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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Welcome to meeting 134 of the Standing Committee on Health. We're going to hear witnesses today on the impacts of methamphetamine abuse in Canada.

I want to welcome our guests. We have, by video conference, Karen Turner from Alberta Addicts Who Educate and Advocate Responsibly. From the Canadian Drug Policy Coalition, by video conference from British Columbia, we have Donald MacPherson. From the Canadian Public Health Association, we have Ian Culbert. Thank you very much for coming. Also, from the Ontario Provincial Police, we have Rick Barnum, Deputy Commissioner, and Lee Fulford, Detective Staff Sergeant. Welcome.

We're going to begin with an opening statement by Karen Turner.

Are you ready to make a statement?

Ms. Karen Turner (Board Member, Alberta Addicts Who Educate and Advocate Responsibly): Yes.

The Chair: You have 10 minutes.

Ms. Karen Turner: I've been an outreach worker in Edmonton for over 12 years.

Regarding meth use in the context of prohibition, meth use is common among members of the community I work with and very common in Edmonton. Although I acknowledge that meth use is the concern of this committee, I think we should understand that meth is not chemically different from drugs that are prescribed to treat ADHD in Canada every day. Drugs like Dexedrine and Adderall are prescribed without the side effects or stigma that meth has. This is because they come in a regulated pharmaceutical dose.

Some people use meth for the same reasons. It helps them focus. Meth comes in unregulated doses, which means that the person using it has no way of knowing what is in their drug. Sometimes the doses bought on the streets are much larger than what the person would get from a prescription, and a larger dose can come with more side effects.

Meth use affects every person differently. For some, it's helpful, and they use it without any problems. Research by Dr. Carl Hart in the United States suggests that only 4% of people who try meth end up addicted to it.

There is a fear that meth can cause psychosis in some people. Meth psychosis is often a result of homelessness and poverty. During the winter in Edmonton, when the temperatures are 30 below, people who are experiencing homelessness use meth just to survive. This means using it to stay awake all night to avoid freezing to death. When people are trying to survive a long, cold winter and have no place to go, they have to stay up, often for days and nights on end, to prevent freezing to death. When people have underlying mental health issues, are homeless and have not slept for days on end, their chances of developing psychosis increase a great deal. I believe that meth use is not the largest issue but that homelessness and poverty are. It's not the drug; it's the policy.

People risk jail or prison to obtain the drug, and when they use it, because of fentanyl contamination in the drug supply, they risk overdose death. Fentanyl is not just in our opiate drug supply; it is now being found in stimulants. The fact of the matter is that Canada's drug supply is contaminated. Unless we replace the contaminated supply with a safe supply, we will continue to lose thousands of people every year. We need a safe supply for stimulant replacement programs to protect people from criminalization and the worst side effects of meth use. While people who use opiates can get access to oral substitution therapy, people who use meth have very few alternatives.

Our government needs to set up programs that provide people who are using meth or cocaine with safe, prescription forms of the same drug. There is a prescription version of meth called Desoxyn that is on Health Canada's special access program. It can be imported into Canada and used to set up a stimulant maintenance program. This is something Canada has to invest in. The same goes for cocaine, which is also used in some cases as local anaesthesia.

To combat the overdose epidemic, we need programs that provide safe versions of what people are using on the streets. This is a must if we are to save people who use drugs.

Thank you.

The Chair: Thanks very much.

Now we'll go to the Canadian Drug Policy Coalition and Donald MacPherson.

Mr. Donald MacPherson (Executive Director, Canadian Drug Policy Coalition): I'll begin by thanking the committee for the invitation to appear today to discuss this important issue with you.

I have been working in the field of drug policy for over 25 years at the community level and then as the drug policy coordinator for the City of Vancouver as we created and implemented Vancouver's four pillars drug strategy.

Since 2011, I have been the executive director of the Canadian Drug Policy Coalition, a partner project with the Faculty of Health Sciences at Simon Fraser University. Our vision is that of a safe, healthy and just Canada in which drug policy and legislation, as well as related institutional practice, are based on evidence, human rights, social inclusion and public health.

We agree with many of the witnesses you have heard already, including the father who, in quoting Dr. Gabor Maté, laments that there is no war on drugs, that there is only a war on people who use them, which means that we are often warring against the most abused and vulnerable segments of society. We agree that this is counterproductive and harmful.

We agree with the police chief who was exasperated by the lack of health and social services and supports for people who use methamphetamine, and with the several witnesses who testified that responses to substance use related harms across Canada, even in the midst of an overdose death crisis and a growing concern about methamphetamine in various parts of the country, have been inadequate in most regions.

We agree that reducing or eliminating stigma is critical to helping support people as they make decisions about their lives.

There is a tremendous agreement across sectors that stigmatizing people with addictions is not constructive. There is also a significant consensus in Canadian society that addiction issues should be dealt with through a comprehensive health and social approach that considers the social determinants of health, as well as supporting people to manage their substance use through a variety of pathways.

Substance use is one of the most complex issues of our time and will continue to be a part of our public discourse in the future. People have been using substances since the dawn of time, and it will continue, sometimes in beneficial ways and sometimes in ways that cause harm to people who use them.

I've wondered for many years why it has been so difficult to change the way we approach these issues. As some of the committee members have remarked over the weeks, how come we haven't yet even addressed the social determinants of health, as we know we must do to make progress in this area?

I have had similar thoughts over the years. Why is it so hard to change the approach we take? Why is it so hard to shift from what historically has been an overreliance on law and punishment to one that embraces contemporary scientific knowledge of public health interventions and an understanding of how and why people use substances?

We note that the foundations of our current approach were laid in the early 1900s and have resisted fundamental change until quite recently, in response to irrefutable evidence that our historic drug policies have utterly failed to achieve their goals of reducing substance use, stopping the flow of drugs and protecting Canadians.

We saw this with the failure of cannabis prohibition over the past 40 years and are seeing this more starkly with the absolute poisoning of the illegal drug supply in North America through the onset of synthetic fentanyl and its many analogues. This is why we are hearing desperate calls from people who use drugs, those working on the front lines and an increasing number of medical health officers for a safer supply of drugs to be made accessible to people.

The history of Canada's drug policy is that it was in large part created in the early 1900s, imbued with colonial values and fuelled by racism and hysteria about opium use on the west coast and the fear of Asian workers who had worked on building the railway, taking jobs away from British Columbians.

By the late 1920s, Canada's drug policies were some of the most draconian policies in the world. Then, as now, if you were white and had power and resources, you had little fear of being impacted by those drug policies. If you were indigenous, Chinese, Hispanic, black or a poor white person who used drugs, you were very likely to be subjected to very harsh penalties. Penalties for possession were up to seven years in prison and a $1,000 fine, and whipping was at the discretion of the judge. Talk about stigma.

Our current policies sit on this foundation and to this day prescribe criminalization and punishment as a response to possession of an illegal substance, along with these consequences: stigmatization, rejection, shunning and the fear and loathing that society often heaps upon people who use criminalized substances. This is why decriminalization is an important concept to consider as we modernize our drug policies.

We also tend to conflate the worst cases of methamphetamine use with all use, when in fact most people who use methamphetamine are not necessarily problematic users. Imagine if we conflated all alcohol use with the worst, severe problematic use. Our view of having a drink would look very different in our minds.

● (1535)

In the Downtown Eastside where I began working in 1987, the most common homicide in Vancouver at the time involved a fight within blocks of a bar, and alcohol and a knife. There was little hysteria about alcohol-fuelled violence, but there was a local campaign to ban knives from the neighbourhood. With methamphetamine there is a tendency to focus on the drug as the problem rather than the circumstances around it: trauma, poverty, abuse, homelessness, disconnection from family and community and the many other social determinants that contribute to the health of our communities.

