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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0845)

[*English*]

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

I welcome our presenters. We have a little challenge this morning in that we think there's going to be a vote around 10:30 or 10:40 and members will have to leave to vote. Depending on the time, we'll either come back or not come back, but we'll do the best we can to make sure we hear from you. I know that we've asked you to make 10-minute opening presentations, but if it's possible to tighten that up a bit because of the restricted timeline we have today, it gives us more chances to ask questions.

Anyway, I certainly welcome all the presenters. I know we're going to hear some interesting testimony. We're going start this morning with Chief Isadore Day, the Ontario Regional Chief.

Chief Day, please proceed and give your opening presentation.

Chief Isadore Day (Ontario Regional Chief, Assembly of First Nations): Thank you, sir.

First of all, I would like to acknowledge that we are on the unceded territory of the Algonquin people, and I'd like to acknowledge the Creator, creation, the prayers, and the protocols.

Today I will accommodate the time pressures. However, Mr. Chair, I do want to make an initial note that these are long-standing issues in our first nation communities throughout all regions across this country. Those who are suffering from this affliction of opioid addiction are living within a prison of physical and psychological torture from this addiction, and I think we need to ensure that we afford the time necessary. I will, however, accommodate the time pressures within this House today. I will ensure that I afford time for my colleagues, who are also presenting.

I'm presenting here as the Ontario Regional Chief, as a member of the AFN executive who holds the portfolio for health, and as the chair of the Chiefs Committee on Health at the Assembly of First Nations. In fact, I represent health issues for 633 first nations across the country.

I'm here because the opioid crisis occurring in Canada is also a crisis that is occurring in many of our first nation communities. Prescription drug abuse is increasing exponentially, and communities are overwhelmed with incidents of illicit drug abuse.

The use and abuse of substances has consistently been a top priority for first nations people as well as their leadership. In fact, a national survey of first nations communities completed between 2008 and 2010 reported that alcohol and drug use and abuse were considered to be the number one challenge to community wellness faced by on-reserve communities, at 82%, followed by housing at 70% and employment at 65%.

Prescription drug abuse is exacerbated by widespread violence, endemic poverty, emotional abuse, and the lasting intergenerational traumas of colonization. The psychological and social effects of residential schools have also contributed enormously to the level of addiction in first nations communities, impacting people of all ages. First nations youth are especially vulnerable to the effects of substance abuse.

The question then becomes, what can be done? More action is needed, and that's what we're here to address today.

In order to reduce prescription drug abuse in first nations communities, the decolonization of the health care system is essential. It is imperative to fully implement the “First Nations Mental Wellness Continuum Framework”. The framework outlines opportunities to build on community strengths and control of resources in order to improve existing mental wellness programming for first nations communities. This includes: community development, ownership, and capacity building; a quality care system and competent service delivery; collaboration with partners; enhanced flexible funding; and, ensuring culture is at the centre of mental wellness and must be understood as an important social determinant of health.

Again, we do have the work. The continuum has been a culmination of several years' work, and we have a document here that we can leave for the committee members.

Full implementation means increasing the amount and flexibility of resources in order to increase capacity, ensure quality care systems, and competent delivery so that all first nations have access to the essential basket of services that make up the continuum of care. A full and adequately funded continuum of services also includes long-term funding for community-based prescription drug abuse programs, such as opioid substitution therapy with buprenorphine, along with land-based treatment and other cultural treatments.

I want to note, Mr. Chair and committee members, that we are probably experts in the experience of alternative use to opiates in our communities. One thing I must underscore, however, is that we're finding that a lot of our remote communities don't have the amount of services that other regions do. In remote and rural territories in other parts of Canada, there simply are not enough resources.

● (0850)

What's happening is that you're almost getting to the point of a solution with the alternatives to opiates, but there's no follow-up. There are no investments being made, and that is really throwing good money after bad. It's actually perpetuating the ongoing and torturous cycle of addiction. What happens is that if there's no aftercare, no completion of that continuum of aftercare, then you're not getting the results you need, and it's complicating the issues.

One of the things we're looking at, Mr. Chair, is that we definitely need to look at the opiate addiction from a.... If you think about what is done in a crisis situation from a medical perspective, they triage that situation and look at all aspects. They look at the environment, the situation, and the injury, and, in this case, addiction being the injury, they are having to fully address in a very specific way that is meaningful at that community level. In the north, there's a very different situation. We do need results-based investments. That investment spending has to include land-based programming. It has to include aftercare for those communities in the north.

With regard to the mental wellness continuum framework, the creation of a community-centred and culturally driven health promotion framework is essential for building effective alternatives to the current treatment system. Ideally, a new system would enable first nations to integrate their values, beliefs, and ways of knowing into programming, making culture a foundation of health care and promotion. It is a plan that provides a broad framework and allows communities to build programs and services based on their unique needs that are responsive to service gaps that exist.

I generally like to complete my presentations, Mr. Chair, but I do have with me Carol Hopkins from the Thunderbird Partnership Foundation, who is an expert in the field. She's somebody we rely on in first nations across the country. I'd like to afford her a few minutes of my time to provide some remarks.

Thank you.

● (0855)

The Chair: Go ahead. You have minutes.

Ms. Carol Hopkins (Executive Director, Thunderbird Partnership Foundation, Assembly of First Nations): Thank you so much, Chief.

The Chair: Welcome.

Ms. Carol Hopkins: Good morning. I'm Carol Hopkins, executive director of the Thunderbird Partnership Foundation. Our mandate is to implement the mental wellness continuum framework and the "Honouring our Strengths" renewal framework. Our focus is on mental wellness, meaning addictions and mental health.

I want to also begin by acknowledging the invitation and saying thank you for that and for sharing time with the Assembly of First Nations. I also want to recognize the Algonquin people on whose land we are meeting today.

I'd like to start by taking us back to 2004, when the third report from the Auditor General criticized the first nations and Inuit health branch of Health Canada for the third time for not doing enough to mitigate the issues related to prescription drug abuse in first nations and Inuit communities. First Nations and Inuit Health then established a drug utilization prevention and promotion working group.

That working group had a mandate to do three things. One was to make data more available from the non-insured health benefits. The second was to engage first nations communities in developing and implementing a community-driven response to prescription drug abuse. The third one was to work with prescribers to address practices and situations of over-prescribing.

That was in 2004. It's 12 years later and one of those issues is still outstanding, that is, the pilot- and proposal-driven nature of funding to first nations communities to address prescription drug use issues. The most critical issue when we talk about the opiate crisis amongst first nations people is that there is annual funding based on proposals, and those proposals are not always fulfilled. It's year-to-year funding somehow expecting that within a year we're going to be able to take care of the opiate crisis that exists in first nations communities.

Addressing the opiate crisis has been a challenge, then, most significantly because of the inconsistent support to community-governed and culturally based treatment. One community-based opioid misuse study reported that among adults ages 20 to 30 years old, 28% of the community was engaged in a buprenorphine/naloxone program. Now, 28% of the community is double the rate of diabetes in that same community. We have dedicated funding, thankfully, to address the issues related to diabetes in our communities, but we don't have the same type of resources when it comes to dealing with the opiate crisis.

The drug utilization prevention and promotion program was successful in demonstrating and piloting a number of community-based programs. We also have a Lakehead study that demonstrated the success of community-governed programs to address opiate addictions. We have other programs in northern Ontario that you'll hear more about and that also demonstrate the importance and significance of this success, unfounded in urban environments and other communities, simply because of the team-based, community-driven, culturally based programs that are offered. Yet they do not have annually committed core funding within their health envelopes.

