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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0850)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call the meeting to order and welcome everybody back.

We have a little bit of carry-over business. To our witnesses, we're going to be a little delayed in getting to you.

Mr. Webber had a motion on the table as we wound up in the last session, and we had to leave because the bells were ringing. Since then, things have changed on the motion.

Mr. Webber, why don't you take the floor and tell us what you'd like to do?

Mr. Len Webber (Calgary Confederation, CPC): Mr. Chair, as most of us remember here, the motion that I put on the table last meeting read:

> That, pursuant to Standing Order 108(2), the Committee undertake an immediate study of the current restrictions imposed on men who have sex with men (MSM) when it comes to the donation of blood to determine if the current five year ban is scientifically supported, or to determine if this restriction can either be reduced or eliminated while maintaining a safe blood supply system.

I've spoken to a number of you since then, and I hope that I have that support. There is an amendment that has to be made to this. However, because of some changes that the government has done since then, they've brought that five-year ban down to one year, which was a positive move.

However, there is still an issue with that one year. I would like to see a study done to determine whether that one year is unreasonable. Is it something that should stay current or do we take that one-year ban out altogether? I know that Rachael would propose that amendment.

Maybe I could get you to read that out, Rachael.

Ms. Rachael Harder (Lethbridge, CPC): The amendment would read, “That, pursuant to Standing Order 108(2), the committee undertake a study this fall of the current restrictions imposed on men who have sex with men when it comes to the donation of blood to determine if the current ban is scientifically supported or to determine if this restriction can either be reduced or eliminated while maintaining a safe blood supply system.”

The two changes to the motion are that rather than an immediate study, we take on the study this fall, and rather than determine if the current five-year ban is scientifically supported, it would now read, “to determine if the current one-year ban is scientifically supported.”

Mr. Len Webber: That is the proposed amendment to this motion. Thanks, Rachael.

I would hope that it would be supported by the committee, and we could go from there.

The Chair: Is there any discussion on this motion?

Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Good morning, Mr. Chairman. I'd like to welcome all committee members back from the summer.

I think it's an excellent motion that is certainly worthy of support. The New Democrats have also gone on record as saying that we don't see a scientific basis for the ban on blood donations from men who have sex with men. It should be a science-based decision.

The only issue I have though is the timing of this motion. I'm wondering if Mr. Webber could elaborate on the time sensitivity of this study.

We are in the middle of a pharmacare study. We had a work plan that was circulated a while back that appears to me to really chew up most of our time for the fall. We have other motions that are very important that are in the docket including studying home care, aboriginal health, microbial resistance, and others.

They're all important, and Mr. Webber's motion is very important and worthy of study, but I'm wondering if he could tell us if he sees any particular time sensitivity to it that would require us to alter the current committee business schedule.

● (0855)

Mr. Len Webber: I appreciate that question. I would see this as an urgent study. The reason is that people are dying right now, lying on tables waiting for organs that are not available. If we can make these organs and blood possibly available to individuals from donors who fit in the category of being in that ban, it could save lives. I know there are many other issues out there that are important as well —you brought up a number of different issues—but I believe that the sooner we get this done, the sooner we could get more organs and blood available to the human organ, tissue, and blood procurement system.

I see it as an urgent issue. I initially wanted this to be an immediate study. I have gone down to it being a study sometime this fall. I realize we have other items on the agenda, but I see this as an important study that should be done as soon as possible. Of course, Rachael has proposed the amendment to study it sometime this fall.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): I think Mr. Webber is talking about organs in here too. In the motion, it is only blood. Do you want to amend the motion to include organ donation too?

Mr. Len Webber: Yes, that is a good question.

Mr. Darshan Singh Kang: The amended motion doesn't talk about organs.

Mr. Len Webber: Yes, that's right. Right now, we will leave it just for blood. I continue to say "organ" and "tissue" because I think that would follow. This is a passion of mine, and I would like to see it evolve into that. Right now, let's just work on the blood donation and get that scientific study in there. I am asking only for perhaps a one-meeting study, just to get some scientific evidence in here. That's it. It is not going to take up a lot of time.

The Chair: Mr. Oliver, go ahead.

Mr. John Oliver (Oakville, Lib.): I am assuming there is general agreement around the table with the intent of the motion as amended. It is just a question of timing. There is probably some downtime in drafting on pharmacare coming up, so I wonder whether we could ask our clerk for a schedule of how we could fit this in and an estimate of the time, just so we can get this concretely mapped out for us. What is the work plan that would be associated with the motion? Is it one meeting or two meetings?

The Clerk of the Committee (Mr. David Gagnon): It also depends on what the committee wants to do on the pharmacare study. A work plan was distributed yesterday. You may want to have a discussion on that. There are a couple of meetings on that. It is up to the committee to decide how many meetings they want to have with this one.

Mr. Len Webber: Mr. Chair, I have looked at the work plan for the next few months. It looks like we are going to be on this pharmacare study for quite some time still. I have looked at a number of the meetings here, and I would like to discuss this—I am sure we will discuss it—to determine what is important and who we feel should come here to present to us. Others perhaps aren't so—I am not going to say "worthy" because they are all worthy to present to us, but maybe we can shorten down this schedule in order to find time to do this study or this presentation with scientific experts. I don't know if you have seen the table here of meetings that we have planned in the future, but I am certain we can squeeze this down a bit in order to get this study done on the motion that I have on the table.

The Chair: Mr. Eyolfson, go ahead.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): I would agree. I see some urgency to this. Even if we are just talking about blood, the blood supply is always precarious at best, and it tends to wax and wane. Having been on the blood donor list, I know they are always calling, because they are always short. Every time there is a long weekend, with our traffic patterns being what they are, we have very large spikes in demand. Anything that restricts the available supply that is not based in science should be dealt with in a reasonably short period of time. I think it is in everyone's best interest.

● (0900)

The Chair: Mr. Davies.

Mr. Don Davies: Well, I'm afraid I don't see the urgency. I see the importance of the issue, but I don't see the urgency. As Mr. Webber has now clarified, this motion doesn't have anything to do with organ transplants. It's about blood donation.

I could make the same argument. We're in the middle of a pharmacare study. I would venture to guess that there are Canadians who are dying, probably this week, because they don't have access to their medication.

We've had testimony already about the effect of cost-related non-adherence, and there are Canadians who get seriously ill because they don't have access to their pharmacare. That's a pressing problem right now.

Quite honestly, the Conservatives were in power for 10 years and never touched this issue once. Frankly, the current government had a chance to look at this and moved from a five-year ban on men having sex with men with regard to blood donations to one year.

This is an important issue. I don't think it's urgent. I think we should be looking at it. Even if we study this issue, say a month from now, and we devote a meeting—which, by the way, I don't think a meeting is enough for this. I think if we want to have a science-based, evidence-based look at this, we're going to have to hear from a number of experts in this field: hematologists and otherwise, Canadian Blood Services.

I haven't heard whether we're going to write a report or not, which we would probably have to do if you want to have an impact with the minister. You're talking about multiple meetings, unless we just want to make a political issue out of this and have a pro forma meeting.

If we want to take a real look at whether there's a basis for this issue, we should treat it with the seriousness it deserves. It would probably need three or four meetings, I would say, to look at that issue.

If we do that, then we're pushing our pharmacare study back significantly. I'm not so sure, when you weigh the competing importance, that there's any real way to differentiate between them. As important as the ban on men having sex with men issue is, again, I think so is pharmacare.

I would urge that we pass the motion, but I'm not so sure that we need to schedule hearings on this until after the pharmacare study.

The Chair: In the interest of time, I'm going to suggest that there seems to be consensus around the table that this is worthwhile and it should be done.

Can we vote on the motion, and then the clerk and the chair will work on timing to get it on the table? In the interest of moving forward, can we vote on the motion and we'll try to find time to fit it in?

First of all, we'll have research tell us how much time, how many meetings it will take, and then we'll work it out.

Mr. Oliver.

Mr. John Oliver: I think the motion would then tie us to doing this review in the fall, because that's built into the amendment.

I guess we would need to have a friendly amendment to remove that and maybe change it to "as soon as possible after pharmacare is completed", or something like that.

The Chair: Is that okay? There is a consensus that it's an important issue and it should be done, but it's a matter of timing. Can you live with that?

Mr. Len Webber: Can we perhaps change that to getting the study started this fall, have one session of witnesses here to present to us, just to get it started, and then from there it would be whenever the clerk feels it's appropriate to put in some other meetings on it?

The Chair: Are there any comments on that proposal for or against?

Dr. Eyolfson.

Mr. Doug Eyolfson: I don't think one meeting is going to cause any undue delay to other initiatives. I think that one meeting to discuss and get our priorities for it...and then some background research can be done and we start collecting witnesses.

I'm certainly in favour of that.

● (0905)

The Chair: If you would amend your motion to that effect, we'll have a vote on it.

Research can help, because a lot of us don't know much about this subject. We need some time to brush up and learn about it.

If you can do that, we'll have a vote on it and move forward. Is that okay?

Ms. Rachael Harder: If I could amend it then, rather than "undertake a study this fall", it would say "initiate a study this fall".

The Chair: Say that again.

Ms. Rachael Harder: Right now it reads, "Pursuant to Standing Order 108(2), the committee undertake a study this fall...". Instead of "undertake", I would be exchanging that word for "initiate."

The Chair: Perfect. "Initiate"; that works for me, but I'm just....

We have a motion on the floor.

Dr. Eyolfson.

Mr. Doug Eyolfson: I'd like to second that.

The Chair: Okay, thank you.

Mr. Davies.

Mr. Don Davies: I'm fine with the motion, but it's on the understanding that the motion won't say this. We understand we'll have one meeting to hear evidence and then carry on at some point in the future.

The Chair: In the event we run out of things to talk about, it may be more than one but the motion says that we'll initiate the study.

Mr. Don Davies: I know, but I want to know what I'm voting on.

The Chair: That's what it is.