In closing, we have a few recommendations for the committee to consider.

We must stop pretending that problematic substance use will disappear if we magically come up with the right set of interventions. We need to accept the fact that substance use will continue to take place in our society along a spectrum of use from beneficial uses to non-problematic uses, problematic uses and, of course, addiction.

We know that most people who use drugs will not become severely addicted to them. That is clear from the evidence. And we know that most people who manage their use, or cease using drugs, do so without the help of professionals or treatment providers. There are multiple trajectories into and out of addiction and multiple non-problematic users of substances.

We must also stop pretending that prohibition of drugs will improve the health and safety of Canadians, In fact, our drug policies are killing Canadians and enriching transnational criminal organizations.

We would acknowledge that at this time in Canada, the illegal drug market is more deadly than it has ever been, and we would prepare for even worse conditions moving forward, meaning that we should scale up harm reduction efforts, not cap them or ignore them as some provinces are doing. Illegal drug markets are dynamic and changing all the time, and we need to be prepared.

We would acknowledge the importance of working with people who use methamphetamine and other drugs to begin to design programs that meet people where they are and support them.

A number of things could be implemented in relatively short order that would go a long way to ending this war on our citizens, some of our most vulnerable, and changing the environment for people who use drugs in their communities.

One, embrace innovation and experimentation. Try new approaches. Review institutional policies and practices that are barriers to engaging people.

Two, support the immediate decriminalization of possession of currently illegal substances for personal use. There is no upside to criminalizing users, given the state of the illegal drug market and the other harms that stem from criminalization, including stigma. We need to maximize connection with people, not push people into the shadows.

Three, it would be good to see more emphasis on harm reduction within the Addictions Foundation of Manitoba recommendations and other provincial strategies, given the toxicity of our drug markets, as well as highlighting the connection between harm reduction, health services and treatment resources. They are not separate. They are a continuum.

The creation of low threshold, welcoming, safe places for people who use methamphetamine where peer workers can help people access supportive services, including help finding secure housing, food, social assistance, help with resumés and job applications, indigenous cultural supports where appropriate, and help build connections to their community, would be an important part of that kind of a plan.

Four, the establishment of supervised consumption services is a powerful message to people who use drugs that we care about them and want to engage people in health services, not back alleys. No one has died of an overdose death in a supervised setting in Canada, by the way.

Five, pharmaceutical-grade methamphetamine would be provided to people addicted to meth as a temporary maintenance regime to give an alternative to the criminalized market and the need to raise the funds to buy meth from unregulated dealers on the street. Methamphetamine under the brand name of Desoxyn is prescribed as a weight loss treatment and for ADHD. Adderall is very similar to methamphetamine and used widely in society, as you heard earlier from David Juurlink.

My final point is that as part of our outreach to people who use drugs, we could also begin to ask people why they are using methamphetamine. This would include non-problematic users as well as those who are clearly addicted. Everyone starts doing something for a reason, and we need to better understand the benefits and the harms that people who use methamphetamine perceive. It would be beneficial to all of us to understand the range of reasons and experiences of people who use methamphetamine.

Thank you.

● (1540)

The Chair: Thank you.

Now we go to the Canadian Public Health Association, and Mr. Ian Culbert.

Mr. Ian Culbert (Executive Director, Canadian Public Health Association): Good afternoon. Thank you again for the invitation to present to you today.

While the overall prevalence of methamphetamine use is low, at approximately 0.2% of the Canadian population, the impact of its use on individuals, families, friends and communities is extremely high. As Donald just mentioned, the reasons a person might use methamphetamines vary as widely as the individuals themselves. Inevitably, the outcomes are common: illness, psychosis, injury, disease and often death. In the testimony of previous witnesses today and on previous days during this study, you've heard about the need for improved harm reduction and more treatment facilities and enforcement to address this problem. These are all important steps to mitigate the current situation.

From a public health perspective, however, there is a paramount requirement to look at why people use psychoactive substances, such as methamphetamines, and to identify upstream approaches to reducing this consumption. Psychoactive substances can be used as a coping mechanism by those who have experienced trauma, violence, social marginalization or the loss of cultural identity. We also know that the social determinants of health often underlie problematic substance use. Homelessness, poverty, social isolation, racism and stigma can all be precursors of problematic substance use.

It is known that those at the lower end of the social gradient have poorer health outcomes. They tend to have higher rates of consumption of intoxicating substances, are more likely to be incarcerated and are disproportionately composed of people of colour and indigenous people. Steps must be taken to address these issues, by addressing the social determinants of health, and the harms we have caused to the indigenous peoples of Canada. I encourage this committee to make recommendations for bold action.

For example, the Government of Canada should develop an action plan to fulfill all the calls to action from the Truth and Reconciliation Commission in the next four years; increase investments in social housing, using a housing first model; fully explore the potential of a basic guaranteed income; support families in raising their children by adequately funding early childhood education and care in every jurisdiction of our country; and, as recommended by the Canadian Association of Social Workers, promulgate an act of Parliament that includes principles similar to those found in the Canada Health Act, to help guide Canada's social transfer and other social investments, and make possible shared performance indicators across our country.

These are just five upstream recommendations that will help slow the number of daughters and sons whose lives are torn apart by methamphetamine use.

It is also important to recognize that problematic substance use is a health condition that can be managed and successfully treated for those who are ready. Unfortunately, methamphetamine use, as has been mentioned, is a very difficult condition to treat. Psychosocial counselling and behavioural-management approaches can be effective, but there are simply not enough drug treatment services in Canada to meet the demand. Further exacerbating the situation is the lack of national standards for private drug-treatment services, leaving patients and their families vulnerable to questionable treatment regimens that cost thousands of dollars.

Unlike opioid-use disorder, where medication-assisted treatment is available, there are currently no accepted drug-based therapies to treat problematic methamphetamine use. Given the millions of dollars spent in the United States on this type of research, I find it unlikely that such a silver bullet will be discovered.

Despite these confounding circumstances, there are actions the Government of Canada can take to relieve some of the suffering associated with methamphetamine use, in the short term. These recommendations are from the Canadian Public Health Association's 2017 position statement on the decriminalization of personal use of psychoactive substances, which I believe was circulated in your background packages.

When CPHA speaks of decriminalization, we are speaking of the simple possession and use of drugs. I'm not talking about the property crime or physical violence that often accompanies drug use. I'm not talking about the large-scale trafficking and manufacture of drugs. Problematic drug use is a health issue that has, for the past 40 years, been recast as a public safety issue. There absolutely are public safety components to this, but for the individual, it is a health issue. If you want to make the necessary changes to reduce the impact of illegal drug use in this country, then you need to treat it as a health issue and act accordingly.

● (1545)

One step in accepting methamphetamine use as a health issue is to decriminalize possession for personal use and to provide the necessary health promotion, harm reduction and treatment services necessary to address the needs of substance users.

To that end, the Canadian Public Health Association calls on the federal government to work with the provinces, territories, municipalities, and indigenous governments to decriminalize the possession of small quantities of currently illegal psychoactive substances for personal use and provide summary conviction sentencing alternatives, including the use of absolute and conditional discharges.

Decriminalize the sale and trafficking of small quantities of illegal psychoactive substances by young offenders using legal provisions similar to those mentioned earlier.

Develop probationary procedures and provide a range of enforcement alternatives, including a broader range of treatment options, for those in contravention of the revised drug law.

