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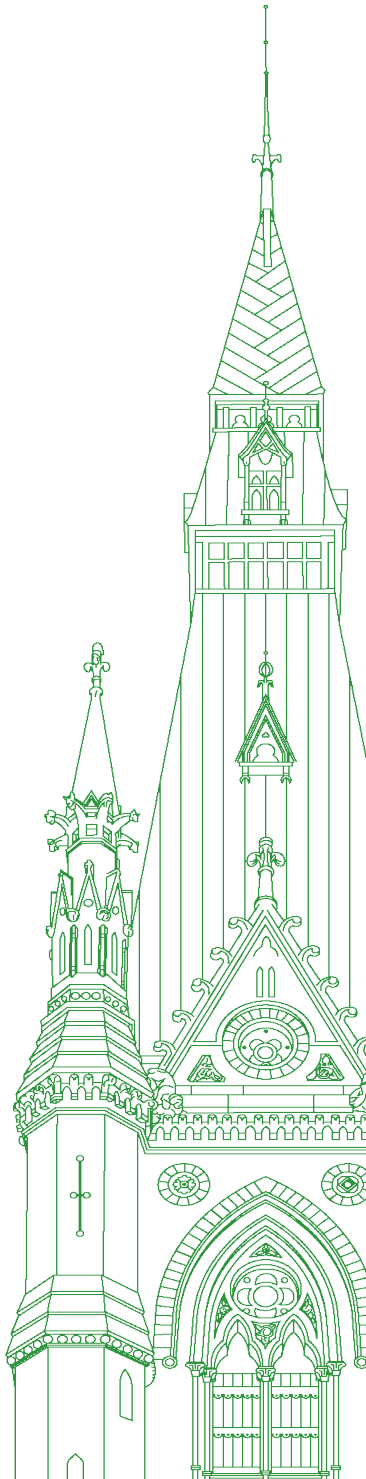
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Chair: Sukh Dhaliwal

Standing Committee on Health

Wednesday, October 21, 2026

● (1635)

[*English*]

The Chair (Sukh Dhaliwal (Surrey Newton, Lib.)): I call this meeting to order.

Welcome to meeting number 38 of the House of Commons Standing Committee on Health.

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

I would like to remind participants of the following points: First, please wait until I recognize you by name before speaking. For those participants who are participating by video conference, click on the microphone icon to activate your mic, and please mute yourself when you are not speaking. At the bottom of your screen, you can select the appropriate channel for interpretation—floor audio, English or French.

For members in the room, if you wish to speak, please raise your hand. For members on Zoom, please use the “raise hand” function.

I will give a reminder that all comments should be addressed through the chair. The clerk and I will manage the speaking order as best we can, and we appreciate your patience and understanding in this regard.

Before I go further, because I always forget, I would like to thank the clerk, the analysts, our interpreters—of course—our technical staff, our support staff, and of course the support staff from the honourable members' offices for the work they do behind the scenes to get this committee going.

With that, I'm going to go to the topic.

Doug Eyolfson (Winnipeg West, Lib.): Mr. Chair, I have a point of order.

Mr. Chair, during the first round of questions to MP Blaine Calkins at our October 7 meeting, I said, “If someone was taking the anticoagulant warfarin to prevent strokes and certain conditions, if they take vitamin D, it counteracts that and gives an increased risk of stroke. In fact, when I'm practising medicine, vitamin D is actually the treatment of choice for someone who comes in and their blood is too thin due to too much warfarin.”

I incorrectly said “vitamin D” when I should have said “vitamin K”, and I would like to officially correct the record.

The Chair: Do I have unanimous consent?

Some hon. members: Agreed.

Doug Eyolfson: Thank you, Chair. I will supply a copy of the paragraph and how it should be corrected to the clerk.

The Chair: Thank you.

Doug Eyolfson: Thank you very much, and I'd like to thank all the members for their help.

The Chair: Thank you, Dr. Eyolfson.

Pursuant to the motion adopted on Tuesday, September 23, 2025, the committee will resume its study on the opioid epidemic and toxic drug crisis in Canada.

I would now like to welcome our witnesses for the first hour.

We have, by video conference, Dr. Azar. He is appearing as an individual. Dr. Azar, welcome to the meeting.

We also have Dr. Kaiser, deputy medical director of the Montreal regional public health department. Dr. Kaiser, welcome to the committee.

I would like to remind witnesses that committee members may ask questions in either French or English. If you need interpretation, please take a moment now to prepare your earpiece and select the listening channel you need in advance in order to take full advantage of the time allotted for questions and answers.

To the witnesses, please keep an eye on the honourable member who is asking the question. As soon as the honourable member raises a hand, I would like you to stop speaking, because it is the member's time. I don't want to interpret, and we want to make it smooth for the interpreters.

With that, each organization has five minutes for opening remarks. We will give the floor to Dr. Azar.

Dr. Azar, go ahead for five minutes, please.

Pouya Azar (Physician, As an Individual): Thank you very much for the invitation and for the opportunity to speak with the committee today.

My name is Dr. Pouya Azar. I am a clinician scientist specializing in addiction psychiatry and pain medicine, so I divide my time between clinical care and research. Clinically, I work in the emergency department, where I care for people presenting with pain and addiction-related concerns. The other half of my time is devoted to research through my professorship at the University of British Columbia. My program focuses on developing practical clinical tools to address the drug poisoning crisis, particularly the challenges created by fentanyl.

As a society, we look at the overdose crisis, at the lives lost and the harms visible on the streets in so many Canadian cities, and we have trouble seeing a way out.

I'm here to provide a message of hope. My career has given me a perspective shaped by two very different periods in addiction medicine. I practised during the heroin era, before fentanyl became widespread, and I have seen first-hand how fentanyl changed clinical practice and contributed to a public health emergency. Fentanyl is a very different drug from heroin and prescription opioids. It is far more potent than morphine, and its effects on the body differ in important ways from those of heroin.

As fentanyl became more prevalent, the treatment approaches and protocols we had relied on became less effective for many patients. The evidence we had was increasingly difficult to apply. In practice, we found ourselves facing an evidence gap at a time when more and more people were dying from drug poisoning. That clinical need led me to build a research program focused on developing and evaluating treatment protocols specifically for people who use fentanyl.

Our approach is grounded in pharmacology and evidence. We need treatments that reflect the realities of fentanyl use and the needs of patients in front of us. Unfortunately, that approach is not yet consistently reflected in the clinical practice across North America. Current guidelines have not kept pace with the changes in the drug supply or with what we are seeing in patients. We need to update our treatments and strengthen the evidence behind them.

We cannot expect better outcomes if we continue relying on approaches that are not working well for the people we are trying to treat. We have seen the consequences of policy and practice that do not adequately account for evidence. In British Columbia, the prescription of pharmaceutical opioids through the safer supply program was intended to reduce people's exposure to the illicit drug supply.

My colleagues and I raised concerns that this approach was not sufficiently supported by pharmacology, or by the broader evidence on opioid exposure and opioid-related harms. In our clinical work, we also saw concerns about diversion, including prescription opioids reaching people who were not the intended recipients. This included children and adolescents developing opioid addiction. The provincial government ultimately ended the unwitnessed component of this program.

Now, please allow me to be clear. Medication is only a first step. Addiction is a biopsychosocial condition. Medication can be essential, but it cannot address addiction on its own. Effective care must also respond to the social and environmental conditions people face, as well as co-occurring mental health concerns. If we want treatment to work, we need to support people with the full range of care and services that recovery requires.

Now, I do want to close with a message of hope. Opioid use disorder is treatable: Recovery is possible. We have developed more effective treatment approaches designed for people who use fentanyl, and continued research can help us improve them. Funding is urgently needed to continue developing, evaluating and implementing these treatment approaches to support recovery and save lives. An evidence-based approach gives us a real opportunity to reduce harm and help people who enter and remain in treatment.

Thank you. I'm happy to take questions.

● (1640)

The Chair: Thank you. That was perfect timing.

Now we will go to Dr. Kaiser for five minutes. Please go ahead.

[*Translation*]

David Kaiser (Deputy Medical Director, Direction régionale de santé publique de Montréal): Good afternoon. Thank you for inviting me to speak to the committee today.

As you can see in the notice of meeting, I am a public health doctor, deputy medical director of the Direction régionale de santé publique de Montréal and director of the residency training program at McGill University, where I've been working to implement a trauma-informed approach since 2023. I was part of the front line public health response to COVID-19, and since 2022, I've been in charge of our public health emergency preparedness office.

In preparation for today's meeting, I reviewed the work the committee has been doing since 2023 and the input the committee has heard from experts and witnesses. Many of them are well-respected colleagues of mine in the public health field. I'll do my best not to repeat comments or figures you've heard pertaining to areas we are already working to address.

It is clear from the witnesses that no single approach can solve the crisis. The response calls for a range of simultaneous strategies. They need to be implemented in a structured and coordinated way tailored to the local community, and subject to assessment. It's a shared responsibility.

I've spent the past few months meeting with those who organize or use supervised consumption services, or who live near those sites or in neighbourhoods affected by the crisis. I want to share some of the things that stand out to me.

I'll start with a few figures. During the first half of 2026, carfentanil came on the scene in Montreal, adding to a host of adulterants in the substances being used. Between 40 and 50 overdoses a week are reported by our services, more than 500 naloxone kits are handed out weekly, and paramedics intervened 1,000 times in the first six months of the year. That is equivalent to what we saw in all of 2025. The strain on services is intense and unrelenting.

As we address the deaths, we have to recognize how widespread the suffering is. To keep people alive, and ensure the well-being and dignity of those already using, we need to expand service access to match the scale of the crisis, and those services need to be permanent and transformative.

