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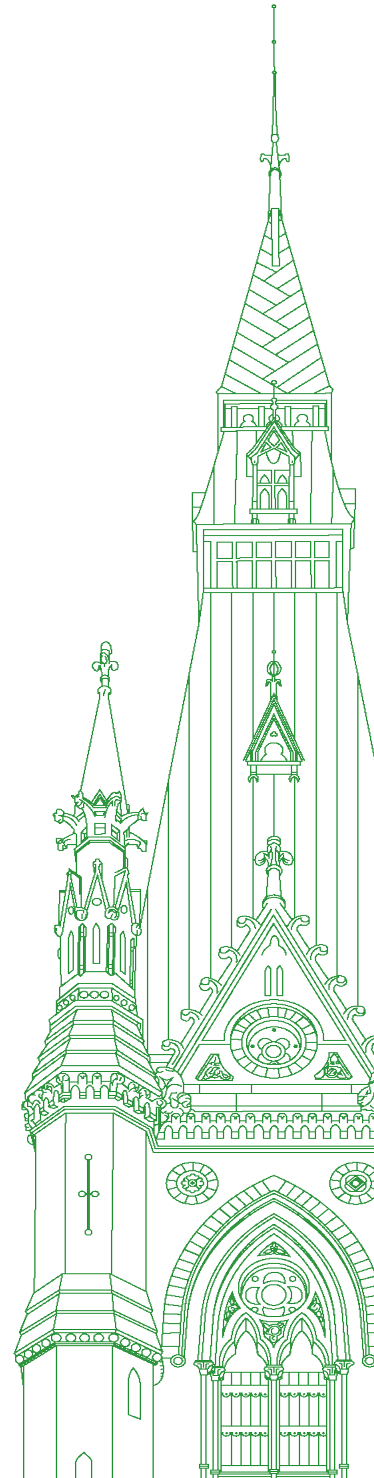

Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, September 24, 2024

• (1100)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 127 of the House of Commons Standing Committee on Health.

Before we begin, I would like to ask all in-person participants to read the guidelines written on the cards on the table. These measures are in place to help prevent audio feedback incidents and thus to protect the health and safety of all participants, including the interpreters.

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

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

I'd like to welcome our panel of witnesses.

We have with us today, appearing as an individual, Dr. Patricia Conrod, clinical psychologist and professor of psychiatry and addiction at the Centre hospitalier universitaire Sainte-Justine at the Université de Montréal.

[*Translation*]

She's on video conference.

[*English*]

Also appearing as individuals, we have Dr. Martyn Judson, who is appearing virtually, and Gregory Sword, who is with us in the room.

Representing the Canadian Mental Health Association, we have Margaret Eaton, national chief executive officer, who is online, and Sarah Kennell, national director of public policy.

Thank you all for taking the time to be with us today. You will each have up to five minutes for an opening statement.

We're going to begin with Dr. Conrod. Welcome to the committee. You have the floor.

Dr. Patricia Conrod (Clinical Psychologist and Professor of Psychiatry and Addiction, Centre hospitalier universitaire Sainte-Justine, Université de Montréal, As an Individual): Thank you very much for inviting me to speak to you today.

As an expert in the field of drug and alcohol prevention, I want to raise a number of concerns. As you know, the—

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Mr. Chair, apologies to the witness, but I have a point of order.

With all due respect, I would like to ask the interpreters to speak directly into the microphone. You know very well that the volume is very low in this room. I've set the volume at 85% and I can hardly hear anything. So I would like the people in the interpreters' booth to make a special effort to speak directly into the microphone, not beside it. Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

I presume you heard that, Dr. Conrod.

Ms. Kayabaga.

• (1105)

Ms. Arielle Kayabaga (London West, Lib.): Chair, I would also request that we increase the volume. I can't hear what she's saying.

Thanks.

The Chair: Okay.

Mrs. Goodridge.

Dr. Patricia Conrod: Yes—

The Chair: Give me just one second, Dr. Conrod.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): I can't hear what's in the room.

The Chair: Okay.

Could you say just a couple of sentences? We need to tweak the sound level so that everyone in the room can hear you. I'm going to have you restart your statement once we get all of this figured out.

Go ahead, Dr. Conrod.

Dr. Patricia Conrod: You want me to say just a few words without going ahead. Is that it?

The Chair: Where are you today?

Dr. Patricia Conrod: Can everyone hear me okay? I'll wait for you to give me the word to start again.

The Chair: Okay. Is the volume in the room okay now? Can everyone hear me all right?

Welcome to meeting number 127 of the House of Commons Standing Committee on Health.

Does that sound okay in your earpieces, folks?

Is that okay, Ms. Kayabaga?

Ms. Arielle Kayabaga: I can hear you fine. I can't hear her sound.

The Chair: Okay.

Why don't you try that, Dr. Conrod?

Dr. Patricia Conrod: Are you able to hear me now? I'm speaking up. I can try to speak louder.

The Chair: Is it okay in the earpieces? Okay.

Please restart. I'm sorry for the hiccup. Sometimes that happens.

Go ahead, right from the top, Dr. Conrod. Thank you.

Dr. Patricia Conrod: No problem.

Thank you for having me speak to the committee today and for your focus on this concerning health crisis, the opioid overdose crisis, that is affecting young people.

I submitted a statement late last night—that I hope you all do read—in relation to how the opioid crisis is affecting young people. More young people have died from opioid-related deaths than alcohol-related deaths, despite the much higher prevalence of alcohol use amongst young people in Canada. The Ontario OSDUHS study recently reported that, compared to all other drugs, opioid use is increasing amongst young people, and now over 20% of high school students are reporting having tried an opioid in the past year.

