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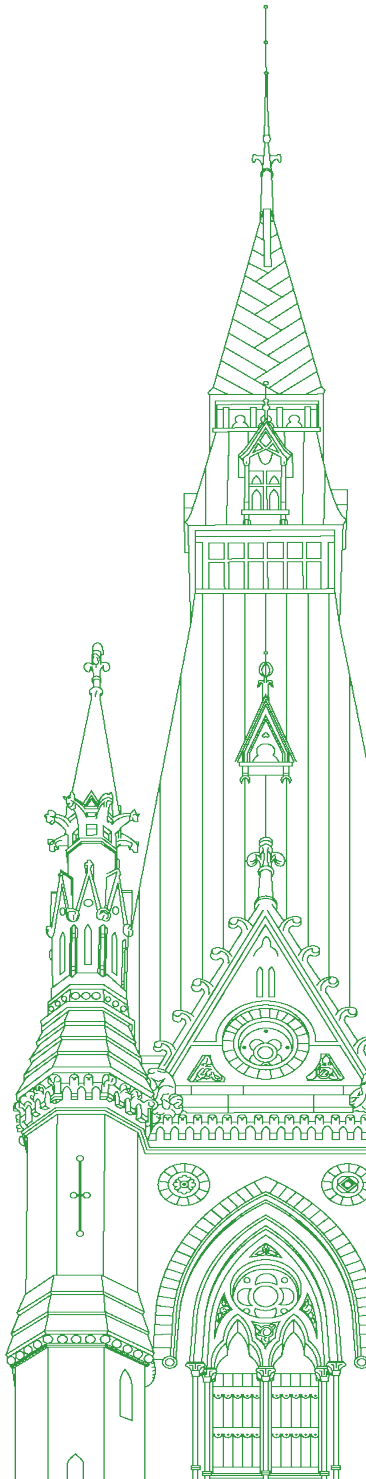

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, February 26, 2024

● (1535)

[*English*]

The Vice-Chair (Mr. Stephen Ellis (Cumberland—Colchester, CPC)): I call this meeting to order.

Welcome to meeting number 104 of the House of Commons Standing Committee on Health. Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

I would like to make a few comments for the benefit of members. Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mic, and please mute yourself when you are not speaking. For interpretation for those on Zoom, you have the choice, at the bottom of your screen, of floor, English or French. For those in the room, you can use the earpiece and select the desired channel. As a reminder, all comments should be addressed through the chair. Additionally, taking screenshots or photos of your screen is not permitted.

In accordance with our routine motion, I am informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Today's meeting is on the opioid epidemic and toxic drug crisis in Canada. Pursuant to Standing Order 108(2) and the motion adopted on November 8, 2023, the committee is resuming this study.

I would like to welcome our first panel of witnesses. Appearing as an individual, we have Dr. Rob Tanguay, addiction psychiatrist, by video conference. Representing the Association des intervenants en dépendance du Québec, we have Louis Letellier de St-Just, chairman of the board. Representing the London InterCommunity Health Centre, we have Dr. Andrea Sereda, lead physician, safer opioid supply program. Representing Pain BC, we have Maria Hudspith, executive director, by video conference.

Thank you for taking the time to appear today. You will each have up to five minutes for an opening statement. I will hold this sign up when you have one minute left. We're looking for good order and discipline here today.

That being said, Dr. Tanguay, you have the floor for five minutes, please.

Dr. Rob Tanguay (Addiction Psychiatrist, As an Individual): Thank you. I'll try to keep it to five minutes, since you'll make me, anyway.

I want to acknowledge that I come from the traditional territories of the peoples of the Treaty No. 7 region here in Calgary, in the Métis Nation of Alberta Region 3.

I'd also like to acknowledge that I'm a person with lived experience as well as a physician. On April 10, 2023, I lost my brother to addiction. He was found in his bathroom, dead on the floor. On September 2, 2021, I lost my best friend Tom to addiction. He was found in his kitchen, alone. On April 3, 2021, I lost one of my best childhood friends, Brent, to addiction. He was found in the basement of a house after a party.

That's why I'm here. I think we all know why we're here. It's because we're losing people every day; the last count was in the twenties. These are preventable losses of life. We are all here to try to figure something out, together.

I want to make sure we distinguish addiction from people who use drugs. We all use drugs. I'm currently drinking a coffee. Human civilization has been well known to use drugs. I am here because I'm a specialist in addiction, not a specialist in people who use drugs. Addiction is a disease. Nora Volkow and so many of us have been advocating for this model for many years. It is a disease of the brain, no different from Parkinson's disease, schizophrenia, depression and anxiety. It is a disease and should be treated as such, with appropriate health measures.

Many of our most vulnerable are affected more by this disease. Right now, we're seeing a shift in Alberta where, as we ramp up treatment, we see more and more loss among those who are living without a home. Now the majority of deaths are occurring on the street, rather than in private residences and other areas. We have to acknowledge that our most vulnerable are often people living without shelter. This represents thousands and thousands of people across our country.

When we start looking at those individuals, we understand that about half have a lifetime prevalence of traumatic brain injury, and about one in four or one in five has a moderate to severe brain injury that would normally require someone living in a home with additional supports. These individuals are resilient enough to be surviving on our streets. There's a massive increase in substance use disorders, chronic pain and mental illness among individuals living without a home, especially those who are unsheltered and not able to get into shelters. In recent B.C. data, two out of every three report significant and severe mental health concerns.

We know these individuals need our support. We know they need help. As with any health disorder, the fact that anybody is debating whether or not we should treat it is not only shocking but also discriminatory, racist and stigmatizing. We would never debate whether or not we'll treat someone's cancer or heart disease, but we will debate whether or not we'll treat somebody's addiction.

When we look at the best evidence for reducing death among those with an opioid use disorder, the data is pretty clear: It's medications for opioid use disorder. Those medications include buprenorphine and methadone. In a study done in 2020 out of Boston—one of the meccas—we saw a 90% reduction in death by adding medication for opioid use disorder in treatment. We know we can reduce overdoses by over 90% with molecules such as buprenorphine. We know we can reduce hospitalizations even more.

If there is one thing I can bring to you today, it is that we need access to treatment for all Canadians, rather than stigmatizing and believing these individuals don't deserve it. Like all of us, they deserve the best health care we can possibly provide.

I could go on for hours, but I will pause there to keep within my five minutes and pass it on.

● (1540)

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Tanguay.

[*Translation*]

Mr. Letellier de St-Just, you may go ahead. You have five minutes.

Mr. Louis Letellier de St-Just (Chairman of the Board, Association des intervenants en dépendance du Québec): Thank you, Mr. Chair.

Members of the committee, thank you for inviting me to take part in your study. It's an issue that deserves your full attention, as well as ours.

I am here today as chairman of the board of the Association des intervenants en dépendance du Québec, or AIDQ. We have expertise in addiction, prevention, treatment, rehabilitation in the community and harm reduction, of course. For a number of years, we have also been keeping a close eye on the changing drug policy landscape.

As a lawyer, I have been practising health law for more than 40 years. In 1989, I co-founded CACTUS Montréal, North America's first needle exchange program. I also teach a course for addictions counsellors on drug addiction, public policy and intervention, in the faculty of medicine and health sciences at Université de Sherbrooke.

My remarks today are not without bias, but that bias is in favour of preserving and improving drug policies that revolve around public health and respect for human rights, especially drug users' right to dignity, and the right to health services. I believe in the importance of evidence because it leads to more objective attitudes and discussions. Evidence also helps us consider some of the measures that are taken through a critical lens.

Now I will turn to the measures that have been taken since 2015-16. I want to say one thing first: the current crisis existed well before 2015. It is no secret that drug policy is a highly political issue. For the last 50 years, governments have chosen the approach of cracking down on drug use and criminalizing it. There is no doubt that repressive policies introduced in Canada between 2005 and 2015 paved the way for the crisis we face today. Of course, no approach is perfect. However, it takes hard work to undo decades of stigmatization, disregard for evidence and discrimination. It takes time.

The AIDQ's assessment of all the measures taken to date is very positive. I will list a few. During the review of the Canadian drugs and substances strategy, the government reintroduced harm reduction, which had unfortunately been set aside in 2005-06—with disastrous results. A review of the strategy's four pillars led to a modern approach, one much more suited to the current landscape. Under the strategy, access to naloxone was expanded. Well done. It was the right thing to do. The government passed the Good Samaritan Drug Overdose Act, which provides legal protection from criminal charges to individuals who seek emergency help in an overdose situation. There may be a slight problem, though: Do police services across the country all have a clear understanding of how the good Samaritan legislation is to be applied?

Reviewing the criteria to extend exemptions to supervised consumption sites, overdose prevention sites, was the right thing to do. Today, we have more than 40 such sites. As mentioned earlier, and as you are all very aware, these services save lives. I encourage all of you to tour a supervised consumption site in your riding or elsewhere. Ottawa has a number of sites. I encourage you to visit one so you can see it in action.

With the passage of Bill C-5, the government established diversion measures. What a great step. However, British Columbia's move to decriminalize illicit drugs in January 2023 has created confusion around which system applies and Canada's bipolar approach, if you will. Let's at least make sure that both systems are successful, the pilot in British Columbia and the diversion measures regime across the country.

I want to make an important point about legislative measures going forward. On one hand, I am asking you to provide greater access to safe supply and drug-checking services. On the other, I urge you not to succumb to the criticism that has been voiced in recent years, especially recently, with respect to British Columbia's decriminalization pilot. It's only a year old.

● (1545)

Let's take the time necessary to see through these essential initiatives. Above all, let's tackle criminal groups and their hold over the illegal market. There you have the recipe. What's more, I encourage you to give thoughtful consideration to the issue of legalization.

Thank you.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much.

[*English*]

Dr. Sereda, you have the floor for five minutes, please.

Dr. Andrea Sereda (Lead Physician, Safer Opioid Supply Program, London InterCommunity Health Centre): Thank you and good afternoon.

I am Dr. Andrea Sereda and I am a physician working at the London InterCommunity Health Centre. I have 14 years of frontline experience providing primary health care to about 2,000 people living in homelessness and people who use drugs.

As an emergency room doctor, I have resuscitated patients who have died due to overdose and I have treated debilitating infections related to the toxic drug supply.

I am also the lead physician for Canada's longest-running safe supply program, which has been in operation in London since 2016.

There are many different models of safe supply, but today I am going to speak about medicalized, prescribed safe supply. The goal of prescribed safe supply is to convert people who are using an unregulated, illegal, street-based supply of fentanyl to a regulated, legal, prescribed alternative opioid of known dose and known purity.

This goal is really important to understand in our discussions, because the reason unregulated fentanyl is so deadly is not just that the fentanyl molecule is so potent. We use highly potent pharmaceutical fentanyl safely in emergency rooms, ICUs and ORs across the country every single day. Illicit fentanyl is so deadly because its composition and potency are so unpredictable. People who use drugs don't know if the piece of fentanyl they have is 5% fentanyl or 70% fentanyl. It's this unpredictable variability in illicit fentanyl that is causing the devastating overdose crisis we see in Canada.

I explain the problem of fentanyl variability to my patients by using a metaphor that compares fentanyl batches to a batch of chocolate chip cookie dough. If you don't mix the cookie dough well enough, you can end up with a cookie that has two chocolate chips or a cookie that has 20 chocolate chips. These metaphorical cookies are from the same batch, but they have wildly different chocolate potencies when you bite into them. The problem with illicit fentanyl is not knowing whether you have two fentanyl chocolate chips or 20 fentanyl chocolate chips.