It's not right that in October, we're still waiting for core funding in Montreal to help with shelters and support people experiencing homelessness. It's not right that agencies have to beg for money and fill out all kinds of forms to renew their exemptions, when they could be spending that time saving lives.

The crisis is complex and goes well beyond opioid consumption, as you know. It requires foresight, agility and great flexibility in adapting to local realities. To respond to the crisis, front line agencies need to be able to rely on tailored, long-term funding and assistance based on trust. The illicit drug market is so volatile that we need a system to effectively monitor red flags, and that requires all levels of government and those on the ground to share data.

We also need to significantly increase our focus on prevention. I'll give you a few figures for Quebec. A third of young people who come into contact with the child welfare system and nearly half of those who stay in youth centres end up on the street. In Montreal, one in five people who die of an overdose is experiencing homelessness. Lastly, 13%—or one in seven—of those experiencing visible homelessness identify as indigenous, and most report having substance use issues.

The Public Health Agency of Canada already recommends a trauma- and violence-informed approach. That means that our practices and organizations have to change, but so does the way we design our systems.

Prevention means addressing the intersection of crisis factors within a whole-of-government or health-in-all-policies approach. That includes addressing the right to adapted housing, homelessness, mental health, and the education, prison and justice systems. We need to respond to the acute phase of the crisis and work on prevention at the same time.

In closing, I want to recognize the work this committee has done. This is a social challenge we face collectively. Behind the overdose deaths are people, stories—some of which you've heard—families and communities. The challenges are complex, but the resources, limited.

Every single one of us is working hard. The intention is noble, but one thing is clear: While we look for an answer, the right answer, the deaths and suffering continue.

I'd like to leave you with three recommendations to advance this effort, and address the needs of those who use, communities and all stakeholders. One, secure funding and empower community resources. Two, coordinate efforts across sectors and evaluate them using codeveloped indicators. Three, increase support for community-based research and ongoing shared learning.

The pandemic taught us that we can do things differently. We didn't wait for all the answers to address what we did know. We were able to work together as new information emerged. Let's apply the same logic here.

● (1645)

Thank you again for inviting me. I'd be happy to answer the committee's questions.

[*English*]

The Chair: Thank you very much. That was perfect timing.

Before I go to the members of Parliament, honourable members, if you can mention who your question is for, either Dr. Azar or Dr. Kaiser, it will make it easier for them to answer.

With that, I'm going to MP Konanz for a six-minute round. Please go ahead.

Helena Konanz (Similkameen—South Okanagan—West Kootenay, CPC): Thank you, Chair.

First I'd like to thank our witnesses for volunteering their time here to speak with us about what I believe is one of the most pressing health issues in our country, which is the continued tragedy of opioid addiction and overdoses. All of Canada has seen this suffering, and my home province of British Columbia has been at the epicentre.

There is almost no family in my province that has not lost a friend or family member to opioid addiction or does not know someone who has lost someone to a deadly overdose. My province is still in crisis. In the communities I represent, we still see people suffering and people dying.

First responders have said that overdose rates in my hometown of Penticton increased by 500% in the first quarter of 2026, compared to the first quarter of 2025. Interior Health has just issued a Kootenay-wide drug alert because of an increase in contaminated fentanyl overdoses. Things do not seem to be getting better.

Worst of all is that treatment and recovery are not available to those who are suffering. If an addict from B.C. walked into this room right now and told us, “I want help. I want to go back to my family”, I've been told that they could face up to a two-year waiting period for a detox or treatment bed if they're from the communities—if they're from my riding—and these treatment beds would be nowhere near their home.

My first question is for Dr. Azar.

Thank you for your message of hope. When I've questioned the Liberals about the policies they've pursued on the opioid crisis—for example, the drug decriminalization pilot that only B.C. was subjected to, the great experiment—I've tried to get clear answers. I'm not getting them. When I asked Health Canada officials whether they viewed the decriminalization pilot as successful, they said it would need a five-year review to answer that question.

Dr. Azar, what do you think of the decriminalization experiment in B.C.? Do you think it was successful in tackling the opioid crisis?

● (1650)

Pouya Azar: Well, I have yet to see the official data. What I can say is that the numbers of overdoses or drug poisoning deaths in British Columbia were not significantly reduced as compared to the rest of North America. If that remains a measure of success, it appears that it was not.

Having said that, I think we need to see the data, and I think real research needs to be done with the data to definitively provide an answer.

Helena Konanz: Dr. Azar, why do you think that it would take five years to get that data?

Pouya Azar: That's a good question, and I don't know. I'm not sure where that figure came from. I can't answer that question, unfortunately.

Helena Konanz: Dr. Azar, you're a specialist in rapid opioid agonist treatment protocols, which avoid a so-called “safe supply” approach in favour of methods that look for medical recovery and abstinence-based pathways. We have that in our treatment centre in Discovery House in Penticton, which is having good results.

Are agonist-based research and treatment methods currently being sufficiently funded by provincial and federal governments?

Pouya Azar: I can tell you that if I apply today for a grant to support my research, it'll be upwards of two years before I see the money and can implement that study. We don't have that kind of time. The illicit drug market is changing rapidly, from month to month even, so we need to move quickly.

Our lab has relied on philanthropy as a means of support, and that's allowed us to move very quickly and develop treatment protocols that address the needs of our patients today.

To answer your question, funding is needed, and it's needed rapidly.

Helena Konanz: You agree that five years is too long in this tragic situation.

We recently had a ruling in British Columbia that stayed drug trafficking convictions of the Drug User Liberation Front. The judge said that it was unconstitutional to limit the distribution of illegally purchased, improperly stored, illegally sold opioids if it did not negatively impact the community or public safety.

Do you think drug trafficking of opioids impacts communities or public safety, and does it worsen the drug crisis we see in B.C.?

Pouya Azar: The evidence we have is that the more opioids we have available in society, the higher the rates of opioid use disorder will be and the higher the rates of overdose death or death by drug poisoning will be.

Addressing this crisis takes a multipronged approach. One of those approaches would be enforcement, but that has to be equated with harm reduction, treatment, etc. However, the evidence that I'm familiar with says that the more opioids we have, the more opioid use disorder we will have and the more overdose deaths we will have.

The Chair: Thank you very much.

We'll go to Dr. Jaczek for six minutes. Please go ahead.

Hon. Helena Jaczek (Markham—Stouffville, Lib.): Thank you, Chair, and thank you again to the witnesses.

Dr. Azar, you've described the changes that you've seen in terms of the opioid crisis—the move from heroin as the primary cause of addiction to now, when fentanyl-contaminated products seem to cause the most urgent need for effective treatment. Thank you for describing that.

Over time, we have seen—and apparently we have some data here—that Canada's opioid-related deaths have been decreasing in the past couple of years. Deaths decreased by 23% in 2025 compared with 2024 and by 10% in 2026 compared to 2025.

In your opinion, what factors have contributed to this decline?

● (1655)

Pouya Azar: The data that I am familiar with speaks to overdose death rates going down across North America. They're going down in British Columbia, in Texas, in the United States and on the east coast of Canada. There remains to be a report that definitively describes the reasons this occurred. I don't believe we can attribute it to any one intervention.

I suspect that much of it is related to the composition of the illicit drug supply. We've seen some decreased percentage of fentanyl and fentanyl analogs. We've seen an increase in adulterants, such as alpha-2 agonists, benzodiazepines, etc., so we've seen a drug supply that may be less potent in causing opioid-related side effects, including respiratory depression and death. However, I don't believe that's the only answer. It's a potential hypothesis.

Again, I want to underscore that this is something consistent that has occurred across North America.

Hon. Helena Jaczek: Of course, we shouldn't just look at the death situation—in other words, the lethality of what is being used. We need to look, as Dr. Kaiser has said, at the concomitant problems.

Perhaps, Dr. Kaiser, you could talk a bit more about what you've seen in terms of homelessness and what the federal government could do in a practical sense to assist on the prevention side of things and with potential treatment for those with addiction.

David Kaiser: How many hours do I have?

Briefly, I think there are a couple of things.

One is that we can take prevention across the lifespan. We know that adverse childhood experiences are linked to substance use, homelessness and mental health issues. When we're looking at what the federal government can do, we know that child care, prenatal and pregnancy care, and quality education are prevention. It's not for 50 years from now; it's for a cohort that will be entering adolescence 10 years from now. I think that's really important. The federal government has a role to play in our young people's structural conditions.

Second is housing. With the pandemic and the changes in the drug supply, we see the overlap clearly. I mentioned the mortality statistics, but we also see it in the people who are using our harm reduction sites. When you're in the streets, you're not sleeping, you're subjected to violence and you're much more likely to have your mental health problem aggravated and your consumption aggravated.

For sure, we need adapted housing. We've had a national housing strategy for a couple of years, and there are things that have been updated, but we know that we still need massive increases in adapted housing, including low-rent and off-market housing with mental health supports and supports for people who are using drugs. That's a place where the federal government has a role in terms of the criteria, the indicators that are being set and the financing that's going to the provinces.

The third aspect, coming back to what Dr. Azar said, is our ability to use all of the services we have as entry points into the system. We're having people use harm reduction services. We're having people come to emergency rooms. We're having people access housing supports. All of that should be feeding into the same trajectory, which is to get people stabilized, off the street and into treatment when they're ready.

Hon. Helena Jaczek: Then, in terms of potential navigation mechanisms, as you've said, it's having entry points and then ensuring that the person gets what they need in a timely fashion.