There are a number of solutions to addressing addiction. They don't just involve acute treatment and pharmacological interventions. They also involve indicated prevention programs, universal prevention programs, and selective or targeted prevention programs, and that's what I want to speak to you today about.

In my brief, I have highlighted a number of systematic reviews. One was reported by the Surgeon General in 2016 in the U.S. and provides a very thorough overview of the evidence-based prevention programs that are currently available and can provide solutions to the current opioid crisis in Canada. There is also a report by the United Nations Office of Drugs and Crime, as well as a joint report by WHO, UNESCO and UNODC. In all three of these reports, there are programs that have been developed in Canada and tested in Canada, but they are not being widely distributed and made available to young people in this country right now.

I chaired a committee, a working group, focused on the emerging health crisis to find solutions for at-risk and young users of opioids. We reported a systematic review that was published in The Canadian Journal of Psychiatry a few years ago. In this report, we identified two programs—only two programs—that have been shown to prevent the uptake of prescription drug misuse amongst young people. One is the Prosper delivery system that has been widely evaluated in the United States. The second is the personality-targeted prevention program, which was developed in Canada and widely tested in Canada.

With regard to a significant evidence gap with respect to solutions for young people who are using opioids and at very high risk of overdose deaths or transitioning to lifelong experiences of addiction and dependence, we conducted a number of focus groups with at-risk users across the country. A number of recommendations are reported, and I refer you to a number of publications that were published in The Canadian Journal of Addiction. The overwhelming message that came from these qualitative interviews with at-risk users was the need for more youth-oriented programs and the desire for more school-based programs, workshops, face-to-face interactions and discussions related to risk for prescription drug misuse, including addressing underlying mental health challenges, peer pressures and concerns about other people's use.

I would be very happy to go over the evidence in relation to prevention programs that are currently available in Canada and that could be widely implemented. I just want to finish with a number of recommendations to the committee on how we could better address young people's risk for opioid overdoses in this country.

First, communities need help reviewing and making sense of very complex literature on drug and alcohol prevention. I recommend that Health Canada maintain a review process and a registry for evidence-based drug and alcohol prevention programs, similar to what has been made available through SAMHSA in the United States and other state registries for evidence-based prevention programs.

We need more federal funding for drug prevention in this country. As you know, alcohol and drug misuse represent enormous costs to society, but less than 1% of those costs are dedicated to implementing prevention programs in the country. Communities need additional resources to help them in adapting evidence-based programs and evaluating their implementation in new contexts where there are evidence gaps.

● (1110)

In light of the growing health threat to young people brought about by the opioid crisis in North America, Health Canada and the Canadian government should explore ways to incentivize provinces and territories in setting statutory orders and minimum standards for drug prevention so that every child in the country is exposed to an evidence-based program immediately.

We need a more coordinated implementation resource and evaluation tool. This could be easily attached to CIHR's CRISM network, but we need more resources dedicated to research and evaluation of prevention and not just a focus on opioid substitution therapy treatments, which has been mostly what the research has been focused on to date.

Health Canada should also stop investing in drug prevention strategies for which there is limited scientific evidence. I can talk more about that.

Finally, we need better online safety for children and young people. The illicit drug market has transitioned to social media, and that is where kids are being groomed for lifelong substance use and misuse. It's extremely important that we begin to look at new ways of protecting young people online.

Thank you.

The Chair: Thank you, Dr. Conrod.

Next is Dr. Martyn Judson.

Welcome to the committee, Dr. Judson. You have the floor.

Dr. Martyn Judson (As an Individual): Thank you, Chairman, for this invitation to speak before the House of Commons Standing Committee on Health.

I am a physician licensed to practise in the Province of Ontario, which I have done for 49 years. Initially, I engaged in general practice and then specialized full-time in addiction medicine, commencing in 1990. I'm certified by the International Society of Addiction Medicine and, in the management of substance misuse, by the Royal College of General Practitioners, U.K. I was the first physician to prescribe methadone for the management of opioid dependence—which is the same as addiction—west of Toronto, and that was in 1991.

I co-authored the first edition of methadone treatment guidelines, published by the College of Physicians and Surgeons of Ontario. Subsequently, I became the medical director of Clinic 528, which at one time retained 22 physicians managing the disorder of opioid dependence for over 1,400 patients.

In the mid-1990s, methadone prescribing was closely regulated by Health Canada and the CPSO, otherwise referred to as “the College”, in order to minimize mismanagement of patients, drug diversion and overdoses. The protocols necessary to achieve these goals were followed strictly, and patient safety and improved health were noted.

Initially, the Clinic 528 operation met significant resistance from local businesses, but after anxieties were allayed, the clinic became a respected part of the community. Anecdotal information from the London Police department indicated that heavy crime decreased.

Since the introduction of what is called “safe supply clinics” in London, the number of patients enrolled at Clinic 528 started to decrease, and many of the patients who have remained have continued to exhibit instability in their recovery from the disease of addiction.

I accept that opioid replacement therapy in the form of methadone and Suboxone does not meet every patient need, and alternative opioid prescribing is acceptable, necessary and indicated, but this should involve long-acting opioids. The use of short-acting opioid preparations such as Dilaudid, which are not monitored nor regulated, significantly increases the risk for patient destabilization, overdoses, diversion, homelessness and crime.

The political situation in London has not helped to mitigate these risks. Both Health Canada and the College of Physicians and Surgeons of Ontario have seemingly abdicated all responsibility for oversight, resulting in many physicians and pharmacists engaging in the practice of prescribing short-acting opioids, which aggravate addiction.