The Chair: Ms. Hopkins, I have to call it. It's time.

Ms. Carol Hopkins: That was the main point I wanted to make. Thank you very much, Chair.

The Chair: I'm glad. Thanks very much.

Dr. Chase.

Dr. Claudette Chase (Family Physician, Sioux Lookout First Nations Health Authority): Thank you for this opportunity. I'm very much hoping this will be a meaningful consultation and not further history made with consultation that doesn't lead to action, because it is not extreme to say there are lives at risk on a daily basis because of the opioid crisis.

I am speaking to you today about what I'm most familiar with, which is how the crisis has impacted northwestern Ontario first nations. I work with a practice that serves remote first nations, and we were the first in the country, I believe, to start community-based treatment programs in partnership with the first nations who wanted help.

I want to make three key points today.

The first is that the communities have worked with their primary care providers to build locally run and community-based treatment programs. These are grassroots, they're innovative, and they are effective, effective if you measure them in terms of children coming back to their parents, people being able to return to work, and education. They provide a model that could be offered to indigenous people across Canada, and I say "offered", not imposed upon. There are ongoing challenges, and I'll get to those, but I want to go through the key points first to make sure I have time for them.

Health Canada's response to this crisis can be measured along a continuum, with the low point being obstructionist and the high point being woefully inadequate. The nurses have been forbidden to work with clients in the addiction program for more than 30 days. If any of you know anything about chronic illnesses, we don't fix diabetes in 30 days and we don't fix addiction in 30 days, and there's abundant scientific evidence to prove that this is a chronic illness. Again, later, I'll speak to why this is problematic.

Number three, I think a key point is disrupting. Our Prime Minister has used the theory of disruption as a positive force, and I believe that. Disrupting the status quo of archaic colonial policies and embracing self-determination for first nations is key to ending intergenerational trauma. I think what this could look like is supporting people to develop the community healing strategies that they believe will work, and that means long-term support. It may also mean funding evaluation so that there is accountability, but I believe this is key.

I want to go back to the first point about the treatment programs and what the challenges are. The ongoing challenges include the lack of stable or adequate funding and little access to land-based treatment. The fuel prices are insane on reserve. We've seen over and over that when communities can commit to these programs, clients get better, but when they come back, especially because they're only on the land short-term, the relapse rate is high. I think that's something very concrete that you could offer to support, and it is something that the communities have asked for—for a long time.

There is no real addiction training or treatment of vicarious trauma for front-line staff. I tear up every time I think about this, because our workers are putting themselves on the line to hear the stories of incredible trauma. We have little funding to train them. These are community members who, because Health Canada has refused to step up, have stepped up themselves. They do this and they get traumatized daily, and I have little or no means to support them other than being their family doctor. It's not acceptable.

My sister worked at an Ottawa clinic for street-involved people. The training she received to work at Oasis was unbelievable. The debriefing was phenomenal. She was able to do it for 16 years. I don't think our workers are going to last 16 years.

I can elaborate more on Health Canada. I've told you that there is an actual policy. You can check with the FNIHB nursing branch about what they have directed nurses to do. I'm sorry that I didn't bring that document, but it has been circulated.

Nurses can help no more than 21 patients and for no more than 30 days, so what has happened is.... I hesitate to even bring this up, but lay people are now storing, administering, and counting buprenorphine/naloxone, which is a very powerful opiate that we use to treat narcotic addiction, and they're doing a fantastic job.

● (0900)

But it's not acceptable. I was a nurse before I was a doctor. We had so much training on how to be accountable around narcotics, and yet.... These community members are doing it and I don't want to undermine them, but it's not fair. It's not a service that would be provided down here—or a lack of a service, I guess. It's creating a divide between the communities and the nursing station. The communities say that this is their most urgent concern, and the nurses are being told by the FNIHB that they are not to be involved in this. It creates an artificial.... It creates conflict at the local level.

For the last point, about embracing self-determination, I've included the article by Chandler and his colleagues. I'm sorry, but it will be translated; it hasn't been yet. He speaks very strongly to what was a protective factor against suicide in aboriginal communities in British Columbia. He said that the in terms of the protective factors for the communities that had lower suicide rates than the dominant culture, they weren't based on economics. They were based on self-determination and attachment to their culture. Those are concrete things that you have the opportunity to support to save lives.

I have a story—it's an all too familiar story for us—of a woman who started snorting Percocets because she had been sexually abused as a child and also as an adult. Her marriage fell apart. She went from Percocets to Oxy, and from snorting to injecting. Luckily, she escaped hepatitis C, which many of the people in the community I serve have contracted. Three of her five kids went into care.

She joined our program in 2011. Her husband joined six months later. To be honest, I thought she would never make it, from what I had seen. Then one day her husband said to me that he was getting better and was back with his wife. He said that she was really strong. I asked who his wife was and he mentioned this woman who I had presumed would not make it. She has proven her strength. She has all her children back. Her marriage is back together.

She and her husband are working, but her children have multiple needs, including for the trauma they suffered when they were apart from their parents. I have no access to family therapy for them. The children need testing. I have no access to get them tested. This is not acceptable care. My colleague, Dr. Mike Kirlew, presented on the lack of services to children in isolated reserves.

These are concrete things you can change.

Thank you very much for your attention.

● (0905)

The Chair: Thank you very much for your first-hand testimony of your experiences.

Our next guest is Dr. el-Guebaly, who is a professor in the Department of Psychiatry at the University of Calgary.

Dr. Nady el-Guebaly (Professor, Department of Psychiatry, University of Calgary, As an Individual): Thank you very much for the invitation and the experience. It's my first time to stand in front of one of your committees.

First of all, I support all the statements that have been made. I was thinking as I was listening to my colleagues here that there's actually a fair amount of consensus around what we're talking about, as in the issues and so forth, and I'm thinking if there's so much consensus, how come we're still having so much difficulty delivering the services we need?

To put things in perspective, I've been in the field for 48 years—too long—as an addiction physician and an addiction psychiatrist, and I want to put this in perspective: when we talk about drugs, we should never forget about alcohol and tobacco first, followed by the other drugs.

I think we all agree that the problem we are facing is a bio/psycho/social/spiritual problem. I think there is a lot of agreement on that. Certainly among the physicians who specialize in the field, this a common agreement. This is not a matter of having one or the other. It's all together. This is the package.

I couldn't help but also think that probably 10 years ago I would have been here talking about methamphetamines. Before that, I would have been talking about stimulants. Before that, I would have been talking about heroin. The field has a way of bringing us continuous crises, one after the other after the other.

I would assume that one of the reasons that we're meeting here is that at this point in time hundreds of our patients in western Canada are dying from the fentanyl crisis as well as the overdoses from prescription drugs. I like to tell people that unfortunately we should also plan for the next crisis, and we already have it. The next crisis is not fentanyl. The next crisis is carfentanil, which is 100 times more potent than fentanyl. What else is coming up?

What is the major difference occurring right now? The major difference is that in the past our addictive drugs came from plants. This is now a thing of the past. Our major drugs will now come from labs. Therefore, the frequency, the potency, and all those qualities are going to change much more rapidly than they used to before. That, I think, is a new phenomenon that we should be careful of.

I'm a strong believer that a crisis is also an opportunity, and when I look at what has been happening over the last while, I just want to point out some topics that I think may give us some hope.

