge:** If an employee were to get into an incident of some sort and test positive—they have hydromorphone in their system—what's the next step?

**Mr. Rory Kulmala:** The next step would typically be through their health and safety processes with the particular contractor. Again, it's not about trying to give them an opportunity at the job site to get high.

**Mrs. Laila Goodridge:** Okay.

Is the next step often referring them to treatment?

**Mr. Rory Kulmala:** It could be. The first thing is to suspend them. If they're clearly impaired on the job site, they get suspended. There will then be a path of investigation to suggest treatment or other employment remedies.

**Mrs. Laila Goodridge:** Okay, so effectively, there is zero tolerance for drug use on site, but you give people the tools to use drugs if they choose to, and you tell them they're not allowed to use drugs at the site. I feel like this is a bit of a revolving door of interestingness.

How do you support employees who are coming back and choose to take treatment?

**Mr. Rory Kulmala:** We're an industry association. We're just advocating. We basically provide a workbook of resources of where they can go. This is determined at the employer level. How they can treat them, what they do and how they support their workers is up to them, not us as an association.

We are basically taking the tools that are available and out there, and putting them into some type of resource package that says, “Here's what there is.” Whether we like it or not—

**Mrs. Laila Goodridge:** Okay.

**Mr. Rory Kulmala:** —there is safe supply; we're not here to debate that. We're here to say, “Here's what it is; here's how you can get help.”

**Mrs. Laila Goodridge:** Do you think there should be more resources available for treatment?

**Mr. Rory Kulmala:** Clearly. I think when we look at the remedies of pain management and mental health, those are all stemming to really drive.... Again, that's a personal issue and nothing to do with the construction sector, but yes, there is lots of room for improvement. As we've heard from Mr. Charles and Ms. MacDonald, from a very young age, and certainly with the doctors on the panel, there is opportunity to make this better.

**Mrs. Laila Goodridge:** You're promoting drug use in your Tailgate Toolkit. Do you also promote treatment for addictions?

**Mr. Rory Kulmala:** We're not promoting treatment, Madam; we're promoting awareness. We're promoting information to tell people that, if they do need help, this is where they can get it.

**Mrs. Laila Goodridge:** So, in your—

**The Chair:** Thank you, Mrs. Goodridge.

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

**Mr. Brendan Hanley (Yukon, Lib.):** I wanted to echo my colleagues around the table in thanking you, Mr. Charles and Ms. MacDonald, for having the courage to share Brianna's story, particularly when the experience is still so raw and the grief so fresh.

One of the most compelling things you said in your very compelling testimony was that Brianna was using drugs to self-medicate. There, I think, lies one of the key links between mental illness and drug use.

Ms. MacDonald, you mentioned the breakup when she was ten and a half. If you look back on Brianna's short life, when was the first opportunity, do you think, for intervention? Was that intervention available and accessible?

**Ms. Sarah MacDonald:** The first intervention was probably when she was about 11 years old and I found her actively smoking weed. It was the first time I caught her. We tried to put her into a treatment centre then. She didn't feel that she needed to go, because she didn't feel it was a hard enough drug.

**Mr. Brendan Hanley:** Thank you for that.

Dr. Wieman, thank you for your testimony.

In Yukon, according to the chief coroner, in 2023, of the 20 deaths from toxic drug overdoses, 14 were first nations people. Again, that echoes the disproportionate impact on first nations communities. I wonder if you can describe some successes that could be emulated, particularly in the areas of prevention, land-based healing or aftercare, and that we could learn from based on what you've observed.

● (1240)

**Dr. Cornelia Wieman:** Around the province of British Columbia, as I mentioned, we're broken into five different regions, and our regional teams each probably have a community or a grouping of communities that has a success story to share. One of the things we hear the most as a model is that culture saves lives for first nations people, so we advocate very strongly for a model that respects both western medicine and what clinical medicine has to offer and what traditional healing, ceremony and being on the land have to offer. There are examples of that around the province.