By providing people with a prescribed safer supply of an opioid of known dose and known purity, they always get the same standard, safe supply cookie of 10 chocolate chips. People know exactly what dose of opioids they are getting. Therefore, they can be much safer when using them.

Safe supply doctors like myself see safe supply as one part of a spectrum of solutions to the fentanyl crisis. Safe supply clinicians support their patients along the entire continuum of treatment, from abstinence to the prescription of medications like buprenorphine and sublocade, to residential treatment, if that is the person's goal. Within prescribed safe supply programs, we provide the full spectrum of treatment for people with opioid use disorder.

Safe supply is not a wild west of overprescribing, as some have described it. We prescribe safe supply very carefully to a group of people with highly complex medical and social needs that have not been met in other addiction treatment models.

To be eligible for prescribed safe supply in the first place, people need to have experienced—

● (1550)

The Vice-Chair (Mr. Stephen Ellis): Excuse me, Dr. Sereda. I just have to stop you there. I think there is a problem with the translation.

[*Translation*]

Okay. It's fine.

[*English*]

I'm sorry, Dr. Sereda. Please continue.

Dr. Andrea Sereda: As I was saying, safe supply is not a Wild West of overprescribing, as some have described it in the media. We prescribe safe supply very carefully to a group of people with highly complex medical and social needs that have not been met in other addiction treatment models. To be eligible for prescribed safe supply in the first place, people need to have experienced very severe health conditions due to their drug use, like untreated HIV or AIDS, frequent overdoses or history of severe infections.

Safe supply patients have tried multiple previous treatment options, like methadone, AA and residential treatment, often dozens of times, and they simply have not worked for them. Prescribed safe supply is another tool in the tool box for these people, and it has helped to stabilize a group of people with enormous health care needs.

Despite the efforts of safe supply critics who say we have no evidence, there is a strong and growing scientific research base of high-quality research on safe supply. Our team has published a comprehensive program evaluation, which found that safe supply patients experience significant decrease in their number of overdoses and their use of fentanyl. This rapid decrease in overdoses experienced by Ontario safe supply patients is not unique. A recent study published in the British Medical Journal found that people in B.C. who were prescribed just one day of safe supply medications had a 61% decreased chance of dying the following week. If people received four days of safe supply medications, they had a 91% decreased chance of dying.

Our team published in the Canadian Medical Association Journal in 2022. We used Ontario health administration data to compare people's emergency department hospital admissions and the number of infections in the year before they were on safe supply with the year after they were on safe supply. This data showed a 50% decrease in emergency visits and hospitalizations among safe supply patients, translating to a 50% reduction in health care costs among people prescribed safe supply.

To this committee, my job is to keep my patients safe, and the evidence shows that safer supply is helping to do that.

I'll end my remarks here, and I look forward to answering your questions.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Sereda.

Ms. Hudspith, you have the floor for five minutes, please.

Ms. Maria Hudspith (Executive Director, Pain BC): Thank you for inviting me to speak to you today.

My name is Maria Hudspith. I'm the executive director of Pain BC, a collaborative charitable organization whose vision is a future where no one is alone with pain.

I'm joining you today from the traditional ancestral and unceded territories of the Musqueam, Squamish and Tsleil-Waututh nations.

In addition to my role with Pain BC, I was the co-chair of the Canadian pain task force, convened by former health minister Ginette Petitpas Taylor following the 2018 opioid summit.

I was invited here to speak with you today about the role of chronic pain in the overdose crisis.

What do we know about chronic pain? Very briefly, chronic pain is defined as pain that persists beyond three months. It can be caused by other diseases, injury or surgery, and it can exist without an identified cause. It is a prevalent, costly and often invisible condition. One in five people in Canada lives with it across their lifespan. People who experience marginalization are disproportionately impacted by chronic pain, including indigenous peoples, people who are incarcerated, veterans, people who are unhoused and others. Best practice treatment includes what we call the three Ps: pharmacological treatment, psychological support and physical approaches.

What are the impacts of chronic pain? We know that in 2019 it cost Canada between $38.3 billion and $40.4 billion in direct and indirect costs. We know that people who live with pain are four times as likely to experience depression and anxiety, and twice as likely to die by suicide. We know that untreated pain is a significant driver of substance use and the overdose crisis. Estimates vary but consistently note that between 45% and 65% of people with substance use disorder report living with chronic pain. Chronic pain impacts our ability to work and earn a living, to go to school, to be a caregiver and to participate in our communities. Despite the prevalence, the impacts and the tremendous financial and human toll, Canada has been slow to address pain as a priority across the health system, and approaches to pain have not been integrated into the overdose crisis response.

What is the connection between pain and the overdose crisis? Well, we know that untreated pain is a significant driver of this problem. People who use substances, and their families, point to the lack of pain care as a contributor to substance use and also as an impediment to successful treatment and recovery. One example is a study focused on primary care patients who used illicit substances, which found that 87% experienced chronic pain and 51% reported using illicit drugs for pain relief. In B.C., coroner's data shows that nearly half of all people who died of overdose sought care for pain in the year prior to their deaths.

Starting in 2016, we began to see a pendulum swing away from prescribing opioids for chronic pain. The change was rapid, driven by new evidence, public discourse and various regulatory and policy levers. Unfortunately, these changes have had significant unintended consequences, as access to opioids for pain was reduced without offering accessible, affordable alternatives. Many Canadians who used opioids to manage pain have been weaned or cut off their medications. We know, through both research and the stories of people with lived experience, that this has driven some people towards the toxic drug supply, with devastating and sometimes deadly results. While governments have noted these unintended consequences of the revised prescribing guidelines, we have not seen a shift in practice, nor a reduction in overdoses. Some people who live with pain have called out the irony of safe supply, with deprescribing opioids for pain on one hand and prescribing opioids for addiction on the other.

As an organization, we care about all people who live with pain, so this distinction between “legitimate” pain patients, as sometimes has been noted—meaning people who don't live with addictions—and people who live with concurrent pain and addictions.... To us, everyone who lives with pain deserves care.

The overdose crisis has continued unabated, despite tremendous investment in prevention, harm reduction and treatment. What has lacked investment is pain management as an essential component of our health system and our overdose response.

● (1555)

The Canadian pain task force was mandated to assess the state of chronic pain in Canada, to advise on best practices and to make specific policy recommendations in the form of a national action plan. This action plan was released by Health Canada in April 2021, and implementation is ongoing through top-down and bottom-up approaches.

The action plan—

The Vice-Chair (Mr. Stephen Ellis): Ms. Hudspith, I'm going to have to stop you there. Your five minutes are up.

Ms. Maria Hudspith: Okay, thank you.

The Vice-Chair (Mr. Stephen Ellis) Thank you.

So we're all very aware, we have a convention in this committee. If someone asks a question, what we suggest is that the response is the same length as the question, and the member will have the opportunity to interrupt you, should they desire, at that same length. We will stick to that convention per the usual chair.

With that being said, let's get to the first round of questions. We'll begin with Mrs. Goodridge.

You have the floor for six minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair. It's wonderful to see you in that spot.

Thank you to all the witnesses for making time to be here today as we study this really important topic.

I'm going to start with my first question for you, Dr. Sereda.

New information has recently been released that corroborates previous reporting that there's mass safe supply diversion happening near the Chapman's Pharmacy close to your clinic. Are you aware of this diversion near Chapman's Pharmacy?

● (1600)

Dr. Andrea Sereda: I first have a question for you as well, Mrs. Goodridge.

What evidence has been released showing this?

Mrs. Laila Goodridge: It was in a series of tweets from one of the journalists, Adam Zivo. It was put out today.

Dr. Andrea Sereda: As safe supply clinicians, we rely on good research and published evidence and not on anecdotes and tweets on the social media platform Twitter or X, so—

Mrs. Laila Goodridge: Thank you.

Are you aware—

The Vice-Chair (Mr. Stephen Ellis): Excuse me, Mrs. Goodridge. If she has more, we'll give her another 20 seconds, please.

Dr. Andrea Sereda: Mr. Zivo is a columnist for the National Post who has dipped his toes into this for the past eight or nine months. Certainly, early in his writing about safe supply, he expressed his desire to burn the whole system down. I'm not sure that he's a terribly credible source of information that we want to rely on in this committee.

In addition, Mr. Zivo visited InterCommunity Health Centre, where he was a very bullying presence to my patients. There is a gate just outside my clinic door, three feet from my clinic door—

Mrs. Laila Goodridge: Thank you.

Dr. Andrea Sereda: I'm not finished, Mrs. Goodridge—

Mrs. Laila Goodridge: It doesn't really matter whether you're finished or not.

Dr. Andrea Sereda: —and Mr. Zivo blocked access to health care through the only door to my clinic—

The Vice-Chair (Mr. Stephen Ellis): I'm sorry, Dr. Sereda. I think I made you aware very clearly of the convention we have in this committee. I request that you respect that. I've done that with respect to Mrs. Goodridge.

Again, let's be respectful today, everyone. Thank you.

Mrs. Laila Goodridge: Does diversion of safe supply worry you?

Dr. Andrea Sereda: I think more important than diversion is the discourse around diversion that's happening in the media. Diversion is—

Mrs. Laila Goodridge: Okay, thank you.

Dr. Andrea Sereda: —complicated, and it requires more than a 60-second answer, if I can finish.

Mrs. Laila Goodridge: Thank you. I appreciate that. I have a very limited amount of time, so I asked really quick, simple questions and wanted simple, quick answers.

B.C. recently developed some protocols that allow for recreational fentanyl to be prescribed to children in the guise of safe supply. What are your thoughts on this?

Dr. Andrea Sereda: I think that the BCCSU has very carefully consulted experts who provide addiction care, harm reduction care and the care of children with substance use disorders. I'm not aware that any children have accessed this protocol to date, but if you read the protocol, it is the same as any other kind of complicated health care for children in Canada, where two experts need to agree and the person needs to be carefully assessed for their risk and any benefit of treatment. For some children who are dependent on the toxic, illicit fentanyl street supply, physicians who are caring for them can make expert decisions on what they need for their health care.

Mrs. Laila Goodridge: Do you think that we should prescribe recreational fentanyl to children?

Dr. Andrea Sereda: I think that if children are at risk of dying from the toxic street supply, which we know over 90% of deaths in youth are from, which is illicit fentanyl—

Mrs. Laila Goodridge: Thank you.

I'm going to turn that over to Dr. Rob Tanguay.

I wondering if you could perhaps expand on this. What are your thoughts when it comes to prescribed recreational fentanyl to children, as has been suggested by British Columbia?

Dr. Rob Tanguay: Again, I'm of the belief of focusing on treatment and a process of such. At the end of the day, the prescription of recreational substances to anyone without a diagnosis and a treatment algorithm can be problematic, and there's really no research, evidence or peer-reviewed literature to suggest otherwise.

That being said, if it's a molecule that has stabilized someone, and it's in a guise of helping someone recover from severe addiction, then I'm all for whatever that molecule may be. It comes down to whether we're focused on treatment and what that algorithm may look like.

Mrs. Laila Goodridge: Thank you.