The crisis at the moment has three components to it.

Number one is the component of overdoses. This is what makes people die. Hundreds of people have died. In terms of lethality, it's probably been many years since I've seen such an amount of people dying so fast. They're not all addicted; they could be my son or my daughter going to a rock concert and taking those blue pills. Sometimes they don't even know what they're taking. Before you know it, respiratory depression occurs, it's an emergency, and you're lucky if you only pass out. These are not addicts. These are experimenters. In terms of overdoses, what we are now providing more and more across the population naloxone injections. I want to congratulate Health Canada. It's not very often that I congratulate Health Canada, so let's congratulate Health Canada when it's due. Naloxone spray is a tool that we didn't have two years ago and is now available to the population for opioids.

The second issue we have is a major issue around what to do with chronic pain. We have more and more older people. We have an aging population and we have all kinds of disabilities, all kinds of things. As a physician, I was the recipient of lectures that were given to us in the 1980s and how we were opio-phobic. Physicians were afraid to prescribe opioids, and it was “what's going on, we're not treating chronic pain properly, we don't know what we're doing”, and opioids would be the solution. As usual, the pendulum swung from A to B, and now we have this epidemic going on with prescriptions.

There are two things. First of all, there's a major effort going on at the moment with educating the physicians. It takes some time to reverse the pendulum, but I think there are some signs that the pendulum will reverse. The other thing is that the treatment of chronic pain is not only about opioids, about giving someone OxyContin. The treatment of chronic pain is a comprehensive program involving a number of alternative methods, one of which is opioids.

● (0910)

By the way, opioids are now increasingly coming up as being not that effective, in fact, in the treatment of chronic pain. The nature of the medication is such that when you use it, it will make you dependent after three to six months.

The third component, then, is addiction—and I agree with my colleagues—but it's not the only one. In addiction at the moment there are new methods of delivery going on. One of the things that has been a problem for us is the non-compliance from people. People are given medication and don't take it. The same thing applies, actually, to schizophrenic patients, so learning from schizophrenia, increasingly the medication that will be provided would be in an injectable form.

We see a number of medications in the United States that are not yet here in Canada. I really would like the committee to make a recommendation about that. There's a medication called Vivitrol. Some of the medications are implants. In the future, there are probably going to be vaccines. A number of future things are coming up. For some reason, we seem to be delaying its introduction in Canada, and I would recommend that we do something about that.

Unfortunately, as the methods of delivery of our medication change, so does the method of delivery of drugs. One of the things that is being singled out at the moment is the famous electronic cigarette. The cartridge for the electronic cigarette, which was supposed to be no problem and all that kind of stuff, can actually be used for a number of things, including the delivery of opiates, including the delivery of your favourite drug and including a number of things. We are really worried about that as, again, a new method of delivery.

In thanking the committee, I will say to please put the crisis in perspective. There are a number of components to it, and think there are some possibilities. I wouldn't talk about solutions, because humanity has experienced addiction since its beginning, but certainly, to reduce the harms of the present day with them is a possibility. It is opening up opportunities too.

Thank you.

The Chair: Thank you very much.

We're going to our seven-minute round of questions. I usually leave a little flexibility, but I'm going to keep it right at seven minutes because we will be restricted with the vote coming up.

We're going to start this morning with Mr. Kang.

● (0915)

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): First of all, I would like to thank all the witnesses for their insight on the crisis we are all facing today.

My question is for Isadore Day or Carol Hopkins. In Alberta, three bands of the Stoney Nakoda reported in July of this year that nearly 60% of their adult population was struggling with opioid addiction. In 2015, the Blood Tribe also declared a state of emergency on this issue. What factors do indigenous Canadians face that increase their likelihood of suffering from opioid addiction?

Chief Isadore Day: I'll answer part of that and then turn it over to Carol.

It is really an issue of access. You have to look at the history of opioid addiction in our first nation communities. Look at the first nations and Inuit health branch of Health Canada and the drug program.

I was a chief of Serpent River First Nation for 10 years. We used to get the drug reports. The two main drugs that were actually administered in our community, the drugs with the highest rates, were methadone and opiates. This is really a systemic issue. The roots of it are that this is how the medical profession was dealing with the health issues in our communities. They would give opiates as a way to deal with the health issues and concerns of our people. This would then establish not only the culture but a really deep dependence on opiates.

I'm going to suggest here very quickly that we have to analyze this problem from a systems and systemic perspective in that this is a shared responsibility. It's not only the individual. The federal government needs to really examine where they are at fault here. The federal government is to blame for a large portion of the problems we're faced with. Our people will have to deal with this as individuals, as families, and as communities, but this is a real systemic and chronic issue, and the genesis is found in the programs that are governed by the federal government.

Carol.

Ms. Carol Hopkins: Yes, I'd like to—

Mr. Darshan Singh Kang: You're—

Ms. Carol Hopkins: Go ahead.

Mr. Darshan Singh Kang: You're pointing fingers at the federal government. What are these faults that we should be looking at? You don't say what those things.... It's a shared responsibility. We would like to know what are those faults on the federal government side.

Chief Isadore Day: Basically, there are no alternatives. Many of our people don't have those types of psychosocial programming or the access to ways to deal with the historical trauma or physical pain. The reality is that this is an investment spending opportunity. As my colleague indicated, this is a crisis, but it's also an opportunity. What it all boils down to is that there is a two-tiered health system in this country. First nations do not have the level of health that mainstream Canada has. The stats are there. We know that a gap exists.

I think it's levelling the playing field. When our first nations have access to appropriate health programs and services, when we actually achieve health equity in this country, first nations will be able to deal with this issue.

Ms. Carol Hopkins: Yes, as I said earlier and as you heard from my friend Dr. Claudette Chase, the primary health care system we have in first nations communities is at the nursing station. Nurses employed by Health Canada do not have the scope of practice to engage in supporting first nations people in their own community in addressing opiate issues beyond 30 days. That's one point.

The second point is that we don't have access to treatment for opiate addiction, and when there is access, it's short-term access. Without access to treatment, many people are suffering in their communities, which leads to illicit drug use, and the problem continues.

I'm thankful that you mentioned southern Alberta, because I also want to say that the research on addiction says that it's permanent brain damage and it can't be undone. I think that's a racist way of keeping people on methadone, because people in indigenous communities have had to leave their communities to access treatment, and the primary course of treatment has been with methadone by physicians who say it's a course of treatment for the rest of your life.

● (0920)

Mr. Darshan Singh Kang: Thank you.

You touched a little bit on naloxone. To your knowledge, do all first nations communities have access to naloxone to treat opioid overdose?

I also have another question. Have there been any differences in the ways this crisis has been felt by the urban population as compared with the rural, and what are the differences or similarities when facing this crisis?

Those are two questions.

Ms. Carol Hopkins: Access to buprenorphine and naloxone has been a challenge for first nations communities. We have been successful in getting some greater access to buprenorphine and naloxone—it's by exception on the non-insured health benefits—and then in Ontario the Minister of Health has just announced greater access.

The program that Dr. Chase is talking about is successful because it uses buprenorphine and naloxone. I would encourage that buprenorphine and naloxone be the first line of treatment for indigenous populations with an opiate addiction, because it allows them to stay in their community and it allows for a team-based approach. Health Canada has to change its policies around nursing in communities so that it's a strength-based primary care program and not a “nurse” program, so that they can work with others in communities.

The other question you had.... I'm not sure that I answered it.