Develop and improve access to harm reduction and health promotion infrastructure, so that all those who wish to seek these services can have ready access, and increase the availability of high-quality treatment services to meet the demand.

Finally, provide amnesty for those previously convicted of possession of small quantities of illegal psychoactive substances.

Thank you.

The Chair: Thank you.

So far, everybody has been within time. That's perfect.

Now we go to Deputy Commissioner Barnum, from the Ontario Provincial Police.

Deputy Commissioner Rick Barnum (Deputy Commissioner, Investigations and Organized Crime, Ontario Provincial Police): Thank you, Mr. Chair, and good afternoon, everyone. Thank you for your invitation to be here today.

I'm joined today by Staff Sergeant Lee Fulford, who is an expert in methamphetamine production, packaging, trafficking and things of that nature. I'll share the task of making comment this afternoon with him.

The OPP is involved in the International Association of Chiefs of Police, the Canadian Association of Chiefs of Police, the Ontario Association of Chiefs of Police, and an organization called the Canadian Integrated Response to Organized Crime. These groups are dedicated to reducing the harmful impacts of organized crime and drugs. CIROC is currently exploring the impacts of meth on public safety and our communities, and how it is investigated. The OPP is also embedded on a CACP special purpose committee researching the impacts of decriminalization on public safety.

Strategically, the OPP has taken the position of focusing on organized crime groups rather than specific commodities. Organized crime groups have a propensity to deal with a variety of commodities. These commodities range from trafficking in humans and firearms to trafficking and production of a variety of drug types, such as methamphetamine. Investigative projects can be international, national, or community-based. We have ongoing projects investigating organized crime groups, including Outlaw motorcycle gangs and traditional organized crime groups as well. For example, we're currently working with our international partners to disrupt methamphetamine coming from organized crime groups in Mexico, which is being imported into Canada as we speak.

A recent example of a locally based project, closed earlier this month, focused on the relatively small community of Hawkesbury, where we seized 4,000 meth tablets, over half a kilogram of cocaine, 16 fentanyl patches, along with various weapons and approximately $250,000 in cash. This project resulted in 20 individuals being charged. This is one example of many similar-style projects taking place across Ontario at this moment. Think about the impact and the message this sends by removing these dangerous elements from within these communities. We have other successfully completed projects that targeted the distribution of methamphetamine into our first nations communities.

Regardless of the investigations, meth is the one consistent commodity found. It has permeated into every one of our communities. Seizures of meth have only been on the incline since 2010. In 2010 there were only 15 occurrences in which meth was seized within the province of Ontario, followed by 453 occurrences in 2015, rising to 890 in 2018.

All drug investigations require Health Canada drug analysis to identify and confirm the types of drugs being trafficked. Mid and high-level undercover purchases require rush analysis in order for the undercover officer to provide feedback to the trafficker. For example, in Project Anarchy a significant amount of drugs was purchased and the delay in determining the purity or concentration of the drugs threatened to compromise our investigation. By that I mean that if we are attempting to buy pure cocaine and we actually purchased cocaine that's cut with some sort of filler, our credibility with the trafficker is compromised, as we're seen as not knowing what we're doing in purchasing or selling a product. Traffickers test their products themselves, whereas we rely on drug analysis.

In addition to the need for expedited analysis of drugs seized operationally, there is also an urgent need to obtain analysis results for drugs seized at the scene of overdoses. This ability can quickly identify deadly substances in our communities so we can alert the public and our partners, such as health care, hospitals, and things of that nature.

We recommend strongly that Health Canada increase their capacity to conduct timely drug analysis, given their unique role, and provide more comprehensive, overarching drug trend reports. It is difficult for police to unequivocally know what is on the streets of our communities and rapidly respond to public safety issues when analytical results are not provided for 45 to 60 days.

The uptake in meth use can be partially attributed to a decrease in price. In 2016, a kilogram of meth was worth approximately $34,000, and in 2018 it was $25,000. We are already seeing a further decrease in 2019 to levels as low as $15,000 for 1,000 grams of methamphetamine. Depending on your location in Ontario, the cost for a meth tablet can range from $1.50 to $10. Geographic location within Ontario determines the form of meth from powder to pills.

● (1550)

In our communities, the OPP are in frequent contact with substance users on a 24-7, 365-day basis. From our preliminary observations of overdose calls for service, it is not unusual for individuals to be using multiple drugs, including meth, cocaine and fentanyl. From the review of our data, there were 59 suspected drug overdose fatalities during the last third of 2018 alone in OPP jurisdictions. Nine occurrences, or 15%, were suspected to have been linked to methamphetamine.

Our work is not only focused on investigations. At a more local level, the OPP has adopted a model of collaboration—the community mobilization and engagement model—which brings a variety of community services together to support the needs of vulnerable persons, including those addicted to substances. We're also focused on highlighting the Good Samaritan Drug Overdose Act and embedding its spirit into our culture. We need to break the stigma associated with substance use disorder and mental health. We know addictions and mental health know no bounds and are non-discriminatory.

Law enforcement is often criticized for criminalizing individuals suffering from substance use disorder, which further stigmatizes them and marginalizes vulnerable populations. The OPP strongly advocates for increased efforts centred on prevention and education, and increased access to treatment. Our communities are unique. Enforcement, prevention, treatment and harm reduction resources vary from community to community. Increased access to social and health services must be available for all Ontarians regardless of their location. The OPP would welcome additional pre-charge diversion opportunities and partnerships to defer those dealing with substance abuse issues to health care professionals.

Let's tackle the topic of decriminalization from a public safety perspective. It's important for policing organizations, including the OPP, to be engaged in discussions on legislative amendments to address illicit drugs and their use. Legislation must not remove the police's ability to investigate street-level crime, which provides the required intelligence to target those who traffic, produce and import harmful substances.

In addition, any legislated reforms being considered will need to prevent criminal organizations from being able to manipulate the law to continue to further victimize substance users. Like many complex societal issues, no single group or organization has the expertise to provide the solution alone. We must work collaboratively to address the availability of these deadly drugs through enforcement while our health partners focus on providing harm reduction and treatment for individuals suffering from addiction.

I'll now turn our remarks over to Detective Staff Sergeant Fulford.

● (1555)

Staff Sergeant Lee Fulford (Detective Staff Sergeant, Organized Crime Enforcement Bureau, Ontario Provincial Police): Thank you.

Our projects have revealed that the primary source of meth is both Mexico as well as domestic production. The OPP has invested significant resources to effectively investigate and dismantle production in Ontario. The OPP has an internationally recognized clandestine laboratory investigative response team. This team quickly responds to dismantle clandestine labs anywhere in the province of Ontario. In addition, they also provide training to emergency services personnel on how to react and respond to toxic and other dangerous hazards usually found at clandestine laboratory sites.

There is a risk of toxic exposure, environmental damage and chemical explosions to the public and first responders, including police, fire and other emergency services personnel who must respond to these scenes. The one-pot method of meth production occurs throughout Ontario. The entire reaction is done in one container with recipes available on the Internet, and takes one to two hours to produce. All the precursors, chemicals and reagents are available commercially through pharmacies as well as hardware stores. This method is efficient at producing methamphetamines.

Since December 2012, a number of incidents involving this process have been discovered inadvertently by police or through other investigative means. This method poses a significant increased risk to the public and law enforcement due to the extreme fire hazard associated with the process. Significant and coordinated police and emergency services personnel are required to carry out the complex, meticulous and hazardous job of investigating and safely dismantling clandestine labs.