One of the big questions we've been facing as we we've been looking at this is the idea of what treatment looks like. Can you describe how you approach addiction medicine and treatment, and how that can look in your practice?

Dr. Rob Tanguay: Yes, for sure.

I work in the rapid access medicine program that I co-founded. It's Alberta's largest addiction medicine program. Everything is about meeting people where they are and with the utilization of motivational interviewing, which, in common-sense terms, is about being nice to someone. It's about listening to someone and helping them in terms of where they want to go and what they want to do when it comes to recovering from addiction, mental illness, homelessness, the sex trade or whatever they're trying to get out of. Often, these are all intertwined.

Treatment is really about a pathway—

● (1605)

Mrs. Laila Goodridge: You're talking about this rapid access program. I don't know that everyone is necessarily familiar with it.

Could you explain how people would access a program such as that, and how something like that actually works?

The Vice-Chair (Mr. Stephen Ellis): Dr. Tanguay, you have about 20 seconds, since we had to interrupt the questioning. Thank you.

Dr. Rob Tanguay: They can walk in or they can self-refer. We get referrals from emergency departments, from in-patient groups, from primary care physicians, from counsellors and from psychologists. It's wide open.

We have full, complete and absolute rapid access for anyone and everyone in Calgary.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much.

[*Translation*]

Go ahead, Mrs. Brière. You have six minutes.

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you to the witnesses.

Mr. Letellier de St-Just, thank you for taking part in the committee's study today.

We have something in common. You teach at Université de Sherbrooke, and I represent the riding of Sherbrooke. You said in your opening remarks that, when the previous government was in power, from 2005 to 2015, it opted to crack down on drug use and criminalize it. You said that, thanks to the measures taken by the government since 2015 and its recognition of evidenced-based decision-making, a modern approach—to use your words—was now in place.

I want to give you an opportunity to elaborate on that. Are we on the right track? What all of us here today want is to save lives and to ease, if not stop, this crisis.

Mr. Louis Letellier de St-Just: Thank you.

Yes, of course, we are on the right track. I said that earlier. What is concerning is the desire among some to go backwards, which would be a monumental mistake. Just think where we would be if those repressive policies had remained in place after 2015: The crisis would be even more out of control than it is now.

I do want to make something clear. I'm not suggesting that decriminalization is the way to fix the problem of the illegal drug market. That's not the purpose of decriminalization. The purpose of decriminalization is to give people access to services. Dr. Tanguay and Dr. Sereda mentioned this: We are here to provide services and save lives. All the law enforcement, anti-money laundering and border control measures are essential, but the important thing today is to recognize that neither the decriminalization effort in British Columbia nor the introduction of diversion measures will, on its own, break the hold that criminal groups and the black market have.

To do that, we have to go further. That is why I encouraged you to consider the issue in a thoughtful way. It's the right thing to do. I know the word “legalization” is scary to a lot of people, but we did it for cannabis, and the recent report card for those first five years is very positive. Why not think about taking that next step for certain drugs or even all drugs?

I just got back from a conference in Amsterdam, where the city's mayor brought together representatives from big cities around the world to discuss their objectives with respect to organized crime and the illegal drug trade. Organized crime plays a major role in the illegal market in Canada. Let there be no doubt. Perhaps the situation is less violent in Europe, but criminal groups are in control. Something has to be done, but we must keep moving in the direction that was taken in 2015. All those measures must stay in place.

Mrs. Élisabeth Brière: Do you think that a model based on the four pillars of the strategy—prevention, enforcement and so forth—is a good idea?

Mr. Louis Letellier de St-Just: The four pillars or four components of the Canadian drugs and substances strategy are definitely important. Fortunately, the strategy was reworked and updated. That is the model we should be following.

Mrs. Élisabeth Brière: Thank you, Mr. Letellier de St-Just.

Dr. Sereda, in your opening remarks, you said your job was to keep your patients safe. I'd like you to talk more about the beneficial impact of safe supply on your patients.

● (1610)

[*English*]

Dr. Andrea Sereda: That is a wonderful question. Thank you for giving me an opportunity there.

My patients are the focus of my work. I'd like to tell a couple of stories, if I have time in the moment.

I'm going to start with a story about a woman who was diagnosed with palliative AIDS. She lived on the street. She had no health care. She repeatedly came into the hospital with pain and was turned away over and over again because she was labelled a drug-seeker.

Eventually it was discovered that her pain was actually due to the consequences of HIV and the infections she had related to AIDS, so she was admitted. At that time, she was told she was palliative—that nothing could be done to help her. She was discharged to the street and back to homelessness with a palliative AIDS diagnosis, no medications and no support.

It was at this point that our team had a chance to intervene. We brought her into care. We prescribed her safe supply and her fentanyl use completely stopped. She is now housed. Her AIDS is no longer AIDS; it is well-treated HIV with a controlled viral load. She is now volunteering in harm reduction programming.

What she needed was that support to move away from the toxic supply, so that she could focus on health issues as well. She makes really great cupcakes.

Do I have time to tell you another story?

Another woman I want to tell you about was also palliative. This woman was deemed to be palliative because of endocarditis, which is a severe heart infection. She was in the hospital and she needed surgery. She needed to receive two new heart valves in order to survive. At that time, the surgery team did not feel she was a candidate because she was a drug addict; she had done this to herself and she was going to do it again.

Again, at this point our team intervened and there were some strong advocacy discussions—

The Vice-Chair (Mr. Stephen Ellis): I'm sorry, Dr. Sereda. I'm going to have to interrupt you there.

The time is up, but maybe someone on your team will come back to that.

Thank you.

[*Translation*]

Mr. Thériault, you may go ahead for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Dr. Sereda, you can finish your story.

[*English*]

Dr. Andrea Sereda: Thank you very much for that opportunity.

We intervened with this woman. We advocated and we put her on safe supply as well, which extinguished her fentanyl use. She was able to receive her two new valves.

She was only 21 years old when she was told she was going to die from endocarditis. That was more than four years ago. She's 25 years old. She no longer uses fentanyl. She is still on prescribed safer supply. She is housed. She also volunteers with us and she has returned to college. She really enjoys singing, dancing and knitting in our clinic.

[*Translation*]

Mr. Luc Thériault: Thank you, Dr. Sereda.

Safe supply and supervised consumption sites clearly emerged in response to overdoses, the opioid crisis and fentanyl contamination in drugs.

Safe supply, however, has given rise to another problem: the diversion of prescribed safe supply drugs. I want to give you a chance to share your thoughts on the problem. I'd like you to discuss that and tell us whether it's something we need to deal with, given what you've seen in the last year. What should we be doing? Enlighten us, if you would.

Dr. Sereda, you can go first since you didn't get a chance to finish what you were saying about that earlier.

Mr. Letellier de St-Just, you can go next.

[*English*]

Dr. Andrea Sereda: Thank you.

It's also important to remember that safe supply is politicized, just the way the safe consumption sites that you mentioned have been politicized. Needle exchanges were illegal during the time of HIV. Safe supply is undergoing that same moral panic and disinformation.

When you speak of what is needed and the concerns around diversion, I'm going to tell you another story. This is going to be a hard one for me to tell.

I was approached by a father at a community event last year—

[*Translation*]

Mr. Luc Thériault: I'd really like you to talk about diversion. I don't have a lot of time, and I'm interested in hearing your thoughts on the issue and what you are seeing on the ground. Is the problem widespread? How can we address it? That's important.

● (1615)

[*English*]

Dr. Andrea Sereda: Absolutely.

The story I'm going to tell speaks directly to diversion.

I was approached by a father in the community, and he told me he had lost his son to a fentanyl overdose in the year prior. He told me that his son died while he was on my waiting list to access safe supply—he died waiting to see me, so that I could maybe save his life. I expected this father to be angry with me. I hadn't been able to see his son. However, he wasn't angry, and what he told me next surprised me even more—and this is about diversion.

He told me that his son had stayed alive longer than he had expected, because he was able to get safe supply hydromorphone tablets from a friend he was staying with, who was willing to share with him, because his friend couldn't watch him go through the profound withdrawals of fentanyl. He wanted to help him. His friend eventually stopped giving him these hydromorphone tablets, and the son went back to using fentanyl, and he died very soon after.

As a prescriber, I don't support diversion in any way at all. I expect my patients to take the medication that I prescribe them, but the discourse around diversion forgets that diversion is a signal of unmet need in the community.

We have barely 6,000 folks on safe supply across the entire country, whereas we have tens of thousands, if not a hundred thousand people who use drugs. We know from the methadone literature that most of the time people who are doing what we call "diversion" are actually helping the people in their communities survive to see the next day.

[*Translation*]

Mr. Luc Thériault: People are claiming that the drugs are being sold to children. Is that something you're noticing? Is it happening? If it is, how do we stop it?

Would you like to continue, Dr. Sereda?

Mr. Louis Letellier de St-Just: Perhaps Dr. Sereda can add to this, but is the diversion of prescribed drugs something that should surprise us? No, I don't think it should. It should not come as a surprise. It's unfortunate, to be sure, but I think it is up to the prescriber, so the doctor, to clearly convey to patients the risks they expose individuals to if they sell them the drug. If it's children, of course, they will be harmed. We don't have any statistics on that.

I'm sure Dr. Sereda could provide some information. Dr. Marie-Ève Goyer and Dr. Marie-Ève Morin, in Quebec, also come to mind. They are both very involved in their communities and are familiar with these realities. I know they do their jobs responsibly, but the college of physicians in each province also has a responsibility to make clear to members their obligations in settings like these.

Just recently, I believe, the Collège des médecins du Québec came out with guidance on the prescription of opioids by its members. It's about greater accountability: it's time for colleges of physicians to pay a lot more attention and to monitor opioid prescribers in the country.

Mr. Luc Thériault: Do you have anything to add, Dr. Sereda?

The Vice-Chair (Mr. Stephen Ellis): Sorry, Mr. Thériault, but your time is up.

[*English*]

Mr. Johns, you have the floor for six minutes, please.

Mr. Gord Johns (Courtenay—Alberni, NDP): In the spirit of good will, I'm going to allow Dr. Sereda to comment on Mr. Thériault's question as well.

Dr. Andrea Sereda: Thank you for that opportunity.

I was listening carefully in my headpiece, but please stop me if I've misinterpreted the question.

You're speaking about youth and the concern that safe supply is being diverted to youth. I think it's really tragic that Canadian youth are actually also being used in this polarizing rhetoric about the potential impacts of safe supply, because I do believe they're being used.

Coroners in B.C. and Ontario carefully monitor overdose deaths. There is absolutely no data to support that children are accessing hydromorphone and dying from it. In fact, we see children overwhelmingly dying of the toxic illicit fentanyl supply when they do have an overdose.

I'm the parent to a small child. Would I ever want her to be able to access opioids? No, I wouldn't. All safe supply clinicians are like that, and we take all of the precautions that are available to us to make sure that our own patients are taking the medication.

Is it perfect? It's not perfect, and maybe you'll give me a chance to speak to our diversion protocols, which are very robust. Again, this dialogue that you see in the media and by critics of safe supply, about the children.... I think it's quite sickening that Canadian children are used in this way, because the data does not support these assertions whatsoever.

● (1620)

Mr. Gord Johns: Dr. Sereda, you talked about anecdotal tweets driving the agenda and political discourse. Can you speak about the impact of that, in terms of the crisis, on frontline staff and patients, people you're working with?