David Kaiser: As a public health doctor, I would say that the work I do is intersectoral. We know that the way we work at the decision level impacts the way the work is done on the ground. It may seem conceptual, but I think it's really important. If transport, housing, health, education and justice are not speaking to each other at a government level and don't have common objectives, we can't expect to have coordination mechanisms on the ground that work. It's not an electronic platform or a new system that's going to change that; it's the way that we work across sectors.

● (1700)

The Chair: Thank you.

We will go to Madame Gaudreau. Please go ahead for six minutes.

[*Translation*]

Marie-Hélène Gaudreau (Laurentides—Labelle, BQ): Thank you, Mr. Chair.

It's true that we don't have enough time for this discussion. Having been a front line worker some 30 years ago and worked in hospitals, I now find myself in the role of legislator with few means at her disposal. There are tools, though. What gives me some comfort today is that we just learned we have a premier in Quebec who's going to do something about homelessness. As everyone of us would say, I'll believe it when I see it. That said, it's a commitment that carries a lot of weight.

I'm going to come at this question from the opposite standpoint. What choices have we made that aren't helping the situation? In other words, are there concrete actions we're taking that we can systematically stop taking to at least slow down the crisis?

David Kaiser: Do you mean things we're doing that we shouldn't do anymore?

Marie-Hélène Gaudreau: That's exactly what I mean.

David Kaiser: I talked about barriers to access. To my mind, access includes physical access. There is also access to treatment. Someone who lives in a rural community may face geographical barriers as well.

I would also remove safety-related barriers, specifically around cultural, physical and psychological safety, and stigma-related barriers so that people feel heard and supported. As far as I'm concerned, anything that adds administrative barriers makes it hard for you and me to access systems. If we want to immediately reduce the unnecessary pressure on people trying to survive, all those administrative barriers need to be addressed. They include making someone fill out a form in a certain way and operating a clinic only during hours that suit the people who work there—not the people who need the services. I'm also referring to the refusal of systems to meet people where they are. As we know, the health care system has shrunk and struggles to provide extramural services. Those conditions make it impossible to meet people's needs.

If there's one thing we need to stop doing, it's putting up barriers that shouldn't be there.

Marie-Hélène Gaudreau: That's absolutely true, but I also feel that everyone wants statistics. They want the information that tells them what's working and what isn't. Those in the hospital community have made mistakes in the past, so people are being even more careful.

I may be off the mark here, but I have a thought. In cases that involve homelessness, overdoses, addiction and mental health, could there not be some agreement to really work together and disregard rules that prevent CPR from being administered to someone because a certain protocol measure is missing? Is the situation really an emergency, or is it the opposite? What needs to be done?

David Kaiser: As far as that issue goes, I think everyone will have examples of things that work in their district or practice area. Yes, you can look at real-life examples of community clinics that deliver government services. For someone to access the system, they need a piece of identification, a health card and sometimes an address.

Things are being done. Workers go into encampments or parts of the city with significant homeless populations or large numbers of people in crisis, and deliver the full range of government services. Providing one-stop access to services removes that barrier.

Similar things are happening at the clinical level. Some wonderful initiatives are in place, such as doctors going out into the community, coming to our supervised consumption sites. It's not complicated: They treat wounds and chronic illnesses, but they also connect with people. We all know that addiction issues don't necessarily resolve after the first clinical contact, or the second or the third. It's about intensifying efforts and leveraging opportunities. These examples exist. The issue is building on them, intensifying the effort, saying “this is what we're going to do” and then doing it consistently, until we overcome the crisis.

● (1705)

Marie-Hélène Gaudreau: Yes, absolutely.

I have a bit of time left, so I'd like to know what's changed in Montreal. We hear a lot about what's happening in other provinces and jurisdictions. How big is the crisis?

David Kaiser: Well, I would say two things.

First, like many other cities, we've seen a huge rise in homelessness. In Montreal, the population has grown by nearly half, compared with prepandemic levels. We are seeing significantly more people on the street, which means income and employment vulnerability are spreading.

Second, we've seen the arrival of fentanyl, as have other regions. It took a bit longer to hit the east coast, so that's something more recent. I would say that those two things combined have exacerbated the crisis; we weren't used to dealing with things at this scale.

Marie-Hélène Gaudreau: Thank you, Mr. Chair.

[*English*]

The Chair: We will now go to Dr. Strauss for five minutes.

Please go ahead.

Matt Strauss (Kitchener South—Hespeler, CPC): My first question is for Dr. Azar.

I'm a critical care physician. I have had patients wake up.... I'm thinking of one gentleman in particular in the ICU following a critical illness related to opioid use disorder. He woke up and said he had been on Sublocade in prison and then discharged from prison, and he hadn't had Sublocade in six months. He said, “Please, please, please put me on Sublocade.” That's anecdotal, but it also makes a lot of pharmacological sense to me that this is a wonderful treatment. I wonder if it's not terribly well publicized.

I see that you have some papers you wrote about buprenorphine behind you. Can you tell us, at a high level, if I take a Sublocade injection—I know you'd have to collate a lot, but I guess your gestalt—how likely am I to die from an opioid outcome in the month that I take that injection?

Pouya Azar: That's a very good question. It's almost zero.

You may not know this, but I was the first physician in Canada to prescribe Sublocade. This was before it was commercially available through the special access program through Health Canada.

Sublocade is underutilized. It is a treatment that can protect people from overdose and reduce cravings in withdrawal for one month at a time.

There isn't one medication that's right for everybody, but I worry that Sublocade—which is a trade name for extended-release depot buprenorphine—is underutilized. I worry that the protocols and the guidelines that are currently available for physicians to initiate their patients onto buprenorphine and extended-release depot buprenorphine are difficult to use and do not meet the needs for patients who use fentanyl. We have newer protocols that significantly reduce the time it takes to initiate these medications and reduce the harm, the morbidity and the difficulty that's associated with experiencing withdrawal and initiating these medications, which was something that was required pre fentanyl.

To finish my answer, yes, it can prevent overdose, and yes, it's being underutilized, and we need to have more sophisticated ways to initiate people onto these medications. We've developed some of those protocols in our lab.

Matt Strauss: Thank you so much. I sort of knew that, but it's startling to hear you say that there's a medication that most people haven't heard of that drops the chance of dying from an opioid event almost to zero. It's just incredible, so I want to keep talking about it.

You anticipated my next question, which is this: What are the common barriers that you see in your practice, or that your colleagues see, in offering buprenorphine? It sounds like the guidelines are not yet where they should be and that the ease of use for physicians and maybe the know-how or education for physicians are not quite where they should be. Are there patient-side barriers that you notice in your practice?

Pouya Azar: Again, I want to preface my answer by indicating that this medication may not be right for everybody who uses fentanyl. It's right for patients who have decided that they want to stop and are interested in abstinence.

There are a few common barriers associated with initiating this medication. First and foremost is accessing a place that can provide this medication rapidly. That would be number one.

Second, there is pain associated with this injection. I've had patients who have received it once, and the second time I offered it to them, they said, “Absolutely not. It was extremely painful.” We've developed pain-free ways of giving it. That should never be a barrier, but there seems to be a lag between putting this evidence out there and incorporating it into clinical guidelines.

The third is a practical one. In many places, there's still an expectation for patients to experience a period of abstinence and withdrawal before they go on these medications. That is no longer required. In our emergency department, a patient can come in, and in less than an hour they're going to receive this injection and be out the door without any suffering.

Some of the main barriers are just education and updating guidelines to reflect the needs of people who use fentanyl.

● (1710)

Matt Strauss: Okay.

As a bit of a shift, there's been a lot of talk about in-patient treatment, access to beds and that sort of thing. When is in-patient treatment in a rehab bed necessary or advisable in your patient population?

Pouya Azar: Again, it depends on the patient and their circumstances, and I want to be very clear about this point as well.

Oftentimes, medication is the first necessary step, but it's not sufficient for most of our patients. In our emergency department, I can get somebody off any amount of fentanyl and onto Sublocade in about an hour, using one of our clinical trials. If I send them right back to the circumstance of being homeless in Vancouver's Downtown Eastside, with all of the psychosocial factors that were driving their addiction, relapse is almost inevitable, and we end up with a revolving door.

I can use the analogy of treating somebody in a facility for a gambling addiction and then discharging them into a casino and saying, “Good luck.” In many ways, this is what we're doing with our patients who use opioids.

In-patient treatment is necessary for many of our patients. We have to address the environmental factors that drive patients to use, beyond just physiological cravings and withdrawal.

The Chair: Dr. Azar, thank you.

We'll go to MP Sawatzky for five minutes. Please go ahead.

Jake Sawatzky (New Westminster—Burnaby—Maillardville, Lib.): Thank you very much, Chair.

Thank you, Dr. Kaiser, for being with us today.

Last year, the City of New Westminster, in my riding, received $290,000 through the emergency treatment fund to help address urgent substance use and overdose-related needs.

From your perspective, how important is flexible funding, such as the emergency treatment fund, in helping municipalities and indigenous communities respond to local needs to deliver effective support to the people who need it?

David Kaiser: The short answer is, “That's my message.”

I'll follow up on something that Dr. Azar said about the lag between evidence and implementation. For me, the experience of the pandemic was highly relevant. We don't want to do “whatever”, and we want to make sure that we're acting based on evidence, but we don't want to be paralyzed by the need to have all of the answers in order to act on what we know already.

I think this is where, starting from local needs and having the least amount.... It's the same idea as the people trying to access care and the people trying to deliver care having the least number of administrative barriers within a framework that is science-based.

Part of that is having an increased capacity to evaluate. If we're going to finance initiatives and we want to understand whether they work, we need to study whether they work. We need to have that built in.

Jake Sawatzky: Thank you.