Mr. Don Davies: No, Mr. Webber said that the suggestion from Mr. Oliver was that we start by having one meeting in the fall. I want to know clearly what I'm voting on, because the amendment from Ms. Harder doesn't clarify that, it just says "will initiate". I'm happy to support the motion if it says that we initiate the need to study this by conducting one meeting to hear evidence this fall and then carry on as the committee meets as it desires or not.

The Chair: We all want that over with.

Mr. Don Davies: We do have this pharmacare study with other motions that this committee has already passed. I had a motion on aboriginal health that was passed by this committee 10 months ago.

The Chair: Do we have an understanding that "initiate" means one meeting?

Mr. Darshan Singh Kang: So when we do the study we are leaving it open-ended.

The Chair: Unless we started and finished it in one meeting. That's possible, but it doesn't sound as if it will be.

Dr. Eyolfson.

Mr. Doug Eyolfson: I would second it if it said "one meeting".

The Chair: All right.

Mr. Doug Eyolfson: As in the definition of "initiating" being one meeting, yes. If that's what would be acceptable, if that's what the group wants, I would still second that.

The Chair: We don't have to change the wording; the committee understands that it would be one meeting. Okay.

Mr. Len Webber: One meeting to initiate the study. It could require more than one meeting but we're going to initiate with the one to start with in the fall. Okay, got it.

The Chair: We're all singing from the same song sheet.

Okay, we have a motion on the floor.

(Motion agreed to)

The Chair: Now I welcome our guests. I'm sorry for the little delay, but this was unfinished business carried over from our last meeting. We did want to finish it, and I think we're ready to move forward.

I believe that we asked you to have a 10-minute presentation. We're going to ask you to wind it down to five minutes so we'll have lots of time for questions. It will help us get through everybody and give everybody a chance to hear what they need to hear. I don't want to miss anything, but you'll find our committee asks questions and they know where they want to go.

We have the Street Health Centre, Kingston Community Health Centres; Centretown Community Health Care; Jane Buxton, professor, University of British Columbia; and the Paramedic Association of Canada.

We'll start with the Street Health Centre, Meredith MacKenzie, physician. Please begin your presentation.

Dr. Meredith MacKenzie (Physician, Street Health Centre, Kingston Community Health Centres): Good morning. Thank you for asking me to come to speak to this bill.

More than two years ago, this committee issued its report “Government's Role in Addressing Prescription Drug Abuse”, which recommended that the government consider overdose immunity law that would exempt individuals seeking help for themselves or others during overdose situations from criminal prosecution. Since this committee's recommendations more than two years ago, the situation in Canada has profoundly worsened. We're now the number one consumer of prescription opioids in the world. Non-medical use of prescription drugs is a public health crisis and there's an opioid overdose epidemic occurring across our nation.

In April 2016, British Columbia's provincial health officer declared a public emergency as more than 200 people had overdosed in the first three months of this year. In June the Coroners Service of B.C. reported that overdose deaths increased by 75% in 2016.

The situation here in Ontario is also grim, with opioid-related mortality increasing 463% between the years 2000 and 2013. This represents one death every 14 hours. Preliminary figures from Ontario's Office of the Chief Coroner show that fentanyl overdose accounted for one in every four opioid fatalities in 2014. So we see we've had 13 years of increasing and record-setting overdoses, more than double the number of drivers killed in motor vehicle collisions.

This government has acted to make naloxone available by amending the prescription drug list. Take-home naloxone programs have been available in most provinces for a few years. As you know, naloxone is a medication that is first aid for opioid overdose and can reverse fatal respiratory depression. Communities that do provide take-home naloxone and overdose prevention training have lower opioid-related overdose fatalities.

We know that 85% of overdoses occur in the presence of another person. Naloxone injections for opioid overdoses are most often given by bystanders, just like epinephrine pens are used for life-threatening allergies.

A critical step to surviving an opioid overdose is seeking medical attention. We know that more than 90% of people who have a heart attack will call 911 for help, but an Ontario study showed that only 46% of people will call 911 in an overdose situation. The primary barrier cited is fear of police involvement.

Opioid overdose is a medical emergency. Once naloxone is given to a person it lasts between 20 to 90 minutes. That means once naloxone wears off the overdose can recur. Calling 911 is a crucial step to survival and a cornerstone of opioid overdose treatment.

With the arrival of more potent opioids like powdered fentanyl and other fentanyl analogues across all communities in Canada, activating 911 is of particular importance. A shipment of one kilogram of carfentanil, an elephant tranquillizer, was seized in Vancouver by the Canada Border Services Agency in June of this year. This drug is 100 times more potent than fentanyl. Put another way, that's 10,000 times more potent than morphine, and this shipment contained enough drug to kill 50 million people. If people do not call 911, the risk of death is increased substantially.

We are also increasingly seeing drug contaminations in our communities. People who report non-opioid drug use are overdosing and dying because the drug they used unknowingly contained fentanyl. In Vancouver earlier this month there were nine overdoses in 20 minutes, in people who were using cocaine that was contaminated with fentanyl.

The best way to encourage people who have overdosed or witnessed an overdose to seek help from 911 is to provide protection from charges of possession. Early evidence in the U.S.A. indicates that 88% of people who overdose on opioids are more likely to call 911 after establishment of good Samaritan law and being made aware of its existence.

Many organizations have supported the adoption of Bill C-224. Some of these include the Canadian Medical Association, the Ontario Medical Association, the Municipal Drug Strategy Co-ordinator's Network of Ontario, the Canadian Drug Policy Coalition, and many boards of health and police agencies across Canada. A parliamentary petition garnered more than 700 signatures from coast to coast to coast.

This time of year many of our children head off to post-secondary schools. This is a time in life when they may make some dangerous or questionable decisions as their frontal lobes mature. They may be at a party and someone offers them a pill or something else to take. This pill doesn't look too dangerous. It looks like medication. We have seen fentanyl and other drugs being pressed into pills that look like prescription medication. The potential contamination of all drugs with highly potent opioids that are readily available in all of our communities makes overdose in this setting a very real possibility. Will their friends call 911 or will they be too afraid to call?

● (0910)

Constable Brian Montague, the media relations officer for the Vancouver Police Department issued a statement in June of this year confirming their position that they will not send a police officer to an overdose unless one is requested. He went on to describe that calls to 911 are not just coming from what he termed, “hard-core drug users”. He stated, “We're getting calls from 16-year-olds and 17-year-olds who are experimenting with drugs.”

The Vancouver police hope that this new strategy will mean that people who use drugs won't ever be too afraid of getting into trouble when they call 911. This government has already shown its commitment to bring forward a balanced approach to drug policy. Health Canada has supported access to supervised consumption sites like Insite in Vancouver. They have also revised the federal prescription drug list for naloxone. These are just some of the actions the government has taken to reverse the tidal waves of death across Canada.

The disaster of opioid overdose deaths across the nation requires every tool we can muster. Bill C-224 is not all that is needed to address this public health emergency, but it is a critical step forward. We need to protect the most vulnerable in our society. We must ensure that people feel safe to call 911. We must help Canadians in all of our communities to do the life-saving thing and to call for help immediately, without fear that their futures will be ruined by criminal charges. Canadians need this law passed now.

I thank the committee for your work on this legislation.

● (0915)

The Chair: Thank you very much. You fit in the time nicely. I appreciate that.

Our next presenter is the Centretown Community Health Centre, and we have Sarah Brown from Ottawa.

Ms. Sarah Brown (Harm Reduction Worker, Centretown Community Health Centre): Good morning and thank you for this opportunity.

I understand that you've received a great deal of evidence on the realities of overdose and the opioid crisis in Canada. I'm here today to offer a front-line perspective and talk about how Bill C-224 would improve community health.

I want to preface my statement by imploring this committee to hear from the community of folks who are most directly affected by overdose and criminalization, and that is the community of people who use drugs. I am here with one member of that community, my colleague, Christine Lalonde. I'm a front-line harm reduction worker at Centretown Community Health Centre, just 10 blocks from Parliament Hill. Every day I provide safer injecting and safer smoking supplies to people who use drugs in this city. In addition to distributing supplies and offering health education and referrals, I also listen, support, and build trust with people who use drugs. At times I am the first and only point of health care contact for folks who use drugs.

Nearly every person I talk to about overdose has had a personal experience with it. Either they have overdosed themselves or they have been present at an overdose. I have worked with people who have overdosed and died in Ottawa's parks, overdosed and been resuscitated in shopping centre washrooms, and folks who have had peers overdose and die in their homes. Community members continue to be apprehensive about calling 911 in overdose situations. Calls occur less than 50% of the time, according to Ottawa Public Health, due to concerns about police presence, fear of arrest, or being implicated in the overdose. Individuals who do call 911 often report being heavily questioned by the police, assumed to be suspicious rather than praised as quick-thinking witnesses.

If you are someone who has regular contact with police and the criminal justice system, you may be reluctant to involve the police in an overdose situation. Past charges and criminal records have a way of influencing police behaviour. One man I work with who has a long history with the police in Ottawa has instructed his partner to never call 911 if he overdoses. He knows he will face charges if that happens. The last time he overdosed, his partner ran to the nearest fire station and asked them to help but not to involve police. Criminalization impacts this community's health. People who use drugs are incredibly stigmatized in our culture. They are frequently judged for their behaviour and perceived as undeserving of care. This stigmatization plays out in health care settings and impacts people's decisions to seek care, be it with their own doctor, or by calling 911 for an overdose. While our law and law enforcement need to adjust their attitudes towards people who use drugs, so too do we as Canadians. Bill C-224 challenges criminalization and stigma by prioritizing public health and safety at overdose scenes.

There are a great many drug policies that you as decision-makers can implement to address the opioid crisis in Canada, which include decriminalizing the use of all drugs, supporting the expansion of supervised consumption services and take-home naloxone programs, increasing access to drug and alcohol treatment, opioid substitution therapy, and medical marijuana. The good Samaritan drug overdose act is just one of a multitude of strategies this country desperately needs to respond to the current public health crisis.

Like some of your previous witnesses and members of this committee, I feel the immunity outlined in this bill needs to be broader than possession. Nevertheless, I support this bill as a first step and I applaud MP McKinnon for proposing it and using his position to support the lives of people who use drugs. Bill C-224 is a harm reduction strategy that this committee has the influence to pass into law. A common definition of harm reduction is “any step towards greater safety is a step in the right direction”. Bill C-224 is a step towards greater safety.