Dr. Andrea Sereda: Yes. When politicians spread disinformation, people die—and people die because of many reasons. It's delaying the emergency response that we so badly need in this crisis. We can't forget that over 42,000 people have died from overdoses, and disinformation that actually slows our response to saving the next 42,000 lives is really disappointing.

I would like to have the people who spread this disinformation—politicians, media, critics—be the ones who call the mothers of the dead, because I think if that was their responsibility and not my responsibility, they would really be focusing on the emergent nature here, on the actual evidence that we have around safe supply and other harm reduction interventions. I think it would be a lot harder to play politics with peoples' lives.

Mr. Gord Johns: You talked about the cost of delays. Obviously, the government is taking an incremental approach. I would imagine that this discourse is having a huge impact on slowing the response. Can you speak about the impacts of, let's say, the delays in the SUAP funding right now getting out to those organizations and clinics, like yours, that have patients and teams that are required to deliver life-saving medicine to people?

Dr. Andrea Sereda: I think we are all waiting on the edge of our seat to know if SUAP funding is going to be renewed or extended. We're scared, and our patients are scared alongside us. My patients are marginalized in a way that suggests that they're not part of the overall community—but they are and they read the news. My patients are scared. They've been asking me, most days for the past six months, if they're going to lose their scrips, if they are going to have to return to what their lives were previously, if they are going to lose connections with their family and lose housing. If these programs end and they have to return to the toxic supply, they ask me if they're going to die, and I don't have an answer for them because I don't know if funding is going to be renewed.

For us, the clinicians providing this care, it is an absolute moral distress. We know that when people are de-prescribed opioids—as one of our speakers mentioned today—they turn to the illicit market. We have decades of data around the opioid crisis, since the early 2000s, showing that de-prescribing, predictably, leads to death.

Clinicians are in this position where most safe supply clinics have maybe a month left of funding, and we don't know if it will continue. Clinicians are stuck. Do they wean people, knowing that data shows that many could potentially die if they do so? Do they transition them to more conventional addiction treatments, like OATs such as methadone and buprenorphine, knowing that these patients have failed multiple times on these previous medications, and the fact that they failed led them to be part of a safe supply program in the first place? Clinicians don't know what to do. The moral distress comes from knowing they've been keeping people alive for three to four years on these programs and not knowing if, in a month, the people they care for, serve and love are going to die.

Mr. Gord Johns: Mr. St-Just, do you want to add to that?

[*Translation*]

Mr. Louis Letellier de St-Just: Yes, thank you. The same goes for us when we hear negative criticism. People can criticize, and they can have concerns or fears about the safe supply or supervised consumption site services we provide, but the fact remains: all these services are delivered in a highly regulated environment.

The Vice-Chair (Mr. Stephen Ellis): Sorry to cut you off, Mr. Letellier de St-Just, but that's it for this round of questions.

[*English*]

The time is up. I'm sorry.

Just so that everyone's clear, the next round of questions from the Conservative side and the Liberal side will be five minutes. However, the Bloc and the NDP only have two and a half minutes, so be judicious with your responses. Thank you very much.

Mr. Doherty, you have the floor for five minutes.

● (1625)

Mr. Todd Doherty (Cariboo—Prince George, CPC): Dr. Sereda, I don't believe you answered the question from my colleague earlier. Are you aware that there is safe supply being diverted at Chapman's Pharmacy across the way from your office, yes or no?

Dr. Andrea Sereda: It's not a yes-or-no answer. I would like—

Mr. Todd Doherty: It is a yes or a no: Are you aware or not?

Dr. Andrea Sereda: I'm going to decline to answer a complicated question without being given a chance for a complicated answer.

Mr. Todd Doherty: That's fine. So you deny that it's happening across the way.

Dr. Andrea Sereda: No, that's not what I said, sir. I said I needed time to explain.

Mr. Todd Doherty: Okay.

Do you agree that it's possible that diverted opioids are ending up in the hands of people they aren't prescribed to, or even children, yes or no?

Dr. Andrea Sereda: We have no evidence that they are ending up in the hands of children. We have no scientific data that supports those assertions.

Mr. Todd Doherty: What's the leading cause of death in the province of British Columbia for youth?

Dr. Andrea Sereda: It is overdose from fentanyl.

Mr. Todd Doherty: Okay. Thank you.

What is the relationship between the clinic and Chapman's Pharmacy? Is there one? Do you meet with them regularly?

Dr. Andrea Sereda: We have a professional relationship because, due to its proximity to our clinic, a majority of our patients choose to use that pharmacy, so we are in nearly constant communication about how to better serve our patients and improve health outcomes.

Mr. Todd Doherty: Do you believe that physicians who prescribe safe supply are morally or legally responsible for diverted safe supply prescriptions that bear their name?

Dr. Andrea Sereda: I believe that every medication that has any kind of value can be diverted, and of course we carry the—

Mr. Todd Doherty: Are you morally or legally responsible, as a physician, for that medication if it is then taken as you prescribe it, and then sold on the street?

Dr. Andrea Sereda: I am morally responsible for my patients to stay alive. I am morally responsible to care for my community. The suggestion that safe supply clinicians don't care about the larger community is, quite frankly, extremely offensive.

Mr. Todd Doherty: I didn't say that, actually. I just asked you if you felt that physicians who prescribe safe supply are morally or legally responsible.

Dr. Andrea Sereda: We have a moral responsibility to our clinic. As for the legal responsibility, you'll have to ask the lawyers.

Mr. Todd Doherty: I appreciate that. Thank you.

A health care worker purchased thousands of hydromorphone pills prescribed through your clinic, which led him to escalate his addiction and cause serious harm to himself and his family. What would you say to him, his wife and his children?

Dr. Andrea Sereda: I'd like to know where this anecdote is coming from first.

Mr. Todd Doherty: I never asked you where your anecdotes came from. Again, I'm asking the questions. It's my time.

Dr. Sereda, how often have community members, including family members of your patients, tried to contact you to express concerns about safe supply diversion originating from your clinic?

Dr. Andrea Sereda: Never. We encourage family members to come into our clinic with their family.

Mr. Todd Doherty: At no time has a patient's family member come to you.

Dr. Andrea Sereda: No.

Mr. Todd Doherty: Okay.

Do you support the improved traceability measures of so-called safe supply?

Dr. Andrea Sereda: I don't. I think that's a slippery slope around marginalized communities.

Mr. Todd Doherty: Why would that be a slippery slope?

Dr. Andrea Sereda: We don't put tracers in any other kind of medication. Why would we stigmatize people who use drugs? Why would we assume that people who use drugs have nefarious intention with their medications? We know that over 90%—

Mr. Todd Doherty: Wouldn't you want to make sure...? Can you and I agree that there are many different tools and there are many different views around this table, but we should be doing everything in our power to make sure that we're keeping people safe?

Dr. Andrea Sereda: Yes, I do, by investing in evidence-based programs.

Mr. Todd Doherty: Do you believe that traceability would then cause diversion to maybe come down?

Dr. Andrea Sereda: No, I don't. I think it would cause people not to use harm reduction programming, because this is a group of people who have been criminalized for decades—actually, a hundred years. These are people who.... In our program, we have 30% indigenous folks, and we know that this is true of most safe supply programs. I don't think that anybody who has had a violent relationship with the structures of medicine and government is going to want to be tracked in any way, so it will lead to deaths because people will not seek treatment.

Mr. Todd Doherty: Dr. Sereda, is diversion illegal, yes or no?

Dr. Andrea Sereda: Is diversion illegal? For people to sell their medications, yes, that's illegal, just like they sell methadone.

Mr. Todd Doherty: Did you receive $1.5 million from the National Safer Supply Community of Practice, which deems diversion as compassionate health care?

Dr. Andrea Sereda: I did not receive that money. Certainly the Safer Supply Community of Practice received that money.

I'm aware of the diversion document that you're referring to. It was written by expert clinicians, with evidence and advice from people who use drugs.

● (1630)

Mr. Todd Doherty: How can you justify that funding, though, if it's an illegal practice?

Dr. Andrea Sereda: I think you're referring to the funding for the National Safer Supply Community of Practice. It's not funded to defend diversion. It's funded to support people nationally in learning about safe supply, helping them in practice and disseminating information.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Dr. Sereda.

We're going to move to Dr. Hanley.

Dr. Hanley, you have the floor for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you.

I want to thank each of you for being here and for your dedication to practice and to this particular crisis.

Dr. Sereda, I'll let you carry on for a moment, but I do have questions for at least three of you. You so eloquently documented the benefits of safe supply. I do want this study to be so much more than this false argument on safe supply and its role in health care. Should politicians be making treatment recommendations?

Dr. Andrea Sereda: Absolutely not. I'm not aware of any other health condition in this country where politicians actually weigh in on whether it should be provided or not. For diabetes care, surgical care, hypertension care, politicians defer to the expert clinicians and researchers in these fields because they know that they are experts, that they want the best for their patients and that they're going to offer them treatments that are going to be beneficial. It's only in this extremely politicized rhetorical debate around harm reduction that politicians seem to think that they know better than the experts and the people who are caring for these patients day in and day out, who have a fiduciary responsibility to see that these people stay alive and do well, in both health and social outcomes.

Again, I've used the word—

Mr. Brendan Hanley: Thank you, Dr. Sereda. I appreciate this, but I do have to move on.

Dr. Tanguay, your first words were very moving. I'm really sorry for your personal losses, and I think it speaks to many of us who have also experienced losses in our families or our communities around the country.

I was also very heartened by your answer to the question on prescribed fentanyl. First, you cautioned against such treatment without a treatment plan or diagnosis—something I think anyone involved in treating opioid use disorder would agree with—and you also said that you support the use of any molecule that helps to stabilize an individual within a treatment plan, if I can paraphrase you. I think that speaks to and validates the four-pillared approach that includes treatment and recovery.

You spoke a lot about the various pillars of treatment. You cited the important role of harm reduction, but you have argued that harm reduction needs to include mental health and addictions services, and to be better connected to community and residential treatment programs. In your opinion, under what conditions should supervised consumption, safe supply and other harm reduction measures occur in Alberta, and in Canada, for that matter?

Dr. Rob Tanguay: I think that, at the end of the day, it's about trying to create a system that makes sense, that's interconnected and not siloed. We have harm reduction, recovery-based and mental health silos, but the reality is that there's a lack of access to any of them, and that's really the biggest problem we have. We're sitting here talking about a new treatment algorithm, which really was an experiment—and is building evidence, for sure—without actually accessing first-line treatment. Most people in Canada do not have access to first-line treatment, to mental health treatment and to supports.

These supervised consumption services should be an entry point to treatment, and they are probably one of the best entry points to treatment that we could possibly have for individuals who are most vulnerable. The concept of meeting them there is so important, but we can't just leave them there, and we can't help them—

Mr. Brendan Hanley: Thank you. If you don't mind, I'm going to cut you off. I just want a few seconds with Ms. Hudspith.

Ms. Hudspith, thank you very much for appearing. In my previous role, I had the pleasure of leveraging your organization's expertise as we began to look at critical gaps in pain care in the Yukon territory. What do we need to do better, as a public health care system, in managing pain? Can you also talk briefly about how we support self-management of pain? I know you have been leaders in that area.

● (1635)

Ms. Maria Hudspith: Thank you so much.