Another example is Cheam First Nation in the Fraser Salish region, which was the first first nations community in British Columbia to have an overdose prevention site located on reserve. I think that took place after a lot of discussion within the community and a realization that because of the number of deaths, something had to be done.

One of our roles at FNHA is to also foster that cross-community communication. For example, the Tla'amin first nation on the Sunshine Coast has spoken publicly about their success in bringing the number of deaths due to toxic drugs down over the last several years, so we're looking for an opportunity where they can share their learnings with other communities, not just within the Vancouver coastal region but also with the other regions of British Columbia.

There are peer reduction programs, and we have different harm reduction grants. We gave out 108 harm reduction grants last year. We have an opportunity at different gatherings for those communities to share what they did with the money, for example, and how that improved the situation in their communities. We do track that and we share it in different fora.

**Mr. Brendan Hanley:** Thank you so much for that. Certainly, I'm sure the committee would be happy to receive any specific experiences from first nations in B.C. on some of these successes, so they can be emulated and shared.

Briefly, Dr. Larney, you talk about some overall trends in Quebec versus other provinces and what you see coming.

Quebec still has, I think, a remarkably low relative overdose fatality rate compared with peer provinces.

Are there protective factors at work in Quebec that are playing out differently than in other provinces?

**Dr. Sarah Larney:** Yes, certainly.

I first will just correct a point of fact: Decriminalization in British Columbia did not extend to people under the age of 18.

In Quebec, one thing that has differed in Quebec specifically compared with other provinces is that traditionally there has been a preference for stimulants—particularly a long-standing preference for cocaine—versus opioids in Quebec. That has, somewhat perversely perhaps, been protective against opioid overdose deaths.

However, the drug supply now is so contaminated and so unpredictable that this protection is no longer present. Basically all drugs now have a much higher risk of overdose because of contamination with fentanyl and other substances.

**The Chair:** Thank you, Dr. Larney.

I'm sorry to cut you off, but we're well past time.

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

[*Translation*]

**Mr. Luc Thériault:** Mr. Chair, earlier we talked about young people's access to drugs. This morning, a very credible radio station in Montreal, 98.5 FM, revealed that Dr. Marie-Ève Morin, who, as you will no doubt recall, has testified before our committee, noticed that Meta's platforms were authorizing ads for illegal drugs. She intervened and went to great lengths to contact people at Meta to get them to close these accounts, but she never succeeded. When she revealed this situation, Meta closed her account.

I'm going to go even further. I hope that all those who are concerned about young people's access to drugs will stop advertising on Meta's platforms. It's one thing to publish something, but it's another thing to advertise and promote.

I'm sharing this with you, and I'll come back to it. I thought it was important to talk about this today, because these platforms are very popular with young people. It is unacceptable that such an undertaking should be tolerated and encouraged.

● (1245)

**The Chair:** Thank you, Mr. Thériault.

[*English*]

Next we'll go to Mr. Johns, please, for two and a half minutes.

**Mr. Gord Johns:** I'll start with Mr. Kulmala.

First, I want to commend you and your industry for your leadership in investing in prevention and education. We don't talk enough about prevention and education.

Can you speak about some of the success that you're finding through Tailgate Toolkit, which is very popular on Vancouver Island, where we both come from.

Also, can you maybe speak about loss of income as possibly being a barrier for those who want to seek treatment?

Do you believe there's an opportunity to provide income supports for those who want to seek treatment and need help?

**Mr. Rory Kulmala:** Thank you.

I think the success we see is really about the interest in our industry and turning to actively seeking out the Tailgate Toolkit. They want to see what they can do to support their workers. We do get people's first-hand expressions of how the program has helped them create awareness, or they say that they know somebody hey can use this with.

As far as income replacement is concerned, there are mechanisms for employed people through their health and benefits plan, so that if they have to take a leave of absence to have mental health or any kind of care, that supplements their income. There's short-term disability or long-term disability. That's why we advocate for employees to have—not necessarily a robust health care benefits plan, but a benefits plan.

When it comes to people who are outside of that, there is always opportunity. For people who are using and need to supplement—they have a mortgage or they have a family to take care of—that just feeds the mental stress if they can't do that.