Thank you.

● (0920)

The Chair: Thank you very much.

Next, we have Professor Jane Buxton from the University of British Columbia.

Dr. Jane Buxton (Professor, University of British Columbia; Epidemiologist and Harm Reduction Lead BC Centre for Disease Control, As an Individual): Thank you for the opportunity to present today. I'm a public health physician and a professor at the School of Population and Public Health. I'm also the harm reduction lead at the BC Centre for Disease Control.

I wish to provide some evidence about the overdose crisis in B.C., the emergence of fentanyl, and the importance of calling 911.

The BC Drug Overdose and Alert Partnership was developed following an increase in illicit drug overdose deaths in 2011. Members include stakeholders from health enforcement, emergency services, coroners, researchers, and people with lived experience. The goal is to coordinate communication and action to enable timely alerting and responses to illicit drug issues.

The B.C. take-home naloxone program was introduced in 2012 and provides overdose training and naloxone to people in the community. It enables naloxone administration by bystanders while waiting for any emergency health services to arrive. We've had over 2,000 overdose reversals reported.

An opioid overdose crisis is occurring in Canada. A public health emergency was declared in B.C. in April 2016 due to rising opioid overdoses. In 2015, there were 505 illicit drug overdose deaths, which is the highest number ever recorded, and in the first seven months of 2016, there have been 433 deaths. We're on route for 750 deaths in the current year.

The proportion of deaths where fentanyl has been detected increased from 5% in 2012 to 30% in 2015 and to a staggering 62% in 2016 year to date. Fentanyl is also increasingly identified in Alberta and across Canada. Fentanyl is a synthetic opioid often described as 80 times more potent than morphine. In an unregulated market, there is no control of the amount and dose of fentanyl in illegal drugs. The Health Canada laboratory has found pure fentanyl in powder sold as heroin and in varying, and sometimes fatal, concentrations of fentanyl in fake OxyContin tablets.

Although some people may intentionally take or seek out fentanyl, many don't know they have taken it. In a study performed in B.C. last year, we found almost three quarters of those who had fentanyl detected in their urine were unaware that they had taken fentanyl.

In an opioid overdose, the breathing slows and a person becomes unconscious. Lack of oxygen to the brain even for a short period of time can cause brain damage and death. The onset of a fentanyl overdose is much faster than other opioids. As we've heard, the effect of naloxone wears off after 20 minutes, and the high concentration of fentanyl in drugs requires large and often repeat doses of naloxone. It's vitally important to restore breathing as soon as possible and seek professional help for immediate and ongoing assistance.

People who administer naloxone in B.C. complete an administration form. The program emphasizes the importance of calling 911, and although the proportion that call 911 has increased over time, in 2015, 30% of people responding to an overdose did not call 911. It varies by region. Approximately 82% of people in Vancouver call 911, but less than 60% in regions outside of Vancouver do. The differences by region may reflect previous interactions with the police and policing policy, and the influence of other bystanders.

Enforcement members of the Drug Overdose and Alert Partnership have shared that most police would not make an arrest for simple possession of drugs in B.C., but this may vary by province. A good Samaritan act would ensure consistency across the country.

We also found people were more than 10 times more likely to call 911 if the overdose took place on the street rather than in a private residence. That may be because they're concerned about the residence being identified and the ability to flee if police arrive.

To explore reasons why people didn't call 911, we interviewed 20 naloxone program participants. They shared the barriers to contacting emergency services during an overdose, which included concerns about being arrested for illegal activities such as drug possession, breach of probation or parole, and outstanding warrants. Police were noted to be collecting the names of those present at an overdose scene and checking the police database.

● (0925)

We also heard stories about people who had overdosed being dragged down stairs into the street before 911 was called, and people calling 911 and then leaving the scene rather than staying with the person until first responders arrived.

According to a review by the U.S. National Conference of State Legislatures, good Samaritan or 911 drug immunity laws are enacted in 37 states and provide immunity from supervision violations and low-level drug possession and use offences. However, a recent study of young adults in Rhode Island found fewer than half were actually aware of the good Samaritan law.

It's important if Bill C-224 were to be enacted that this would be communicated broadly to the populations at risk of witnessing or having an overdose. Dissemination will require different approaches for youth experimenting with drugs and afraid of arrest and parents being informed compared to those with substance use disorders.

In summary, fentanyl prevalence in illegal drugs is increasing. Fentanyl has a rapid and long duration of action and overdoses may need large and repeat doses of naloxone. Therefore, it is imperative to call 911 and receive rapid and professional help. There is evidence that fear of arrest deters people from calling 911, and that good Samaritan laws can increase the likelihood of calling for medical assistance if people are aware. Expanding immunity in Bill C-224 beyond simple possession to include supervision violations could increase the rate of calling 911 and thus prevent further brain damage and save lives.

Thank you for your attention.

The Chair: Thank you very much.

From the Paramedic Association of Canada we have Mr. Pierre Poirier.

Mr. Pierre Poirier (Executive Director, Paramedic Association of Canada): Good morning. Thank you for the opportunity to speak today. My name is Pierre Poirier. I'm the executive director of the Paramedic Association of Canada.

There are approximately 40,000 paramedics in this country, and we respond to almost three million calls annually. I want to note that there are different classifications or designations within the term “paramedic” that cover different scopes of practice, and that's an important detail that I'll refer to later.

The Paramedic Association of Canada absolutely supports Bill C-224, although we have concerns about its application or whether it sufficiently meets the intent to save lives in a timely manner.

I've taken some excerpts from other presenters and have parsed some of their words.

Opioid overdose deaths are preventable with timely intervention. Good Samaritan legislation is one component of a comprehensive public health approach to overdose within a harm reduction paradigm. We need to improve the community response of Canada as part of a comprehensive response to overdose deaths. The community response must involve a comprehensive approach.

Let's make naloxone available, absolutely. Let's provide naloxone to the overdose victim in a timely manner, because seconds count. Let's coordinate the health care system on this important issue—and that's an important piece that I want to make reference to—with consideration of the alignment of a federal initiative with the provincial mandate in the health care system and with the way we approach health care.

This is an important piece that I want to spend a couple of seconds on. I have to admit that change has been rapid, but I still don't think our addressing of this issue has been fast enough. Paramedics regularly respond to incidents in which an individual has overdosed. We provide medical care. This is a life-and-death event.

Let me explain how a patient is treated. There is the 911 call, and paramedics are requested. Police are often asked to attend for safety and security reasons. Recognizing the triage system and that for a medical emergency it is the paramedic who is called and not necessarily that police go to attend to every call is, I think, an important point.

The paramedic will assess the patient and determine an overdose. This is the important piece: often the paramedic is required to call a physician for permission to administer naloxone, and oftentimes some paramedics may not have permission to provide this drug in this country. That's an important distinction. We have this law that approaches it in good Samaritan terms and as a public health issue, but we should also recognize that the individual providing care may not be allowed to provide the care that is really intended or that is life-saving. This is important as an issue.

Here is the problem. I noted earlier that seconds matter in this life-and-death situation. In the event I described, paramedics may not have permission to administer naloxone. That could happen in Saskatchewan, Ontario, Nova Scotia, and Newfoundland.

Also, if they do have permission.... They may be required to call for permission to administer. A paramedic who administered without permission would now be subject to discipline by the health care system or by a regulatory agency to which they report. This is a significant issue.

On the one hand, then, we would have legislation that supports an individual's providing it, but by the same token a paramedic on scene may not have that permission. How do we resolve this? There are a few things.

I have to admit that I'm not familiar with all the nuances of the prescription drug list and its relationship to the Controlled Drugs and Substances Act, but if we were to remove naloxone from schedule I of the Controlled Drugs and Substances Act, that might actually help the situation.

One question is whether there is really a need that naloxone continue to exist within schedule I. I think there are important lessons to learn. Paramedics often work under medically delegated acts or things with that description. When we went through the last 40 years of experience with AEDs, automated external defibrillators, we came to a point at which we made them publicly accessible, but we removed the designation of their use being a medically delegated act, which really benefited the community and all health care providers in that situation.

● (0930)

I'm not sure that we can consider Bill C-224 is applicable to all Canadians, and that would be a motivation behind this, because if you look at good Samaritan legislation, if there's remuneration, there is no longer the cover of the good Samaritan legislation. Paramedics in the performance of their duties are deemed to be providing a service and therefore being paid to provide that service, and therefore are not provided the cover of the good Samaritan legislation. That's an issue, and I think it can be resolved.

Last, we should consider other applications of the drug, and look at the provision of naloxone in a similar manner to the development of EpiPens. You don't need to provide it as an injection; it can be provided as a nasal spray or by other methodologies. That wouldn't require it to be a medically delegated act, and it would be a simpler, more accessible, easier way of providing a service to our community.

Thank you for the opportunity to speak today.

The Chair: I want to thank all of you for your presentations. All of you experience a reality that we don't experience, and I compliment you on the job you do and thank you for it. I can only imagine what your day is like for some of you. I appreciate your contribution. You've already taught us a lot.

We're going to start questions with Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, witnesses, for coming here today and giving us your expert testimony about this important issue. It is very enlightening. My question is for all the witnesses.

Can you tell us what evidence there is, if any, that bystanders are not seeking emergency assistance in suspected overdose cases because of a fear of being prosecuted?

We can start with Mr. Poirier.

Mr. Pierre Poirier: I think it has been noted previously that it's about half the emergency calls, and paramedics respond to probably about three million calls across this country. I don't have the number of overdose calls we attend to. That data isn't available, but as was noted before, half our calls are ones where people do not call for fear of an overdose offence.

● (0935)

Ms. Sonia Sidhu: In the U.S., some states have laws similar to Bill C-224. Do you know of other places and jurisdictions with similar laws? Can you point to some of these laws? Are they very different from Bill C-224?