No, naloxone kits aren't widely available. That's true. We need greater access to naloxone, and we need support for broader distribution to high-risk populations for naloxone.

The Chair: Your time is up.

Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much to the witnesses for being here today. I think we could probably spend a lot more time on getting your input, and maybe that's something we can look at.

I want to ask for a couple of specifics. We're all looking for solutions. You may know Alvin Fiddler, who a few years ago was the deputy grand chief of the Nishnawbe Aski Nation. With Deb Matthews, the minister in Ontario, he was pushing to make the entire class of opioids tamper-resistant, because one of the things that was problematic, I guess in first nations.... Ms. Matthews even said that in one community in northern Ontario 85% of the community was addicted to opioids.

Dr. Chase, you were saying that they get generic OxyContin, they crush it, they snort it, they inject it, and it's very problematic. I am wondering whether you still support the idea of making that entire class of drugs tamper-resistant.

Also, how much money is allocated to mental health and addiction in first nations, and what services are offered with that money? I wondering whether you could answer that.

Dr. Claudette Chase: I'll speak first to the tamper-resistant things. They don't work. People who are addicted are in tremendous physical, emotional, and mental pain, and that motivates them to get around all those tamper-resistant things. While that may slow some things down in being injected, it doesn't stop them from being abused.

I'll let the others speak to the actual amount that's allotted, but I can say at the community level in Eabametoong, the community has taken money from other projects so that they can pay someone with a master's degree in social work to come in and offer counselling. There is one drug and addictions worker in a community where a survey five years ago found 400 people openly admitting that they had an opioid addiction—one worker. Then there are three mental health workers with various levels of training and ability who are from the community and who work with people in the program.

The program gets funding from Health Canada, and this is at the higher end of the spectrum of them being helpful. The program was on an annual basis, so the people in the program were using their energy every year to write a new proposal. I heard from a mole within Health Canada that the advice was to fund these programs at approximately 60%. I can't swear by that, but I think that was accurate information, so here you have a program that's underfunded and understaffed. We have people on the waiting list who want to join our program. We don't have enough staff to do the direct administration of the Suboxone, so whatever the funding's at, it's not adequate to truly fund a community-based treatment program.

There's the trickle-down thing. Pikangikum, which I'm sure is a first nation most of you have heard about, has a huge housing crisis. I don't know how many new houses they get a year, but there's never been someone who has came in and said that "this is how many houses you need and we're going to build them this year because we know this is why you still have tuberculosis, rheumatic fever, and all these things."

I think it's the same thing with the addictions treatment. We know how many people are addicted. The communities are aware. They know what they need. Let's fund it adequately. Let's admit that it has to be five-year funding, at the very least, and let's start saving some lives.

● (0925)

Mr. Colin Carrie: I think we've heard that prevention is one of the best ways. I believe it may have been that chief—I don't remember who the quote was attributed to—who said, "The drug pushers in my community wear white jackets." We've had witnesses say that physicians have a role here, and Chief Day mentioned the program. It seems that the simple thing is to give out the opioid instead of looking at these long-term treatments.

I was wondering about the whole idea of proper prescribing. Again, we're looking for your advice. If you had to lay out a solution and give us some concrete recommendations on what the federal government needs to do differently in regard to opioid abuse, what would that be?

Dr. Claudette Chase: I can only speak to my practice, which includes the physicians who serve the Sioux Lookout zone. Our practice of prescribing is very cautious. When we do prescribe opioids, it's often because there is very little funding for physiotherapy and occupational therapy. People get injured at work and we have no access to those services. The basic service that would prevent acute pain from becoming chronic doesn't happen.

We do have some challenges, but increasingly, in Thunder Bay and Winnipeg, specialists are no longer sending home orthopedic patients with 200 Percocets for a procedure where it might be required that they take them for a week. We are very cautious in our prescribing practices. I appreciate your bringing that up. I absolutely own that it was physicians who started this. Our prescribing practices in Ontario started this, but often it's because we don't have other services. Getting physio, OT, massage therapy, and chiropractors into these communities would decrease the need for many of my arthritic patients, whom I'm obligated to provide—

Mr. Colin Carrie: I was wondering if I could get some comments from the others too.

Dr. Claudette Chase: Certainly.

Mr. Colin Carrie: I'm a chiropractor. Seventy per cent of these opioids are given for back pain because there are no other services out there.

I think everybody would like to comment.

Dr. Nady el-Guebaly: Just very briefly, I want to make sure that we don't go to a knee-jerk reaction of suddenly moving on and saying, okay, no more opioids. Unfortunately, I have an impression that part of the fentanyl crisis that has occurred has been because of people getting desperate because suddenly their medication was cut down.

We're talking about a progressive reduction with the emphasis on "progressive" reduction and also the progressive reduction with the substitution of alternate methods. I sympathize with Dr. Chase. If you have nothing else to play with, then it's kind of difficult to look for alternatives. We really need to have a systematic approach to funding those alternatives and making them available too.

Chief Isadore Day: I'll be very quick.

Let me talk about the 30,000-foot solution. It really is about health transformation and looking at first nation jurisdiction on health. That's where we need to be, because essentially jurisdiction means authority, and authority means responsibility. We've not had a history of having our ability to respond to our own issues being respected.

For an example, look at the Indian Act system. The Indian Act system is really at the root of much of the oppression and the outside impositions that have affected the daily lives of first nations people: on land, on the people, and on our economy. That's the first piece.

If you think for a second about what has transpired here in the last two decades, you'll see that two significant studies have taken place. One was the Truth and Reconciliation Commission. The other one was the Royal Commission on Aboriginal Peoples. Those two provide the guideposts that are needed. One is on an institutional self-determination level, which really talks about the imposition of the Indian Act. Those are things that talked about nationhood and the overall community. The other one is the TRC, with the 94 calls for action. All the solutions are in there. That's the 30,000-foot solution.

The issue here was looked at by the first nations of Ontario. A few years back, we took the approach of studying this. We did a "take a stand" approach in our report, and it looked at four strategy areas that address prescription drug addiction.

The first one is obviously looking at prevention and health promotion. The second is looking at healthy relationships at all levels to address complex issues, because this is a very complex issue. It involves everybody in being part of the solution.

The third is reducing the supply, and I think this incremental approach to disentrenchment of this insidious addiction is really where we need to go. The fourth is the need for a continuum of care, that continuum of care being here, again, with first nations being responsible, responsive, and respected within that process.

Overall, this is going to require the investment needed to address the issue. The problem we're looking at right now with respect to the joint review on non-insured health benefits in Canada for first nations is the fact that historically the program is not a needs-based program. It's based on funding levels, with the allocation that comes down from Treasury Board not so much looking at the cost to deal with the solution. Again, it's throwing good money after bad and not really addressing the root of it and eradicating terrible issues like the opiate addiction.

To the committee, we do need investment spending. This is the only way.

● (0930)

The Chair: Mr. Davies.

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

Thanks to all of you for being here today. It's very compelling and helpful testimony.

The first thing I want to establish is a benchmark.

Dr. el-Guebaly, I think you made the excellent point that in many ways these issues have been with us for a long time. The substances change, but the causes, challenges, and lack of activity and action remain the same.

I want to briefly get each of you to tell me whether, in your experience, the rates of addiction are going up, down, or staying about the same.

Ms. Hopkins.

Ms. Carol Hopkins: Addictions continue to be one of the number one issues noted by first nations people. In the first nations regional longitudinal health survey, first nations people—82% across this country—said that substance use is the number one barrier to wellness in first nations communities. That might not seem surprising, but it is surprising when it's 82% saying that addiction is the number one issue, before housing and before employment.