In addition to the emergency treatment fund, there are additional funding mechanisms. There are bilateral funding agreements with provinces and programs like the building safer communities fund for prevention for at-risk youth and the Reaching Home fund for people at risk of homelessness. I know you mentioned the prevention side of things. Of course, these are all separate issues, but they are often associated with each other.

The next question is for Dr. Azar.

First of all, I just want to say that I love the scientific papers on the skateboard decks behind you. I think that's pretty great.

I want to ask you about mental health disorders that co-occur with substance use disorders. Could you speak generally to the importance of treating co-occurring disorders and how that treatment needs to be specific and targeted?

Pouya Azar: Thank you. That's an excellent question.

When I did my addiction medicine fellowship a few years ago, we were taught that there's no evidence for psychosocial interventions in addiction. I think that is such a bizarre thing to teach emerging physicians. The evidence shows us otherwise. A hotel study out of Vancouver showed that 50% of the people who were struggling with addiction in that hotel study in Vancouver's Downtown Eastside were experiencing psychosis.

We know that addiction is rarely just a biological condition. It's often driven by multiple other factors, including mental illness. If we don't address the underlying drivers of addiction—if we address it only through medication and address only the physiological drive to use—relapse is almost inevitable, so it's important, absolutely critical, that we move away from this medical-only model of addressing addiction and towards this biopsychosocial concurrent disorders model to address all the underlying drivers of addiction. Otherwise, we're going to continue to have this revolving door.

● (1715)

Jake Sawatzky: You mentioned the importance of housing and the importance of having mental health supports and addiction supports within that housing. Could you speak further to that, please?

Pouya Azar: Absolutely, I can, and I believe that my colleague Dr. Kaiser can speak to this as well. He mentioned it too.

That's very clear, when a patient is living on the streets of, say, our Vancouver Downtown Eastside. I often ask them if they have anybody in their life who doesn't use fentanyl. They'll say no. I'll ask them how long into their day it is until they encounter fentanyl, and they'll tell me, “Almost immediately. When I wake up, it's there.”

How do we expect this person that I've started on Sublocade or opioid agonist therapy to remain off opioids? It's almost impossible.

Housing is a critical component of treatment. Otherwise, again, we'll have this revolving door.

Jake Sawatzky: Thank you.

My last question is for you, Dr. Kaiser.

We have a national strategy for boys' and men's health right now. We know that men and boys face significantly higher rates of overdose. Is that something you've seen as well?

David Kaiser: Yes, for sure. We see it in the population experiencing homelessness, and we see it in our overdose stats.

I think it comes back to prevention. The way we are going to change that is by investing in what happens in the first five, 10 or 15 years of men's and boys' lives.

The fact that there's a men's and boys' strategy doesn't change the fact that there's also a really important component of violence towards women. In looking at the underlying determinants, I think we can work on both of those at once.

The Chair: Thank you.

Now we'll go to Madame Gaudreau for two and a half minutes. Please go ahead.

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Mr. Chair. I am again going to approach my question from the opposite standpoint.

I'm worried, because we understand the issue and we want to do something about it. I'll give you an example. In my riding, in Mont-Laurier, we have Maison Lyse-Beauchamp, which I talked about. It works on a number of fronts, particularly substance abuse and addiction. It has a 90-day residential treatment program and a warming station. It even provides emergency housing and mental health resources. It offers intermediate resources, and those supports have increased over the years. It provides social reintegration programs, and adapted and supportive housing.

People don't know enough. They're scared. They ask me what's going on and say we're bringing homeless people and people with mental health issues to the area. It's the not-in-my-backyard mentality. I understand that there are things Quebec has to do, but let's talk about what we can do here. Let's face it, the simple solution is to give Quebec the money to address the problem. What, though, can we as lawmakers here in Ottawa do to help provinces and territories take action on the ground?

David Kaiser: You already said it. I think the funding component is something you can help with while respecting provincial jurisdiction.

Now I'm going to talk about what you can do, but through a different lens. Words become reality. As a physician, I firmly believe that. The things you say have a direct impact. When you're in a position of power, you have to use it responsibly. That's something all levels of government can do.

As I said earlier, it's also about figuring out how to work together. It's important to model what you want to see on the ground. When you invite divergent voices, demonstrate that you're able to have a conversation about a challenge, recognize the complexities and move towards solutions, you model behaviour you want to see on the ground.

I want to say one last thing. I've gone to public meetings. I was at one two weeks ago where one person spent half the meeting complaining that the neighbourhood wasn't what it used to be and that she wouldn't raise her kids there today. She went on, but eventually she said she didn't want to spend the next 20 years complaining. She wanted to know what she could do. I firmly believe that the vast majority of people want to help; they just want to know what they can do. That means reaching out to them and creating spaces where people can talk to one another.

● (1720)

Marie-Hélène Gaudreau: That requires political will.

Thank you.

[*English*]

The Chair: Thank you.

Now we'll go to Mr. Bailey for five minutes.

Please go ahead.

Burton Bailey (Red Deer, CPC): Thank you, Chair.

Dr. Azar, other than in a hospital setting, where strict prescription and monitoring are present, is personal consumption of fentanyl safe?

Pouya Azar: Are you speaking of unprescribed fentanyl, illicit fentanyl?

Burton Bailey: That's correct.

Pouya Azar: Fentanyl is an extremely dangerous substance. It poses an extremely high risk of death by overdose. It is not safe under any unsupervised circumstance, as far as I'm concerned.

Burton Bailey: Thank you.

According to a recent study in the Canadian Medical Association Journal, the failed dangerous drug decriminalization experiment in B.C. found no significant changes in drug-related hospitalizations or toxic drug deaths compared to the rest of Canada, where drug laws hadn't changed.

Do you think the decriminalization of hard drugs is a mistake?

Pouya Azar: I have not seen any evidence. I'm a clinical scientist. I rely on data, and I rely on evidence. I have not seen evidence convincing me that the decriminalization strategy in British Columbia was helpful. I'm open to seeing the evidence and analyzing it. I just haven't seen it.

Burton Bailey: Thank you.

Are you familiar with the Alberta model?

Pouya Azar: I am.

Burton Bailey: All right.

Basically, they're trying to simply stop enabling, and they're promoting recovery with over 10,000 publicly funded beds.

Do you believe that this should be expanded into other jurisdictions in Canada, such as B.C., where we have these severe epidemics going on?

Pouya Azar: Absolutely. How could access to increased numbers of beds and access to the recovery communities they have in Alberta not be helpful?

Again, I've spoken extensively about the issue of using these sophisticated pharmacological treatments in a facility and sending people right back to the streets. How is that even ethical, knowing full well that they are going to relapse and eventually be at risk of overdose?

Then, absolutely, how could that not be helpful?

Burton Bailey: Thank you.

Are you familiar with Dr. Nathaniel Day's study for the Centre of Recovery Excellence, the one that was done in Red Deer? Are you familiar with that one?

Pouya Azar: No.

Burton Bailey: Basically, they did a study comparing Red Deer and Lethbridge, which are similar in size. They took away the opioid injection site and compared one year of findings. What they found is that without the supervised consumption site, there was no increase in deaths and there was no increase in hospitalization, and the removal of that opioid injection site gave them the ability to put more money into recovery and get rid of the social disorder in downtown.

Do you believe that these opioid injection sites are saving lives?

Pouya Azar: I'm not familiar with that study, and I'm not familiar with the exact psychosocial circumstance of that community as compared to a community like the one I'm familiar with, Vancouver's Downtown Eastside.

I believe that addiction is on the spectrum. I think harm reduction is a real need. If I have a segment of my substance-using population that I know today are not going to stop using, and if they can go to a safe place to use and be able to access care and eventually move up the steps towards a path of recovery, I don't think that's a bad thing, but I believe that—

● (1725)

Burton Bailey: I'm going to go to something you're more familiar with.

You co-authored a paper stating that the logic of a so-called “clean” supply is clear, but saying that the devil is in the details and noting the lack of systematic evidence of benefits from pharmaceutical opioids outside a therapeutic context.

Why, if there is a lack of evidence, do certain jurisdictions, including the federal government, continue to approve these methods that enable addiction and do not help those in need to recover?

Pouya Azar: My message is that we have to follow evidence. We have to follow public health principles.

I believe there's plenty of evidence that unsupervised immediate-release opioids can be harmful if their availability is expanded in society. We saw that with the Purdue Pharma experience in the United States. We saw that with the safe supply experience here in British Columbia.

I can't answer your question in terms of why other people are approving these strategies. All I can say is that we need to follow the evidence. Our interventions need to be evidence-based, and I don't believe that approach is evidence-based.

The Chair: Thank you.

The last member of Parliament to ask questions is MP Sidhu. Please go ahead for five minutes.

Sonia Sidhu (Brampton South, Lib.): Thank you, Chair. Thank you, Dr. Kaiser and Dr. Azar, for your work in the communities.

My question is for Dr. Kaiser.

You talked about education. What role should school, family physicians and community health organizations play in identifying substance use risk before it develops into more serious health challenges?

David Kaiser: There are many school programs that exist already that are run by schools, that are run by community organizations, that are run in conjunction with health systems. I think those can be systematized, making sure that students have access to safe and secure environments to access care, for example, if they are experimenting with drugs or having a mental health condition or substance use problem when they're in school. They need to be sure that they can access a care provider in a safe and confidential way.

Then I think there is a whole second component, around education. We need to be educating kids to navigate the environment they are going to find themselves in, in terms of being able to understand health information and being able to navigate conflict and the types of difficult conversations that are necessary in order to get through a world that is really complicated for young people and teenagers.