Dr. Jane Buxton: As I mentioned, 37 states in the U.S. have good Samaritan or 911 drug immunity laws and they also sometimes are for low-level possession, but often will include supervision violations as well. There is evidence when they did a survey in Washington state, the vast majority—88% of people who used opioids—indicated they would be more likely to call 911 during a future overdose, knowing it was there. But there is the issue of making sure that people are aware of the good Samaritan law, and I think that's where we need to make sure it happens.

Ms. Sonia Sidhu: Sarah Brown, is there any evidence in other places and jurisdictions that having a good Samaritan overdose law in place increases reports of overdoses? Do these laws make a difference?

Ms. Sarah Brown: I'm not sure about whether or not they make a difference in other communities. I can speak to the community here. I think they would make a difference in our city. Yes, I think more people would call if they knew they wouldn't be charged for possession.

Ms. Sonia Sidhu: Thanks.

When we had Donald MacPherson from the Pivot Legal Society come before this committee in June, he talked about how such laws and policies should try to restrict police attendance to overdose calls. He said that police should maybe only show up if there are public safety issues.

Do you agree that restricting police attendance at routine overdose events would do what Bill C-224 is intending to do?

Dr. Jane Buxton: Certainly, for the last 10 or so years, Vancouver police have not routinely attended overdoses. There are obviously certain times where the police will attend whether it's due to a death, whether there's concern around violence, or safety of the responders and the police. As I mentioned, in Vancouver, in the study that we did, 82% of people actually called 911 in an overdose situation compared to 60% or less in other regions. I think it has made a difference.

BC Emergency Health Services introduced a new policy in June such that they will not inform police and enforcement except in certain circumstances which include the ones I've mentioned, but also if there's concern on chemical biological radiological terrorism, anything like that, but also attempted suicide.

Ms. Sonia Sidhu: The definition of overdose in the bill notes that a reasonable person would believe that the situation requires emergency medical or law enforcement assistance. Given that individuals in the circumstances encompassed by Bill C-224 may be impaired by drugs or alcohol, could the use of the reasonable person standard in the definition of overdose be problematic? Please explain why or why not.

My question is for Dr. Buxton.

Dr. Jane Buxton: I know overdose is when somebody has over and above what the body can tolerate. We do know that, frequently, it's not just a single substance that is causing the overdose, and it may be taken intentionally or unintentionally.

We know that people can respond and if they make a plan, can contact emergency services. People can respond and use the naloxone very effectively as a bystander. We're well aware that people who are in a situation can call 911 and it really does make a difference.

● (0940)

Ms. Sonia Sidhu: Thank you.

The Chair: Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): I want to thank everyone here because this is an extremely important bill. I want to thank the witnesses for being here today because it's vital that we all work together to combat drug overdose and help save the lives of those who have lost their way or, as was mentioned, people who are just experimenting.

I want to thank Mr. Poirier for pointing out a loophole that maybe we have overlooked something in regard to the paramedics who, as you quite correctly pointed out, Mr. Poirier, you guys are the guys on the ground. We do have the parliamentary secretary here who is monitoring the committee, and we also have an emergency care physician which we are very fortunate to have.

If there's some type of a regulatory change that could be made that would make your job on the ground better and not give your members a situation where they could be confronting a risk for actually saving a life, that's something we could all support. Thank you for pointing that out.

I also want to thank you for pointing out that this bill is really important, but it's only part of a comprehensive and coordinated approach to work with our provinces and territories. I thank you for your positive suggestions to improve the bill.

We can't ignore that a major issue when it comes to overdose is that there's currently nothing in the pipe. You mentioned prevention. There doesn't appear to be a lot in the pipe to prevent overdose. We're facing this crisis. We're looking at Canadians, as was pointed out, being number one in the world with opioids. Something needs to be done.

We can enable addiction by providing, whether it's a syringe or heroin, whatever, but it does nothing to treat the problem.

I'd like to read a quote from the International Task Force on Strategic Drug Policy, which stated:

> We oppose so-called `harm reduction´ strategies as endpoints that promote the false notion that there are safe or responsible ways to use drugs. That is, strategies in which the primary goal is to enable drug users to maintain addictive, destructive, and compulsive behaviour by misleading users about some drug risks while ignoring others.

We must not forget that addiction is a treatable and, in fact, a curable disease. Putting bills like this one forward is a positive step in the right direction. There's still little being done by governments to actually help treat drug addiction, and we need to address that.

With that statement, I do have some questions for you. Maybe I'll start with Mr. Poirier.

When an overdose happens, who would you say that your members see? Who is more likely to call for help? Is it the avid drug users, individuals battling addiction or familiar with overdosing, or is it just basically somebody who is around there? Who do you see as the major people who are actually calling you in?

Mr. Pierre Poirier: For the most part, it is a bystander or somebody who is nearby. There are many scenarios, but oftentimes it is a loved one of that individual. This is the first scenario. In the second scenario, it is a bystander who recognizes somebody is unconscious or unresponsive. This is the terminology we use. Those would be the two designations or categories by which we receive those calls, usually: a bystander or family member or loved one.

Mr. Colin Carrie: Are you seeing a lot of calls now where people are just at parties and suddenly you get called in?

Mr. Pierre Poirier: Absolutely.

Mr. Colin Carrie: If this bill were to become law, I believe the general public would need to be made aware of it in order for it to do its job. How do you think this should be communicated with citizens in order for the bill to be successful?

Mr. Pierre Poirier: This is a tough question. I think there is absolutely a requirement that it become part of a communication strategy on a national basis, because this truly is an epidemic. The health community has recognized this, probably going back five years, at least. We are just catching up in terms of legislation and what we do.

Without promoting drug use or drug abuse, I think it is absolutely a requirement that this be communicated broadly and be part of a national strategy on this issue, absolutely.

Mr. Colin Carrie: One of the concerns, too, is there is a challenge because you don't want to provide a false sense of security. In other words, people think that if they overdose, we have this treatment we can utilize. I think that communication is going to be so important in moving forward with these types of strategies.

You pointed out that there is a loophole or a challenge with the legislation. We also had Paul Saint-Denis, senior counsel in the criminal law policy section of the Department of Justice, who told the committee that the Department of Justice would have drafted the bill differently. Here is what he said:

> The bill is drafted in a peculiar manner in the sense that it directs police not to charge, which is not something that we would typically do in terms of, certainly not in terms of criminal legislation.
>
> We would suggest rather, if we were drafting it—if this were a government bill—that the person who meets the criteria here is not guilty of committing an offence rather than say that the police shall not charge. There are two reasons. One is, that is not the way we typically draft legislation. Two, we try to impose or restrict police discretion as little as possible.

In your opinion, should the bill be amended so that it reflects the wording described by Mr. Saint-Denis? Please explain why or why not. Would you be able to comment on that?

● (0945)

Mr. Pierre Poirier: Again, this is a very difficult question.

From a paramedic's perspective, we are always caught between the public safety and the health care models. We are absolutely, first and foremost, advocates for the patient we treat. I give you the scenario of somebody who may be impaired, who was at the scene and now wants to drive a vehicle. There is an imperative on the paramedic to prevent that, so there may be a call to the police, in terms of assistance.

The scenario for someone who is engaged in what is termed "criminal activity" provides the same kind of difficult ethical dilemma for paramedics, but for the most part, paramedics fall on the side of patient first and patient care first.

In terms of answering your question, I would offer no expertise in terms of how the legislation is crafted. I would just say that we should promote it in the best way to recognize, in how it is finally drafted, that health care providers are also protected, in terms of recourse.

Mr. Colin Carrie: Thank you.

The Chair: Mr. Davies, go ahead.

Mr. Don Davies: Thank you to all the witnesses for being here today.

I come from British Columbia. I represent a riding in Vancouver, where, in our province, Dr. Perry Kendall has declared the opioid overdose a public health emergency. I think we're looking at about 800 people who are expected to die this year in British Columbia. That's more people than will die from motor vehicle accidents. It's been estimated that 2,000 people will die in Canada this year from opioid overdoses. I think we have a crisis on our hands that is not being given the seriousness that it really ought to be given.

I'm in favour of this bill. The purpose of this bill is to save lives. It's to encourage people at the scene of a drug use to call 911 in case of an overdose, and it's to remove impediments to doing so. I'll be supporting this bill because of that.

Also, I want to drill into this a bit from a devil's advocate point of view, because if we are going to treat this crisis as a crisis, then I think it behooves us all as legislators to actually bring in a law that will be as effective as it can possibly be. Where I'm going to drill into is whether this bill actually will accomplish what we want it to accomplish, and whether or not we can and should do more.

I'm going to read a brief excerpt from a letter from deputy chief Mike Serr, who is the chair of the Canadian Association of Chiefs of Police drug abuse committee. He says:

> In consultation with those working in the addiction field, it was learned that the premise under which the bill was written may not be accurate.
>
> Specifically, during a recent tour of Vancouver's East Side, staff of INSITE...were asked if clients were fearful to call police. The staff responded that the hesitation to call police was based on outstanding warrants or fear of breaching court imposed provisions, not fear of being charged with simple possession.

Dr. Buxton, in an article published in *The Province* on May 29, you are quoted as saying:

> "...people aren't concerned they're going to be arrested so much for possession... more likely when, if the police do arrive, then they may run their names through —whoever's there—and find that they're in breach of probation or they have outstanding warrants."

Finally, Dr. MacKenzie, if I had your testimony correct, you said that people aren't calling 911 for fear of police involvement.

My question is this. If we really want to encourage people to call the police at the scene of drug use, and this bill only grants immunity from charges for drug possession, why in God's name do we not take this opportunity right now and broaden this bill to include a broader suite of offences, including immunity from being arrested for any kind of outstanding warrants or breach of probation having to do with drug use? Would you agree with me that this would actually have a broader and more immediate impact? Is it needed?

● (0950)

Ms. Sarah Brown: Yes, I would agree with that. I also believe that having police not attend overdose calls.... There are quite a few things we need to put in place for people calling 911 to feel comfortable 100% of the time.

I think the immunity could be broadened. I understand that legislators take slow and careful steps around health, and particularly the health of people who use drugs. I'm happy that a step is being taken.

I agree with you, Mr. Davies. I think the immunity in the bill could be broadened and more people would call in that instance.