First nations communities have been struggling with addressing substance use issues in their communities for a long time, but again, on outdated formulas, not based on needs. Some communities receive funding based on per capita, which doesn't even—

Mr. Don Davies: [*Inaudible—Editor*] I have a number of questions.

Ms. Carol Hopkins: Okay.

Mr. Don Davies: I'm just trying to find out if it's getting worse or better. I know it's profoundly important.

Ms. Carol Hopkins: We are seeing success with programs that are currently available, but is it meeting the need? No.

Mr. Don Davies: Okay.

Chief Day, is addiction becoming a greater problem, a lesser problem, or is it as bad as it always has been?

Chief Isadore Day: I think you have to look at addictions as a systems issue. I think we can look at the numbers and certainly generate the stats, but this is a very complex issue. For example, the cost impacts of alcoholism or marijuana misuse is, in some cases.... I don't like to use the comparison, because it's all bad, but when you talk about fentanyl and the types of opiates that are wreaking havoc on our communities, the cost is enormous.

I would also suggest there may be a need to start drawing some correlations among poverty, nutrition, diabetes, and addiction. If we have elevating rates of diabetes, chances are we're going to have elevated rates of addiction as well. That's just my comment.

Mr. Don Davies: Dr. Chase, is addiction getting more prevalent or less?

Dr. Claudette Chase: I've been in the area of Sioux Lookout since 1982, when I first went as an outpost nurse. When I first arrived, alcoholism was a bigger problem. The introduction and use of OxyContin, many of my patients said, was the first time in their lives that they remembered feeling relaxed and not anxious. You all know the story. It was engineered to have that impact.

I would say that there are more people involved than there ever were with alcohol, and I would say the rates are going up and the users are getting younger. We have seen 12-year-olds and 14-year-olds injecting in some of the communities.

The numbers appear higher to me, but part of the challenge is that the numbers aren't there. I would reiterate the point that this is a complex systems issue and we need data.

● (0935)

Dr. Nady el-Guebaly: I'm going to talk about general population surveys, where sometimes the figures come from the States. At this point in time, looking at the last 20 years, the rates for alcohol are—the answer for you is to go drug by drug—more or less steady, maybe slightly increased, but really steady.

There's an interesting phenomenon among the final grades of school. While we are very proud of the fact that we have reduced the rates of tobacco use, which have really come down, well, marijuana use has gone up. That's really what it is today.

Opioids, I think, are a more episodic phenomenon. I don't think we have 20-year studies on that. At this point in time, they've been on a high, particularly for overdoses and so forth.

Mr. Don Davies: Thank you.

The reason I asked is that in some ways when we look at a study like this I think we're talking about water being wet. We know it's complex. We know there are incredible social determinants involved, including poverty, lack of housing, lack of employment, the impact of colonization if we're talking about first nations, trauma, lack of treatment facilities, regional differences, and the fact that our health care system does not pay for physiotherapy, chiropractic, or counselling. You can go to a doctor if you're sick and get a prescription for a pill and go get that paid for, but if you are directed to a psychologist, you can't get three or four sessions, which may be more a appropriate angle of good care.

By the way, I noted that at the AFN assembly in Ottawa in 2011 a resolution was passed to support the Mohawk Council of Akwesasne's declaration of a state of crisis due to the community's alarming rate of substance abuse. Five years ago, it urged the federal and provincial governments to identify funds and resources for community-based programming and services. In 2012, the AFN Special Chiefs Assembly directed the National Chief and executive committee to urge the federal government to develop and fund a first nations opiate recovery and prevention strategy. That was four years ago. We have been calling for these programs and responses for years. It just doesn't happen.

My last question to you is going to give each of you an opportunity to follow up on Dr. Carrie's question. To get a resolution, what is a suggestion you have that the federal government should take? If you were the Minister of Health, the Minister of Indigenous and Northern Affairs, or the Prime Minister, what would you be directing right now to help us deal with addictions to opioids and other drugs in this country, in first nations communities and otherwise?

Ms. Carol Hopkins: I would suggest that the federal government seriously look at the resources to fully implement the first nations mental wellness continuum framework. It addresses the lifespan. It has a core basket of services that are required.

Neonatal abstinence syndrome has grown at four times the rate. First nations schools have now classrooms full of children who were born on methadone. We don't know the long-term impacts of methadone. With in utero, infant, toddler, and early childhood development, we don't know what those long-term impacts are, but we have classrooms full of kids who are struggling with that. We also have a senior population with chronic health issues and substance use issues.

This mental wellness continuum framework is a model that is intended to address that, and it relies on indigenous culture and indigenous governance over those services, and we need the resources to implement this. We keep developing these frameworks, but we don't have resources to implement them.

Mr. Don Davies: Chief Day.

The Chair: Your time is up, Mr. Davies.

Chief Isadore Day: I think this is going to require that we don't just do a committee report. I think there needs to be the commissioning of an opiate crisis response strategy for Canada. That would include the engineering of a meaningful, shared, and effective national response to opiate addiction and the crisis. In Ontario, for example, we do have the taking-a-stand strategy, but it doesn't have all the jurisdictions around the table investing in a shared solution and response, and that would include the individual. That would also include the families, and it would certainly include first nations jurisdictions.

I think we need to step it up. It needs to be commissioned, and it needs to be funded appropriately.

● (0940)

The Chair: Okay.

Moving right along, we have Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you very much.

Thank you for your testimony today. As you are aware, we've been studying the opioid crisis across Canada.

Claudette, to your concern, I think our goal as a committee is to bring some concrete recommendations forward to the minister, to Parliament, and to Health Canada to address the crisis.

What I've heard is that the opioid crisis in Canada is absolutely magnified in first nation communities, both in terms of rate of use and lack of treatment.

The frame I've been using for this, which came from one of our earlier presentations in testimony, is that we need to move from a specialized model of addiction treatment to primary care. We need to have primary care physicians and nurses, providing treatment. We need a nationally agreed to and evidence-based treatment plan, so that we are all using the same frame and are moving forward on treatment. There has to be far better access to treatment programs, both from ER referrals and from safe consumption site referrals, so that people are getting follow-up and are not just left in that state of addiction.

Also, there has to be a dramatic increase—and this is what I wanted to come back to—in funding directed to treatment centres, not filtered through a mental health frame but directly to those treatment centres.

Listening to your testimony, I'm looking for specific recommendations to deal with first nation communities. What I heard was that for northern communities in particular it's going to be very difficult to get treatment programs and centres based in those northern communities. I think the terminology was “land-based”. Does that mean services right in those communities? We don't want to fly people out for treatment, right?

Ms. Carol Hopkins: Right.

Mr. John Oliver: We want the treatment services there.

The second thing I heard was that there are significant problems with Health Canada program restrictions, particularly around scope of practice for RNs, with almost artificial time limits in terms of what service limitations they can provide.

The third was an overreliance by first nations on pilot funding and year-by-year funding. You can't get these programs established and funded and get permanent staff recruited. It's really hard to recruit people in southern Ontario on year-to-year contracts, let alone in northern Ontario or northern Canadian communities.

The fourth thing was health care worker burnout and the fact that there doesn't seem to be adequate training and adequate consultation services for the health care workers. They burn out much more rapidly in northern communities.