It is important to recognize that those who suffer with addiction can be considered to be suffering with a disease, but the use of opioids is also a choice, a means of coping and a reflection of the decay in society. The remedy is not to prescribe abundant amounts of opioids. Instead, introduce controls and support systems, which will help not just patients, but also prescribers, dispensers and the local communities. Once patient stability is established, health, responsibility, pride and integrity can develop.

Safe supply, for the most part, does not induce such progress.

Thank you.

● (1115)

The Chair: Thank you, Dr. Judson. Next we have Mr. Gregory Sword.

Mr. Sword, welcome to the committee. You have five minutes for your opening statement. Go ahead, sir.

Mr. Gregory Sword (As an Individual): Thank you for having me. I lost my daughter two years ago to this opioid crisis. I fought for the last two years to save her life, and I failed. She was able to get safe supply with just one click on Snapchat, and she would be able to get any drug she wanted within five minutes.

She was in and out of the hospital for the last two years of her life. Her first overdose was with fentanyl. The mental health team was called in to give a report, said she was okay, and within five minutes she was released from the hospital. My daughter was suffering from ADHD. When we did the lockdown for COVID, it took her out of her regular routine and she had no escape. She wasn't used to being confined for the entire day, so she started to go online more and more. At that point, she started to dabble. She started with marijuana, and then went to bars, which was the street Xanax, and then finally she was introduced to dillies. Being a naive father, when she would talk about going out for a dilly bar, I thought that was ice cream, so it never raised any concern for me. She would hang out at Dairy Queen with all of her friends. It progressed from there to the point where she had another overdose, almost a year to the day before she died. We had one year to save her, and we failed. Every time a youth counsellor would come in, they'd give me the same thing. She had to ask verbally for help. My daughter was stubborn. She would never ask anyone for help. As a father, I had to sit there and watch my daughter commit suicide for a year and I wasn't able to help her.

We would have drug counsellors come in to talk to her, and they would tell her that it was okay for her to continue to use marijuana. They took me right out of the picture. I could not control any substance my daughter took. In her mind, that gave her the right to keep on smoking marijuana, which put me in the hardest position of my life. Would I let her go onto the streets to get her marijuana, or would I become a drug dealer for my own daughter? I took the latter approach and started to sell, to give my daughter the marijuana she needed to make sure she was getting a safe amount.

But that wasn't good enough for her. She liked the pills. The ease with which she was able to get the pills was unbelievable. She would go to the local park, and she would have what they call safe supply within five minutes. She was embarrassed about doing it. She and her friends, after the second overdose, decided that they needed to stop, but they would not ask for professional help. She got to the point where she was embarrassed and she was an addict, so she started to hide it. She would wait until I went to sleep and then she would take her pill in her bed. I would be gone to work the next morning, so I would never see the effect of it, until I got that fateful phone call that she was found dead in her bedroom.

Since then, I've reached out and tried to figure out what went wrong. I've talked to MLAs. I've talked to the police. The police keep telling me they're handcuffed. I've talked to counsellors; they don't have enough resources. After my daughter died, one of her best friends overdosed two more times. Another best friend has overdosed three more times since her death. We finally got one of them into rehab after she finally reached out and asked for help. It took her a month and a half to find a bed.

● (1120)

For teenagers, a month and a half is a lifetime, especially when they're struggling with addiction. We could have lost that girl very quickly, because we do not have the funding to help these children overcome their addictions.

That's everything I have to say right now.

The Chair: Thank you, Mr. Sword.

Next, we have Ms. Eaton from the Canadian Mental Health Association.

Ms. Margaret Eaton (National Chief Executive Officer, Canadian Mental Health Association - National): Thank you so much, and good afternoon. Thank you for this invitation to appear before the committee to support this timely study.

I very much want to thank Greg Sword for his powerful words, and for the courage that I know it took for him to come and share his story. I offer my condolences to him and the families across this country who have lost loved ones because of this toxic crisis.

The Canadian Mental Health Association delivers free front line community mental health substance youth health services in more than 330 communities across every province and Yukon, in rural, northern, and urban settings.

Community mental health and addictions care is a critical complement to physician and hospital-based care. Our services can range from mental health literacy and integrated youth hubs, case management and navigation, clinical counselling, addiction withdrawal management and treatment, stabilization units, supportive housing and mobile crisis teams, and help lines, including participating in the national 988 suicide distress line.

However, it is a constant struggle to meet the growing needs of Canadians, with long waiting lists for services across the country. Front line community health organizations sit outside the primary care system, a reality that is baked into the 40-year-old Canada Health Act, which only guarantees access for those struggling with mental health and addiction issues to emergency rooms, psychiatrists, and family doctors. It does not provide access to essential mental health and substance use health care provided by community organizations.

This means that most community-based mental health and substance use health services are not covered under provincial and territorial health insurance plans. As a result, we are underfunded and left to piece together short-term project funding and fundraising off the goodwill of Canadians who have the capacity to give. Further, community health organizations are often left out of crucial health care conversations with decision-makers.

There are also severe wage inequities for our staff, compared to hospitals and other health care centres. This, coupled with the long waiting lists, leads to high levels of burnout, low retention, and high turnover. Our workforce is exhausted, and grappling with moral distress, trying to respond with compassion and energy to a crisis that is worsening.

I've heard from frontline staff about the challenges they are facing in response to the toxic drug crisis. Across the country, they tell us about how their clients are ready to be in treatment, but they sit on a wait list for four months, because there are no publicly funded treatment options available. They tell me about their clients who are in recovery, but they relapse, because they don't have housing, let alone housing with wraparound supports. They tell me about the pain of losing multiple clients to opioid poisonings in just one week.