Mr. Don Davies: Dr. Buxton, do you have a comment?

Dr. Jane Buxton: Yes, I would agree, definitely. Certainly in our research we heard that it's breach of parole and breach of probation as well as outstanding warrants. I think that obviously a blanket immunity for an outstanding warrant probably is not appropriate or would be difficult, but I think your suggestion of a warrant related to drug use would be very appropriate.

Mr. Don Davies: Dr. MacKenzie.

Dr. Meredith MacKenzie: Yes, I agree with all the concerns you've identified.

My concern would be that this would stymie this bill and the progress might be regressive. I have no legislative or legal opinion that would matter. However, is there a way to move forward with the existing wording and then make an amendment at some future time? I think that if we bring this back, as Sarah said, it may take a very long time to actually get the wording correct.

While we're waiting for the wording to get corrected, more people will die because they're not calling 911, especially in the context of what we discussed this morning, which is that we're seeing something new. There are drugs that are contaminated with substances that people do not know they're using. You get people using stimulants who are overdosing on opioids and who wouldn't even maybe have a naloxone kit around to give them that few minutes of time they needed to call 911. In addition, the way people are taking drugs is changing a bit.

I think if we wait to get it perfect, more lives will be at risk.

Mr. Don Davies: I agree. It's the old phrase, “let's not let the pursuit of perfection get in the way of progress”.

I am concerned, and I do want to make sure we're hitting the target. If we pass a law that grants immunity for something that is not the reason people aren't calling 911, then we're not doing too much. We might make ourselves feel better, but we're not addressing the barrier to calling 911.

Could you give me and the committee an idea of what is the barrier? If there are people shooting drugs in an alley in east Vancouver right now and someone overdoses, what is the barrier for them calling 911? Is it the fear of being charged with possession, or is it the fear of being charged with breach of probation? Can you give me an idea—it's probably both—of the relative weight of each. What is the real problem here?

Ms. Christine Lalonde (Peer Researcher, Centretown Community Health Centre): The fear is all of that. In Ottawa, when OPS, Ottawa Police Services, shows up at the scene, usually we call the paramedics. OPS shows up for the safety of the paramedic and for nothing else. That gives them an opportunity for interrogation and intelligence, and that's what they use at that point. It's a tragedy, but what happens in saving a life turns into a witch hunt. I'm sorry, but that's the way I see it. The simple possession is not enough, like you say. I know, to get it forward, but what's it going to do? I'm not going to go back to my community and encourage this, but there's this, there's this, and there's this.

Mr. Don Davies: Thank you for saying that, because that's exactly my fear. It's the law of unintended consequences.

If people think they have immunity, but it turns out the police come, they end up not being charged with possession, they get their names run through the system, and they're charged with breach of probation, then could this have a boomerang effect the other way and cause, on the street, people not to call? They don't have the sophistication, necessarily, at the moment of overdose to weigh through, “Okay, what could I be charged with, and what can't I be charged with”.

Vermont has a law that has a broad suite of immunities. Would you not agree that we should amend this law right now in this committee to use the more broad Vermont standards that cover breach of probation and other drug-related offences if we're going to make a dent and take immediate action to deal with this crisis? Would that not be your recommendation to this committee?

● (0955)

Dr. Jane Buxton: If it can be done without delays, then yes. As I mentioned, breach of probation and breach of parole should be included, definitely. That's a simple addition to have to it. I think including the warrant with regard to drug-related offences would be ideal.

The other thing to mention is that in Vancouver, where the police don't routinely turn up and where the police don't arrest for simple possession, the rate of calling 911 is far higher than anywhere else, so I think we do have evidence that it works when the message gets out. The other important thing is that we are hearing about youth who may be experimenting or people who are using stimulants and being naive to opioids and having overdoses. They're also a population that needs to know this bill has gone through, so they're not afraid that parents will be angry or they'll be charged.

The Chair: Thanks very much. I hate to stop you in full flight.

Dr. Eyolfson.

Mr. Doug Eyolfson: Thank you, all, for coming. I'm the emergency physician that Mr. Carrie referred to. I have worked in an inner city emergency department in Winnipeg, where there's a lot of violence and a lot of drug use. I also spent six years as the medical director of Manitoba's EMS system.

Mr. Poirier, maybe offline, I'd like to talk to you about the regulatory changes. I didn't know there were still jurisdictions in Canada where you had to call the doctor to give naloxone. Every provincial director I've spoken to said it was offline, and it was a delegated act with offline control. I'm curious about that.

Dr. MacKenzie, we talked about marginalization and stigma in regard to drug use. We know that many people in society think those who use drugs just made “bad choices” and treat people like that accordingly. Do you think this stigma affects people's willingness to seek help in regard to drug issues, including overdose?

Dr. Meredith MacKenzie: Yes, I definitely do. I've been working with a marginalized population for the past 16 years and that is absolutely the story that they will tell me should be true.

Mr. Doug Eyolfson: There's still a controversy today: harm reduction versus abstinence only. In regard to reducing drug use and reducing the harm of drug use, do you believe that harm reduction leads to any sort of increase in drug use?

Dr. Meredith MacKenzie: You're looking at naloxone specifically as a harm reduction technique, which most people would call naloxone. There's actually a study showing that it did not increase the use of drugs or the way in which people use drugs. For example, it did not increase the riskiness of the drug use.

Mr. Doug Eyolfson: Thank you.

Ms. Lalonde, thank you for coming and doing this. It must be quite difficult to come and be open about the issues you've had with the system.

Do you believe this bill would increase access for people who feel marginalized by the system because of the issues they have with substances?

Ms. Christine Lalonde: Not from the way it's written here.... Where it's amended in here, you're presuming that there's going to be charges. It's the assumption that there will be repercussions from trying to do this, whichever way it is, if it's calling and running away and waiting around the corner. The only solution I can offer, and that's to my own community, is to maybe call your lawyer after the paramedic is there so you have some kind of immunity. That's what we face, especially in this city.

● (1000)

Mr. Doug Eyolfson: We talked about the issues of broadening the law. Do you think broadening the law would help with that?

Ms. Christine Lalonde: Definitely.

Mr. Doug Eyolfson: Dr. Buxton, you mentioned broadening it versus delay. Would you agree that the situation right now is urgent enough to pass this without delay? Given the choice between adding those amendments with a bit of a delay or passing this now and then amending it to broaden it, what would be in the best interests of the public, from your point of view?

Dr. Jane Buxton: From my point of view, I think it's very difficult. I don't know how long the delay would be, but I would imagine it wouldn't be too hard to add the breach of parole and breach of probation as an amendment quickly, and then discuss the warrants at a later date. I really don't want to delay and to actually get the messaging out.

Mr. Doug Eyolfson: If it were to delay it by several months, would you think it would be worthwhile doing that?

Dr. Jane Buxton: I'm concerned. We need to act now. It is just one of many other pieces of the puzzle that we're trying to help.... All deaths should be preventable from an overdose. This is one that will help and improve, but it's one of many.

Mr. Doug Eyolfson: Thank you.

I'm sorting through these questions because so many of the questions I had prepared, you've all answered during the testimony so far. That means you're doing your part very well.

Dr. Buxton, I know you're on the spot a lot here. Some of the questions again resonate with the subject matter I know. When legislation is an abstinence-only approach and nothing else—zero legal tolerance, abstinence only—what effect do those such laws have on drug use patterns, and illness and mortality from that?

Dr. Jane Buxton: Basically, it drives people to hide their use, which means that people will hide their use and use in a much more risky way. They will not tell other people that they are using.... Harm reduction is a pragmatic approach. It really accepts people where they are and then works with people to help them work through things. Abstinence is not the answer for everybody, and we actually find abstinence can cause more damage. If people go into treatment and there's an abstinence base, if they do try using again, they're more likely to have an overdose because they've lost their tolerance. I think an abstinence-based approach may suit some people, but the vast majority really need a harm reduction approach, and opioid agonist therapy and other things to help stabilize things and help them move along.

Mr. Doug Eyolfson: Thank you very much.

I believe that's my time.

The Chair: Thanks very much.

That completes our first round.

Our second round will start with Ms. Harder.

Ms. Rachael Harder: I'll direct my first question to Ms. MacKenzie, if you don't mind.

You made a comment with regard to young people and their use. Would you happen to have a percentage or a number that goes with the use among young people with regard to opiates and fentanyl?

Dr. Meredith MacKenzie: I don't have a percentage.

I can tell you from our personal experience at our clinic that we have a number of youth, which is broadly defined now to include ages 16 to 25. The vast majority of people who attend our clinic are people who use drugs and who may use them in a riskier fashion or maybe in a fashion that's less predictable. They would use stimulants and also opioids, one or the other, and not often, so they would use intermittently.

● (1005)

Ms. Rachael Harder: One of the other things that came up in this conversation was with regard to making sure that we get the message out. I view that as a really critical piece. It's one thing to put the legislation in place as that's our job around this table but it makes no difference for the general public and saving lives if we don't get that message out.

Starting with you, Meredith, can you comment on how we might go about doing that as a society?

Dr. Meredith MacKenzie: If we look at the example of what Washington state did when they enacted their good Samaritan legislation in 2010, they followed that up about a year later with a survey of all the Seattle patrol officers during roll call. That survey had an incredibly high response rate of 97%. I've never seen a survey with that high a response rate. They asked those officers if they were aware of the good Samaritan legislation.

To give the committee some context, 67% of those officers who presented had an overdose in that prior year. Only 16% of those roll-call officers were aware of the good Samaritan legislation and of those 16%, only half of those were aware that it included bystanders as well as the victim in that legislation.

The police force took that information, and realized this wasn't good, and they started an education initiative that involved the narcotics police officer, public health, and the legal people to all get together. They made a video that they would show at every roll call for all new officers. I think roll call is mandatory; other people probably know more about that than me. That got the message out to every new recruit and it was repeated over and over again to police officers to make them aware of that. Federally we're lacking a drug czar, for lack of a better word, who can quarterback the need for a national response to this opioid overdose crisis. I think a part of that response would be something like getting the word out on good Samaritan legislation. That would include police, harm reduction people, and people with real lived experience, and people who are doing opioid substitution therapies. Public health would be a part of that as well.