First of all, is that a fair summary? Those four things are differentiating a bit in first nations, without getting into root causes, without getting into why—

Ms. Carol Hopkins: I want to clarify. It's not just a northern Canada issue; it's first nations, indigenous communities. While in northern, remote, and isolated communities, we have transportation issues and access to stabilized health human resources, the opioid crisis is not just in remote, isolated communities, however—

Mr. John Oliver: Yes.

Ms. Carol Hopkins: —the example being southern Alberta. In every first nations community that is dealing with an opioid crisis—

Mr. John Oliver: Other than the treatment centres, the others I meant to refer generally to all the first nations.

Ms. Carol Hopkins: Yes.

Mr. John Oliver: Besides those four, are there any others that you would add to the list that would add to the complexity of treatment in first nations?

Chief Isadore Day: Yes. I think integration of aftercare is one. I think it's really important to recognize that one of the bigger complex issues is poverty. Often how people get involve in addictions, for example—

Mr. John Oliver: I'm sorry, Isadore, but I only have seven minutes. I totally get that there's the mental wellness framework. I actually wanted to come back and ask you a question.

Chief Isadore Day: Housing and social income—

Mr. John Oliver: Yes.

Chief Isadore Day: —that's a very important piece. They're the basic needs.

Mr. John Oliver: Here's my question on that. What we heard from a physician is that we need to end this crisis right now and deal effectively with the people who are suffering from quite significant addictions and overdose and death. We need to direct funding directly at the treatment programs, not through the mental health lens that sort of filters the money, and then limited funding seems to trickle through to the treatment programs.

Given that there is the first nations mental wellness continuum, and I totally understand that, is it your priority to fund that right now or to get the money into the treatment centres? If you had to choose, what would your...?

● (0945)

Chief Isadore Day: We need both.

Mr. John Oliver: You need both.

Chief Isadore Day: We definitely need both. On this continuum, the work has been done. We have the capability. We have the experts in our communities. We need both. We need the treatment and we need to fund the continuum.

Dr. Claudette Chase: Could I speak briefly?

I don't think there's a problem with getting the program started in the community. I have been humbled by the skill set at the local level.

The support isn't there.

One very specific thing that I think could be done to decrease mortality is that the nursing stations are allowed to give out safer injection kits between the hours of 8 a.m. and 5 p.m., and I think naloxone should be included in those kits.

Mr. John Oliver: Thank you for that.

Are there any other recommendations around treatment?

Dr. Nady el-Guebaly: I just want to mention that there's a crisis right now and I think the short-term solution is the long-term solution. The short terms are not as long, but people are dying every day. Something has to be done about this. Then that gives us an opportunity to think also in the long term.

One of the things we've done, I think, is that we're not satisfied with the way services are delivered in our country. I'm sure it's better than others, but we take an international perspective, and I'm humbled by the fact that I cannot think of any country that has found a magical solution, including the Scandinavian countries, which are supposedly providing more of a social cushion than ours is. However, when you go there, opioids are there, and everything else is there, so it's really a humbling experience.

For me, it would be around overdose and longer-term education of physicians—and health professionals, by the way, not only physicians—and looking at what's evidence-based and so forth, because what we're providing right now is not evidence-based, I have to admit.

Mr. John Oliver: [*Technical difficulty—Editor*] Big pharma: the prescription practices of physicians seem to be following through on advice, direction, and training from pharma on the use of opioids. Do you have any thoughts or comments on the role and responsibility of pharma in this crisis?

Ms. Carol Hopkins: They need to be held accountable for the education they provide. We've seen that history with Purdue Pharma, specifically with the misinformation they provided to prescribers related to the issues of OxyContin.

The only other one I would add to your list, now that I have the mike on, is harm reduction.

Mr. John Oliver: Sorry?

Ms. Carol Hopkins: We need more education on harm reduction.

I want to recognize Minister Philpott's championing of harm reduction in international conversations. We need to apply that at home. We need much more investment in educational resources to support harm reduction.

Dr. Nady el-Guebaly: One example of big pharma was the temporary approval thing. When I saw this brought up, I remember actually resigning from the committee that recommended it. It was a joke, all our patients put in boiling water.... That was the end of the temp approve....

The Chair: Okay. That ends our seven-minute rounds. We're going to five-minute rounds.

We're going to start with Mr. Webber.

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

My first question is for Dr. Nady el-Guebaly.

Doctor, you mentioned in your presentation the experimenters, the one-timers, the young kids who go to rave parties and maybe experiment with ecstasy or marijuana. In a number of cases, there's fentanyl laced in these things, which causes them to either die or end up in emergency. I've been doing a bit of reading with respect to the testing of these drugs and the access to tests that these kids or these individuals who are taking these drugs might have. They could then test to see whether there's fentanyl in the particular drug or if it's laced in a marijuana bag.

Are you familiar with these test strips at all, Doctor, in regard to the way they work or if they even do work?

Dr. Nady el-Guebaly: I guess I have some difficulty.... First of all, I want to differentiate the statuses that we're seeing right now from addiction. Not all the kids who are dying today are addicted. Sometimes it's their first, second, or third time. They were looking for something else that turned out to be laced with whatever. That goes on.

Now, with regard to the strips, I am unaware that somebody who starts doing a test strip.... Suddenly the kid is going to—I don't know why I say “kid”, because all kinds of people take it—take the product that's been given and test it? I'm not that encouraged by that kind of thing.

● (0950)

Mr. Len Webber: I'm just concerned because the Liberal government is looking at legalizing marijuana in the future, and of course it will be in abundance in society. With the problems now with fentanyl-laced marijuana, we're going to be seeing a lot more of this. I think we need to look at ways of testing these drugs before they get into—

Dr. Nady el-Guebaly: By the way, Mr. Webber, as you know, I was at an international conference in Montreal last week. So was Dr. Chase. I think the wisdom at the moment is that our recommendation for physicians is to go through a phase of decriminalization, which is urgently needed, the next step being legalization. We are worried, as physicians, to move from criminalization to legalization without going through the step of decriminalization.

Mr. Len Webber: Thank you.

I'd like to talk to our first nations representatives here today with respect to education. That's a bit of my background for politics.

With respect to how you are educating your young or your community, what do you do to reach your populations to educate them and to warn them of the risks involved?

Are there settings in your classrooms? Or do you constantly scare them with the fact that this is dangerous and they should not be experimenting? Could you speak a bit about the education of your first nations children?

Ms. Carol Hopkins: We've developed an early intervention program. It's called "Buffalo Riders". It educates primarily grades 7 and 8 children at risk of substance use, but it's also in every community. We've implemented this program in a number of first nations communities. They have found the curriculum to be so beneficial that they have used it not just with kids at risk, but to educate grades 7, 8, and even 9, and their parents, about the risks related to substance use issues. It's a program that has met every provincial and territorial standard for the health curriculum, so schools in communities have implemented this program.

Again, one of the issues is that there are not enough resources to expand it. The Thunderbird Partnership Foundation has a mandate to serve all of Canada, and I have eight staff. We are developing a train-the-trainer model to expand the capacity to deliver this early intervention program. It's had good results in terms of reducing substance use. It's been used as an alternative justice measure as well, so it's had good success.

Mr. Len Webber: That's interesting.

Chief Isadore Day: I'll take a different approach and look at this issue of legalization of marijuana and recreational use.

There is a very important process that's under way in Canada right now. It's the examining of the regulatory landscape on marijuana use. I think it will be critical that first nations are directly involved and participating in that, because the situation as it unfolds in terms of access to marijuana in our communities is going to have a very interesting, complex, and sometimes insidious impact.