Yes, there's a part of education around health education and health promotion, but I think part of our education system needs to be equipping our teens and young adults to actually function in a complex world where drugs can often be a response to distress, to mental health issues and to an inability to function in that world that generates a lot of that.

Sonia Sidhu: Thank you.

My next question is, how can federal investments in community-based prevention and treatment be better aligned with the priorities identified by provincial and municipal public health authorities?

David Kaiser: I think it's just having, as I said in my opening remarks, confidence. I think it's having confidence in the people who are on the ground and doing the real work and providing them with the tools they need to do that work.

Yes, we need to be evidence-based. I think the federal government has an important role to play in translating evidence into action, and we need to be able to orient financing and evaluation as a function of what the people who are doing the real work tell us.

I just want to say that in the perspective of translating evidence into action, I think it's really important that we don't take a small component of a complex system and draw conclusions. In the study in Red Deer that was mentioned, the conclusions of the study say the following:

> Short-term effects on acute healthcare utilization and mortality appear stable but remain inconclusive due to the limited 26-week follow-up period and low event counts.

That is not a study that I would expect a federal government to make decisions on in isolation. What I expect is that we have confidence, that we base our decisions on what is happening on the ground, that we bring in all of the science that brings us different perspectives, and that decisions are made as a function of the whole body of evidence.

● (1730)

Sonia Sidhu: My next question is for Dr. Azar.

Dr. Azar, stigma plays a significant role in preventing an individual from seeking help for substance use. From your perspective, what can public health organizations do to reduce this stigma and encourage more people to access and support the treatment they need?

Pouya Azar: That's an excellent question.

Traditionally, we have done prevention quite poorly. I'm looking at moralistic, fearmongering campaigns. We're familiar with the “Just Say No” and “This Is Your Brain On Drugs” campaigns. When you think about what a young person actually experiences, a young person who is at a party feeling insecure and feeling anxious, and the drugs are being passed around, they're not going to think to themselves, oh, Nancy Reagan told me to just say no.

I think we need to be more sophisticated around our prevention campaigns. One of the things my lab is working on to help reduce stigma is essentially employing strategies that have been already used by corporations: targeting young people for marketing utilizing social media and peer-to-peer messaging. We want to use that same approach, but target it towards reducing stigma associated with mental health and addiction. I feel that we know it's already effective for corporate marketing. I think we can potentially use that same strategy.

We're launching a pilot program called The Natural Stance. It's on social media right now. We are going to evaluate it and, hopefully, we'll have some data around that.

The Chair: Thank you.

With that, on behalf of the committee members, I would like to thank both Dr. Kaiser and Dr. Azar for their valuable and professional input. I appreciate it.

I will briefly suspend the meeting, and then we will welcome the second panel of witnesses.

● (1730)

(Pause)

● (1735)

The Chair: I would like to call the meeting back to order.

On behalf of the committee members, I would like to welcome the witnesses who are joining for the second hour.

Even though the regional chief was scheduled to appear in the first meeting, because of the technical difficulties, he's here now. From the Assembly of First Nations, we have Regional Chief Wendell LaBobe. Welcome.

Appearing as individuals, we have Dr. Nickie Mathew, addiction psychiatrist, and we also have Dr. Julian Somers, clinical psychologist. Welcome.

From Métis Nation-Saskatchewan, we have the Minister of Health, Mental Health and Addictions, Madam Beverly Fullerton-Trotchie. Welcome. We also have the minister of Self-Determination and Self-Government, Mr. Brennan Merasty. Welcome.

I would like to make a few comments to our witnesses.

Before speaking, please wait until either I recognize you by name or the member asks a question directly to one of you.

For those participating by video conference, click on the microphone icon to activate your mic, and please mute yourself when you are not speaking. At the bottom of your screen, you can select the appropriate channel for interpretation: floor audio, English or French.

For those in the room, you can use the earpiece and select the desired channel. Committee members may ask questions in either French or English. If you need interpretation, please take a moment now to prepare your earpiece and select the listening channel you need in advance in order to take full advantage of the time allotted for questions and answers.

This is a reminder that all comments should be addressed through the chair. Even though I give a lot of flexibility here, my particular request to the witnesses is this: If you can keep an eye on the honourable member who's asking questions, as soon as they raise their hand, I would suggest that you please stop speaking, because it is their time.

To the honourable members, if you can say the name of the witness the question is for, then it will make it much easier.

With that, each organization has five minutes for opening remarks, and then we will proceed with the round of questions. We will start with the Assembly of First Nations, Regional Chief LaBobe.

Please go ahead.

[*Technical difficulty—Editor*]

We can't hear you.

Okay. They're going to check. We can go to the next witness in the meantime.

I'm sorry, Chief. We'll come back to you.

We will now go to the individual witnesses. We will start with Dr. Mathew.

Dr. Mathew, you have five minutes. Please go ahead.

● (1740)

Dr. Nickie Mathew (Addiction Psychiatrist, As an Individual): I'd like to thank the committee for inviting me to this.

I want to speak about the rise of synthetic drugs in the Canadian drug market and how this has affected the minds and safety of the Canadian population.

How did we get here? In 1958, Arthur Sackler launched the Terramycin campaign and invented direct-to-physician marketing. In 1959, Paul Janssen invented fentanyl. Arthur Sackler and his brothers made so much money from the Terramycin campaign that they bought Purdue pharmaceuticals. In 1980, Porter and Jick wrote a five-line letter to the editor that addiction was rare in people prescribed narcotics. In 1996, James Campbell, president of the American Pain Society, launched the campaign “pain as the fifth vital sign”. In that same year, Purdue pharmaceuticals released OxyContin. They used the direct-to-physician marketing that was invented by Arthur Sackler and cited the five-line letter to the editor by Porter and Jick. This laid the groundwork for a population that had a tolerance for fentanyl. OxyContin became supplanted by fentanyl in 2010.

In 2006 there was a restriction on the sale of Ephedra in Canada. The Mexican cartels responded by perfecting the phenyl-2-propanone method. When they were using the ephedrine method, they would make one molecule of l-methamphetamine and one molecule of d-methamphetamine. L-methamphetamine was a nasal decongestant and d-methamphetamine was psychoactive. With this new method, they had a very potent version of crystal meth. Both of these invaded the Canadian drug market.

When you look at these drugs, they tend to be co-ingested. When you look at the overdoses that occurred in British Columbia in 2021-22, about 70% of the folks who died of overdose that year had stimulants in their system.

By 2017, the most used drug by incarcerated individuals in British Columbia was methamphetamine. Why is this problematic? Well, there's the issue of substance-induced psychosis. Substance-induced psychosis is a neurotoxic event. It means initially people won't get psychotic when using meth. They get psychotic during intoxication, then during withdrawal and then during the sobriety phase. Every time they get psychotic, it's more likely to happen again, it's harder to treat, and it tends to be more severe.

In 2022 Premier David Eby had the Butler-LePard report done. They looked at random stranger violence. They found in that report that three of the main drivers were, one, mental illness; two, acquired brain injuries due to the toxic drug supply; and three, methamphetamine use.

This also affects recidivism. There's a term called “concurrent disorders”, which is when folks have psychiatric and substance use disorders at the same time. Of folks who were incarcerated in British Columbia, 72% who had concurrent disorders were likely to have recidivism during that time, so it was the most important risk factor.

When we look at the population of British Columbia writ large, by 2021 there were about 75,000 people with opioid use disorder. Now, 80% of them had a psychiatric disorder, so concurrent disorders in British Columbia are the rule, not the exception. When we look at folks with opioid use disorder in British Columbia, about 12,000 of them will have a psychotic disorder as well.

I'm not sure if you have been to the Downtown Eastside in Vancouver. There are about 18,000 people there. There was a study called the “The Hotel Study”, in which they found that about 95% of the people in the study had substance use disorders, about three-quarters had a mental illness, 47% had psychosis and 45% had diagnosable neurological disorders. There was a clinical triad of substance use disorders, psychiatric disorders and brain injury.

What do we do about it? Treating addictions is complicated. The opioid crisis has been approached as though there's been an opioid deficiency: If we prescribe more opioids, we'll get out of this. Almost the entire focus has been on giving people enough different kinds of opioids, assuming this will solve the crisis.

Opioid use disorder is not an opioid deficiency. Any place on earth that has treated the opioid crisis used multiple approaches where medication was just a small part. Psychological therapies are not covered. The intervention with the most evidence for amphetamine use disorder is contingency management. We need to look at a wide range of evidence and solutions. It is unlikely we'll find a home run intervention. With the varied population, we'll need input from public health, addiction medicine and addiction psychiatry, among others.

● (1745)

There is Canadian evidence that treating people with mental health and addiction issues concurrently will help keep this population alive. Psychosis increases the risk of violence fourfold, so treating psychosis is important in preventing violence. Early access to treatment for concurrent disorders can help change the trajectory of the illness and the associated risks. Clients, especially high-risk clients, need timely access to treatments. Along with treatments, there needs to be stable housing with appropriate supports. There needs to be vocational rehabilitation opportunities. There's the "approved home" model in British Columbia, which is a service that has two main purposes. One is to provide long-term residence, and the second is to provide secure, low-barrier treatment and recovery. They have severe—

The Chair: Thank you, Dr. Mathew. That was five minutes and 30 seconds. You had five minutes to speak.

We'll go to Dr. Somers for five minutes.

Please go ahead.

Dr. Julian M. Somers (Clinical Psychologist and Full Professor, As an Individual): Thank you.

I'm a clinical psychologist and a scientist. I began my career in 1986 at B.C.'s Riverview Hospital during deinstitutionalization. Since 1996, I've helped design and evaluate federal, provincial and territorial initiatives to prevent and treat addiction.