On average, a small synthetic clandestine lab that produces less than one ounce per cook cycle can require one full day to dismantle, and in excess of 20 emergency services personnel, whereas an economic-based lab that has the potential of cooking multiple kilograms per cook cycle requires an average of three full days to dismantle. Due to the size of the toxic sites, emergency services personnel required for the duration of the cleanup can be in excess of 45 emergency services personnel members, including police, fire and ambulance.

Greater intelligence related to incoming shipments and purchases of precursors and lab equipment is required. We applaud the work of the RCMP's chemical diversion program to identify precursors, but we call for increased notifications from them. Enhanced collaboration, particularly in Ontario, where the RCMP does not have provincial jurisdiction, will aid in disrupting the production and distribution of these deadly substances.

The production of one kilogram of methamphetamine produces six kilograms of toxic waste. This waste is usually disposed of through careless dumping, resulting in environmental contamination and health hazards to the public. There have been several incidents of chemical waste and precursor chemicals being found abandoned along roadside ditches. Some of these locations are littered with empty containers of acetone, iodine, isopropyl alcohol, caustic soda and ephedrine. For example, over the winter of 2018, the Caledon OPP detachment received eight dump-site calls for service in their jurisdiction. They appeared to contain the waste of economic-based labs of methamphetamines.

In closing, the OPP is well positioned to proactively investigate organized crime and to respond to clandestine labs. To further enhance our impact and promote public safety, a formal collaboration between public safety partners domestically is required to ensure that critical information-sharing relating to precursors and lab equipment occurs in a timely fashion.

Thank you.

● (1600)

The Chair: Thank you all very much.

I'm surprised to hear the call for decriminalization from almost everybody. I think it was all of the witnesses.

Anyway, we'll start our questioning now with a seven-minute round with Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you all for coming.

This has been very interesting testimony from all of you. I wish I had more than seven minutes. I could probably spend all day asking the questions that were generated by this testimony.

Mr. MacPherson, I'll start with you. You mentioned underlying mental health issues. I'm an emergency physician and I understand how many people with underlying mental health issues do turn to illicit drugs. Would you find it helpful if, as a society, at a national level, we were increasing funding and resources dedicated to primary care mental health for better mental health outcomes? Would this contribute in the long term to helping this and other illicit drug problems?

Mr. Donald MacPherson: In the long term, yes. I think we underfund addiction and mental health services to a great extent across the country.

Mr. Doug Eyolfson: Thank you.

I'll ask both Mr. MacPherson and Mr. Culbert about this.

You've talked about harm reduction. This is something I have advocated since very early on in my mandate, again from my experience at the street level in the emergency department of an inner city.

Now, we know that in Canada and the United States as well—even more so in the States—there's a lot of resistance to harm reduction at the societal level. In some jurisdictions, it's at the political level. In my own province of Manitoba, the provincial government is still dead set against harm reduction. They don't believe in supervised consumption sites.

I'll ask you first, Mr. MacPherson, then Mr. Culbert. Can you suggest to us an approach to clear up these misunderstandings in the public and in the political sphere on this?

Mr. Donald MacPherson: It's not easy to have these discussions with some sectors of society. What we learned in Vancouver in implementing the four pillars drug strategy, which had a very big focus on harm reduction, was that if you get people together in a room and really talk about the common goals, you'll find that more often than not, they all agree that they want to save lives and to reduce infections and infectious disease transmission.

It takes a lot of dialogue. It's very difficult to have these discussions in partisan political forums because, unfortunately, drug policy is a subject used for political gain. That's very sad, especially at a moment in our history right now when so many people are dying. There's so much evidence that harm reduction helps people and actually saves lives.

While we're building these long-term systems of treatment that you were referring to in your last question, we really need to acknowledge that tonight, on the streets of our country, people are in desperate need of support and life-saving services. It's not an either-or. Trying to articulate that continuum, I think, is one of the things we have to really get better at doing, and not play one part of the continuum off against the other. We need them all. We need services now, this evening. We need, of course, to build that system of treatment of mental health and addiction that you're referring to.

● (1605)

Mr. Doug Eyolfson: Thank you.

Mr. Culbert, do you have anything to add to that?

Mr. Ian Culbert: I would say that at our current place in time, there are some people who are ideologically opposed to thinking differently about the situation in which we find ourselves. They think that people who use drugs inappropriately have no one to blame except themselves and that if they want to get out of it, they should pick themselves up by their bootstraps.

I equate it in certain way to those who are opposed to vaccinating their children. Nothing you can say to some people will convince them of the science that's clear, so we stop wasting our breath in certain directions and look for other non-traditional allies who can support you, such as public safety players who are on the ground, see the impact of drug use and, while historically may have been of the same mindset, have come to realize that there has to be a better approach.

Look for those new allies who can strengthen our argument and work with us moving forward.

Mr. Doug Eyolfson: Thank you.

How much time do I have, Mr. Chair?

The Chair: You have one minute and 59 seconds.

Mr. Doug Eyolfson: Great. Thank you.

Mr. Barnum and Mr. Fulford, we talked about decriminalization of these substances. I think there's been a misunderstanding. Certainly when anyone advocates for decriminalization, as was described in our testimony today, not of large-scale trafficking, not of the crime associated with it, but just for simple possession, there are those who counter that these advocates want to legalize all drugs. I'm hoping we can get over that.

It sounds like both of you understand that, and I think every one of our witnesses understands that. We're not talking about legalizing all drugs when we talk about decriminalization.

Mr. Barnum, in your testimony, you said that what you need is an ability to deal with the organized crime surrounding the drug trade. Again, in my previous practice, I took out more bullets due to the drug trade than I care to count.

Do you believe that if we were to decriminalize simple drug possession in small amounts for personal use, it would interfere with the ability of the police to deal with these large-scale criminal activities with drugs?

Mr. Fulford, you could make a comment on that as well.

D/Commr Rick Barnum: From my position, I'm not sure. I think it's tricky. When we talk about decriminalization, it's important to look after the users who are on the street and have no other alternatives. We absolutely agree with that and would support that ahead of any investigation into somebody who's trafficking these drugs.

It's also important to recognize that we fully support the wraparound essential services that need to exist before decriminalization happens. Our position would be absolutely to look after those who are in dire need and are addicted, but don't take away our tools to do investigations and find out who's dealing at street level, which can lead to who's dealing above street level and up and up. We can't start at the top in these investigations. It would be nice, but we can't start at the top.

That's essentially our point on that.

Mr. Doug Eyolfson: Do you have anything to add, Mr. Fulford?

S/Sgt Lee Fulford: No, thanks.

The Chair: That's good, because your time's up.

Mr. Webber.

Mr. Doug Eyolfson: Thank you very much.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair.

I'll direct my question to Mr. Barnum and his last comment about not taking away his tools for investigation.

The decriminalization of products such as methamphetamine would require a lot of your tools to be taken away. For example, you wouldn't be able to take away someone's small amount of methamphetamine, because it would likely be legal if it were governed by the same type of legislation as for marijuana. If it is decriminalized, your tools would be taken away. Would you not think that would be the case?

● (1610)

D/Commr Rick Barnum: When we talk about the wraparound services, I think it's important to make sure that it's done thoroughly and with full understanding. If we can't seize a small amount of methamphetamine—a half a gram or less that somebody has in a syringe or whatever—that's probably not going to make or break a case for us. We still need access to understand if a bunch of people are overdosing in a community on a specific street. We need the analysis much quicker. That's a huge tool for us, so we can inform the community and to be able to find out what's in common there. If everybody gets a chance to walk away from this and whatever happened on the street, we can't find out how it got there in the first place. That's what I mean when I say give us that co-operation tool.

Mr. Len Webber: Right. Okay.