I believe that everyone in this room shares a common vision to ensure that our communities are safe places, where our families and friends can thrive. It is a vision that ensures there are supports for those who are struggling with mental illnesses and substance use disorders, so that they can get the help they need when they need it.

Of course, we want to respect jurisdictional areas of responsibility, but there are specific programs, policies, and legislation that you as federal decision-makers have the power to act on, so here are three.

Number one, most importantly, amend the Canada Health Act to explicitly include community-based mental health addictions and substance use health care services. Number two, earmark funding under the national housing strategy, specifically for transitional and supportive housing units. Individuals can receive the best possible addictions treatment, but if they don't have a place to call home, we are neglecting a foundation to their recovery. Number three, task Health Canada with coordinating a federal plan to address the crisis.

Our system can't rely on jails and hospitals. Our communities deserve better. Federal leadership is needed to coordinate a compassionate and integrated approach. The opportunity of this study is to bring mental health and addictions health care on par with physical health care. I urge you as federal legislators to act.

I'm joined by my colleague, Sarah Kennell, national director of public policy, who is in the room with you today. She is there to answer any questions that you might have.

Thank you so much for this time.

● (1125)

The Chair: Thank you, Ms. Eaton.

That concludes our opening statements.

We're now going to begin with rounds of questions, starting with the Conservatives.

We'll go to Ms. Goodridge for six minutes, please.

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

I want to thank all of the witnesses for their testimony, specifically Gregory Sword for sharing about his daughter's circumstance. I really appreciate that.

I'm going to start my questions with Dr. Judson.

In your opening statement, you stated that both Health Canada and the College of Physicians and Surgeons of Ontario have seemingly abdicated all responsibility for oversight.

I was wondering if you could expand on that.

Dr. Martyn Judson: When I first started prescribing methadone, I had to get approval from Health Canada. I had to have a special exemption to be able to prescribe methadone. It was contingent on having taken a course in the prescribing of methadone, which outlined its neurochemistry and the pharmacokinetics of methadone. I had to meet special requirements before the College of Physicians and Surgeons to prove that I was in good standing to be able to prescribe opioids.

Those two authorities, the college and Health Canada, effectively screened me out as being someone who was going to be prescribing methadone for legitimate reasons, and the likelihood of over-prescribing or inappropriate prescribing was minimal.

That doesn't seem to be the case just because the number of patients who are experiencing opioid misuse renders it far too difficult, really impossible, for so many physicians treating that patient population to keep controls over things. It would just consume far too much time, I presume.

I can't say more than that.

Mrs. Laila Goodridge: Thank you.

Could you, in your professional opinion, share what the correlation is between the availability of substances and the harms they cause?

Dr. Martyn Judson: If you think not just of opioids, you recognize that all substance misuse that is the problem. It doesn't matter what you use; it's the fact that an individual uses a substance that really defines what addiction is.

As long ago as the early 1970s, soon after I opened up a new practice, I was impressed by a research paper that had been published by a sociologist at the University of Western Ontario. His conclusion was that the more available alcohol is, the more alcohol is consumed. The more alcohol that is consumed, the more problems occur as a result.

That has recently been corroborated by a study conducted actually in Ontario but published in the journal entitled “Addiction”, which is published in the UK, which looked at opioid use. The conclusions were that the more opioids that are prescribed, the more opioids become available to all people for legitimate and illicit reasons, and the more problems occur as a result, including increased health issues and increased visits to emergency rooms.

Those two reports, spanning a 50-year history, indicate the more substances are available, the more problems there are going to be. That's what we're witnessing as a result of these safe supply clinics, which are putting an abundant amount of opioids onto the streets. If these clinics were better regulated, then it would probably rein in the amount of opioids that are finding their way onto the streets.

● (1130)

Mrs. Laila Goodridge: Thank you.

Dr. Conrod, I see you shaking your head. Could you perhaps expand and share your thoughts on that subject as well?

Dr. Patricia Conrod: My understanding of the literature is very similar, so I concur with all of those comments. It also puts people at risk. The more substance use in the adult population, the greater risk for a youth population; the more there are liberal attitudes about substance use, the more young people are likely to use, and at younger ages. There are even studies demonstrating that proximity to alcohol outlets, for example, will influence young people's rates of substance use or alcohol use, for example.

I'll reiterate how concerned I am about the fact that opioid use among young people is rising. What that means is that Canada will continue to have a very significant problem for decades to come.

Mrs. Laila Goodridge: I appreciate that.

Greg, how easy was it for your daughter to get access to these potent Dilaudid pills?

Mr. Gregory Sword: With one message on either Snapchat or Instagram, she would have someone delivering her whatever she wanted within five minutes. She could get dillies, cocaine, acid and alcohol whenever she wanted. Even after she died, they were still messaging her cellphone.

My friend had access to her Snapchat account and they were still asking if she needed any dillies.

Mrs. Laila Goodridge: I know Kamilah's friends have said that dillies were widely available at their school.

Can you expand on this? It terrifies me as a parent that highly potent opioids are available in schools.

Mr. Gregory Sword: Most of the kids there would get their supply from someone who could go to Vancouver's Eastside, pick up a bunch of pills and bring them back to the smaller community where I lived. Before my daughter died, there were two other girls in the same area who had died of the same thing, with no mention of it. I only found out from other parents.

It is so easy for these kids to get their hands on it because we don't monitor it in B.C. We just hand out the pills and hope the addicts will take them and not sell them for the drugs they want. They give them to the kids or the gangs, and they come back out to the smaller communities.

The Chair: Thank you, Mr. Sword.

Madame Brière, go ahead for six minutes, please.

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Mr. Chair.