Ms. Rachael Harder: Thank you.

Sarah, this piece of legislation is one step but it would appear to me that a bigger strategy needs to be in place. I think all of you here today have alluded to that. What else needs to be a part of that bigger strategy to tackle the problem of opioid and fentanyl overdoses here in Canada?

Ms. Sarah Brown: I'm not sure how many years ago—Jane may know—Portugal decriminalized the use of small amounts of all drugs. The use of drugs is a criminal activity in this country. Their overdose deaths and overdoses have plummeted so that is one strategy. We've talked a lot about opioid substitution therapy. That includes methadone, suboxone, and even heroin prescriptions so there needs to be more access to that. Most people on social assistance don't pay for that stuff as it's covered by the provincial government but many people who are working have to pay. That was in the news last week; you may not be able to manage $7 a day for your methadone.

What else? Supervised consumption sites; thank you. These are places where people can inject. People are at a higher risk of overdose when they're injecting quickly and when they're trying to hide their injection. They might be doing it outside in public, in a Tim Hortons washroom, or in an alleyway. They're going to take more risk and they're going to be more likely to overdose. A lot more education needs to be done post-treatment. Jane alluded to this earlier. When people finish addiction treatment the reality is that a number of people will relapse in the first year of their treatment. They are at a very high risk of overdose in those instances. Similarly, they're at a very high risk of overdosing coming out of jail or a hospital where they haven't used for a number of months. A lot of education needs to be done at those opportunities.

Dr. Meredith MacKenzie: I was just going to mention with the other things that we need real-time surveillance of drug use. We have no idea of what's going on across the country. Most of our data is at least two years old by the time it comes to us from the Office of the Chief Coroner.

● (1010)

Ms. Sarah Brown: That's true.

Dr. Meredith MacKenzie: Also, we need to do something about how we prescribe medication in this country. There needs to be a national approach.

Ms. Sarah Brown: The pharmaceutical companies need to be involved. One of the reasons why we're facing this fentanyl crisis is because OxyContin's formula was changed a few years ago. We squash one drug—we squashed OxyContin, or we changed the chemical makeup of OxyContin so it couldn't be tampered with—and then another one pops up in its place. In this case it's fentanyl.

The Chair: The time is up.

Mr. Kang.

Mr. Darshan Singh Kang: Ms. Brown, my questions are about the fear of prosecution. It is suggested that fear of prosecution is a barrier to calling 911 in the event of an overdose. How real is this fear? Would removing the barrier to calling 911 really mean anything to drug users? Have you been keeping some kind of record of how many drug users have been calling for an overdose and what kind of impact this is going to have on more people calling?

Ms. Sarah Brown: The relationship between the people who use drugs in this particular jurisdiction and the police is not a good one. There's not a lot of trust, so the community often takes care of itself. They try to manage the overdose on their own without calling 911. There was some earlier discussion about having people dragged onto the front porches of houses. Then 911 is called and the person hides in the bushes and waits for the paramedics to arrive. The fear is very real.

People will make decisions or they'll hesitate or they won't call.

Mr. Darshan Singh Kang: As a front-line worker, you have first-hand knowledge as to how removing the barriers to calling 911 might help in overdose situations. The problem, however, is not the law. It is making drug users aware that it's safe to call for help. Can you tell us what needs to be done to make drug users aware of this legislation?

Ms. Sarah Brown: There are a number of ways that we can communicate if this bill is passed. We can communicate this bill to people who use drugs. I am one of maybe 30 people in the city—maybe 40 or 50 really—who have daily contact with people who use drugs. We also have a very large peer network of people who are doing research, like Christine, who are working in harm reduction fields. That's a really great network to disseminate information about this bill. Methadone clinics offer another opportunity, as do pharmacies.

I think my concern with communication around this bill is that police are communicated to about the passage of this bill and the immunity outlined in this bill, that police are aware of this and that they actually follow through with it.

I'm a bit concerned. There was something mentioned earlier about police discretion. I actually worry quite a bit about police discretion and would like to see them have a bit less discretion.

My other concern is for the community of experimenters, people who are newer to the drug scene, and we've alluded to that at this meeting as well, younger people, people who are trying drugs for the first, second, or third time, people in party situations. They are not people that I see. Most people that I see daily are well established in their drug use. The folks who are newer to it need to be communicated to. I suppose in that instance it would have to be a much larger public message, perhaps through advertising, perhaps through billboards.

Mr. Darshan Singh Kang: Don't you think that if the law enforcement agencies came forward that would be a much more effective way to communicate with people who are doing drugs? I think we should have a concerted approach around educating them, so that they know they will not be charged if they call the police. If it came from the police or a law enforcement agency, I think that would have a bigger impact.

● (1015)

Ms. Sarah Brown: Do you mean if the police departments were telling people who use drugs, “We won't charge you”?

Mr. Darshan Singh Kang: This would be some form of education that should come from them, too. I'm not saying that they tell them, “If you use drugs, we won't charge you.” I know what you're getting at, but I think the people are afraid of the police.

They are not afraid of the first responders on the medical team. There should be some form of education on that side too, somehow, such as having an open house. It's not the police; it's not saying, “If you do drugs, we won't charge you” within the context of some overdose. It's just to let people know their rights.

Ms. Sarah Brown: My concern with the police disseminating the information again is around trust. The community of people who use drugs need to hear it from people they trust. They need to hear from someone they can trust that their health and safety is a priority and that they won't be charged.

Mr. Darshan Singh Kang: My concern is that they trust you, but still in the back of their mind they're going to think that if the police show up, they may be charged. That's where I'm going.

Ms. Sarah Brown: So it has more weight if it comes from...? I see, okay.

The Chair: The time's up.

Mr. Webber.

Mr. Len Webber: Thank you, all, for being here today.

Dr. MacKenzie, you mentioned that Canada is the number one country using opioids in the world. You also mentioned that there's been a 75% increase in deaths due to opioid overdose usage, one death every 14 hours. That's shocking.

Ms. Brown, you mentioned that this is the first step, Bill C-224, but that this is one of a multitude of strategies that can be implemented.

Dr. Buxton, you mentioned that there are 750 deaths in a year due to fentanyl and that we need to act now.

Mr. Poirier, you mentioned that this should be a federal initiative for a provincial mandate, that we need a national strategy, and that this is an epidemic.

I would ask Dr. MacKenzie first, is this a public health crisis?

Dr. Meredith MacKenzie: Yes, it is a public health crisis.

Mr. Len Webber: Ms. Brown, is this a public health crisis?

Ms. Sarah Brown: Absolutely.

Mr. Len Webber: Ms. Lalonde, is this a public health crisis?

Ms. Christine Lalonde: Yes.

Mr. Len Webber: Dr. Buxton, is this a public health crisis? And of course, Mr. Poirier, is it a public health crisis?

Dr. Jane Buxton: Yes.

Mr. Pierre Poirier: Yes.

Mr. Len Webber: I suspect that everyone on this committee also sees this as a public health crisis, the use of deadly fentanyl, and so notwithstanding normal practices and procedures for introducing a motion, I'd like to seek unanimous consent to discuss this issue promptly before this committee, in the hopes that we can save lives.

I would ask that I receive unanimous approval to table the following motion for debate, and then I would also ask my colleagues that we move immediately to a vote, so as to not belabour this, and allow the clerk as much time as possible to plan for such a meeting.

My motion is that, pursuant to Standing Order 102(2), the committee undertake an immediate study of the fentanyl and opioid crisis in Canada, in light of the alarming and growing number of deaths caused by these substances, to determine what action can be taken by this federal government.

That is the motion I have now put on the table, Mr. Chair.

I'd like to thank you all again for being here today. I hope that this committee will support this opportunity for me to table this motion.

The Chair: I'm just advised that normally this type of motion requires 48 hours' notice. I wonder whether you could give us the 48 hours, and then we'll discuss it at the next meeting.

Mr. Len Webber: I'm asking for unanimous consent around the room here to allow this to be tabled now.

The Chair: That's fair, but normally it takes 48 hours. I just asked whether you would consider it, to give it thought.

Mr. Len Webber: The fact is that this is a national crisis, a public health crisis. This is an emergency, Mr. Chair, and I would ask that we have a vote here right now to determine whether or not we need to proceed forward immediately on this motion.

● (1020)

The Chair: We have a motion on the floor seeking unanimous consent.

Yes, Mr. Davies.

Mr. Don Davies: Mr. Chair, I have a question for the clerk. Procedurally, our Standing Orders require 48 hours' notice of any substantive motion.

Can a standing order be waived by unanimous consent?

The Clerk: Yes, if we want to move them parallel to a motion that we have adopted, we need unanimous consent. It is sometimes done, but usually it is 48 hours' notice for substantive motions.

The Chair: Are there any other comments?

Mr. Len Webber: Mr. Chair, given the fact that our panel of presenters have all admitted that this is a public health crisis and an emergency, I would say that we move forward with this study immediately and pass this motion.

The Chair: Mr. Oliver, go ahead.

Mr. John Oliver: During the evidence that was presented by our witnesses, I heard many other issues arising, such as removing naloxone from the schedule I prohibitions so that it is available for treatment. I think there are a number of very urgent things at stake here, and I am just worried that rushing to one aspect of the problem doesn't really look at what the most direct beneficial thing we can do is, in addition to passing this very important piece of legislation.

I just have a concern that we haven't given this full consideration to be unanimously waiving a 48-hour notice of a motion.

The Chair: Would your motion also consider the debate about decriminalizing all drugs and about public injection sites?

Mr. Len Webber: It would consider every aspect of the crisis that is happening right now. There is one death every 14 hours. We have to get on this immediately. This is very urgent. I believe we need to pursue this, and my motion should be discussed and passed.

The Chair: Mr. Davies, go ahead.