My point is that we all need to be involved. There's a shared solution approach that's needed. If we get in on the ground floor with something like the regulatory landscape on the recreational use of marijuana and the decriminalization of marijuana, then certainly our first nations communities will have to be involved in the very wide education of these issues.

The Chair: Mr. Ayoub.

[*Translation*]

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

Listening to your remarks and reading about the opioid crisis, especially in Sioux Lookout, makes me dizzy. I am not making a pun. We are talking about naloxone as a quick treatment to save a life in an emergency. This is nonetheless a short-term solution.

The situation in Sioux Lookout is nothing new. It has not been going on for a week, two weeks, a month or since we noticed the crisis. Studies show that it dates back to 2013 and perhaps even earlier.

I am interested to know the causes of this crisis. We must of course have a short-term plan to save lives immediately. We also need a long-term plan to change the situation so that we do not see the same problems in two years or five years from now.

I would like to hear your views on this. What is your plan for the medium and long term? What do you expect from the government? What has been done already that did not work and what in your opinion might work? In short, we have to consult you and we have to change things. There is no point doing the same things that may not have worked. I would like your comments on that.

I know that five minutes for questions is very little time to discuss it, but we have to look at this.

Thank you.

Ms. Hopkins, I think you wanted to say something.

● (0955)

[*English*]

Ms. Carol Hopkins: One of the things I'd like to contribute to the answers among the panel is that this framework talks about the paradigm shifts that are necessary to implement this—so it's systems change—and one of them is in the background colour of this model. The colour is what they call "P.E.I. red". It's a colour to represent culture. One of the significant changes we need to make is to shift from an evidence-based absence of indigenous knowledge and cultural practices to the inclusion of indigenous knowledge and cultural practices.

That has not been consistently part of our answer in addressing any issues in first nations communities because it's not recognized as credible evidence, but we do have evidence now that says culture makes a difference. In fact, in the centre of this framework, we talk about four outcome measures—hope, belonging, meaning, and purpose—and there are 13 measurable indicators. We have the instrument to measure that and to demonstrate the impact that culture makes, but again, we need capacity to be able to help communities use instruments to collect data and to demonstrate change that they make both for individuals and for overall community wellness. It's about shifting from evidence-absent to evidence-inclusive.

[*Translation*]

Mr. Ramez Ayoub: Were you able to achieve results with this approach?

[*English*]

Ms. Carol Hopkins: Yes.

[*Translation*]

Mr. Ramez Ayoub: Have you had the opportunity to put it into practice and have you had good results?

[*English*]

Ms. Carol Hopkins: Yes.

[*Translation*]

Mr. Ramez Ayoub: It has to be recognized so we can continue using it.

[*English*]

Ms. Carol Hopkins: I was the director of a youth treatment centre for 13 years. In that time, we had 100% of the youth completing the program. Nationally, in any program, mainstream or first nations, the outcome is 50%. Not only did they complete their course of treatment, they also returned to school at a increase of 40%: 40% coming into treatment and 40% more returning to school post-treatment. Eighty-six per cent of youth discontinued sniffing gas and solvent abuse post-treatment, and the reason they did was the access to culture. Their common statement to us was, why did my life have to end up in such turmoil before I had access to culture? That's just a little insight.

With the native wellness assessment, we're seeing an increase of at least 30% from a whole-person perspective, meaning a 30% increase in having hope in their lives, knowing where they belong, having a sense of meaning, and having a sense of purpose in their lives through the use of cultural practices.

Mr. Ramez Ayoub: Thank you.

The Chair: Your time is up.

I need unanimous consent to continue. The bells are ringing.

How much time do we have, do you know?

Mr. Colin Carrie: I think it's just for the opening of Parliament right now.

Hon. Gerry Ritz (Battlefords—Lloydminster, CPC): They have to get through routine proceedings.

The Chair: Okay. We'll continue.

Mr. Ritz, welcome to our committee. You're up for five minutes.

Hon. Gerry Ritz: Thank you, Mr. Chair.

Thank you, ladies and gentlemen. It's tremendous knowledge that you possess, and you have some of the answers in front of you, I guess. The problem is, how do we coordinate all of that and have a footprint that means something?

A lot of what Mr. el-Guebaly was saying is that we're pushing a bubble through society here. As you said, there have been addictions throughout history. You talked about heroin and alcohol, and now it's designer drugs. How do we ever get ahead of that bubble and start to make a real difference? What's it going to take? I know that funding is a big part of it, but how do we put that money on target to see results that then draw more funding? That's the key with government funding: to show those early results to start building on those successes.

Ms. Hopkins, you talked about some successes you've had. How do we get that message out?

● (1000)

Ms. Carol Hopkins: We've demonstrated the results.

Dr. Nady el-Guebaly: [*Inaudible—Editor*] I'm unaware of a prevention program that has been tremendously successful, and when I hear—

Hon. Gerry Ritz: I understand. There's no magic bullet.

Dr. Nady el-Guebaly: There is no magic bullet. I think at the moment some of the programs that provide the best data have, first of all, two levels of prevention: primary prevention for everybody in the schools, for example, and having that there, and then the second level, for people who we identify as being at risk. That starts with children whose parents are already using drugs.

My personal preference would be to start with the people at risk as being a good prevention program, but I don't have a magic prevention program.

Hon. Gerry Ritz: Ms. Hopkins.

Ms. Carol Hopkins: As I was saying earlier, a number of pilot programs have been tested and have demonstrated good evidence, but there has never been any continuity to those programs, and the investment in them has often been short term. We do have a demonstration. We do have the evidence. There are a number of journal articles showing that this is the type of evidence you're looking for. Some of these speak to the success of programs like those in Sioux Lookout in northern Ontario.

We have the evidence from the drug utilization prevention and promotion program, which didn't get sustained in the long term. The youth treatment programs and the residential treatment programs also have good data, but lack the resources to make the difference that they could.

For example, with that network of resources, they could be a part of the solution in supporting youth when they go home. There could be added resources for web-based mental health services or social-media-based services. We don't have that capacity right now to reach youth. We have the implementation of a brand new helpline, which is fantastic, but it's not enough. We still need to keep going.

Hon. Gerry Ritz: A lot of it is the continuity.

Hon. Gerry Ritz: I understand your concern with project-by-project and year-by-year funding. You never get the critical mass that lets you start to roll towards the finish line to show you can actually do it.

I think it was Chief Day who mentioned the aftercare and how important it is to maintain the continuum.

Ms. Carol Hopkins: Continuity is lacking, yes.

Chief Isadore Day: Yes.

Hon. Gerry Ritz: How do you see that rolling out? Will this be done on site, with a combination of elders and mentors and community-based—

Ms. Carol Hopkins: Yes.

Hon. Gerry Ritz: —aftercare, along with professionals?

Chief Isadore Day: It's all of the above. I think we have the solutions already. It's all here.

I think there's a social contract required in this country. This addiction affects everybody. It's not just in the remote areas. It's everywhere. We need a new configuration of shared responsibility matched with investment spending that is innovated to address the issues of today. That hasn't happened yet. We're still passing the buck.

We're still looking for data. We're still looking for solutions and approaches, but we need to approach this from a perspective of shared responsibility. I think it's incumbent upon this committee to call for getting everybody at the table at the same time to reconfigure a shared responsibility and put the investment into it.