Thanks to the witnesses for being with us.

[*Translation*]

Dr. Conrod, in your opening remarks, you talked about the various solutions, which aren't necessarily drug-based solutions, but rather universal prevention programs and more targeted programs.

Your research focuses, among other things, on reinforcing factors that may push a person to use. I wonder if you could talk about those reinforcing and predisposing factors, as well as the preventive approaches you're working on.

● (1135)

Dr. Patricia Conrod: Yes, absolutely. Do you mind if I give my answer in English?

[*English*]

Mrs. Élisabeth Brière: It's okay. It's no problem.

Dr. Patricia Conrod: Thank you very much. You've clearly done your research, and I appreciate that.

Absolutely, there are a number of evidence-based prevention programs that should be widely available to all young people. There are only 3,400 high schools in the country, so that's not an enormous task. They are under-resourced and require dedicated resources in order to support these programs, because they are not just a poster in a hallway or a lecture by someone who has had an experience with substance use. These are psychological interventions or multi-year programs that involve building skills in families and in young people that help them manage stress and confidently resist peer pressure to use. Giving young people tools on how to say no really does work.

In terms of counteracting some of the social norms that come from social media...my research has demonstrated that social media is promoting problematic substance use norms, as well as norms that come from other media, families and society generally.

I also want to talk to you about prescription drug misuse, because prescription drug misuse appears to be particularly linked to risk for other mental disorders. What we now know, from decades of research on psychopathology and neurodevelopment, is that there are a number of risk factors for early onset mental health problems.

There are psychological traits that are very good markers of who is likely to develop difficulties with anxiety, depression, impulsivity and ADHD, as Mr. Sword described, and other thrill-seeking behaviours. Young people can report on those traits very easily. How they report on individual differences, such as impulsivity and thrill-seeking, will predict who is likely to misuse a substance, what substance they are most likely to misuse, what prescription substance they're most likely to misuse and what kinds of mental health difficulties they're likely to experience in relation to their substance use.

My work has demonstrated over and over again—and these are large, randomized trials that have been conducted in the U.K., Australia, Canada and Europe, involving thousands of young people—that you can deliver cognitive behavioural mental health interventions early on, in the 7th, 8th and 9th grades. When they're delivered in high fidelity by a trained mental health professional, you can delay the onset of substance use in young people. You can prevent young people from developing a substance use disorder.

I believe we haven't yet demonstrated this scientifically, but that is how you're going to be able to begin to start to address this problem and reduce the burden on the acute substance use and mental health services. You have to help young people delay the onset of use and stop new users from taking up opioid use, which is what is happening right now and has been increasing every year for the past 10 years, almost.

[*Translation*]

Mrs. Élisabeth Brière: You have developed PreVenture, I believe.

Dr. Patricia Conrod: Yes. Do you want me to talk a little bit about that program?

[*English*]

The PreVenture program, I have to say, is one that I was involved in developing, but there are other researchers—for example, Dr. Sherry Stewart at Dalhousie University—who have collaborated with me on this. This is a program that has just been packaged to be able to train school-based mental health and educational professionals on how to effectively deliver cognitive behavioural interventions preventatively. This program has been demonstrated to be effective when it's disseminated broadly in a community.

In about a month's time, there will be a large publication in the American Journal of Psychiatry, demonstrating a very significant effect on substance use outcomes over a five-year period in a randomized control trial in Montreal involving 31 high schools.

Other trials in Australia have also demonstrated that the PreVenture program is effective in reducing substance use over seven years of a young person's life trajectory. The program has been very widely tested. It's mentioned as an evidence-based program in the Surgeon General's Report published in 2016. I have a lot of experience doing this work in schools in Canada and around the world. Through that experience, I do see that schools have become more and more burdened. They're less well-resourced to do the work.

As my colleague said, they are overwhelmed. Rates of staff turnover and burn-out are very high. Social media, addressing bullying and this need for testing in schools have overwhelmed psychological resources in schools right now. That's why it's absolutely necessary that we add to the available resources in schools across the country. One or two health professionals or prevention professionals across the country, in every school, would dramatically improve young peoples' lives and reduce the risk of further addiction and overdoses, in my opinion.

● (1140)

The Chair: Thank you, Dr. Conrod.

Thank you, Madame Brière.

[*Translation*]

I now give the floor to Mr. Thériault for six minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

First of all, Mr. Sword, I offer you my deepest condolences. Your testimony was very touching, shocking even.

Dr. Judson, I would like to take advantage of your experience and thank you for your dedication to the fight against drug addiction: 49 years in the field is a very long time. It could be likened to a calling.

Today the toxic drug crisis is very complex, much more so, I guess, than when you could prescribe methadone to a heroin addict. The drugs of today are made up of a number of substances. Experts have even told us that when you begin to treat someone addicted to synthetic drugs, you can suddenly realize that the individual is becoming very ill because you don't have what it takes to wean him off a certain drug that plays a role in his addiction.

With regard to the crisis we are currently facing, I would like you to tell us what additional challenges we are facing compared to what it was like at the beginning of your career in substance abuse treatment.

[*English*]

Dr. Martyn Judson: I cannot speak French that well.

[*Translation*]

Mr. Luc Thériault: Of course. You can speak in English; there is an interpretation service. Are you saying you didn't understand the question?

If that is the case, Mr. Chair, the witness should be told how he can hear the interpretation.

[*English*]

The Chair: Dr. Judson, were you able to avail yourself of the simultaneous translation?

Dr. Martyn Judson: No, I did not hear any of it.

The Chair: Okay. On your screen, you should see there that you have the option between hearing the proceedings in English, French, or the language that's being spoken. So you must have yours on floor. Can you adjust it to hear everything in English, please?