We've been making great strides on the self-management side, building out virtual care and supports to enable people to use those things. People can throw up a website, and it can have all kinds of great resources, but people often need a hand to hold as they walk through that and as they apply those learnings.

What we need to be—

The Vice-Chair (Mr. Stephen Ellis): Ms. Hudspith, I'm sorry; I'm going to have interrupt you. The time is up.

[*Translation*]

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

Mr. Luc Thériault: I'll try to be brief.

Mr. Letellier de St-Just, in a very interesting document updated on February 9, 2024, you indicated that decriminalization does not guarantee safe supply. We've been talking about it for a while. You're also targeting organized crime.

There are four pillars. Do you believe that enough is being done when it comes to law enforcement and fighting organized crime? I'm asking the question because it's really the law of the jungle right now. What is happening is truly shocking. When the government is forced to take care of people and create supervised injection sites because anything goes on the black market, there's a problem.

Is enough being done? If not, what more could be done?

Mr. Louis Letellier de St-Just: In Amsterdam, an undercover police officer who infiltrated criminal gangs told us that he spent months preparing a major operation to arrest the leaders and seize huge quantities of drugs, but the impact lasted just two hours. That's shocking and astounding, to say the least, because law enforcement isn't on a level playing field. Criminal groups have much greater resources than law enforcement does.

Are we doing enough, then? We're already doing so much more. Money laundering and arrivals at major ports, be it Vancouver, Halifax or Montreal, need to be tackled. We need to do what has to be done, but with the full knowledge that it's not a level playing field right now.

Mr. Luc Thériault: Is that what you—

Mr. Louis Letellier de St-Just: The only way to ensure progress would be to regulate certain drugs. For example, there's talk in Europe about regulating cocaine and MDMA. That kind of approach needs to be followed or, at the very least, considered.

Mr. Luc Thériault: You've answered my question.

Mr. Louis Letellier de St-Just: Thank you.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. Thériault.

[*English*]

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

Mr. Gord Johns: Thank you.

My question is for Dr. Tanguay.

First, Dr. Tanguay, I also offer my condolences to you and your family for your losses.

Dr. Tanguay, you were part of a report commissioned by the United Conservative Party in Alberta in 2020 on safe consumption sites in your home province. That study has been widely criticized for its poor scientific methodology, yet it was key to the closure of the safe consumption site in Lethbridge, which has reported a record number of fatal overdoses since the closure of the site.

Additionally, a study was published in The Lancet this month showing a 67% reduction in overdose deaths in neighbourhoods within 500 metres of safe consumption sites after they opened. It demonstrates the life-saving impacts of these sites and the importance of them.

Have your views changed since this government-commissioned report was used to leverage the closure of safe consumption sites in Alberta?

Dr. Rob Tanguay: Just to be clear, the consumption site in Lethbridge was transitioned to an AHS one out of the not-for-profit. It's still active and still going, and never has it turned someone away.

There is a record of overdoses at all sites, whether one of these consumption sites exists or not and whether treatment is available or not. I don't think that kicking a specific small piece and saying, “Here's the answer” is always the easiest way.

The report never once said to shut any service down. It was never once written in that report to shut any supervised consumption service down, but rather that these services require support such as medical treatments, buprenorphine, methadone, mental health treatments, wound care treatments and primary care treatments. The big support is that these processes should be more than under the realm of harm reduction; they should be under the realm of health care. That was something—

● (1640)

Mr. Gord Johns: Do you believe, Dr. Tanguay, that there should be more safe consumption sites, including maintaining and improving the one in Red Deer, for example?

Dr. Rob Tanguay: I believe that supervised consumption services are a part of a pathway of treatment and, like all harm reduction services, should be a part of the treatment algorithm.

I think the biggest problem we have is that we pick one little piece to focus on and think that's all we need, and that's not an answer.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Dr. Tanguay.

Mr. Johns, that's the end of your round.

We will now turn to Mr. Doherty. You have the floor for five minutes.

Mr. Todd Doherty: Thank you, Chair.

Dr. Sereda, in January 2022, you produced a report that claimed that your program was successful because of a 94% retention rate, which is a surprising finding that people with addiction will return for free government-supplied drugs. It was only later during a webcast, when you were asked directly about the other 6% who were no longer enrolled, that you acknowledged that some of the 16 had died from fentanyl overdoses or from infections acquired from injection drug use. Your study also did not analyze the impacts of diversion.

How can you claim that it shows hydromorphone from your program works?

Dr. Andrea Sereda: I think there's always this question of whether it is the safe supply that is making people well. What we need to know is that the outcomes we were seeing.... We compared them to match controls and people who were not receiving a safer supply, and we simply could not see the positive health and social outcomes that we are seeing if people are on mass diversion, as is being alluded to here in this committee.

The 6% of folks we lost were lost to long-term incarceration, long-term hospitalization, and yes, we have tragically lost some people to infections and overdoses. What we do know is that, of the people who are confirmed by urine toxicology to be only using safe supply hydromorphone, zero of those people have died. It is people who continue to engage with the toxic illicit fentanyl street supply who have gone on to overdose. We know that proportionally we've lost so many fewer.

Mr. Todd Doherty: It's interesting that you say that, because you're familiar with Dr. Sharon Koivu. She is a site chief at the London Health Sciences Centre, and former acting medical officer of health. There was a study by her and Allison Mackinley, a nurse practitioner—and I'm sure you're aware of this—that examined the charts of over 200 patients who had been referred to Victoria Hospital's addiction medicine consultation service between January and June 2023. It shows that safe supply hydromorphone from your program is causing harm, such as serious infections and new addictions.

What do you have to say about that?

Dr. Andrea Sereda: I have a lot to say about that.

I've actually been in communication with Dr. Koivu about this data that you just discussed, for about three months—maybe a bit more—trying to find out what her methodology, her inclusion and exclusion criteria—

Mr. Todd Doherty: You're questioning her methodology.

Dr. Andrea Sereda: Yes, because she hasn't released it. This is not a published study. There's no—

Mr. Todd Doherty: Then that would be anecdotal information as well.

Dr. Andrea Sereda: When I have approached her, she's told me she actually cannot discuss any of this with me. Although she can't discuss the findings of her research or give her methodology, which all good researchers do, she can release it to Adam Zivo of the National Post, and she can release it on social media.

These things don't line up, and when you look at the denominator—

Mr. Todd Doherty: Dr. Koivu also stated that some of her patients who get safe supply hydromorphone from your program have housing but choose to sleep outside Chapman's Pharmacy in tents to be first in line to get the prescription in the morning, which they often sell so that they can buy illicit fentanyl.

Some of these patients are vulnerable women who are being pressured to secure as much hydromorphone as possible so that their spouses or pimps can confiscate the drugs for resale. These patients also claim that the criminals wait outside the pharmacy and intimidate vulnerable people to hand over the hydromorphone.

What do you have to say about that?

Dr. Andrea Sereda: I would say that Dr. Koivu tells a lot of stories. Another story she is—

Mr. Todd Doherty: Again, you're discrediting another doctor. Is that what you're doing?

Dr. Andrea Sereda: I am saying that what she has shared with you is not accurate in my experience. Dr. Koivu has also testified that safe supply has a 100% mortality at five years, yet she works in this community that has had safe supply for eight years and has 300 living patients.

I think we need to take those reports with a big grain of salt.

● (1645)

Mr. Todd Doherty: Dr. Koivu is also stating that safe supply hydromorphone from your program was present in London before there was much, if any, illicit fentanyl, and that hydromorphone from your program has fuelled the fentanyl gangs and new addictions.

Dr. Andrea Sereda: I really think that—

Mr. Todd Doherty: Do you discredit that as well?

Dr. Andrea Sereda: I really think that speaks to Dr. Koivu's lack of experience with this population, because that's not true. Fentanyl has been present in London, Ontario since 2012. It really started to pick up in 2013 through 2015, which is why we actually started the program in 2016, because at that point fentanyl was dominating the opioid sales on the streets of London. That's why we needed to make a change at that point.

Mr. Todd Doherty: Dr. Samuel Weiss from the Canadian Institutes of Health Research testified to this committee on December 4 that based on a study they were conducting on 11 safe supply programs, wraparound supports are critical to any purported benefits from the program.

Given that your program offers wraparound supports, how can you credibly claim that a safe supply of hydromorphone is providing any benefits?

Dr. Andrea Sereda: First, I think it's pretty funny that a criticism of safe supply programs is that they give excellent care and excellent wraparound supports, but also, the data that I presented to you from the CMAJ study was before we had SUAP funding for those wraparound supports. The data I reported to you about a 50% reduction in emergency department admissions and the number of infections and a 50% reduction in costs was only from safe supply prescribing. At that time, we had no wraparound supports. That speaks clearly—

The Vice-Chair (Mr. Stephen Ellis): Dr. Sereda, I'm going to have to stop you there, please, because your time is up.

Dr. Powlowski, you have the floor for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Dr. Sereda, convince me.

I like Gord Johns over there. He's a very passionate guy. He has a lot of good ideas.

My daughter actually works in the homeless community in Vancouver and she's a big advocate for safe supply. She's having trouble with dad. I'm not just a politician. I've worked in acute care medicine for almost 40 years, including 20 years in a Thunder Bay emergency room, which sees its fair share of overdoses.

We've heard anecdotes on both sides here, but I'd like you to comment on the recently released JAMA internal medicine study from January 2024, “British Columbia's Safer Opioid Supply Policy and Opioid Outcomes”, where they found that after B.C. instituted safe supply, “the opioid-related poisoning hospitalization rate increased by 3.2 per 100 000”, which was statistically significant, with a *P* value of .01. Deaths from opioid toxicity didn't increase significantly. They did increase, and the *P* value was .26.

The authors of the paper, as they're commenting on why these numbers went up, ask:

> What could explain the higher hospitalization rate after the policy's implementation? One potential reason is that participants in British Columbia's Safer Opioid Supply policy program diverted safer opioid supply for various reasons, including to purchase unregulated fentanyl. It is also possible that a higher supply of prescription opioids led to an increase in prescription opioid misuse, which in turn, could increase hospitalization risks.

It doesn't look real positive for safe supply. Can I have your comments with respect to that article?

Dr. Andrea Sereda: The authors of that JAMA article seem to confuse correlation with causation. We know that there are about 4,500 people on safe supply in British Columbia, but we also know that there are over 225,000 people who were diagnosed with opioid use disorder and use street-level fentanyl. The idea that we can have a population effect from 5,000 people in the context of a denominator of 225,000 people is not reasonable. Safe supply prescriptions are not prevalent enough to be able to do that. We also need to remember that over 90% of hydromorphone prescribing in British Columbia is actually to chronic pain patients and not to safe supply patients. They're less than 10%.

The reason fatal overdoses have climbed in B.C. is actually because of an increase in the volatility in the supply. During that time period, we have seen the introduction of benzodiazopenes and xylazine to the toxic supply. People are dying because the fentanyl they're using is more deadly.

Mr. Marcus Powlowski: Let me just point out, though, that in that study they also compared mortality rates in British Columbia versus Manitoba and other provinces—Nova Scotia, I think, and Saskatchewan—and a number of other places that did not institute safe supply. They looked at their rates over the same period and asked if this is because there's a more unsafe supply of fentanyl. However, B.C.'s increased more. Yes, you can't prove causality, but certainly it's suggestive of a problem there, and certainly the authors pointed that out.