The behaviour of these meth addicts is certainly a lot different from that of fentanyl addicts. They are erratic and often have unpredictable behaviour, of course. How would you deal with them as a police force? If you have a meth addict on the streets. You don't know how that individual is going to react to your presence, for example. They are also a danger to society.

How would you deal with them differently than, let's say, a fentanyl user?

D/Commr Rick Barnum: I think it's important to recognize that we have to deal with each case individually based on how the person is presenting themselves. There is no strategic or specific way to deal with every individual case. They have to be taken on their own merits.

It's also important to recognize that the challenge we have with methamphetamine users, more than anything, is what to do with them. Often we'll take these individuals to the emergency room and they'll be turned away because some may be acting violently or lashing out and there's no way for the hospital to deal with them. They're still in our custody, so we have to take them back to the detachment and lodge them in cells, which is not where we want these individuals. Often they harm themselves or try to harm others and the situation gets worse.

What to do with somebody on meth who reacts violently, or unpredictably or lashes out is the challenge we have. That's a real dilemma for us in policing. Obviously we can't leave them on the street where they're going to harm themselves or others, so we pick them up and then we have to try to get them help.

That's the type of thing I'm talking about when I talk about wraparound services before legalization or decriminalization. We can't put it all on the hospitals. We can't leave it all to the police. We need that full wraparound service, so we would be able to take somebody who's really struggling and violently lashing out to proper help. We can deal with the legal part afterwards.

Mr. Len Webber: Thank you.

Mr. Fulford, you mentioned in your opening statement that there needs to be greater intelligence and collaboration between you and the RCMP. How is it right now? Is it poor? Obviously you think there should be more enhanced collaboration. Is anything going on now?

S/Sgt Lee Fulford: There's a lot of collaboration occurring. There's always room for improvement. With the amount of precursors coming into Canada, and the amount of domestic production we're seeing, there's always room for improvement for us to work with our municipal and federal partners to do a better job at proactively investigating and dismantling these clandestine labs.

Mr. Len Webber: Ms. Turner, you mentioned that one of the reasons people use meth is to stay awake— otherwise they'd freeze to death. As a fellow Albertan, before my political days, I served on the Alberta Alcohol and Drug Abuse Commission, and there was always a facility in Edmonton or Calgary for homeless people to go to on cold days when they had the potential of freezing to death.

Is that not the case now?

Ms. Karen Turner: A lot of the community those places serve tend to bar some of our community when they act out, when they're intoxicated or on some other substance. Sometimes they have nowhere to go. We have very limited resources for shelters in Edmonton, considering the amount of homelessness we have. Yes, there are people who have to sleep on the street, who have to walk around all night. The meth will help them stay a little bit warm and help them to walk around and stay awake so that they don't freeze to death.

● (1615)

Mr. Len Webber: Apparently, there are a couple of ways you can use meth. You can smoke it or you can inject it. Sarah Blyth appeared before the committee the last time, and she told us there should be safe smoking sites available for meth users, because it improves their healthy outcomes since injecting the drug is apparently worse for you. Is that the case, Ms. Turner?

Ms. Karen Turner: Sorry, what was that?

Mr. Len Webber: Injecting meth or smoking meth, which is better?

Ms. Karen Turner: I don't think you can...

Mr. Len Webber: Neither is good, of course.

Ms. Karen Turner: With the drug itself you're ingesting, it doesn't matter which way you're doing it.

Mr. Len Webber: Exactly. There are people out there who—

Ms. Karen Turner: A lot of the meth in Edmonton is contaminated with fentanyl. They're getting both. We are losing people who just use stimulants, or think they're just doing stimulants, when it's in fact contaminated with fentanyl.

Mr. Len Webber: We have a number of people advocating for community safe-smoking sites similar to the safe-injection sites we have throughout the country. I know in my community we have a safe-injection site where there are a lot of problems with break-ins and crime going on. Certainly these problems have increased significantly because of this injection site. Now we're thinking of bringing in safe-smoking sites for methamphetamine users, whose behaviour tends to be even more erratic and unpredictable. There is a big concern in the communities about this.

What are your thoughts on safe sites?

Ms. Karen Turner: It's all about wraparound services. I work in a place that has a safe consumption site and it's like a one-stop shop. It has housing. It has the wraparound services that our community needs. It's all about relationship-building. We don't have a problem in Edmonton at our safe-injection sites like maybe other cities do. I know there are some safe-injection sites in other places where the workers are being treated very poorly by the community. I mean community surroundings, not the people who use drugs.

The Chair: Thanks very much.

We're moving on to Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair.

Ms. Turner, I'm going to start with you.

As my colleague mentioned, Sarah Blyth, the executive director of the Overdose Prevention Society in Vancouver, emphasized the need for people who use stimulant drugs such as methamphetamine—in fact, all drugs—to have access to a safe supply of these drugs. This is because of the harms associated with the drugs when they're obtained on the black market, which is where I presume all of the drugs are being obtained now.

She explained that methamphetamine is often contaminated with other substances, including laundry detergent and pig dewormer, as well as fentanyl, which you mentioned. In your testimony, you said that a methamphetamine user has no way of knowing on the street what they're getting. They don't know the dose or that Canada's drug supply is contaminated.

What can you tell this committee about the contaminated supply and what you suggest as a way of dealing with this problem?

Ms. Karen Turner: I think the best way to deal with the contaminated street supply is to offer a safe drug supply, such as by Dexedrine and Adderall prescriptions. I've asked some of the community who use meth whether, if there were a "prescription meth", they would switch over to a similar prescription, and they said they would, absolutely. Some people need it to be able to focus and concentrate.

There are some good outcomes that could come from some people using it. There is also a lot of problematic use; I see that too. If we give a safe supply, we don't have to worry about all the garbage that's going into people and hurting their health outcomes.

● (1620)

Mr. Don Davies: Thank you.

Mr. MacPherson and Mr. Culbert, both of you have made mention of advocating a policy of decriminalizing simple possession of small amounts so that we're not treating people with substance abuse disorders as criminals but rather are treating them as patients.

Where would you suggest they get their supply from? If it's no longer illegal to have it and to use it in small amounts in personal possession, where would you foresee them obtaining the drugs they would be in possession of?

I'll start with you, Mr. MacPherson.

Mr. Donald MacPherson: That's a conundrum, when we talk about decriminalization. People generally have to get the supply from the illegal market, and right now in Canada, the illegal market is a contaminated market.

I'm not suggesting that we should not decriminalize. Decriminalization is really saying as a society that we're all going to work together as institutional partners—health and enforcement and police—and treat this as a health issue and that someone is not going to end up in the criminal justice system just for possessing small amounts of these substances for their own personal use. It's a huge signal to people.

It still leaves us with the problem of the source of the drugs. That's why, as Karen Turner has been suggesting, we have to look at that side of the equation too. There needs to be a safe supply of substances for people who we know are going to use them.

It's really an ethical choice for us: to allow people to continue to use the contaminated, illegal, deadly market, or to offer them substances that are very common substances in our medicine cabinets and our pharmacies today—some of the stimulants that Ms. Turner was talking about.

There are, then, two different issues, and I think there are ethical questions around both.

Mr. Don Davies: Thank you.

Mr. Culbert.

Mr. Ian Culbert: I'll just add that when we talk about harm reduction, it's not just about supervised consumption facilities. It can also include drug testing facilities, in which technology has not advanced as far or as rapidly as we would like it to have.

The federal government has just announced a contest to develop a compact, portable, effective testing device. That's an important step as well. If the product still comes from the illegal market, at least you could test it to make sure you know what you're using.