Mr. Don Davies: Mr. Chair, I am strongly in favour of this motion. In health care, there are literally hundreds of issues, and lots that are important, but I think it is rare that we have something, as I already said, that has been declared, by British Columbia, a public health emergency. We are hearing these witnesses who are all very experienced in different aspects of this. I regard this as a very pressing public health emergency. I think it does warrant adjusting the committee's business. We would probably need to give our analysts some time to put together a witness list. I haven't heard how many meetings we would devote to this, but if we had, right now, a viral epidemic in this country that was killing people every 14 hours, I think we would be acting immediately, and this is similar to that.

I am going to support the motion. I think it is wise and it is needed, and I think we should waive our standard 48 hours' notice. I think it is a good idea to give the analysts some time to come back and work with Mr. Webber and the committee on how we can move this very quickly, but also make sure that we have the right witnesses before this committee who can give us good evidence to advise the government on the best steps it can take to deal with this crisis.

The Chair: Mr. Oliver, go ahead.

Mr. John Oliver: We have a very important bill in front of us, Bill C-224. We have to go to the clause-by-clause study. We have about 20 minutes left, so I am going to move that we waive further discussion on this motion.

The Chair: Do I recognize Mr. Carrie, or do we move on Mr. Oliver's...?

Mr. Colin Carrie: We'll just vote. I agree with Mr. Davies. This is an emergency situation. I applaud my colleague for bringing it forward. There are challenges with the bill in front of us, but I think it is very important that we move forward, as Madam Buxton said. We have something on the table that I think warrants the immediate attention of this committee. I am not going to debate it. Let's just vote.

The Chair: Mr. Davies, go ahead.

Mr. Don Davies: Sorry, now I am a little unclear.

I didn't take this motion by Mr. Webber to mean that we would suspend what we are dealing with today. I want to make sure, Dr. Carrie, that I am clear on that—that we can still continue this meeting to deal with this very important bill, but my understanding is that our next order of business, perhaps on Wednesday or maybe next week, will be to devote time to the opioid crisis generally. Is that correct?

● (1025)

Mr. Len Webber: Absolutely. That is correct, Mr. Davies. The fact that we can give our clerk some time to plan some possible meetings—

Mr. John Oliver: On a point of order, sir, I thought I had moved the motion that we end debate on this and begin our clause-by-clause study on Bill C-224.

The Chair: Mr. Oliver, we need unanimous consent to waive the 48-hours' notice. If we vote on that right now—

Mr. John Oliver: I think we should end debate, have the vote, and get on with the work that we're supposed to be doing right now.

The Chair: There are actually two votes. We have to vote on unanimous consent. Will we accept unanimous consent? Then we need to have the vote on unanimous consent. No, I'm sorry: to waive the 48 hours. I'm going to go to that step. We're going to vote on whether we will waive the 48 hours as normally required.

Mr. Carrie.

Mr. Colin Carrie: I'm sorry. Are we voting?

The Chair: We're voting on this: are we going to waive the 48-hour requirement? We need unanimous consent on this too.

We don't have unanimous consent on waiving the 48 hours.

Mr. Webber, you'll have to put your motion in writing and submit it for 48 hours, and then we will have a look at it.

Mr. Len Webber: That's very disappointing, Mr. Chair, but I will do that.

The Chair: It's an enormous proposal that you have. I realize how urgent it is, but it is enormous, and it's only fair that everybody have a chance to consider it.

Mr. Ayoub, you're next.

[*Translation*]

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

I thank you for being here with us this morning. I think that everyone here recognizes the goodwill and the possibility for action that this bill represents. We would like to do more, but in doing so we might prevent actions that could be taken more rapidly in order to save lives.

We are really talking about drug possession, and not about illegal acts like trafficking. We are talking about legal mandates for people who sometimes use these drugs or people who help them to obtain these drugs or medications, or to inject them.

My question is addressed to all of you.

What should we do? Should we legalize a group of drugs while specifying all of the ones that would be included?

Firstly, I fear that we will be opening the door to certain behaviours. Our primary purpose is really to save lives. However, this could affect the behaviour of some drug traffickers or people who live in illegality and contribute to the problem. We do not want to persecute certain people.

What is your opinion?

Let's begin with Ms. Brown.

Ms. Sarah Brown: I understood part of your question.

[*English*]

Mr. Ramez Ayoub: You can answer in English. That's not a problem.

Ms. Sarah Brown: Do you mind repeating the crux of your question in English for me, just the nuance that I'm not touching?

[*Translation*]

Thank you.

[*English*]

Mr. Ramez Ayoub: My point is about not pursuing the people who have an illegal trafficking mandate, but a way to save lives.... We're not contributing to resolving the problem for the rest of the society. That's one point we're addressing very specifically—saving one life every 14 hours—but the rest of the problem is not addressed. Maybe we're missing some points. I heard other options that maybe would be a solution: to legalize more drugs or to legalize possession for more drugs. Where do you stand on that?

● (1030)

Ms. Sarah Brown: I absolutely think we should legalize, or let's start with decriminalization. That's a bit easier than legalizing drug use, so let's decriminalize drug use in this country.

I want to clarify what you're asking. Are you saying that if we grant immunity to people on scene, then we're leaving out the rest of Canadians who may also be at risk of overdose or...?

Mr. Ramez Ayoub: No, we're just opening the door for more trafficking or more legally...not pursuing because I sense a different situation between calling 911 and calling the police, or calling the paramedics. There's a big difference when you call the paramedics. They're on site quickly and they can act from a medical point of view. When you call 911, you have the sense you're calling the police. You're contacting the legal side of it, or the prosecution of it, and those are two ways of addressing the problem and helping people. That's what I'm getting at.

Ms. Sarah Brown: It's my belief that an overdose is a medical emergency and it's not a criminal act. I think that needs to take priority at an overdose scene. Police do often arrive at overdose scenes for a variety of reasons. Fire crews arrive as well in the city quite often.

I don't think we are going to cause an increase in trafficking of drugs with this bill. I don't think we're going to encourage more people to use drugs, or we're going to encourage people to continue to use drugs. I think it's addressing a specific medical emergency. We're not addressing it well right now, because not enough people are calling.

The Chair: Thank you.

Mr. Davies.

Mr. Don Davies: If we could amend this bill today by adding in protection from prosecution for breaches of probation or of parole, would you advise this committee to do that? Do you think that would save lives?

Ms. Christine Lalonde: Absolutely.

Mr. Don Davies: I'm seeing all witnesses nod. Okay.

We had some mention made of supervised injection sites, and I think we're all starting to recognize that the opioid crisis requires a generalized suite of responses. There's no magic bullet, but it seems there's a bunch of separate things we can do that would help address the problem. I'm wondering if it would be the witnesses' suggestion that former Bill C-2 be repealed or at least amended to streamline the application process so that communities or municipalities that want to open supervised injection sites can do so much more quickly and without as much administrative bureaucracy.

Ms. Sarah Brown: Yes, it needs to be repealed. There are 26 labourious steps to open a supervised consumption site in any jurisdiction in this country and that is slowing things down. It is making it difficult, and we only have two or three sites. It absolutely needs to be repealed.

Mr. Don Davies: Dr. Buxton, what is your opinion?

Dr. Jane Buxton: I agree completely with no reservation.

Mr. Don Davies: Dr. MacKenzie.

Dr. Meredith MacKenzie: I agree.

Mr. Don Davies: Ms. Lalonde.

Ms. Christine Lalonde: I agree, and when it comes, it doesn't have to be a whole site. We can use a room in certain community centres to do things like this.

Mr. Don Davies: I'm trying to get a bit of a handle on the types of situations we're trying to capture with this bill. We have street level drug use by experienced drug users, and we're also hearing stories of young people who are maybe inexperienced drug users and who are getting captured by fentanyl. Can you give me a rough idea of the percentage of each of those?

Where are the overdoses happening? Is it 90% on the street among experienced drug users and 10% among inexperienced as an example, or what? Do you have any idea?

● (1035)

Ms. Christine Lalonde: In Ottawa and surrounding areas we have moms who are asking for naloxone outside the city in Manotick because they know their children, teenagers, and university students are experimenting with this stuff. Once it's said that it's one thing, it's hard to tell the percentage of drug in it or what else is in it. It's a powder and it's just passed on.

Mr. Don Davies: I want to just read a quick example of something that's happened in the United States:

> Last July, Shane Ward overdosed on heroin and other drugs while getting high in a van with three friends. When he passed out...21-year-old Devan Miller got behind the wheel and took off, calling 9-1-1. She was told to pull over, which she did, [by police] instructing another friend to perform CPR on Ward while they awaited an ambulance. When help arrived, Ward was taken to a nearby hospital and probably owes Miller his life.
>
> Rather than being offered amnesty from low-level drug charges—as Illinois's Good Samaritan law suggests...Miller...was charged with "aggravated battery" under the apparent contention...that she helped Ward inject himself.
>
> Miller was also charged with...drug possession, and drug delivery....

Now, what I'm worried about is if it gets out on the street that people are charged with other things besides drug possession, do you think that may have a rebound effect where all of a sudden drug users may be less likely to call police because of that fear?

Dr. Meredith MacKenzie: Yes, I think that will be the result. I think of my own patients who have actually done federal time for exactly the scenario that you're describing. But I think there's another scenario in addition to what you're describing, and we spoke about it this morning.

There are many people who are using very dangerous medications and drugs in unsafe ways who have no criminal record whatsoever. So I do believe there are parts of this that will support those folks to call 911. I'm just thinking of the kids in university. We're talking about drugs that are entirely different from any other drugs that you've ever seen before, where a grain of salt is enough to kill you. That is what's being pressed into pills and is being taken at pill parties.

I'm not saying this is perfect, but it is a step in the right direction.

The Chair: That concludes our meeting today with our presenters. On behalf of the whole committee, I want to thank all of you for your incredible information and the experience you bring to tell us about the world you work in and how you handle it. Very few of us, with the possible exception of one or two, have ever experienced what you go through. I want to thank you very sincerely for your valuable presentation, and I hope you come back soon.

We're going to take a break and then we're going to do clause-by-clause study. I should say there's another meeting here at 11:00, and we have to be out in 10 minutes, so it's going to be tight.

● (1035)

(Pause)

● (1040)

The Chair: I call the meeting back to order.