I'm today asking the Government of Canada to build on federal work that anticipated today's crisis and charted a path out of it. That includes the Senate's landmark report, "Out of the shadows at last", federal investments in collaborative care, and drug treatment courts, as well as the "At Home/Chez Soi" trials, the world's largest randomized trials on homelessness, addiction and public safety. In the trials in Vancouver, recovery-oriented housing cut criminal convictions by 71% and halved the medical emergencies at no greater cost than leaving people homeless.

B.C. has been in a declared public health emergency over drug poisoning for a decade, and more than 18,000 British Columbians have died. There are only two ways out of any public health crisis: stop new cases and treat existing ones. B.C. should by now lead the world in both. Instead, the province adopted policies that were predicted to escalate harm, and harm to public safety, encampments, businesses, families and indigenous communities escalated.

In my view, this happened because the lessons Canadians had already paid for were set aside and because policy was made without adequate safeguards against conflicts of interest. I will offer four examples, each with a question.

First, in 2020, a year after B.C.'s provincial health officer called for decriminalization and safe supply, four of the policy's most prominent proponents announced companies in the same field: a former provincial health officer, a former executive director of the BC Centre for Disease Control, and two leaders of B.C.'s HIV/AIDS research community. The former executive director's company dispensed opioids from vending machines and received at least $4.5 million in federal funding. I am not alleging that any of this was illegal. That's the problem. What federal rules govern senior officials who shape a policy and then build businesses around it?

Second, these policies were never meaningfully evaluated. B.C.'s Auditor General found deficiencies in target setting, evaluation and public reporting on prescribed safer supply. One week after I briefed senior B.C. officials on federally funded research on recovery, the province ordered my university to destroy our entire research database, including data for an approved and funded study of drug-related deaths. Why was the evidence that could have evaluated these policies destroyed rather than used?

Third, federal granting agencies have provided millions of dollars to the BC Centre on Substance Use, the leading academic advocate of safe supply. The centre also receives pharmaceutical industry funding, and the amounts are not publicly disclosed. Should Canadians not know who funds the research that shapes their drug policy?

Fourth, researchers affiliated with that same centre designed an evaluation of the Drug User Liberation Front, the operators of which have since been found guilty of drug trafficking. On July 29, 2022, Health Canada wrote to refuse DULF's exemption request and warned that the model would violate federal law. According to the researchers' own publications, data collection began four days later. When DULF later challenged the federal government under the charter, the judge noted, “Of marked significance, the Crown called no evidence, expert or otherwise, to challenge any of the evidence called by the applicants”. What oversight applies when publicly funded research proceeds after a federal refusal, and why did the Crown call no evidence?

Ending this crisis requires a federal vision of prevention and recovery with meaningful metrics to evaluate progress. It requires mandatory disclosure of pharmaceutical payments to researchers, clinicians and patient groups; conflict of interest rules that cover the move from public office to private enterprise; federally funded research that complies with federal law; and a Crown that defends the public interest in court. It requires the community-based, recovery-oriented care that was promised as a replacement for institutions, care that serves patients and communities together rather than pitting them against one another.

Thank you.

● (1750)

The Chair: Thank you very much. That was perfect timing.

Now we will go to the Métis Nation.

Between the two of you, you have five minutes. Please go ahead.

● (1755)

Brennan Merasty (Minister of Self Determination and Self Government, Métis Nation-Saskatchewan): Thank you, Mr. Chair.

Good evening, ladies and gentlemen. Thank you for this opportunity to speak with all of you today.

My name is Brendan Merasty. I'm the minister responsible for self-government, self-determination and justice, as well as a regional representative for northern region 3 with the Métis Nation-Saskatchewan.

I want to start by saying that institutional concepts will not heal our people. It is discovering our spirit through identity, culture, values and language that will carry us forward. It will ground us. It will give us the balance we need in everyday life and, more importantly, a connection with purpose. Then we can say:

[*Witness spoke in Michif and provided the following text:*]

Kay nantaw itihta.

[*English*]

It means, “Don't worry.”

Over 25 years, I lived through and learned from the impacts of intergenerational trauma, addiction, abuse, bullying and disconnection. I bring my lived experience to this space and this conversation grounded in community and identity connected to culture and a responsibility to lift others as I move forward.

Métis Nation-Saskatchewan proudly represents section 35 rights-holding Métis citizens across the province, advancing our rights, strengthening our communities and preserving our culture, language and traditions for generations to come.

On August 19, 2025, our provincial Métis council declared a state of emergency on drugs, gangs and violence, and alcohol across the Métis homeland within Saskatchewan. The resolution recognizes that these interconnected issues are affecting Métis communities throughout Saskatchewan, with particularly urgent pressures identified in our northern and eastern regions.

This declaration was not symbolic. It was a recognition that what we are experiencing cannot be addressed by one ministry, one government or one intervention. Addiction, mental health, homelessness, violence, involvement with the justice system and family instability are interconnected.

We have been reaction-based to date. Our response must be deeply rooted, connected and with purpose. This is not simply an addictions emergency. It is a community safety, health, housing, justice and family emergency. It is about reshaping our future.

Part of our response is recognizing that addiction intersects with gangs, violence and community safety, which creates that chaos, so the objective is not enforcement alone. The goal is to change outcomes and empower and create a pathway where people can self-reflect to take ownership, rather than becoming another statistic.

With that, I'll hand it over to my colleague, Minister Fullerton.

Beverly Fullerton-Trotchie (Minister of Health, Mental Health and Addictions, Métis Nation-Saskatchewan): Thank you, Minister Merasty, and thank you, Chair, for this opportunity.

As mentioned, my name is Beverly Fullerton. I am the Minister of Health, Mental Health and Addictions, and regional director for western region 2A.

I am a Métis woman, a mother of seven and a kokum to two grandsons. I sit before you with 14 years in recovery. Before I held this title, I lived through abuse, foster care, gangs, addiction and incarceration. Today, I carry those experiences into my responsibility to advocate for our citizens and for Canada. The woman I was then deserved safety and care just as much as the minister sitting before you today.

Saskatchewan continues to experience serious drug toxicity harms. As of October 1, the Saskatchewan coroner's service figures showed 193 confirmed and suspected drug toxicity deaths from January through December. Saskatoon has had over 2,500 emergency calls, and we know these numbers are greatly skewed towards members of our community.

Our response is grounded in full continuum prevention, intervention, treatment, recovery, housing, reintegration and community safety. Our first step is meeting people where they are.

We have programs that meet people where they are: We respond with a low-barrier response to overdose crises. Our program, Wichihew Li Moond mobile outreach, includes 28,006 people supported, 1,500 naloxone kits distributed, 903 housing connections, 390 health care reconnections and over 12,000 transports to shelter, medical and addiction services.

The work that connects people to safety and care creates opportunities to intervene before a situation becomes an emergency room visit, an arrest or a death, but piecemeal programs that depend on short-term funding agreements cannot provide the continuity our citizens need. This is also why we are advancing a Métis-distinct, land-based recovery lodge near Batoche, in our homeland. Current planning provides for 60 spaces: 10 for medically supported withdrawal management and stabilization, and 50 for structured 90-day inpatient treatment.

The model brings together clinical and traditional land-based healing, family involvement and structured aftercare. For me, that connection matters. We are supporting a person who needs somewhere to belong, relationships they can trust and the opportunity to build a life beyond addiction.

Métis Nation-Saskatchewan's state of emergency is a call to partnership and action. Saskatchewan needs a connected response that takes someone from crisis to safety, treatment, housing and recovery and supports their connection to a family and community.

We sit before you as lived experience. We have been through the trenches.

Thank you.

● (1800)

The Chair: Thank you very much.

We can go directly now, to save time, to Mr. Bailey.

You have six minutes. Please go ahead.

Burton Bailey: Thank you, Chair.

Dr. Somers, I'm going to ask you a couple of yes-or-no questions, because my time is so limited and you gave us such a great description to start us off. I'd like to welcome you back to committee.

Other than a hospital setting, where strict prescriptions and monitoring are present, is the personal consumption of fentanyl safe, yes or no?

Dr. Julian M. Somers: No.

Burton Bailey: Do you think the decriminalization of hard drugs is a mistake, yes or no?

Dr. Julian M. Somers: Yes.

Burton Bailey: Thank you.

You're familiar with the Alberta model. We've been setting a standard for recovery for people suffering from addiction. The first question I have for you is, if we were to bring this into other provinces, such as B.C., what number of recovery beds would be needed?

I'll help you a bit. Alberta has 10,000.

Dr. Julian M. Somers: I've worked in Alberta on the design and implementation of the recovery model. I would estimate—I haven't calculated this—that it would be at least comparable for that one component, and you're talking about one component.

Burton Bailey: The other question I have for you is this. Beyond the study findings of no significant change in hospitalizations or toxic drug deaths, what other public health, criminal justice or social indicators changed in B.C. after decriminalization?

Dr. Julian M. Somers: It took about a year before municipalities took the province to court, requesting that stipulations be put in place to curtail open drug use in parks, in playgrounds and on transit. Eventually, we saw drug use in hospitals. The immediate aftermath was striking, visible and alarming. The province has been determined to have been negligent in its own evaluation of those policies. This is from the B.C. auditor general.

We've been relying mostly on the evidence of our senses and the evidence we can see in our streets, and it has been terrible.

Burton Bailey: First of all, I want to thank you for your work in Alberta. I'm very proud of what our province is doing to help people recover and not enable.

I'd like to talk a bit about a study that Dr. Nathaniel Day did in the Centre of Recovery Excellence. Are you familiar with this study?

Dr. Julian M. Somers: Yes.