Another example is what Ottawa Inner City Health does, whereby the medical practitioners prescribe, in their case, opioids so that their clients have a safe supply of a product of known quantity and strength. Then they can work to reduce their dependence over time. It's not just a PEZ dispenser for meth or opioids. There's a program in place with wraparound services.

There are, then, a number of different options available.

Mr. Don Davies: Thank you.

I want to shift to treatment. Mr. MacPherson, you're quoted in a May 2018 article as saying, “Nowhere in Canada is there a good treatment system, so you have the opportunity to build one in the face of this catastrophe”—the opioid crisis—“But we also need to come to grips with the fact that drug prohibition itself is at the end of its road.... It’s failed. So we have to start looking at allowing people to have access to a safer drug supply.”

You've commented, then, on the safe drug supply. I want to move to the treatment.

What would you suggest, as a policy or program, to us as federal representatives? What would you like the federal government to do to address the poor treatment system that we have in our country?

● (1625)

Mr. Donald MacPherson: It's very much a federal-provincial issue. The federal government could take leadership with standards and supporting innovative guidelines similar to what the Province of B.C. has developed. We need to lengthen the continuum of options that people have, including low-threshold treatment options. Most treatment programs tend to be higher threshold programs, and by definition, they serve fewer people.

Another aspect of this is that at the same time as building a good treatment system, we can't fool ourselves into thinking the system will solve the problem. In reality, most people don't use treatment. There will never be enough beds or access points for treatment. We need to build a system of treatment, but it's one tool in an array of tools that we need to have.

The Chair: Thanks very much.

Time is up. I'm going to vacate the chair and ask Vice-Chair Marilyn Gladu to take over. I have a private member's bill, so I'm going to finish off tonight.

Thank you very much, everybody.

The Vice-Chair (Ms. Marilyn Gladu (Sarnia—Lambton, CPC)): Now we'll go to Ms. Sidhu, for seven minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you all for being here, and a special thank you for serving our community.

I'm from the region of Peel, part of which I represent. We heard before from the mayor of the City of Winnipeg. He also said that Manitoba meth originates in Mexico. There's a border. I also heard from you that we got meth from Mexico.

Can you describe what steps the federal government could take to combat the importation of meth into Canada? What steps do you suggest?

S/Sgt Lee Fulford: There's already enforcement and protection at the border, as is. As I said before, there's always room for improvement, but drugs will get into this country. It's our job to focus on our organized crime groups and not the commodities, and tackle the organized crime groups that are bringing the drugs in. There has been the importation of drugs throughout the history of this country. It has never stopped.

We can do a better job at collaborating with our partners to gather and share intel to increase the efforts to dismantle or disrupt organized crime.

Ms. Sonia Sidhu: There are obviously a lot of different ways to think about the cost here. There's the human toll, the cost in lives, and a dollar cost in terms of police response, emergency medical response and hospital use.

Can someone comment on the economic impact of the meth issue that arises in Canada?

Mr. Ian Culbert, can you comment on that?

Mr. Ian Culbert: Unfortunately, I can't. I don't have the data, partially because we don't track drug-specific economic data in that way. Perhaps Donald or someone else could comment.

Ms. Sonia Sidhu: Donald, from the Canadian Drug Policy Coalition, can you comment on the economic impact of the meth rise in Canada? There's a lot of economic impact.

Mr. Donald MacPherson: No, as Ian Culbert said earlier, meth use is very low. It's one of many substances that our courts, our border agencies and our police focus on, as well as our health side. We haven't been able to pull out the numbers in terms of the economic cost for methamphetamine by itself.

Ms. Sonia Sidhu: Okay.

I also heard that there have been several incidents of chemical waste, especially dumping sites. Are there any steps the OPP is taking to put cameras on the sites? What steps are you taking to prevent that?

● (1630)

S/Sgt Lee Fulford: We treat each site as an individual investigation. There are steps that our officers will take when they attend a scene. It's our job to gather evidence. Sometimes there's evidence of a dump site at a scene and sometimes there's not, but our officers will attend. They'll process a scene like any other scene to gather evidence, and that's how we further our investigations.

Ms. Sonia Sidhu: What are some best practices related to training the health service providers and the law enforcement officers? Is there any special training to combat this fight?

S/Sgt Lee Fulford: For police? Specialized training in relation to investigating and dismantling clandestine labs?

Ms. Sonia Sidhu: Yes.

S/Sgt Lee Fulford: The Ontario Police College has a two-week course. There are only two in Canada. The RCMP has one at the Canadian Police College. There's the course at the Ontario Police College. It's a two-week course that teaches officers how to investigate clandestine lab operations and synthetic drug productions, including meth, fentanyl, ecstasy or MDMA, and ketamine. That course also teaches officers to properly and safely dismantle wearing our protective equipment. The self-contained breathing apparatus has chemical suits for us to go into these dangerous environments to gather evidence to be able to hold people accountable for their actions.

Ms. Sonia Sidhu: Is there any special support for the family? I know there are two-week or three-week programs, and after that if somebody is using meth, what kind of programs are there? They have a long-term addiction program. How are we dealing with that?

Ian Culbert, perhaps you could comment on that.

Mr. Ian Culbert: Certainly there are more generic addiction programs across the country that support families of people living with addictions. I'm not aware of any that are specifically focused on the loved ones of people who use methamphetamines. There are certainly family support groups, either formal ones through treatment centres, or the classic ones that follow a 12-step program that supports family members in that situation as well. Again, there are a number of different options. It depends on what resources are available in your community.

Ms. Sonia Sidhu: Thank you.

The Vice-Chair (Ms. Marilyn Gladu): Now we'll go to Mr. Kmiec for five minutes, and he's sharing with Mr. Webber.

Mr. Tom Kmiec (Calgary Shepard, CPC): I have one or two questions.

This is not my regular committee.

There was a comment made that Mexico, and then Canada, were the sources of this drug trade.

Can you give us a mix of at least an Ontario experience? Do you find it's fifty-fifty, where half of it is coming from Mexico and half of it is locally made? What is the mix and are you able to tell the difference?

S/Sgt Lee Fulford: I can't tell you the statistical analysis because we don't find every shipment of precursors that produce methamphetamines in Ontario, and we don't intercept every one.

There are current investigations involving methamphetamines from Mexico as well as domestic production within Ontario by organized crime in Ontario.

Mr. Tom Kmiec: Okay.

Is the importation mostly of the precursors or is it the finished product, so to speak? Is it the pill or the injection?

I have a friend who works in northern Alberta. I think he called it a “pint”; in Alberta; that's what they call it. It is injected mostly.

Is it the precursor or the material to make the drug that people are importing illegally for that purpose, or is it the finished product?

S/Sgt Lee Fulford: Importation from Mexico would involve the finished product, whether powder or the crystalized methamphetamine. Within Ontario the precursors to make synthetic drugs are imported into Canada through source countries, mainly China and India. Once they enter the country they're diverted, and organized crime produce the drugs on a large scale for sale as well as export.

● (1635)

Mr. Tom Kmiec: Can you comment a little on your collaboration with CBSA and customs at the border? We often think about the provincial police forces working with the RCMP, but do you have a direct working relationship with the CBSA? If so, can you describe it for us and the information-sharing that goes on there. For instance, when you make a bust on the street and you identify the source, do you then tell CBSA they missed stopping this one and then share that information with them?

How does that work?