Dr. Martyn Judson: Where do I adjust that? Sorry, I don't....

The Chair: It should be on the bottom of your screen.

Dr. Martyn Judson: I just have the audio, video, participants, raise hand.

The Chair: After raise hand, you should see interpretation. Do you see that? On the bottom of your screen.

Dr. Martyn Judson: No... I do. Oh, raise interpretation. I do now. Thank you.

The Chair: Okay. So if you press that and then enable English.

● (1145)

Dr. Martyn Judson: I pressed English, yes.

The Chair: Okay.

[*Translation*]

Mr. Thériault, please resume. You have the floor for six minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

Dr. Judson, I'm going to get right to the point. I was complimenting you on your commitment to substance abuse treatment. One could say that this has been your calling, given that you have been working in this field for several decades.

I also said that it was much simpler to treat a heroin addict when you started out than it is today, when we are dealing with people caught up in the current toxic drug crisis. I would like you to tell us about the difference between those two eras.

According to the experts we've heard here in committee, at the beginning of their treatment, people become very ill because opioids are not the only thing contributing to their addiction. There are also other types of drugs in their systems. So people are facing challenges that they didn't face before.

What is your experience in this area? What are your thoughts on the complex crisis we're facing? I imagine that you were working in an institutional environment at the outset and that your work was determined by that setting. Last winter, young Mathis Boivin died after taking a single pill, the first one of his life. Doesn't that makes things more complex?

[*English*]

Dr. Martyn Judson: Thank you for your compliments.

You're correct in saying that it's easier to treat someone with a heroin addiction compared with someone who is using readily available Dilaudid. When we first started treating opioid dependance some 40 years ago, the only available drug at that time was methadone. Methadone is a long-acting opioid agonist that was first developed for the treatment of pain at the end of the Second World War.

The first methadone clinic was established in Vancouver in the very early seventies. At that time, Dr. Cassidy noted that patients who were prescribed methadone for treatment of their pain were quite comfortable and remained on that dose for a long period of time and never required increasing doses.

On the other hand, shorter-acting opioids, such as heroin and Dilaudid.... Because they are so short-acting, the effect is that every two to three hours the patient is going into withdrawal. They respond—combat those feelings of withdrawal—by taking more opiates. When you take more opiates.... You have to understand the neurochemistry of the drugs. To simplify it for the committee, I can only emphasize that opioids, in actual fact, end up destroying nerve endings. When nerve endings are damaged, they do not respond to medication. That's why doses of opioids have to, over time, be increased. It involves those chemicals called cytokines, which some people will have heard of.

When it comes back to treating heroin addicts some 30 or 40 years ago when there weren't any other substances on the street—it was mainly heroin and opium—then the prescription of methadone was very successful. The number of physicians treating this gradually grew, and we were able to keep up with the demand.

It's really since the introduction of these safe supply clinics that [*Technical difficulty—Editor*] the overabundance of short-acting opioids, which are naturally destroying the neurochemical integrity of the users, that we've seen the demands that those same patients need ever-increasing doses. Safe supply clinics are, in actual fact, doing more harm than good.

I'm not opposed to alternatives to methadone and buprenorphine, which is Suboxone, which I said in my opening statement. The alternatives should be long-acting, akin to methadone and Suboxone, and they need to be monitored so that we don't get this abundance of short-acting drugs, which are diverted. I've witnessed that myself first-hand. I've seen it on the streets outside my own clinic. You don't get the abundance of divertible opioids that end up, unfortunately, in the hands of young people, such as Mr. Sword's daughter.

I hope that's answered your question.

● (1150)

[*Translation*]

Mr. Luc Thériault: Yes. We are now dealing with massive doses and much stronger substances than heroin, and that's why the situation is complex.

Dr. Conrod, we talk about this toxic drug crisis and the death rate associated with it. Sometimes a single dose is deadly, which means drugs are something you try for the first and last time. Furthermore, organized crime does not seem to have any qualms or pangs of conscience about what it is peddling.

What are your thoughts on supervised consumption clinics and safe supply? Do you think that we have moved past the stage where we need to save lives and that we can now strictly focus on prevention and treatment, or do we still need to intervene to prevent people from suffering and dying on the street because we are unable to control their consumption?

Are you in favour of safe consumption?

The Chair: Dr. Conrod, Mr. Thériault's time is up, so please provide a brief answer.

[*English*]

Dr. Patricia Conrod: Briefly, we need a comprehensive drug strategy that includes safe options for people with opioid dependence, one that includes a much stronger focus on programs and interventions that are going to stop young people from using any drug. A young intoxicated person is much more likely to try other substances, for example. What is circulating currently on the streets and on the Internet is extremely dangerous for young people.

The last thing I would say is that it's not just safe supply clinics that have contributed to circulating opioids. It is also day surgeries and the prescription of short-acting pain relief medication for pain management. That was the beginning of the opioid crisis. It then caused people to transition to other, more potent forms because they were underdiagnosed for their dependence on opioids, then undertreated.

This has been a 30-year problem that has evolved and morphed into a very complex situation that requires a comprehensive approach to its treatment.

The Chair: Thank you, Dr. Conrod.

Next, Mr. Johns has six minutes.

Mr. Gord Johns (Courtenay—Alberni, NDP): First, thank you to all the witnesses for their important testimony, especially Mr. Sword for his courage to be here and share. It's such a difficult issue for everybody trying to find solutions here.

I want to thank you for sharing so we can talk about them.