Could you please send me the evidence? You say there's a lot of evidence for the use of safe supply and how it helps.

This is all my evidence, and I have it all before me. I'm looking at it.

The one fairly good paper, I think, was the BMJ paper of 2023, Slaunwhite's, which I could talk about further. I would suggest that there are possible problems with that paper.

There's the CMAJ paper of 2022, on London. As has already been pointed out, it wasn't just safe supply. There were also comprehensive health and social supports involved.

I looked through the other studies that were “evidence”. A lot of them were basically a bunch of anecdotes. They talked to people on safe supply who said, “Yes, I feel better on safe supply”, but it's not exactly good evidence. A lot of the other trials—the Andalusian trial and all the heroin-assisted treatment studies—were all with directly observed treatments—not letting people go home with a lot of narcotics.

If you could, please send me the evidence.

Lastly, if I still have time, I would like you to comment. We had the chair of the Stanford-Lancet commission here, who was against safe supply. His reasoning for being against safe supply was this. He said, why did we get into this trouble to begin with? It was because of the over-prescription of narcotics by us doctors. There's evidence that it's often not the person who's prescribed it who is using it, but someone else who is using their drugs, someone else in the family, or it's being sold to other people. That was the source. How can you argue against his saying that if we provide safe supply we're just doing the same thing again?

● (1650)

The Vice-Chair (Mr. Stephen Ellis): Dr. Powlowski, I'm enjoying your scientific debate with yourself. However, unfortunately, there's no more time. Perhaps your colleague Ms. Sidhu may have that question answered for you. I do apologize for that.

Mrs. Goodridge, you have the floor for five minutes, please.

Mrs. Laila Goodridge: Thank you.

Actually, I'll just say, in the spirit of friendliness, could you answer Dr. Powlowski's question?

Dr. Andrea Sereda: I absolutely can. There's a lot there. I'm going to do my best to remember everything that came up.

I think you were first speaking to the JAMA study. You were talking about how they compared B.C. to Manitoba and Saskatchewan. Those illicit drug supplies are vastly different. In Ontario, the average amount of fentanyl in a piece of fentanyl is 5%. In B.C., it is 16% to 20%, so B.C. is unique. These are not directly comparable patient groups because the fentanyl in B.C. is at least four times as strong as what people in Manitoba and Saskatchewan would be using. I think it's very reasonable to understand that when you have a more toxic supply in one province, you're going to see a greater proportion of deaths than in a province where you have less toxic supply.

Mrs. Laila Goodridge: Dr. Sereda, thank you. I really appreciate that.

Could you table with us any of that information so that we can have that as evidence?

Dr. Andrea Sereda: Absolutely, yes.

Mrs. Laila Goodridge: One thing that really scares me as a mom and as someone who lives in a community that is impacted by addiction—like so many of us—is that when people hear “safe supply”, they think that this is now somehow safe, just like Dr. Powlowski mentioned about the fact that much of this was born out of the over-prescription of opioids. This is now a marketing tool, a marketing term, to call it “safe supply”. Would you consider using a different word?

Dr. Andrea Sereda: The term “safe supply” actually comes from the community of people who use drugs, so we honour their participation in this and we use the language that they would like us to use.

In terms of calling it “safe”, “safer supply” or “managed opioids”, whatever you choose to call it, all people who receive a prescribed safe supply are counselled extensively on the benefits and potential harms and potential risks. That's part of a normal consent procedure, so we do—

Mrs. Laila Goodridge: I'm sorry. We just have very little time.

The studies that purport all the benefits of safe supply are based on questionnaires to patients who are prescribed safe supply. Is that not anecdotal?

Dr. Andrea Sereda: It's not anecdotal. It's qualitative studies, which are highly prevalent in science and medicine and certainly not unique to safe supply investigations.

Mrs. Laila Goodridge: One thing I find kind of ironic is that after eight years of the Liberals being in power and eight years of your clinic being open, it seems like the only thing in Canada that's cheaper is the price of hydromorphone tablets. In fact, Dr. Sharon Koivu said that hydromorphone dropped from about $20 a tablet in London to $2 a tablet. Does that not show that there is a diversion clearly happening en masse in London?

● (1655)

Dr. Andrea Sereda: Maybe, but maybe not. The price of fentanyl has also dropped dramatically.

Back in 2016, when we started, a point of fentanyl was $40 to $50. A point of fentanyl is now maybe $10, often less. You have Costco-sized buys of fentanyl, where people are getting better deals for a larger volume. The prices of all drugs on the street have actually declined.

Mrs. Laila Goodridge: Does that not terrify you?

Dr. Andrea Sereda: Of course it does.

Mrs. Laila Goodridge: Why are you not doing more in your clinic to prevent diversion from happening? There are so many.... I get that you're going to say that they're anecdotes, but there are so many stories that I have read specifically of your clinic, with your name on it, of pill bottles going out with hydromorphone that's being sold and that people think is safe.

They might be coming from someone else. They might be coming from some big, bad cartel that's making them and putting them into your pill bottles. It doesn't really matter. They are on the streets in London, and it has your name on it, and they're being sold to kids.

Dr. Andrea Sereda: They're not being sold to kids. Our diversion protocols in London are very robust, so every single—

Mrs. Laila Goodridge: Diversion is illegal.

Dr. Andrea Sereda: Yes, but I don't cause diversion. It is not my responsibility.

Every single person who is seen in the safe supply clinic receives a urine toxicology at every single visit. We monitor people very closely. Is it a perfect system? No, it's not—just like methadone monitoring through urine toxicology is not a perfect system either—but we intervene whenever there is any objective evidence of diversion. We meet with patients and we move them to observed models when we have objective evidence, and we support people through that.

Mrs. Laila Goodridge: I appreciate that.

In your observed model, if someone does a urine test and it shows a drug other than hydromorphone, what does the conversation look like?

Dr. Andrea Sereda: Our patients actually really welcome that feedback, because what we do with people's urine toxicology is that we actually summarize it. When people give urine, they know they're giving information to their community about what's present in the drug supply. It helps us to know what analogs people are from.

If your question is whether they continue to receive safe supply, of course they do. Our intervention is meant to reduce or extinguish.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Dr. Sereda. Unfortunately, the time is up in this round as well.

Ms. Sidhu, you have the floor for five minutes, please.

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

Thank you to all the witnesses for being here.

Dr. Sereda, can you tell me how we can keep Canadians safe and speak about the importance of research and a data-driven approach so that it's not based on misinformation? Can you elaborate on that?

Dr. Andrea Sereda: I think that if I had the answer to that question, we may not be having half of the discussion that we're having today.

How do I interrupt misinformation? I don't know. It's so much easier to spread misinformation and disinformation than it is to actually rebut it with truth. It's very easy to make things up. It's more difficult to actually do the work of showing the truth of what's out there with research.

Certainly, our group and safe supply clinicians across the country are involved in robust and ongoing data generation and research. There are multiple ongoing studies about diversion, because we know it is a concern that is being raised, and we are studying it, but that science takes time. Good-quality research is not something that we can produce in weeks or months, but those studies are ongoing. That's why it's hard to stay ahead of that misinformation campaign.

Again, I can make anything up and I can tweet it out or put it in the media. That takes 10 minutes or half an hour. How long does it take to make something up? However, to actually do the research, to show the truth on the ground, takes time, expertise and commitment, which all safe supply clinicians, including me and my program, are committed to.

Ms. Sonia Sidhu: You talked about the stigma. Stigma is a very real factor. In this debate and in responding to the crisis, what is your opinion on how to combat stigma? Can you give a few examples of how the disclosure around the issue can further stigmatize those already suffering in the communities?

Dr. Andrea Sereda: In the two patient stories I discussed near the beginning of this session, I highlighted two women, one with HIV and what was considered palliative AIDS, and another who was declined a heart valve replacement because she was a person who used drugs. That is stigma in action. The medical system assumed those two women were going to die—that this was going to be the outcome. Except, when we provided an intervention that stabilized their substance use, which was safe supply in this case, those women lived. They received their medical surgeries and medication for AIDS and they are thriving and doing well.

In these instances, stigma almost killed these women. Stigma kills many more our team doesn't hear about, isn't able to intervene with and doesn't get wind of. Those stories absolutely break my heart, because we hear them every day from our patients who have friends who went through it but didn't have a team to support them.

We're hearing so much about diversion today. It's a critical issue that we discuss, but the premise behind many of these questions is that people who use drugs can't be trusted—that they're nefarious criminals looking to sell their medication to children and other people, or looking to profit off the medications they are receiving.

Starting that conversation with those assumptions is also stigma in action. The stigma from our assumptions about drug users is limiting our ability to respond to this crisis in a timely manner. It's limiting our ability to respond to this crisis with research-based evidence. To your first question, we're spending so much time responding to the disinformation campaign that it's taking away from our ability to provide that direct clinical care and research we need to do to save lives.

● (1700)

Ms. Sonia Sidhu: Can you expand on the importance of an integrated, wraparound model of care that addresses the social determinants? How specifically does this model engage more people who are ready for recovery?

Dr. Andrea Sereda: Absolutely.

I think we've heard references to the CMAJ paper a couple of times. I would like to reiterate that the CMAJ paper showed 50% reduction in poor medical outcomes and 50% reduction in cost only from safe supply prescribing.

Since then, we've been able to add the wraparound care. In my experience, we are seeing people do so much better. There is a glass ceiling on how well I can make people when they are not housed. We help them find housing. There's a glass ceiling when they're on social assistance and can't afford enough food to eat. We provide people with food security. I could go on and on.

We are planning to repeat that study to look at the impacts of wraparound care on people receiving safe supply—not just a prescription, but the entire program—and we have every expectation that it's going to show even better outcomes, because we're seeing this every single day with the people we serve.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Ms. Sidhu and Dr. Sereda.

The next round will go to Mr. Thériault.

[*Translation*]

Mr. Thériault for two and a half minutes.

Mr. Luc Thériault: All right.

In your presentation, Mr. Letellier de St-Just, you indicated that the period from 2005 up until the implementation of programs paved the way for the current crisis. Could you expand on that?

Mr. Louis Letellier de St-Just: Indeed, it was quite clear. The then government cannot be accused of lying to the public. Its election platform included cracking down on crime and strengthening the Controlled Drugs and Substances Act to impose mandatory minimums for drug-related crime.

I remember very clearly the 2011 case involving Insite in Vancouver, which went all the way to the Supreme Court of Canada, here in Ottawa. I was one of the lawyers for an international coalition appearing before the Supreme Court. The government refused to renew the exemption for the Insite supervised injection site, which was the only supervised injection site back then. Today, there are 30 such sites.

Such policies exacerbated the crisis by removing harm reduction from the Canadian Drugs and Substances Strategy. That is a major flaw and the main reason why the situation worsened. By focusing first and foremost on enforcement, the government increased prison sentences and filled prisons. Legislation resulting from Bill C-5, which was passed in November 2022, confirms the overrepresentation of indigenous and racialized individuals in our correctional facilities. This is due to the fact that people have been locked up, put in prison and sentenced for minor offences that, for the most part, have had no impact on public safety.

This is an archaic attitude, and it's a misinterpretation of international conventions. When you have the World Health Organization, the UN High Commissioner for Human Rights and the UN Office on Drugs and Crime telling us that we need to move toward decriminalization, adopt a public health approach and respect human rights, it's quite clear. That's the current direction.