D/Commr Rick Barnum: As I mentioned earlier, we deal closely with the CIROC committee, the Canadian Integrated Response to Organized Crime. It's co-chaired by the deputy commissioner of the RCMP and me. We have members from various enforcement communities across the country, including CBSA. At that committee, we would share major high-level cases and major findings formally. Informally, day in, day out, there are relationships that exist across the country. It's common that if we started a major investigation into a precursor chemical lab or transportation and importation group, we would have CBSA as part of that investigative process. They would sit on the investigative team or at least be part of the regular updates on a weekly basis at minimum, but it's back and forth pretty regularly.

Mr. Tom Kmiec: Thank you.

Mr. Len Webber: Deputy Barnum, you mentioned in your opening statements that you recommend that Health Canada increase its capacity to conduct timely drug analysis with these methamphetamine drugs on the street. Of course, 45 to 60 days to get back results is ridiculous. Is there a way for the police to be able to check it right on the street? I'm sure there is. Is there something that can possibly be done to get those analyses back within hours rather than two months?

D/Commr Rick Barnum: I'll start answering and then I'll turn it to Lee, because I know he's an expert in this area.

We have ion scanners that the OPP has bought. They're expensive. We have a certain number of those distributed around the country. They're not easy to use, but they will give our officers a breakdown of what's inside of the drug we've seized. However, they don't give us a specific analysis of what the problem is. It's hard for us to go and really...it would never stand up in court. I'll put it that way. It's hard for us to go to a hospital and say, “Get ready, because we're starting to see and hear in this small community that there are going to be a lot of people using this batch of whatever is coming to our community, so watch out.”

If somehow we can get that analysis from Health Canada, on an emergency type of basis and get it back within a day or two, we could save lives. It's not a huge investment, in my opinion, compared to the front-end work that needs to be done.

I'll let Lee explain a bit more about the ion scanner.

S/Sgt Lee Fulford: We acquired a Smiths Detection IONSCAN 600. It's the same technology that's used at the airport. It gives us a presumptive test within five seconds. The machine can detect trace amounts. As the deputy said, the issue is that we may not necessarily need to know what it is. We'll need to know how much is in that sample. The only people right now who can tell us that are Health Canada.

Mr. Len Webber: Madam Chair, is that my time?

The Vice-Chair (Ms. Marilyn Gladu): Yes.

Now we go to Mr. Ouellette for five minutes.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Thank you very much, everyone, for coming here today. I really appreciate it.

I still have a few questions.

Mr. MacPherson, you were talking about why people use drugs. I am just wondering if there is a lot of data you could direct us to at some point for the analysis of why people use drugs. Do you have any more information?

Mr. Donald MacPherson: There's some research out there. It's often not a question that the research looks into, but there's a fair amount of research that demonstrates the wide range of reasons people use drugs. I would certainly be happy to direct you to that.

Mr. Robert-Falcon Ouellette: Thank you very much.

Second, I was just wondering if you could talk a little bit about recreation and arts and sports. I had a town hall with a number of young people and other service providers who look at meth in Winnipeg Centre, and we were discussing the meth issue down there. It is quite serious. Recreation and arts and sports came up quite a bit as giving people something useful and creative and fulfilling to do with their time. Instead of sitting around on their front steps, talking to people and watching other people use meth, go play soccer.

I was just wondering if you have any research or any knowledge about something related to that.

● (1640)

Mr. Donald MacPherson: Well, there's certainly a growing body of research that shows that engaging people who use substances like methamphetamine in meaningful involvement in the arts, recreation, or community-building enterprises is helpful. People are really pushed away from society, pushed away from those activities, and it makes sense. I hope some people who use meth are included in those soccer games and recreational activities you're talking about.

Mr. Robert-Falcon Ouellette: I have a number of further questions. I guess I can open it up to the group here. I was just wondering if we have any understanding about the additional costs related to the use of meth, for instance, in terms of policing, health care, or even treatment.

How much more does it cost to treat someone who's using meth compared to opioids or another type of drug? For instance, if the government had a million dollars that it could allocate towards something, how far would that go exactly in the treatment of meth users compared to users of other drugs? Does anyone have any information?

Okay, I guess we have—

Mr. Ian Culbert: I can simply say that we don't have that information. It's not reported at the level of granularity that we need it to be. If you want to know how much meth costs our society, how much it costs our health care system, we can't answer that question because it doesn't get reported that way provincially, and then it doesn't get rolled out to give those meaningful types of reports.

What we know is that, over the entire population, only 0.2% use methamphetamine, so you can extrapolate some numbers of the overall drug costs to society. However, it's only going to be modelling; it's not going to be exact.

Mr. Robert-Falcon Ouellette: Part of my issue, for instance, is with policing. In the city of Winnipeg, what we heard in testimony is that it takes a lot more time to deal with someone who's on meth. Where do you take them? In the hospitals, it takes a lot more personnel to deal with someone. All of that costs something.

The federal government came out with a little program related to the opioids and then decided to include meth. It was $4.2 million combined with the province, working with the provincial premier, Brian Pallister, to provide funding. However, compared to the funding going to Vancouver or other places that might be dealing with different types of drugs, the impact might be a lot less. If addiction treatment is three months for meth use compared with one month or 28 days for alcoholism or some other types of substance abuse, I suspect the costs are higher.

So, I'm just kind of surprised that there's not a lot of research related to that.

Mr. Donald MacPherson: People use a lot of substances. They are polysubstance users, so it's not always that simple to just to treat one drug at a time. You heard that in Vancouver, 40% to 50% of people using one of the overdose prevention sites use methamphetamine. They probably use other drugs as well, so it's really quite a complex question you're asking. I'm not suggesting that we shouldn't look for the answers, but it's not just as simple as meth users per se.

Mr. Robert-Falcon Ouellette: Thank you very much.

S/Sgt Lee Fulford: I'll just add that Australia has classified the socio-economic cost of particular drugs per kilo. You may want to look into some of that research for our federal government.

The Vice-Chair (Ms. Marilyn Gladu): Very good.

We'll go to Mr. Webber again for five minutes.

Mr. Len Webber: I will share my time again with Mr. Kmiec.

Sergeant Fulford, you talked about the one-pot method of production of methamphetamine and the precursors for building and making this stuff. Is there any work going on to co-operate with pharmacies and drug hardware stores on the sale of these precursors and monitoring that—seeing who's buying this stuff and in what quantities? Has that been looked at at all?

S/Sgt Lee Fulford: The precursor for methamphetamine production is ephedrine, which is found in a cold medication, Claritin, etc. It's still available in the aisles.

Mr. Len Webber: Yes. How much do you need to make one pot? Do you need a lot of cold meds?

S/Sgt Lee Fulford: Essentially, the pills are crushed. You would need a few boxes of pills. You crush the pills. You add the other precursors: lithium, ether, sodium hydroxide and some others. They are mixed together, and it's left. It's a very, very volatile method of production, and it can result in explosions.

However, there is room for improvement and to refresh and re-educate the pharmaceutical industry on what to look for in suspicious transactions, but we're not seeing economical-based labs getting their ephedrine from these stores. It's with our small production that it's occurring.

● (1645)

Mr. Len Webber: I can see its being difficult to monitor and to investigate, if you're selling a box of cold meds. It's difficult.

You have a question on that as well.

Mr. Tom Kmiec: Thank you.

I was going to ask a question about the manufacture and distribution because, again, there's this friend of mine, Bernard, in this northern Alberta community, where they have this pint that's being used. We've heard a lot about reducing the stigma associated with drug use and about helping the drug users find ways to help themselves by offering them opportunities—as many as possible—to get off drugs. We've talked about offering a different route through a pretrial diversion option, but is there something else we could do?