Burton Bailey: Basically, Red Deer closed down that opioid injection site, and we saw no increases in hospitalization or deaths. We saw recovery increasing. Lethbridge had the opioid injection site continuing.

My question to you is, do you believe opioid injection sites should continue operating?

Dr. Julian M. Somers: I believe we can do better. I believe a model that was proven effective at reducing the transmission of infectious diseases in the 1980s and 1990s has now been eclipsed by more effective and immediate interventions that no longer require the intermediate step of supporting people using drugs.

The danger of consumption sites is proven in B.C. It used to have the only one in the world, Insite, and we went, over the last several years, to 58. The problem with scaling up in that manner is that the people who use consumption sites are known to consume the majority of their drugs elsewhere. This is part of the explanation of how a jurisdiction like B.C. can add massively to the number of consumption sites while deaths increase. It's because we're not meeting people in all of the settings where they require our assistance. That, essentially, moves the discussion immediately forward to safer homes and supports that enable people to socially reintegrate.

Burton Bailey: Thank you for that answer, because in Red Deer, the millions of dollars that were being spent on that opioid injection site to help 100 individuals.... That money was taken and put into recovery, and it's helping those same individuals. We feel the public's money is being spent much better.

On the Conservative side, we're not interested simply in criticism. We want to identify and pursue solutions that will alleviate the opioid epidemic in Canada and return our loved ones home drug-free.

To that end, I'm curious about Portugal's experiment. In your work, you've alluded to the Portuguese focus on social integration and the payoff of that approach. Has Canada done well enough on social integration, or did our focus on safe supply perhaps further marginalize the individual impact?

● (1805)

Dr. Julian M. Somers: I agree with the inference in your question. Where do we do social reintegration? What national policy addressing addiction focuses attention on the importance of social reintegration?

The Portuguese strategy states, “Strictly speaking, there is no such thing as [addiction] treatment without social reintegration”. The Portuguese were extremely clear-eyed about it. They introduced about 63 therapeutic communities and zero consumption sites between 2000 and 2010, when most of their major changes were accomplished. B.C., in contrast, introduced zero therapeutic communities and, as I said, 58 consumption sites.

I'm not aware of where there is currently a federal focus on promoting social reintegration, as emphasized in “Out of the shadows at last” and revealed to be highly effective and feasible in the At Home/Chez Soi trials conducted across the country.

The Chair: Thank you. That was perfect timing.

Now we'll go to Mr. Rana for six minutes.

Please go ahead.

Aslam Rana (Hamilton Centre, Lib.): Thank you, Mr. Chair.

Thank you to all of the witnesses for your valuable time.

Minister Fullerton-Trotchie, as of August, the emergency treatment fund has committed over $139 million to more than 141 projects in municipalities and indigenous communities, including for Métis-led projects in British Columbia and Manitoba. What kinds of projects would make the biggest difference for Métis citizens in Saskatchewan?

Beverly Fullerton-Trotchie: It is very unfortunate that the proposal we put in for the emergency treatment fund was actually denied.

We sit in front of you, and we have the tools to connect with our citizens. As a Métis community, we're distinct. Unlike first nations, our relatives who are usually bound to the reserve or the land mass, we are provincial. You will find that our folks in northern and remote communities don't access services and programs as easily as a lot of our folks in the urban centres.

If you look at the demographics of the indigenous people who are homeless or experiencing the opioid crisis and addictions, we're going to find a large majority of them coming down from the north, so we're trying to meet them where they are. If we were to have stable funding....

It's that cultural connection. We talk about social reintegration. We talk about a Portuguese model. If you look at the folks, you're going to find that the highest number of those who are addicted are indigenous people. We're not talking about our indigenous ways, our cultural ways or our traditions. We can actually heal our people and put them back on a journey.

When we talk about short-term funding or the cutting of funding, we'll get a program that is working—we're connecting, we're reunifying families, we're getting to *oskâpêwis*, we're doing these things—and then we're stuck looking for another proposal to find money. Unfortunately, we have to go and tell our citizens and their families that our funding has been cut and we can't continue this.

We're doing everything we can. We see other models that are happening in the other provinces. We have a framework. We have a continuum of care model developed. We just need the partnerships and the supports. I can guarantee you that in 10 years, you would see those numbers change drastically.

Aslam Rana: The Public Health Agency of Canada's youth substance use prevention program is putting $20.2 million over the next five years into community projects that prevent or delay substance use among young people. How would a project like this work for Métis youth?

Beverly Fullerton-Trotchie: Prevention is our absolute priority. When we look at our family units, we're looking at intergenerational trauma and residential school survivors. We have kokums who are gang members with their grandchildren. When we look at prevention, we need to connect with our families right from the very beginning, and we need to walk alongside them.

When I started my recovery, I learned from a correctional guard that we actually sit down, create meals and make memories. It's bringing the basic needs back into lives. These are a lot of things that people take for granted or don't take a second to really think about. A lot of our families just need that help getting those basic needs, budgeting and understanding how they can do things differently.

That prevention is going to start right from our little ones being in pre-K, following them through school, meeting them and identifying it before an issue becomes...not so much a problem, but.... Again, within our community, if we had that availability for our supports to be in there, enhancing our elders' and youth-led programs, we would definitely see a difference.

● (1810)

Aslam Rana: Opioid deaths are down about 10% nationally over the last 12 months, and Saskatchewan has seen them come down too.

What's helping in Métis communities, and what should we build on?

Beverly Fullerton-Trotchie: I'm sorry. For clarification, are you saying opioid use is down 10%?

Aslam Rana: That's right.

Beverly Fullerton-Trotchie: We're burying our people, if that makes sense.

When the numbers go low in terms of who's using, it's probably because they've passed. We've buried more folks in the last year or two. The changes in the drugs and the violence have been drastic in the last five years. We're seeing an increase in our northern, remote and rural communities. We're seeing it move out of the urban centres.

I don't know what statistic is saying those numbers are down, because if we look at our community—and we know our people—they're not going down.

Aslam Rana: That's not good.

What helps people stay well once they come home from treatment or custody, and where could the federal government help?

Beverly Fullerton-Trotchie: We are looking at sober living. Again, with our land-based healing lodge, we need support in the health infrastructure funding. We're working with the province and with Canada, and we're building that land-based healing lodge. We are seeing land-based healing lodges across Canada that are connecting their people back with their families and their community.

For Métis Nation–Saskatchewan, to see what's going to work.... I'll use myself as an example. I came home from a five-year federal sentence. I was a junkie. I was a needle user. I was a drug addict. I was a gang member. I was the wife of the leader of the most violent gang in Saskatchewan. When I came home, I did not know my community. I did not know how to live life differently. I took it upon myself that I had to change. By the creator's will, I found my way back to the Métis Nation. I went to Batoche. I connected with our people. I ran into our president, and he said, “Welcome home.” I started going to our cultural events. I started wanting to help. I found a voice that so many of our people don't have. I'm sitting here as a voice for our voiceless.

I know what little things help. It was as simple as a bag of groceries just before Christmas, with ingredients to make cookies with my kids. It's the little things that really change a person's journey completely. We need the resources and the support to be on the ground, working with our people and making sure that they're reminded that they're worthy. They're not just another statistic just because they have a label on them. They're our relatives, and they're worthy.

We sit here as proof. We were the worst of the worst. Canada, organizations and governments wanted to lock us up and throw away the key. We fought and crawled out, and we proved that change is possible. Listen to those lived experiences, and give our indigenous people the opportunity to create.

We see the Compassionate Intervention Act coming. We know the population that fills those forced involuntary treatments.... It's needed for some. We were not given the full tools to provide for our people before another institution was built.

Aslam Rana: Thank you very much for being open and for sharing your experience. It's so nice.

I think my time is up.

The Vice-Chair (Raquel Dancho (Kildonan—St. Paul, CPC)): Yes. Thank you very much.

Colleagues and witnesses, I am the vice-chair of this committee, and I'm temporarily assuming the role of the chair.

Thank you very much, Minister, for that excellent testimony. It's going to really add to our study, so thank you very much.

[*Translation*]

It's now over to Ms. Gaudreau for six minutes.

Marie-Hélène Gaudreau: Mr. Somers, did you say in your opening remarks that prior work had anticipated the opioid crisis? Did I understand that correctly?

[*English*]

Dr. Julian M. Somers: Yes.

● (1815)

[*Translation*]

Marie-Hélène Gaudreau: What year was that in?

[*English*]

Dr. Julian M. Somers: There are several, but probably the most important in British Columbia was in 2016, showing the rise in diagnosed addictions among people who were detained in B.C. custody. This was associated with not only more mortality but a doubling in the average number of prior convictions that people had. It was a clear warning of repeat criminal convictions.

[*Translation*]

Marie-Hélène Gaudreau: I think you're brave coming back here. The reason I got into politics in 2019 was that I fundamentally believed a lot of things needed to change, including poverty, homelessness and substance use—these very issues. I was part of community groups, but I felt the need to help in a different way.

Today, it's clear that there are models that have been able to regulate the situation. We talk about looking at what other countries are doing, but no, we have models here—in your region, in my region—we can draw on. At the end of the day, it's a matter of political will. Earlier, Mr. Kaiser pointed out that we were able to take action when the pandemic was unfolding. We didn't wait for 12 million studies. We had to do something because people were dying. What crisis has to happen to elicit an immediate response?

Seriously, I want to bring all of this back to the fact that each and every one of us is seeking self-preservation. For some, that means knowing where they're going to sleep that night or how they're going to feed their family the next day. I can say that, for me—and this is true for others as well—it means figuring out how I'm going to win in the next election. Seriously, that is what is happening in society. The more you suffer, the more you wonder what's going on.