It's clear that, by tightening the rules around the strict enforcement of the law between 2005 and 2015, we missed the mark. Should we go back to that? Please, don't go there.

● (1705)

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Thériault.

[*English*]

Mr. Johns, you have the floor for two and a half minutes.

Mr. Gord Johns: It's really good to hear everybody at the table say that there's no one-size-fits-all in terms of responding to this. We know it's a complex issue that requires a comprehensive response.

I'm going to go back to the safer supply claims that have been made, because we saw B.C.'s overdose death rate go up 5%. That's not good. In Ontario it was 6.8%. Those are two provinces that have safer supply programs. But we saw in Alberta that death rates went up 23%. Saskatchewan had gone down but jumped up by 32% last year. In 30 U.S. states, according to the numbers we have, the rate doubled from 2019 to 2021. Baltimore's death rate is four times that of Vancouver. In Philadelphia the rate has doubled. In Washington and Milwaukee it is higher. They're all without safe supply.

Dr. Sereda, when you hear people point to safe supply as the cause of this crisis and as driving death rates, and then you hear about the numbers in places that have no safe supply, could you speak to how that isn't factual and how anecdotal comments are causing harm to communities? You have a minute and 20 seconds and you can add whatever you'd like to.

Dr. Andrea Sereda: Yes, it sets my brain on fire a bit, to be completely honest, because it is simply not possible for safe supply to be driving these deaths. It's not possible, with the number of people receiving it compared to the number of people who use drugs and the number of people who are dying.

You're absolutely correct that in Canadian provinces that have robust harm reduction programming—not just safe supply but robust harm reduction—we have seen less death, as we have in provinces that embrace an entire spectrum of treatment approaches, as I mentioned in my opening remarks.

When I see what is happening in these other cities, my heart absolutely breaks, because that means there are four times as many families that don't have their loved ones anymore. It means there are four or five or eight times as many kids without their parents or parents without their kids.

Mr. Gord Johns: What do you believe needs to happen? We hear that 1.8% of those who use substances on a daily basis in British Columbia—225,000 people—are getting access to safer supply. What are the responses necessary in this health crisis?

Dr. Andrea Sereda: Just to be clear, 225,000 are not receiving safe supply. It's 4,500 of 225,000 who are receiving it.

As for getting ahead of this crisis, I'd say the horse is not just out of the barn; it's all the way down the country laneway, and we're just chasing it and trying to get it back. We need—

The Vice-Chair (Mr. Stephen Ellis): I'm sorry, Dr. Sereda. I'm going to have to stop you there.

However, the good news, Mr. Johns—because you have a benevolent chair—is that there will be two more rounds on the Conservative side, two more on the Liberal side and one more for each of you. It's good news.

Moving on, Mrs. Goodridge, you have the floor for five minutes.

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

Dr. Sereda, a series of letters came out in the last little while from some of Canada's leading addiction doctors sharing their concern around safer supply. Do you not take their words seriously?

Dr. Andrea Sereda: I take them very seriously.

First of all, they are self-described leading addiction physicians. There are 30 people who signed that letter.

There is also a letter that was signed by 130 experts in substance use care supporting safe supply. That letter gets a lot less attention and we need to pay attention to it.

Mrs. Laila Goodridge: Thank you. I appreciate that.

It's frustrating to me. I also think this information is extremely damaging. The addiction crisis is incredibly troubling. In my home province, there are five addiction deaths a day. This is not something small. This is not something I take lightly.

I don't think giving more drugs is somehow going to solve the problem. If that were the case, we wouldn't have anyone dying from alcoholism, yet we have alcoholism leading in deaths across the country.

My question is going to be for Dr. Rob Tanguay.

You talked in your opening statement about some of the OAT pieces. I am just wondering whether you could explain to the committee in a bit more detail what OAT is and how Alberta goes about getting rapid access to OAT prescriptions for people struggling with addictions.

● (1710)

Dr. Rob Tanguay: I think that, when we look at OAT, which is opioid agonist therapy—another term for it is medication for opioid use disorder—we have guidelines based on massive studies. Guidelines suggest first line A is buprenorphine or naloxone and first line B, the gold standard, is methadone. These are not accessible to many Canadians around the country, which is very unfortunate. Access is everything. Getting access to these medications is key. Again, it's very important that this comes with wraparound services.

A molecule isn't about treatment. It's about stabilization. It's about initiating treatment. That's a very big differentiating feature. When we look at treatment of opioid use disorder, we talk about the use of buprenorphine, methadone, slow-release oral morphine or whatever molecule we have. It's about stabilizing that individual so we can work through some of the reasons they're suffering with addiction. That may include mental illness or trauma. There are a variety of reasons. It may include chronic pain.

I am lucky to work with Maria on a lot of things as the co-chair for the Alberta pain strategy. One thing is that our virtual pain program works directly with our virtual opioid program to deal with these issues.

Again, this is about medicalizing addiction as a health disorder, not about activism and other aspects. The reality is that following the evidence is something that doesn't seem to be the focus here.

Mrs. Laila Goodridge: I appreciate that.

Frankly, I am a politician. I don't think I should be the one setting the policy when it comes to these pieces. I believe we need to be listening to medical evidence and peer-reviewed evidence.

At the end of this, we will have a report going back to Parliament. What would your recommendation be when it comes to opioid agonist therapies and perhaps having more access to them?

Dr. Rob Tanguay: Yes, well, there it is: There should be more access.

We talked about the opioid crisis and how we got here. The reason we got here was the diversion of prescribed opioids. It was the over-prescribing. The people who were being prescribed and taking the medication were never the problem. It was the fact—and this was mentioned—that it was family members and friends, or other reasons people were diverting them. That, then, led to the issues.

We heard about correlation versus causation. The correlation coefficient—which has been published—on the amount of prescribed opioids and death is 0.99. A perfect correlation that can cause causation is 1. We know that the more we prescribe, or the more access there is to a substance that can cause harm, the more danger there is from that substance. This is simple public health knowledge. Anybody who works in this area knows this. That is why a lot of my colleagues are up in arms. It's not about the molecule. It's about the fact that we're not taking the time to prevent that molecule from being diverted and being harmful.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Dr. Tanguay. I appreciate that.

Mrs. Goodridge, thank you.

Just so we're clear, it will be Mr. Jowhari, Monsieur Thériault, Mr. Johns, then back to the Conservatives, and we'll finish off with the Liberals, just so we're fair.

Mr. Jowhari, you have the floor for five minutes. Go ahead, please.

● (1715)

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair.

I'd like to thank all the witnesses for being so prepared and for the work they do out there.

Dr. Sereda, I would like to start with you.

You made a comment, which I hope I wrote down properly, and I'd like you to expand on it. You said diversion is a symptom of unmet needs in the community. Then in another response you talked about that and how you'd really like to have the opportunity to talk about some of the diversion protocols that you have in your practice.

Can you expand on what you mean by "unmet needs in the community", if I actually understood that correctly?

Dr. Andrea Sereda: Yes. There is an unmet need. Because safe supply programs have a limited capacity in terms of the number of people they can take in, the number of those who benefit compared to the number of those who are not able to access it results in a lot of translation between those two patient groups, if we can say that. We know from the literature on methadone that methadone is widely diverted because of that unmet need as well. When we read that research on methadone, we know that people are distributing methadone to their friends and their family members who are in withdrawal, who may have just had an overdose or who are trying to get away from fentanyl. We know that clearly from that research.

That's what we see at the street level with people using safe supply as well. People will "divert"—and I would like to put air quotes around that—to their spouse who is in profound withdrawal. They may divert to their roommate who just had an overdose. This is being done out of caring and compassion, so I think it's really important that we be careful with the morality that we're overlaying on the word "diversion". When I say "morality", does that mean people don't sell it? I'm not sitting here and saying that. I am saying that we are actually not looking at it in its entire context, because we stigmatize people who use drugs. We always assume that they're doing a bad thing, when the research shows that they are doing loving things for the people around them.

You asked me to expand on the diversion protocols, and I did mention these to Mrs. Goodridge. As I said, every single person on my program submits a urine toxicology test every single time they come in to see me, which for most of my patients is once per week. We monitor those urine toxicology tests and we always do them sequentially, because we know there is a false negative rate in those. If we see people who do not have hydromorphone in their urine, our first step is actually to have a conversation with this patient, because we have a long-term relationship. Within this, we say, "Do you have enough food to eat? Do you have a partner who is taking these medications? Are you at risk for violence?"—outside a pharmacy, as the Conservative MPs have alluded to here. We talk to them about the problems they're experiencing and we seek to fix those.

As I said, we provide food security, and we can provide safety planning. We help women leave partners when that is necessary. The vast majority of the time, that solves the issue of what we're calling "diversion". When it doesn't—

Mr. Majid Jowhari: Thank you.

I want to go quickly to Dr. Tanguay.

I also want to extend my condolences. Losing so many loved ones—close friends and family members—must be very hard on you, so thank you for the continued advocacy you do.

Dr. Tanguay, do I understand correctly that you say the prescription of safe supply should be used in the context of stabilizing the patient to a point where their other needs could be addressed through treatment? Am I right in my understanding here?

Dr. Rob Tanguay: You are correct. All prescribing that we do in addiction is about stabilization of that individual so we can move forward with treatment.

As physicians, we also make sure there are no harms to the community or others when we prescribe. For instance, when we do a urine test with respect to methadone treatment, this is something we do all the time, but we don't check for methadone. We check to see if they're using illicit substances. If they're not, then they get to start taking methadone home and not just picking it up at the pharmacy—not the opposite way of trusting that everybody is perfect.

Mr. Majid Jowhari: I have just 30 seconds, so thank you.

I want to come back to you again. What would that treatment look like? At the end of the day, we're trying to come up with recommendations as to how safe supply could be managed and how it could be complemented. In the short time you have, could you talk about the treatment and what it would look like?

Dr. Rob Tanguay: It's a staged approach. I could do this all day long.

It would start with stabilization biologically and then move into the psychosocial treatment aspect. It would include treating the underlying mental health conditions and treating the trauma, but it would also be looking at workplace training and how to help someone look at returning to the workplace, or looking at a house and what that looks like. So many of our people have never lived in a home that's been stable and have never really appreciated that they can have it.

What treatment is all about is simple: hope. Our job is to create—

● (1720)

The Vice-Chair (Mr. Stephen Ellis): I'm sorry, Dr. Tanguay. I'm going to stop you there. I apologize. As you said, maybe you could go on for days, but we don't have days.

[*Translation*]

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

Mr. Luc Thériault: Dr. Tanguay, I'll continue along those lines.

I was struck by something you said earlier in your presentation. You talked about providing care for people who are suffering and struggling with addiction. On a practical level, how do you provide that care? It's not simply a matter of being admitted to a drug treatment program; people have to be very determined. We can't just lock them up. I'd like you to tell us about your experience and your successes.

[*English*]

Dr. Rob Tanguay: I can give many success stories about patients. I didn't really want to go down that road.

I think the concept.... I have patients who have gotten their jobs back, gotten their spouses back. Most important is when you help people get their children back. That's the biggest home run in my work—seeing someone come in and introduce their children to you because you helped them in their path to recovery.