**Mr. Gord Johns:** How much time do I have left, Mr. Chair?

**The Chair:** You have just under a minute.

**Mr. Gord Johns:** Okay.

I'll turn my time over to you, Dr. Wieman. Is there anything you'd maybe like to add to what you heard today, or is there any message you feel needs to be heard by the federal government to help tackle the toxic drug crisis?

**Dr. Cornelia Wieman:** Thank you for that. I'll be brief.

I think what I want to leave you with is the understanding, as I said earlier, that the toxic drug crisis of 2024 is not the toxic drug crisis of eight or nine years ago. The current unregulated supply of drugs is very dangerous and potentially lethal.

I also think that most people who are interested in saving lives are advocating for the whole range of services, all the way from prevention, education and awareness to harm reduction, detox, treatment and recovery, and aftercare. That's what we advocate for at First Nations Health Authority. As mentioned by Dr. Larney, this attempt to create a false dichotomy between either-or, that harm reduction and treatment are mutually exclusive, is false and harmful.

I think the other thing that needs to be understood is that there are nuances to this toxic drug crisis. People who use substances come from all walks of life. I'm really glad Mr. Kulmala was here today. There has to be an understanding of the shades of grey around the toxic drug crisis. There are many different stories. There are many different pathways to better health and wellness for people who use substances. We have to acknowledge that entire spectrum.

**The Chair:** Thank you, Dr. Wieman.

Dr. Ellis, you have five minutes, please.

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

Mr. Charles and Ms. MacDonald, thank you for being here. I apologize for not being here earlier, but I have read your testimony. Thank you for that and telling Brianna's story to Canadians.

Now, I realize you're not experts in this, but you do have, obviously, significant lived experience. If you had to design a system talking about a couple of things, the prevention of drug use and then rehabilitation afterwards, what advice would you give to us and all Canadians?

● (1250)

**Mr. Lance Charles:** Time is the key, honestly. It's all based on how these children are. Every child is different. Every person is different. It shouldn't be time-specific. If it takes longer, they deserve longer. If treatment isn't working, there should be a broad spectrum of available research just to be able to develop treatments for other people. Some treatments work for some but not all. It can't just be a blanket. There needs to be research and there needs to be a lot of time put into deciding which path to move forward on.

I don't think there's one solid, good answer. I believe if time, structure, education and all of these things were followed, there would be a good program in place and this stuff wouldn't happen to our children and our people.

**Mr. Stephen Ellis:** Thank you very much, Mr. Charles.

When we're talking a bit about prevention, obviously this is the health committee, but that falls under education, perhaps. Do you believe there should be programs in schools to educate kids on the harms of drugs and that type of messaging out there, such as what drugs look like and what they can do to you? Do you have any thoughts on that at all?

**Ms. Sarah MacDonald:** I do think there should be some sort; there is for sex ed and stuff, so why isn't there for drug education?

**Mr. Lance Charles:** I'm with her on this one, but at the same time, you have to be sensitive. These are children's minds. They are undeveloped. They don't deserve to really know these things just yet; maybe in the teenage years, yes.

It's the same thing with the sex ed programs. They're teaching them younger and younger these days, allowing children to think, “Hey, look, I can think like an adult. I'm learning about stuff that adults know.” It's making them comfortable—too comfortable. I believe education should be there, but it should be very sensitive to what the child's mind is, because it is undeveloped.

**Mr. Stephen Ellis:** Thank you very much. That's an excellent point. We have to be cautious with the messages we're giving and at what ages. I think that's very well said.

Maybe we can turn our attention a bit to looking at the criminal element in this entire problem. Again, what advice would you give to the Canadian government to say, “Do you know what? Obviously, there's a criminal element here. People are selling drugs. People are making them illegally.”

Do you have any ideas, perhaps, around punishment and jail time, etc.? Are there efforts we're making on that front that should be different?