You will have to bear with me. This is my first clause-by-clause study. We have with us Mr. Philippe Méla. He is going to help us do this.

Pursuant to Standing Order 75(1), consideration of clause 1 is now called upon.

A voice: No, Mr. Chair.

Mr. Don Davies: Mr. Chair, I don't have that.

The Chair: Oh, I'm sorry, the chair calls clause 2.

(Clause 2 agreed to [See *Minutes of Proceedings*])

The Chair: Shall the short title carry?

Some hon. members: Agreed.

The Chair: Shall the title carry?

Some hon. members: Agreed.

The Chair: Shall the bill carry?

Some hon. members: Agreed.

The Chair: Shall the chair report the bill to the House?

Some hon. members: Agreed.

Mr. Don Davies: I'm sorry, I would like to move an amendment to one of the clauses, Mr. Chairman, specifically when we get to proposed new subsection 4.1(2).

The Chair: It was already adopted and carried.

Mr. Don Davies: We were moving very quickly. I was expecting that we were going to go through this clause by clause. I did not hear that clause called. It went from short title to the whole bill.

The Chair: It is clause 2, and we had called for it to carry, and we received unanimous consent to carry it, and the title and the bill.

Mr. Don Davies: I would like to back it up a little bit, Mr. Chair.

I did not understand that. I'm working off a bill where I thought clause 2 was number 2, and I was waiting for numbers 4.1(1) and 4.1 (2) to be called.

The Chair: We need unanimous consent to go back.

Do we have unanimous consent to go back and review clause 2?

Mr. Don Davies: Mr. Chair, could I speak to that?

The Chair: Yes.

Mr. Don Davies: I don't know how we're going to operate as colleagues, but this is the very first time we've done clause-by-clause. We obviously moved extremely quickly. I have a right to move amendments, and I was waiting for that.

I would ask my colleagues to not rely on a quick technicality to prevent one of the members at this committee from moving an amendment. You can vote the way you want, but I believe that in this kind of circumstance, to treat a colleague that way is not very collegial. I don't think that's the way this committee should be operating or treating each other.

The Chair: Do we have any discussion on this?

● (1045)

Mr. Len Webber: Mr. Chair, I think we should allow Mr. Davies to move his amendments, and then we can vote from there.

The Chair: Mr. Eyolfson.

Mr. Doug Eyolfson: I agree.

The Chair: The committee as a whole has operated smoothly. As a committee we've done well, so I agree with this.

We will go back and allow Mr. Davies to move his amendments.

Mr. Don Davies: Thank you, colleagues. I appreciate that.

The Chair: I just want to say, too, that I appreciate all the members and the way this committee has worked so far. I appreciate it a lot.

(On clause 2)

Mr. Don Davies: Thank you to all my colleagues.

Essentially what I want to do is propose an amendment to the bill at proposed new subsection 4.1(2).

I'm going to preface my comments by congratulating Mr. McKinnon and thanking him for bringing this important bill to Parliament's attention. As I said before, I will support it in any event.

My amendment would be to broaden the exemption in 4.1(2), to exempt people at the scene of a drug overdose not only from being charged with possession but from being charged for any violation of pretrial release, probation, furlough, or parole related to a drug offence.

As soon as people have internalized that, I'll speak to that.

The Chair: We need that in writing so we can analyze it.

Mr. Don Davies: Amendments don't have to be put in writing at this stage. They can be made from the floor.

Mr. Philippe Méla (Procedural Clerk): If I may, Mr. Davies, just for my own purpose, it's to look at it in terms of procedural admissibility, to see where it fits in the bill, and then I can advise the chair if it's admissible or not.

Mr. Don Davies: I don't have it in writing, so we'll have to fit it in now. I know they don't have to be put in writing, and certainly not in either official language either.

It's kind of awkward, because with 4.1(2), it's hard to see where it actually does exempt from possession.

I would propose, then, that after the words “to be charged” in the third line, adding the words “with any offence concerning a violation of pretrial release, probation,”—tell me if I'm going too fast.

Mr. Philippe Méla: —“with any offence concerning a violation of pretrial release”—

Mr. Don Davies: —“, probation, furlough, or parole relating to a drug offence,” and then I think the rest of the paragraph can continue.

I'll speak to that briefly, colleagues. We've all heard the evidence, so I won't belabour the point, but Mr. McKinnon's very laudable goal in this is to save lives, and we want to remove impediments to people at the scene calling 911.

We've heard directly from the witnesses. In fact, I think we've heard that being charged with possession is one factor, but it actually may not even be the main factor for people at a drug scene not calling 911. I believe that if we're going to make a dent in this, we should actually be evidence-based. The evidence that we've heard before this committee makes it very clear that those are the reasons people are not calling 911, and we want to do everything we can to encourage doing so.

I think it's an easy amendment. If we're going to be giving immunity to people for having possession of heroin, then a breach of probation for being in possession of heroin should also be a factor. Many people come out of jail. Just about every single person who comes out of jail on probation has a condition that they have to stay away from drugs and alcohol. Very often those people are drug addicts.

In fact, the public safety committee several years ago did a study and found that 80% of offenders inside our federal corrections system suffer from an addiction. It's epidemic. They come out of jail. Very many of them, not having access to treatment, start using drugs again. If they're shooting drugs in Vancouver or Ottawa or Toronto and are in breach of their probation for being in possession of them and can be arrested for the breach of probation, then this bill is not going to do anything. It's not going to encourage that person to call the police.

Now I'll—

● (1050)

Mr. John Oliver: Mr. Chair, I'm wondering if we should call the vote.

Mr. Don Davies: You can't. I have the floor right now, Mr. Oliver. I'm speaking. You can't interrupt to call the vote.

I'm speaking to my amendment. The reason that this is particularly important is that if we pass this bill and, as the evidence suggested, people are only immune from possession, and then it turns out that we give people a false sense of immunity and they then are arrested for these other offences, we may run the risk of spreading among drug users the idea that they shouldn't call police. That's counter-productive to what I believe Mr. McKinnon's objective is.

We have an opportunity to act on this right now. For people who say this will cause delay, it won't cause delay. We can vote on this right now and get the law right, right now. I can't think of a principled reason for anybody's being opposed to broadening this to include the suite of reasons for which people don't call 911, when the evidence before us is that this is why they don't.

The Chair: Mr. Davies, we're running out of time here; in fact, we're out of time.

Mr. Don Davies: Those are my submissions.

The Chair: I think that everybody probably agrees with you in principle—I can't say that for sure—but I'm advised that your amendment does not fit within the scope of the bill and is not admissible, so I can't accept the amendment. Even though I might agree with it, I can't accept it.

Mr. Don Davies: I find that preposterous. The title of the bill is the "good Samaritan drug overdose act". The purpose of the bill is to give immunity to people from criminal prosecution for a drug offence. Broadening that to include another type of drug offence has to be within the scope of the bill. How could that possibly not be within the scope of the bill?

The Chair: Well, I'm advised that it's not within the scope of the bill, and we're out of time—

Mr. Don Davies: Can I get an explanation of why it's not within the scope of the bill?

Mr. John Oliver: Mr. Chair, we're out of time. Could we call the vote, because we're out of time, and maybe explanations could happen after the committee's....

The Chair: Can we call a vote on an amendment that is not admissible?

A voice: No.

The Chair: We can't call a vote on a motion that's not admissible.

Mr. John Oliver: Can we call the vote on the original motion?

The Chair: Yes, we can call....

I think the rule—

Mr. Don Davies: May I say just one thing?

We have been quite loose in procedure, but there are a few things that are not working well in this committee.

First, people are talking when they're not recognized, and second, we keep going out of order. We have an order of business on the floor. I appreciate that Mr. Oliver may not like what we're dealing with here and may want to rush to the vote, but we have business that precedes that on the floor. We can't just dispense with it because we want to get to the end.

I have put forward an amendment, and apparently we have advice from the clerk that this is not within the scope of the bill. I challenge that. I'd like to hear an explanation of why this is outside the scope of the bill, given what I've just said.

The Chair: I'm going to ask the clerk to speak to it.

Mr. Philippe Méla: The bill looks at exempting from prosecution somebody who calls 911 or calls for help, if they are in possession of drugs. As you pointed out, you broaden the scope. Just by saying "broaden the scope", you're going beyond the scope of what was adopted at second reading, which was to limit the scope to that possession. If you go over by adding trafficking, or other suggestions that you made, you are broadening the scope, and therefore going over what was adopted by the House at second reading. That's the reason.

The Chair: Yes.

Mr. Don Davies: Mr. Chairman, first of all, "broaden the scope" as a term of art describing what you can amend at committee is not the same as my use of the vernacular "broaden the scope of the bill". What my amendment does is it adds other examples of immunity; it does not broaden the scope of the bill. The scope of the bill is to grant immunity from prosecution. It simply adds other examples, so I would challenge that ruling, Mr. Chair.

● (1055)

The Chair: Look, I'm going to rule the motion inadmissible, and I'm going to call the vote on the original bill.

All right, I'm going to call the vote—

Mr. Don Davies: Mr. Chair, I challenge your ruling that the—

The Chair: You can appeal the ruling—

Mr. Don Davies: I can't appeal it. I'm challenging your ruling, and I would call for a recorded vote on my challenge that my amendment is outside the scope of the bill.

The Chair: The motion is now that the Chair's call that the amendment is not admissible be sustained. The vote is to support my decision or not, and it is a recorded vote.

(Motion agreed to: yeas 6; nays 1 [See *Minutes of Proceedings*])

The Chair: Thank you very much.

I'm sorry that this worked out that way, but those are the rules.

We have to go back now to clause-by-clause study.

Shall clause 2 carry?

Shall the bill carry?

Mr. Don Davies: Sorry, Mr. Chair, I'm going to start... It is just a bit of procedure. You asked if the bill carried, and I didn't even see anybody vote, so I think we have to...

The Chair: Shall clause 2 carry?

(Clause 2 agreed to)

(Short title agreed to)

(Title agreed to)

(Bill agreed to)

The Chair: Shall the Chair report the bill to the House?

Some hon. members: Agreed.

The Chair: Thank you very much everybody.

The meeting is adjourned.

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