Hon. Gerry Ritz: There are also some gaps and overlaps when you consider that on-reserve is federal, while off-reserve people slide into the social services at the provincial level. Of course, there are a lot of cracks to fall through in between. How do we streamline that operation so those cracks shrink?

Chief Isadore Day: That's where first nations come in. We are the experts. We understand the landscape of the multi-jurisdictional overlaps on primary health care and on policy. We have the ability to do that. I think we need to be involved in the solutions, and we need to be there at the table to help configure those solutions.

Hon. Gerry Ritz: Dr. Chase.

Dr. Claudette Chase: I just wanted to speak to the fact that we have the evidence of prevention in this room: good nutrition, good education, solid housing, and an overall sense of well-being. As the dominant culture, we have deliberately not allowed this in the first nations and our indigenous peoples in Canada. I think the evidence for prevention is strong before us all. We just need to acknowledge it and support what my colleagues have talked about: a new social contract.

The Chair: Your time is up, Mr. Ritz.

Dr. Nady el-Guebaly: I have something that I would like to add. Taking the kids out of their culture and sending them somewhere by plane somewhere else is an utter disaster. Unfortunately, I've seen Health Canada do that several times. If there's a crisis, they send kids somewhere else. We've had this experience in Calgary with people from the northern communities coming in. I'm not too sure what the recovery rate there was, but I think it was very close to zero. Establishing programs within the people's communities is critical.

● (1005)

The Chair: Thank you very much.

Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thanks very much to all of you for coming and for your valuable input.

I apologize, but I had to step out for a moment, and on a slightly unrelated note, I understand that there was an implication that the legalization of marijuana might lead to an increase in marijuana laced with fentanyl. From what I understand, part of the purpose of the legalization is that you would have a legalized, regulated, and inspected supply chain that would in fact prevent this. This is one of the reasons for legalizing it. When you're buying it from a legal source, you don't have that problem. I wanted to clarify that this was behind that strategy.

Going back to what we were talking about before, there are a couple of different physicians groups, the College of Family Physicians, and the Indigenous Physicians Association of Canada, and there is a guide, “Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada”, which was released in 2016. It noted that there was unintentional racism that would manifest in the way of erroneous assumptions. Again, having been in the health care system for 20 years, I'd say that not all of it was unintentional. It said that these assumptions would change how health care providers, all the way from first responders up through nurses and physicians, might affect care.

Ms. Hopkins and Mr. Day, in your experience, has this kind of racism in the health care system affected how victims of addiction are treated?

Ms. Carol Hopkins: I'd like to go back to my earlier comments related to methadone. We've had significant issues related to methadone clinics and risk to first nations communities.

I believe in methadone. It's an absolutely necessary part of the solution. But when the solution is absent of and disrespectful of first nations governance, who then have to carry the burden of risks related to methadone in that community, that, to me, is racism, as is telling first nations people that once you are on methadone, you are on methadone for the rest of your life, meaning you can no longer go home. You can't take your new children to meet their grandparents in the isolated remote community. You have to live in an urban environment, in poverty, outside of a family system of support. That's racism.

We have seen evidence where first nations people have been moved from methadone to Suboxone, to being opiate replacement therapy-free and living well in their communities. The connection to land, to people, their lineage, and their language, is critical for their overall wellness. I offer that as an example.

Chief Isadore Day: I'll be very quick on this.

We met last week with about 40 to 50 service providers, dental, vision, and rheumatology. What we were doing, sir, is asking questions about providing service to first nations under the non-insured health benefits program right now and what the problems are, and every one of them was experiencing the same thing. They were saying that they want to treat the issues and they want to deliver solutions, but they can't because there are constraints and policy guidelines that are based on the Indian Act system. That is very much at the root of the problem, because this is a race-based program.

What we're finding is that the situation and the impacts are exacerbated by racism at the institutional level within the funded program of non-insured health benefits. The joint review right now is critical. I think the committee should take a very close look at the outcomes there and deal with racism at the source.

Mr. Doug Eyolfson: Thank you.

I went to medical school in the early 1990s. There was some training in population-specific health. Much of it was for first nations people. I went to medical school in Winnipeg, which, as you know, has a large first nations population. Do you find that there's been any improvement in the training of health care providers in terms of them having more awareness of the particular challenges of our first nations people?

● (1010)

Ms. Carol Hopkins: I think there's interest. Certainly, there's a great movement in cultural competency training, but do we have measures to demonstrate the impact of cultural competency and client outcomes? We don't have that data currently.

I know there's greater interest in the College of Family Physicians to ensure that physicians have appropriate training in addictions, but also in understanding how to provide trauma-informed care to first nations populations. We don't know what the outcome of that is yet.

Mr. Doug Eyolfson: All right. Thank you.

The Chair: Your time is up.

Mr. Davies, you have three minutes.

Mr. Don Davies: Thank you.

Dr. Chase, in an article that was published recently you described a program that takes patients out on the land as part of their treatment. To quote, you said:

> There are very few things I've been involved with in my medical career that I can say have made as much difference as this program. It is really very impressive.

Can you expand a bit on that program and how you think it may help?

Dr. Claudette Chase: I mentioned that Eabametoong has a program that has evolved over the years. We started in 2010 in response to the state of emergency, and it has evolved. Whenever there is funding, people are taken out, with elders involved. They go out by canoe or by motorboat, and they get back in touch with their culture.

One of the first minor successes we had in the program was I had someone say to me, “For the first time in three years, my wife and I went out and got wood.” That may sound simple to you, but it wasn't just a trip to get fuel. It was a day out on the land. They laughed together and they worked together. They came back feeling really proud that they had gotten it. It was a spiritual connection that I don't fully understand—I am not Anishinabe—but I could witness it. That's where the successes come.

Sandy Lake also had a program. They took people out for two weeks. They were abstinent for two weeks, and they felt great at the end of the two weeks. When they went back to their community, where there was so much around and no real ongoing support, they all relapsed. It was a 100% relapse.

Mr. Don Davies: Chief Day, on October 1, 2013, as a result of the British Columbia tripartite agreement on first nations health governance, B.C.'s First Nations Health Authority assumed the programs, services, and responsibilities that were formerly handled by Health Canada. Has this transfer or type of transfer of authority helped to support improved health and well-being for indigenous people and communities in that province? Is that a model you would suggest to us that might help in the transferring of authorities to first nations communities?

Chief Isadore Day: Thank you, Mr. Davies.

It certainly is the direction that we're going in. Last week we met with the health ministers. We in the indigenous communities were at the table representing the Assembly of First Nations. What we put forward is the first nations health transformation agenda. That is going to be conjoined to the health accord discussions and negotiations going forward. It essentially says to get first nations into the process in moving forward on first nation health jurisdiction.

We know that the B.C. experience is happening in smaller isolated areas throughout Canada. For first nations, once we have a place in configuring our solutions, and once we have that authority, we then start to put forward the real costs of treatment and the real costs of prevention and we get results. Certainly, first nation jurisdiction on health is key.

The Chair: We've completed all our testimony right on time. The bells have just started to ring for the vote.

I want to thank the presenters for their answers and their concise responses to our questions, and I want to thank the members for their questions too.

Dr. Chase, you said that you hope this doesn't fall on deaf ears. I'm not exactly sure about the way you expressed it at the beginning, but you've added a unique perspective to this debate for us, and it will be reflected in our committee report as strongly as we can present it.

I want to thank all of you for your presentations. They were excellent presentations.

Now we're going to vote. This meeting is adjourned.