**Mr. Lance Charles:** I believe the criminal justice system should actually be a little bit more strict. It should really crack the whip down on these drug dealers and people who are selling drugs, especially to children. I believe the revolving door that's happening in this system is failing us. Criminals are getting locked up for a couple of months, tops, and then they're back out. They just keep doing it, back and forth, nonstop. They don't care: they're making money. It's all about money.

I believe stricter policies should shut this revolving door. If they are caught doing it more than once, there should be an indefinite suspension. They should be kept there, because these are the people who are killing our children. I feel that the policies in place right now need to be really updated a lot. I feel that the justice system needs to stand strong and stand by the people who matter, and that is the parents of these children who are dying.

● (1255)

**The Chair:** Thank you, Mr. Charles, and thank you, Dr. Ellis.

The last round of questions for this panel will be for Dr. Powlowski, please.

**Mr. Marcus Powlowski:** Continuing with my earlier line of questioning, you brought Brianna to the emergency room more than 20 times. Out of all those times, they only kept her twice.

Now, as I said, the emergency room doctor has the power to keep someone who has a mental illness and presents a threat to themselves or is unable to look after themselves. They have the power to keep them involuntarily in the hospital for up to at least 72 hours. I would say that they also have the obligation to do that.

The obligation is twofold. When people tell me, “What about my rights?”, well, the obligation of the doctor and society to intervene with those people is, one, to protect people from themselves. With time, people will often get better. They may be going through a bad time, as Brianna was. Often, with a chance and with time, they'll get better. You intervene to protect them from themselves.

The other reason you intervene is to protect the families, those like yours, who suffer the long-term consequences.

I would say that the medical profession, the emergency room doctors, had an obligation to act and to keep her had they thought she was actively suicidal. Why did they not keep her?

**Mr. Lance Charles:** I believe they didn't keep her just because she was that manipulative of a person. She could literally look at you, tell you that she was fine, and you would believe her. She was very talented in that department. The manipulation was actually so strong that she could tell anybody anything and they would believe her.

Even when we warned the doctors in the emergency room that her manipulative skills were absolutely amazing, I don't think they believed us. Honestly, that's what it was. I don't think they actually believed what we were telling them. They thought we were just trying to drop a problem onto their lap. Honestly, I don't think their response was a proper one. Yes, they were obligated to keep her.

**Mr. Marcus Powlowski:** Yes. I would suggest, perhaps, that you were not very happy with the quality of care you received from the doctors. You warned them that she was manipulative. Clearly, she'd had repeated attempts that put her life at risk. Frankly, I would suggest that the care you got in the emergency rooms was not good.

Did you either complain to the college of physicians and surgeons or the hospitals or consider legal suits as a result of her treatment?

**Mr. Lance Charles:** We've been in discussion about legal pursuits. There's been a discussion on how to approach the situation, especially against doctors, especially at CAPSU—Surrey Memorial and especially when Brianna sat there putting a pencil through her hand and the doctors told us she was fine to come home—the psychiatrists, you know. Sarah advocated so deeply to keep her there. She basically cried. The doctor literally looked at her and told her, “No, we're not keeping her.”

**Mr. Marcus Powlowski:** In society and with the legal system, I think that there's this kind of balance between recognizing individual autonomy and individual rights and the role, if any, of society, of other people and of families to intervene. Within the health care system and the judicial system, do you think we have that balance right, or do you think we've given too much power and autonomy to people with mental health problems and are unwilling to intervene where we ought to be willing to intervene to protect those people?

**Mr. Lance Charles:** I honestly think we have given too much power to the individuals who are mentally ill. I believe we need to start drawing that back to be able to speak out and be an advocate.

**Mr. Marcus Powlowski:** Sarah, you looked like you wanted to say something.

No.

**The Chair:** Thank you, Dr. Powlowski.

I offer a heartfelt thank you all of our witnesses for being with us here today.

Colleagues, before we move to adjourn, there's one housekeeping item I'd like to dispense with. In connection with the brain injury study, can we set a deadline for the submission of briefs? I would suggest October 16. Are we okay with that? I see heads nodding around the table.

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

**Some hon. members:** Agreed.

**The Chair:** We're adjourned.