Dr. Conrod, we heard from Mr. Sword about the fact that his daughter was able to access the Internet. In minutes, she could get fentanyl, cocaine, meth, hydromorphone, or marijuana. It was just a click away. You also highlighted, in your speech, the impact of the Internet. You mentioned the need to improve online safety for youth.

Can you answer and share your thoughts on a couple of questions? What role is social media playing in the youth mental health crisis? Do you have specific recommendations on how we can make the Internet safer for youth?

● (1155)

Dr. Patricia Conrod: Thank you for this question.

I have conducted quite a bit of research on the topic. The work I have done has demonstrated that social media, more than other forms of media, is contributing to young people's poor mental health. The work we published was attributed to having inspired some of the work done by Meta on young people and the impact of their products on mental health.

Canadian research is informing and changing policies in other countries right now around online safety for young people. I really like some of the solutions that have been proposed and passed in the U.K. and Europe. There's even a report I could make available to everyone on some changes that industry has had to implement in relation to some new regulatory policies in Europe. They result in safer practices for young people on social media platforms.

What I can say is this: The more a young person uses social media the more they are likely to experience depression and anxiety symptoms. The more they learn that underage drinking is normal the more they're influenced to drink at an earlier age. We find the same effect for cannabis. We have also shown that using social media impacts cognitive development and makes a young person more disinhibited and impulsive, and it contributes to ADHD symptoms. We know that all three of those behavioural and symptom profiles place a young person at much higher risk for early-onset substance misuse.

Therefore, social media is directly and indirectly increasing young people's risk for addiction, in my opinion. It's through access to substances, but it's also impacting young people's cognitive development and the development of self-control, as well as influencing their attitudes about substance use. There are three separate effects.

What is a solution for Canada with respect to online safety for young people? Hold industry responsible for the harms. We're not doing that in Canada, to my understanding. I don't think we should only be focusing on hate speech. There are other harmful effects of social media on young people, and there are solutions to this. I don't know how much time I have left. The idea is to make sure products are safer for young people. We can talk about this, perhaps, at another time.

Hold industry responsible for making their products safer for young people—recognizing that young people are using their products.

Mr. Gord Johns: Thank you so much, Dr. Conrod.

We could ask you questions all day, I'm sure. Youth prevention is so important. We just don't talk enough about prevention. We look forward to you sending that information to us.

Ms. Eaton, you talked about a recommendation that was made to the committee at a previous meeting to take a good look at the Canada Health Act because it doesn't cover or support interdisciplinary care for people with chronic, complex illnesses.

Do you think that the constraints of the Canada Health Act are hampering our response to the mental health and toxic drug crisis that we're facing right now?

Ms. Margaret Eaton: Thanks so much for that question.

I'm going to turn to Sarah Kennell, who is in the room and is our Canada Health Act expert, to answer that question.

Ms. Sarah Kennell (National Director, Public Policy, Canadian Mental Health Association - National): Thank you very much, Mr. Johns, for the question and good morning, committee members.

The fact is that the Canada Health Act only covers services delivered in hospitals and by physicians, which means that services like counselling and psychotherapy—those upstream interventions that Dr. Conrod spoke to such as addictions treatment services—all fall out of scope. That means that people who are looking for life-saving addictions treatment services and counselling services that can prevent the worsening of symptoms have to either go without or pay out of pocket.

They go without because they simply can't afford that treatment as an option. That means that the symptoms worsen over time to the point where they are dealing with highly complex issues resulting in criminal activity and repeated hospitalization, which ultimately cost our system more and is harder to treat.

We also see the increasing prevalence of the delivery of addictions treatment services by private providers, which means that there is no accountability, no standards, no regulatory oversight and people have to pay tens of thousands of dollars to get into these programs. I've heard of stories where families have to take out second or third mortgages in order to pay for their family members to have access to this treatment.

It's just not considered part of our public universal health system.

The solution that is on the table right now is to create an amendment to the act that would explicitly include a reference to "community-delivered", just like the services that Mr. Sword was so sorely looking for, for his daughter and other community members. This would create an inclusion in provincial and territorial health insurance plans, so that people can get the care they need when they need it.

● (1200)

The Chair: Thank you, Ms. Kennell.

Next we have Mr. Moore.

Congratulations on your promotion to the health committee. You have the floor.

Hon. Rob Moore (Fundy Royal, CPC): Thank you, Mr. Chair.

This question is for Dr. Judson.

You mentioned in your comments the difference between someone being prescribed a controlled substance and how that medication is closely monitored by their doctor and their pharmacy.

Can you explain to those who are watching how this differs from what is now referred to as the so-called safe supply that we're seeing in our communities?

Dr. Martyn Judson: Certainly. I'd first like to say that I concur and endorse the comments offered by Dr. Conrod. We share the same opinions.

First off, I would say that it's a misnomer. The very fact that these clinics are called "safe supply" is an attempt at misinformation in implying that anybody who takes these drugs will be perfectly safe to use them. All they are are pharmaceutical-grade opioid prescriptions, so the recipient knows that the drug has come directly from a pharmaceutical company and it's not being made in a clandestine street laboratory.

However, the use of such medications is still dangerous. Using the short-acting opioids is just an alternative to patients using street opioids.

I want to emphasize that the taking of the medication, whether it be methadone or Dilaudid prescriptions, is just a small part of the treatment for addiction. I always emphasize that when prescribing methadone or Suboxone to a patient, that was an attempt to engage with the patient, establish rapport and get them steered in the right direction of going to address their psychosocial needs.

The perpetuation of a supply of opioids is in actual fact just perpetuating the addiction. It's not doing anything to change the lifestyle of the individual. That's where most of the resources need to go. If we're spending a lot of time and money prescribing short-acting opioids, we're in actual fact not really effecting any change.