Alberta introduced a law to ban pill presses, with $50,000 fines, and $125,000 fines for second offences plus jail time. I know that former MPP Michael Harris tried to do that in Ontario as well. There is precursor material, but for some of the tools used in the production, is there anything that could be done on that end to ban their import by those who should not be allowed to use them? In Alberta, pharmacists can import a pill press, but nobody else can.

Is there anything like that that could be done in addition? Or is it just too simple to make the stuff? Is it really just impossible to stop it? Should we really be focusing solely on reducing the harm on one end? Or is there something more that we could do on the manufacturing side to at least make it more difficult and more complicated?

S/Sgt Lee Fulford: With the production of synthetic substances, they're using lab equipment that any pharmaceutical company in Canada utilizes. The RCMP has a chemical diversion program, a ChemWatch hotline. People can report suspicious transactions in lab equipment, such as when someone who they believe is suspicious comes in and purchases a large round-bottomed flask, a big thing that you would see in a chemistry class when you're in high school.

The focus is on that further collaboration with the RCMP and its chemical diversion program to work with our partners to proactively investigate these transactions within the province of Ontario.

Mr. Tom Kmiec: It's the focus. Okay.

You mentioned that this program is called ChemWatch and is run by the RCMP.

S/Sgt Lee Fulford: It's the RCMP's chemical diversion program. They're responsible for information regarding importation of precursors. There is a 1-800 number, I believe. It's called ChemWatch. You can report suspicious transactions, and chemical companies can call regarding suspicious transactions of chemicals that are precursors.

Mr. Tom Kmiec: Okay. I wondered about that more broadly for the committee. I know that my time is up, but how often does this 1-800 number get used? That would be an open question.

S/Sgt Lee Fulford: You'd have to ask the RCMP.

The Vice-Chair (Ms. Marilyn Gladu): All right. We'll go to Mr. Ayoub for five minutes.

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you.

I'll be asking the questions in French. Feel free to answer in English.

[*Translation*]

The comprehensive approach to drug use and addiction seems to be more complex, because drug use cannot be treated in isolation from everything else. Many things are connected. We heard from Steve Barlow, the Calgary Chief of Police, as a witness. He told us that the reported crimes are not always related to drug possession, but also to the consequences of the actions of people who want to obtain or buy it. To do so, they break other laws and are arrested or caught in the act for crimes other than simple drug possession.

In your opinion, what is the solution? What can be done to improve the situation? Some courts can refer people to treatment if they need it, so that they do not start again and are able to get out of this vicious circle. The people you arrest may be arrested more than once. You probably know them. They are the consumers.

Then, there are the producers. So one approach is based on enforcement and another approach is based on prevention and treatment. The two approaches could be implemented at the same time, but probably not by the same organizations. What are your thoughts on this?

I see Mr. Barnum nodding.

● (1650)

[*English*]

D/Commr Rick Barnum: Thank you.

Besides what Lee has already mentioned about the precursors and things of that nature, I'll take two parts of your question.

On the big part, the importation, I think it would be wrong for me not to mention the fact that, whether it's huge importation or minor importation or above street-level dealing, one of the tools we are absolutely handcuffed by in policing—and it's taking lives in our country—is the inability of police officers to legally gain access to information that individuals have on their cellphones.

What I mean by that, and as a prime example I could talk over and over about, is that when a trafficker of any type of illicit drugs causing someone else to have an overdose or an overdose fatality, and we come to do the investigation, if they have specific information inside their cellphone, we can't get it unless we can gain their password. In other words, the person is holding a cellphone that answers why somebody is lying there dead, and we can't get access to that.

It's the same thing when high-level traffickers come into our country, whether they're dealing Mexican meth by the kilo or multi-kilo or they're bringing in precursors, when we bring our investigations to a conclusion, we often find they're using high-end encrypted devices that only they have the passwords for. We can catch them in vehicles with millions of dollars worth of methamphetamine and other products, and we can't get the information that we need to prove our case successfully because it's locked up behind a cellphone that's right in their hand or right in our hand, and we'll take months and months to try to open that cellphone. Sometimes we get lucky, and other times we don't. As a result, we lose vital information.

To me it's absolutely crazy that when we're dealing with victims' families, and a parent, brother, sister, husband or wife want to know what happened and how it happened, we can't tell them.

Mr. Ramez Ayoub: What do you expect the government to do to change that?

D/Commr Rick Barnum: Update legislation to make a threshold where we can approach a judge or a justice of the peace and say, "Here's the evidence we have. As a result of that evidence, we need the password, and the individual has that password".

If we pass that threshold on these major investigations or an overdose fatality, then we'd be able to gain—

Mr. Ramez Ayoub: Do you have those conversations with your counterparts outside of Canada?

D/Commr Rick Barnum: I talk with the FBI all the time about this. They're very much on the record about what they need in the United States, what we need in Canada and beyond.

Mr. Ramez Ayoub: Is there a solution?

D/Commr Rick Barnum: Not yet.

Mr. Ramez Ayoub: I think my time is up.

Thank you.

The Vice-Chair (Ms. Marilyn Gladu): Now we go to Mr. Davies for three minutes.

Mr. Don Davies: Thank you.

Mr. MacPherson, I just want to come back to a word you used. You used the word "conundrum", and I want to explore that a little bit with you. You're quoted as saying:

> Drugs that are currently illegal, we should make them legal. Then we can focus on problematic substance use and issues like dependency and addiction. The so-called war on drugs is this sort of masterful distraction that we will get it right someday in the future if we just try a little harder. That's not going to happen. If we were to just legalize these substances and put our resources to helping people who develop problems with them, we'd waste less money and have much better outcomes.

You're also quoted as saying:

> The irony of our drug control strategies is that they don't control drugs. They actually create a free market for these substances and the free market is managed by organized criminal gangs with a global reach.

I very much agree with you in those quotes.

Recently, Dr. Theresa Tam, the chief medical officer of Canada, has vocalized what many stakeholders across the country are saying, which is that we have a poison, toxic street supply in this country, and it's killing people. I fail to see what the conundrum is.

I see a straight line to a logical answer, which is that we need to address it head-on by making sure that people who are using drugs aren't killed by toxic poison in the streets. That means we have to make sure that they have access to a safe, regulated supply of known quantity and known dosage, preferably I would say, through a highly regulated medical system.

Do you agree with that, or do you think we should continue to leave drug supply to organized crime on the streets?

● (1655)

Mr. Donald MacPherson: No, the conundrum is that we refuse to do what is right under our very nose, like the last example we just talked about in the committee. We make a choice. By not allowing people access to a pharmaceutical stimulant like Adderall, Desoxyn, or these substances, we basically deliver vulnerable people to organized crime. You're listening to the extent to which police are trying to grapple with organized crime, when in fact we are allowing a huge market to continue to be available to organized criminals and unregulated dealers. You're beginning to see that with opioids. You're beginning to see hydromorphone being prescribed to people who are using heroin or fentanyl, not as a treatment program, but as a way of removing them from the illegal market.

The conundrum is, why don't we just do that? If we legalize and regulate drugs, we can put all of our energy in that system of treatment that is so elusive to us. We spend so much money running around chasing criminals and organized crime, but should really be focused on that small percentage of people who develop addictions to drugs, and allow people to access real pharmaceuticals.

Mr. Don Davies: Thank you for clarifying that.

The Vice-Chair (Ms. Marilyn Gladu): That's very good.

Before we suspend to go in camera and talk about committee business, I want to thank all of our witnesses today. You've been tremendous in helping us understand what we can do about the state of the nation with regard to methamphetamines. Thank you for your testimony.

We'll suspend now to go in camera.

[*Proceedings continue in camera*]