First, I'd like you to tell us how your approach became such a model. What is the reason it made such a difference where you're from? We have yet to be able to implement something similar here. What's your recipe?

I'm embarrassed to be here alongside my 342 fellow members of Parliament, and to know that this was coming, like the housing crisis. Ten years ago, I knew this was coming. We know—people are getting older; people are getting poorer. What is that?

I'm going to give you the floor. I'm very discouraged, so I want to hear what you have to say. Thank you for being here.

[*English*]

Brennan Merasty: Thank you, member.

We need safe spaces to heal, to discover the root causes and to look in the mirror and ask ourselves why, and only safe spaces will allow us to do that, like they did for me. I don't need places to keep using, because if you keep giving me a crack pipe, I'll keep smoking.

Generational disconnect is a big problem for our people because of the institutional concepts that came to tear our people apart. My uncle Robert is a survivor of the Île-à-la-Crosse residential school. He cannot even hold a conversation with his children because of what was taken away from him. The experiences he endured in residential school have caused a disconnect between him and his wife and kids—a divorce, a broken family.

My late dad took his story to the grave. For me, it took 25 years to want to look in the mirror and ask myself why and be able to understand why he made the choices he did and why he broke our family apart. I had a lot of hate and a lot of anger. When I learned about his story, I was able to connect with myself to understand and truly forgive and move forward in a good way. What was supposed to be six months in that safe place turned into 16 months. You cannot put restrictions and timelines on people's healing journeys, and you cannot continue to give us safe spaces to keep using.

This is not about a theory or another study. You have two people here who have lived it, who have overcome it, and there are many more, but 90% don't. Think about that. We are not a theory; we are real.

● (1820)

Beverly Fullerton-Trotchie: You asked for the recipe.

Give indigenous people back opportunity with stable funding. Stop putting our folks in places where they're begging for food. They're not able to make ends meet, and they're struggling in an economy in which they can't advance. Indigenous people in rural and remote communities are at a disadvantage.

Thank you.

The Chair: Thank you very much.

We will now go to MP Konanz for four minutes.

Please go ahead.

Helena Konanz: Thank you.

I want to thank all the witnesses here today. It's been such an informative day and a heartfelt one.

My first question is for Ms. Fullerton-Trotchie.

Your story is so impactful. Thanks for sharing that, and thanks for sharing your lived experience.

We're hearing that, statistically, deaths have gone down and overdoses have gone down, but you disagree. You're saying that those statistics are wrong, and that's not what you're seeing. I agree. In our communities, it's the same thing.

Why do you think the statistics are so different from what we're actually seeing on the ground? What do you think is happening?

Beverly Fullerton-Trotchie: We have frontline workers who work directly with our people. They have our data; we have internal data and tracking, and we're seeing those needs. We're meeting with our people on the spot. We watched an encampment get torn down just a couple of weeks ago.

I don't know who's collecting the data and statistics that go to you. Nobody has asked me. Nobody has gotten a new number. Maybe you haven't gotten the new numbers that include a couple of teenagers in a family whose mom just overdosed and they started using. We're seeing it personally, so I don't know how we can contribute to the stats that you're seeing.

Helena Konanz: I want to agree with that. In my communities, we're also seeing an increase. I mentioned earlier that in my hometown of Penticton, statistics have gone down for deaths, yet first responders have said that overdose rates in Penticton this year increased by 500% in the first quarter of 2026 compared to the first quarter of 2025. It's shocking, actually.

Thank you for that.

I have a question for Dr. Somers.

Can you explain what you think of the consumption sites in B.C.? You already have, but they're sometimes called “safe injection sites”, and many of these are being shut down now by local governments, because they have been so destructive to the communities, especially if they're located in the middle of a small town, or even a large town. Many of these towns and communities don't have any other support. They don't have mental health support, and they don't have any detox beds. All they have is a place for someone to go and be given drugs or take drugs and continue the cycle.

Can you explain why you think this isn't working?

Dr. Julian M. Somers: Our government decided at the same time to invest in consumption sites and in pharmaceutical alternatives that proved to be not alternatives but supplements to illegal drugs, and, of course, decriminalization. Then there were all of the ancillary expenses associated with that, such as first responders, policing and so on, and adverse impacts on businesses—all things that are either direct or indirect harms to our public economy.

It did that while withdrawing from things that had been increasing slowly over time, such as dispersed housing. All of that went away and was replaced by low-barrier congregate housing as a model rooted in an ideology that we should not discuss addiction, which is the loss of control over a behaviour that's harmful to someone, as something that we consider a mental illness, but we should instead regard it as a lifestyle choice, and this was deeply misguided.

● (1825)

The Chair: Thank you very much.

Helena Konanz: Thank you so much.

The Chair: Now we'll go to Dr. Eyolfson for four minutes or less.

Doug Eyolfson: Thank you, Chair.

Thank you to all of the witnesses who are here.

Ministers Merasty and Fullerton-Trotchie, the testimony I'm hearing is really resonating with me. I did my emergency medicine training in Winnipeg and spent eight years at a downtown hospital. A lot of my patients were indigenous. A lot of them were from isolated communities.

One of the things we found is that it's notoriously hard to treat someone for addiction if they don't feel ready. I've also found it a tremendous challenge when there might be facilities that we will offer to indigenous patients, but they are from other communities, and they don't feel at home. They don't feel that these centres have anything for them. I would imagine this is even more of a problem in these isolated areas, where you don't have any.

In your experience, when you don't have the culturally appropriate places, are people from your communities less likely to seek treatment and agree to treatment?

Beverly Fullerton-Trotchie: I'm going to speak to that quickly.

When you go into an institutional setting with staff who don't know you, don't know your culture, can't connect with you and don't relate to you, and they approach you at a very authoritative level, you're put on a pedestal: If you're not healing according to these milestones when you're following this program, you're failing. When you're in a program like that, you're constantly feeling like if you mess up, you're not worthy of that healing.

Our people need a purpose. Their purpose right now is to find their next fix and find their next high. That's what their purpose is. You put somebody in there, and you're like, “Heal. You're changing,” but if they don't have something to work towards, it's an idle minds, idle hands kind of thing. Again, if you're an indigenous person and you're put into a community that has no connection to you, how are you supposed to connect and then want to try to recover?

Doug Eyolfson: Absolutely.

Are you finding any improvements, even if you don't have these appropriate centres in your communities, at the very least in the larger centres? Are you seeing more culturally appropriate spaces being set up for treatments when the treatment is not available in the home community?

Beverly Fullerton-Trotchie: We go above and beyond for our folks. We are meeting them where they are. We have locals who will have events and bring them in. We have a medical transport program. We have a mobile outreach program. We have mental wellness grants. We have local youth wellness grants. We are using every federal dollar that we can, and it's going right back to our citizens. We have community grants that go out all the time to try to support people for mental wellness and addictions, and we're hoping to keep expanding that.

For the people we do connect with, we see a change. I don't want anybody to be confused that because I say there are rising numbers, we haven't changed or helped anybody. We have helped a lot of our citizens. We are proof that everyone is worthy, and we're seeing changes happening. We just want that to be sustainable.

Doug Eyolfson: Thank you.

To use a rather tired cliché, it does take a village. Is that what you're saying?

Beverly Fullerton-Trotchie: Absolutely.

Doug Eyolfson: In regard to homelessness, this is going to be a self-answering question. On finding stable housing, would you say it's even more of a challenge in your isolated communities to find stable housing for people in this situation?

Brennan Merasty: You can't keep building houses if people aren't ready to live in them or take care of themselves. We need safe spaces to heal, first and foremost.

Doug Eyolfson: All right. That's my time. Thank you very much.

The Chair: I appreciate that.

We'll go to Madame Gaudreau for two minutes.

Please go ahead.

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Mr. Chair.

Dr. Matthew, as you probably know, a brand new budget is coming on November 5. It won't be printed tomorrow. It will be printed the day before, so we have some time to talk. Given what you know about public health and safety, what would you like to see in the upcoming budget?

[*English*]

Dr. Nickie Mathew: In terms of public health and safety, I'll mention some of the things that I highlighted in my introductory talk. One of the big things that have been coming out is random stranger attacks, and they've been occurring because of people with untreated mental illness having access to very potent substances. We need more places for folks to be treated concurrently for their psychiatric illnesses and their substance use disorders.

We also need to have a whole throughput of treatment, in that we need primary prevention of substance use disorders in kids so that we can reduce the amount of addiction in the population to begin with, and then we also need supportive housing for these folks when they leave.

When you look at schizophrenia, about a third of the people with schizophrenia aren't going to respond to medications, and they're going to need long-term supports even after they're discharged and stabilized in these acute settings. By doing all of these together, we can reduce a lot of the violence that's occurring out there.

● (1830)

[*Translation*]

Marie-Hélène Gaudreau: Thank you.

Sorry, it's the end of the day. I'm listening to the interpretation, and my colleagues are talking. This is a hugely important topic.

I did hear what you said, but I'd like to give the others a chance to comment. We are talking about service delivery, so we have to remember that the service delivery experts are the provinces and territories.

Ms. Fullerton-Trotchie and Mr. Merasty, what needs to be in the federal budget? What are you looking for?

[*English*]

Beverly Fullerton-Trotchie: We need Métis-specific funding that is not lumped into indigenous streams.

[*Translation*]

Marie-Hélène Gaudreau: Great. Thank you.

[*English*]

The Chair: Thank you very much, Madame Gaudreau.

With that, on behalf of the committee members, I would like to thank the witnesses for the valuable and professional way they have shared their lived experience with us.

Thank you.

I see the consensus in the room to adjourn the meeting. The meeting is adjourned.

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