We talk about calling people. I've made many of those horrible calls. I've had tears on the phone with moms and dads, brothers and sisters. At the same time, I've had tears of joy and hugs when we're discharging people and they're successful, when they've been with us for years and they're showing us that they can and do recover.

It's about building hope. It's about believing that you can—if you want to—move down the path to remitting your addiction or your mental health disorder and get your life back, and that you deserve it.

[*Translation*]

Mr. Luc Thériault: Do you agree that relapse is part of the drug treatment and healing process?

[*English*]

Dr. Rob Tanguay: Part of that is acceptance, accepting that some of the decisions and aspects of being in a health disorder such as addiction have also led to issues and that you have to deal with those issues.

I also believe that people do remit and relapse because it's a chronic, complex illness. With that, we need access to supports, and we need communities of care and health and wellness. That takes time. There's no easy answer to that.

[*Translation*]

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Thériault.

[*English*]

Thank you, Dr. Tanguay.

Mr. Johns, you have the floor for two and a half minutes.

Mr. Gord Johns: First of all, I want to thank all the witnesses for the important work they do in serving our communities.

I'm going to go back to you, Dr. Sereda. You got cut off a few times on yes-or-no answers. I'm going to cede the next two and a half minutes to you if you want to follow up with some of those responses that you weren't able to complete and with anything else you'd like to add.

Dr. Andrea Sereda: I was thinking hard about what I want to leave this committee with.

In our program, as safe supply clinicians, we see the deaths of so many people who cannot access safe supply. We knew them and still care about them. When these people die, Mr. Johns, we identify their bodies. As I said, we call their mothers. We plan their memorials and we don't sleep, because we don't know who is going to be dead in the morning. The next day, we get out of bed. We wipe our tears and go back outside. We put our knees on the dirty pavement and do CPR again and again. We've been doing this for eight years.

I'm sorry. I used to keep a list of the dead on my office wall because I didn't want to forget them, but I ran out of room to put that paper on my office wall. Maybe I ran out of the emotional fortitude to look at it every day. I took it down and put it away because it was too much. However, even that empty space on the wall still says something to me. It tells me about the people we have not been able to save. We cannot forget these people. We cannot forget them in these rhetorical discussions we're seeing, and the misinformation. Those people are dead and we're not getting them back. We have 42,000 dead. We lost 44,000 Canadians in World War II. In less than a year, we're going to lose more Canadians than we did in the entirety of World War II.

This crisis is producing mass death and it's forever traumatizing to those of us who care for them, their families and their communities. The frontline health care workers are working so hard to save every single life we can.

If I can leave this committee with anything, it is this: Rely on the actual scientific evidence and expert evidence brought to you here, not the media, misinformation, anecdotes and stigmatizing discourse.

I want you all to picture that blank space on my office wall and the names I can no longer look at.

Thank you.

● (1725)

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Sereda and Mr. Johns.

We have two final rounds of questioning.

Dr. Kitchen, you have the floor for five minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you all for being here. It's much appreciated.

You know, it's interesting. It's not anecdotal that we are asking questions here today. We're asking questions because the Canadians watching this want answers, since what's happening isn't helping. They want their children home, as Dr. Tanguay indicated. They want to be able to see their children. They want to be able to see their family members and have them back the way they were. That's the information we hear from our constituents who continually portray this to us. As much as you might want to call it anecdotal, it is our constituents around this table who are telling us this information.

Dr. Tanguay, you had some great comments. I have a number of questions for you.

You mentioned the lifetime prevalence of TBI, suggesting that there's an increased incidence of drug use because of that. Can you elaborate on that, please?

Dr. Rob Tanguay: I'm sorry. To be clear, that's the lifetime prevalence of people living without homes, in terms of traumatic brain injuries being that high.

Looking at moderate to severe...10% of all brain injuries are because of overdoses occurring on our streets. That's just published in the peer-reviewed literature. That's pure data that's been published and looked at. It talks about just how severely vulnerable those populations are.

Mr. Robert Kitchen: Thank you.

I appreciate that, because I know a 16-year-old boy who was the victim of a hit and run. He went head-first through the front windshield of a vehicle and had brain matter draining out of his left ear. He's deaf in his left ear, had multiple broken bones, multiple injuries to his face, etc., and he definitely had concerns many times in his life about where that could take him.

This happened to me. I'm that boy. It happened 50 years ago this May. Fortunately, many people helped out along those lines, ultimately.

I want to talk to Ms. Hudspith.

You talked about the pain task force. Fortunately, through my career, I put myself through education and sports to get myself to where I am today. In the time I spent at the Royal University Hospital in Saskatoon, I was with Professor Emeritus Gordon Wyant. He was an anaesthesiologist who started the pain clinic at the University of Saskatchewan. One of the things he talked about was exactly what you pointed out, the three things: pharma, psychology and physical and all those aspects of it.

I'm wondering whether you could comment a bit more on that.

Ms. Maria Hudspith: Thank you for the question.

I think this is one of the pieces. As Rob was saying, safe supply needs to include all these other pieces. Providing medication is one thing. We know people need other aspects of pain control.

We've talked a lot about the issue of over-prescribing opioids for pain leading us here. We know we cannot just prescribe our way out of this problem. We need to be providing wraparound services, mental health services, addiction services and pain services for people who are at risk of overdose.

I'm particularly concerned about the population of people who have been on long-term opioids for pain and who are being deprescribed and are at risk of overdose. They are not meeting the criteria for safe supply.

● (1730)

Mr. Robert Kitchen: Thanks for that. I appreciate it.

Ultimately, what we see and what I alluded to earlier is that the people who are watching us here today aren't the addicts. The addicts aren't the ones watching what's going on. It's the parents. It's the families that are watching, from the conversations we've had.

I had a conversation, in fact, just two days ago with a constituent of mine who was talking about her son who is addicted. He gets arrested, and the police have been very helpful to her, but he can't get the treatment. He can't get what he needs because he can't get into the treatment centres. He has finally recognized that he needs that aspect of it, to the point where, when we were having our conversation, he was screaming at me over the phone because of what was going on and his mother doing this. These are huge challenges.

How do we get people...? Those are the steps that we need. I think you're all alluding to it, but we first need to get health care to our constituents right from the get-go.

Mr. Tanguay, I'm wondering if you have any suggestions. What can we do differently to improve that?

The Vice-Chair (Mr. Stephen Ellis): Dr. Tanguay, if you could tell us that in 15 seconds or less, that would be terrific.

Dr. Rob Tanguay: We have to take a good look at the Canada Health Act. The Canada Health Act does not support or include interdisciplinary care for those who need it the most. It does not include care for chronic, complex illness. It doesn't include physiotherapy. It doesn't include psychology. It doesn't include occupational therapy. It doesn't include all of our allied health. The provinces do this through their own decisions and of their own will. It is not covered under our Canada Health Act.

Quite simply, everything we want to do we can't do, because our health care act doesn't allow us to.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Tanguay.

Thank you, Dr. Kitchen.

The final word will go to Dr. Hanley. You have the floor for five minutes.

Mr. Brendan Hanley: Thanks again to all of you for your really valuable contributions.

I'm going to try to keep this short for each of you.

Ms. Hudspith, I probably won't actually ask you a question, but we did leave a question unanswered. I was wondering if you would be able to submit some written answers around the role of pain care in the public health care system, and the role of self-management and the work that you've been doing in that regard.

Dr. Tanguay, again, thanks so much. It's been really helpful testimony.

I know this is not a quick question, but I'm going to make it a quick question. It's about getting OAT into rural communities. In 30 seconds or less, can you talk about the importance of that and how we can best leverage that?

Dr. Rob Tanguay: Absolutely.

Virtual care is absolutely paramount in this. Look, we live in Canada. We know there are health disparities. We know that part of the health disparity includes where you live. If you live in a rural area—like where I'm from, in rural, small-town southern Alberta, and northern Alberta previously—where you have to drive for hours just to see a doctor, virtual care is absolutely a way of closing that gap and making it simple.

Of course, there's working with your pharmacies. When I started treatment, fentanyl came in a green bean that was a “shady 80” or a fake oxycodone 80. It was never anything else. That's when the cookie kind of thing actually made sense. We couldn't get a pharmacist to prescribe suboxone outside of a very specific one. Now you can go to Safeway. You can to Superstore. I'm going to get in trouble for naming companies, but you can go anywhere.

Mr. Brendan Hanley: I'm going to cut you off, Dr. Tanguay, but anything else that you could supply in writing would be greatly valuable.

Since we're focused on the federal government's response, can you tell me one thing that we should be doing more and that we could be doing more as a federal government to address the scale of this crisis?

Dr. Rob Tanguay: Yes. It's time for us to really step up and decide whether we are going to take care of our most vulnerable or not. That means looking at the Canada Health Act and deciding if we are going to cover interdisciplinary care or not. It's time to really take a look at that aspect. If we're going to cover interdisciplinary care, and that means taking care of our most vulnerable in their complex and difficult illnesses, then this is the way we're going to do it, so that they don't have to access small centres of excellence that are almost completely inaccessible.

● (1735)

Mr. Brendan Hanley: Thank you very much.

Dr. Sereda, I'll bring the question to you. I think what I've heard is that there's far more in common between the testimonies we've heard from all the witnesses about the spectrum of approaches we need. We also know that with the number of Canadian who are dying every day, we need to do much more.

As a country, are we responding at the scale we need to? You did mention waiting for SUAP approvals, but what else? What other concrete actions could we and should we be doing as a federal government?

Dr. Andrea Sereda: You mentioned agreement. I think it's important that we rapidly and emergently scale up the scope of the spectrum of all interventions that people need to survive this crisis. I've been asked a lot of questions about safe supply today. Obviously, I think many Canadians could be kept alive with that approach, but we also need to rapidly scale up access to conventional addiction medications like methadone and buprenorphine. We need to scale up access to treatment on demand through bed-based treatment, if that is what people desire.

As a country, what do we need to do now? We need to stop blaming the people who are dying for the fact that they are dying. We need to stop stigmatizing people who use drugs, because that is directly impairing any kind of response we can have on any kind of emergency timeline. We need to lay all that stigma and marginalization behind us and really focus on saving lives.

Mr. Brendan Hanley: Thank you.

I might have a few more seconds. Can you briefly distinguish for us the difference between anecdote and qualitative research? You did highlight that briefly.

Dr. Andrea Sereda: Qualitative research is done by experienced academics and researchers who have been trained in qualitative methodologies. These things go through ethics review panels. The methodologies are examined and are closely followed.

Anecdote is different. Anecdote is asking one person what happened and not putting that under any kind of critical appraisal. It's not going through any kind of ethics review to see the impact of the information you're seeking on the community of a person. It doesn't go through any kind of peer review, which all qualitative research does.

Anecdote just stands alone as someone's statement. Qualitative research has a long-standing history of quality and describing people's experiences in health care.

Mr. Brendan Hanley: Thank you.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Hanley.

Thank you to all the witnesses for taking the time to appear and sharing such valuable information with us today. I know that it will be important to our analysts as we create a report for the Canadian public as we go forward.

Members, our next meeting will be Thursday, February 29, to continue on the opioid epidemic and toxic drug crisis in Canada. That's just a look forward.

Since we started late, we've had a bit of extra time. Is it the will of the committee to now adjourn?

Some hon. members: Agreed.

The Vice-Chair (Mr. Stephen Ellis): The meeting is adjourned.