Hon. Rob Moore: Thank you, Doctor.

This is ripped out of the headlines, but I want to get your comments on it. This was just yesterday. "A police raid at a heavily used harm reduction site in Nanaimo resulted in several criminal charges against two people." In summary, one individual was charged with "14 counts of possession for the purpose of trafficking and eight weapons offences", and another was charged with "six possession for the purpose of trafficking counts and five weapons offences".

Doctor, based on your extensive experience, does that news surprise you?

Dr. Martyn Judson: No, because crime and addiction are somewhat inextricably linked. However, I want to emphasize that it's not the patients—the users, those who suffer with substance misuse disorders—who should be targeted. It's the dealers and the suppliers who need to be reined in. That's why I feel sufficiently strongly that many of the doctors who are prescribing short-acting opioids...I question whether they really understand the harm they're perpetrating. They're not regulated. If they have inadequate education on the subject, that is just going to contribute to the problem.

I want to emphasize, too, that I refer to substance misuse as the "four-two-one" condition. Most medical students spend four years in their institutions. If they are lucky, they will get two hours of teaching on what is the number one cause of morbidity.

If you're graduating doctors who really don't understand addiction, you can see how easy it is for them to over-prescribe and inappropriately prescribe, and the same applies to pharmacists. They don't have the training and education necessary to prevent excessive amounts of opioids ending up on the street. Most of those opioids that seemingly come from safe supply end up in the hands of the traffickers, the accounts of which you just described. They're accumulating these supplies because their business is to promote drug use.

● (1205)

The Chair: Thank you, Mr. Moore.

We'll go to Dr. Hanley, please, for five minutes.

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

Thank you to all the witnesses.

I will also echo my colleagues in thanking you, in particular, Mr. Sword, for sharing your tragic story about your daughter.

On that theme, I'd like to begin by asking Ms. Kennell to consider the situation where a child is in distress, but not asking for help. Are resources in place? Are interventions in place to assist such a child, and what would you amplify to enable that child to be helped?

I'll ask you to keep it as concise as possible, because I have many questions.

Ms. Sarah Kennell: Thank you very much, Mr. Hanley.

The short answer is no. We do not have the necessary supports to help children and youth deal with the mounting mental health and substance use health challenges they are facing and are going to face as they age.

The solution, to echo Dr. Conrod's points, is building in upstream preventative and mental health promotion interventions that meet them along the way and create effective referral pathways into available, community-delivered, out-of-hospital treatment options. These could be early psychosis intervention or prevention programs that deal with addiction and substance use health, to name a few.

The issue is that everything is behind a paid door, not available or behind long wait-lists.

Mr. Brendan Hanley: Thank you.

Ms. Kennell, do you consider mental health care part of primary health care?

Ms. Sarah Kennell: I do, 100%. I would wager that it is core to what medical students learn every day.

The challenge, though, is that our health system is not equipped to deliver mental health and substance use health care that is on par with physical health care or primary health care. With the shortage of access to family physicians and the lack of adequate and robust training for medical health care professionals, the resulting consequence is that people don't know where to go to get help, they face long wait times or there are inadequate solutions when it comes to addressing their mental health concerns.

Mr. Brendan Hanley: Dr. Conrod, I will ask you the same first question about the child in distress who is not asking for help.

Could you comment briefly on that and the availability of interventions?

Dr. Patricia Conrod: The best way to deliver services to that young person who might not be asking for help but is demonstrating signs of struggle is in a school—where the young person has to show up every day until the age of 16, where it is very easy to provide early upstream psychological interventions to young people, and where there are programs that have been shown to be effective in preventing mental health problems as well as substance use problems.

The challenge right now is staffing mental health teams in schools. There are some advantages to this model, though, in that they can be linked to community-based resources so that when the problem is beyond the capacity of the school, there's a way for a school-based team to interact with health services, for example, and rapidly refer that young person to more intensive care.

● (1210)

Mr. Brendan Hanley: Excuse me, Dr. Conrod. I'm going to interrupt you there. I want to give a minute to my colleague Mr. Morrice to be able to ask a question.

Thank you very much.

Mr. Mike Morrice (Kitchener Centre, GP): Thank you, Brendan. I appreciate it.

The situation in my community in the Waterloo region is dire. Over 63 folks have died from preventable deaths this year. We haven't seen organizations get renewed funding from the substance use and addictions program as of yet. We also have a premier who is looking to close safe consumption sites that are saving lives.

I guess my question is for the CMHA. I really appreciate that you've worked with Thresholds to launch an integrated crisis centre for mental health in our community. Thank you for that.

In your testimony, you talked about having Health Canada launch a new task force for a national strategy to address this crisis. In the time I have left, maybe 30 seconds or so, can you share just a few key points of what you'd want to see in that if we were to listen to the experts and not the partisanship?

Ms. Sarah Kennell: Thank you very much, Mr. Morrice, for the question.

I want to really reiterate that the view of the Canadian Mental Health Association is to provide comprehensive wraparound care that spans upstream interventions to help prevent the onset of crisis into more acute services, and then to really support people into their path towards recovery. I would be remiss if I didn't take a moment to really echo support for that wraparound long-term support, which is the social determinants of health. As my colleague Margaret mentioned, unless we have adequate housing and unless we have income supports, we will be facing a revolving door of a crisis.

Our recommendation to Health Canada and the federal government writ large is to develop a comprehensive and integrated plan that scopes out what existing programs are available for community providers like CMHA and others to do that life-saving work on the ground, fill the gap of what's being provided through the acute care system and then assess where there are additional gaps. Perhaps it's prevention in school-based prevention programs. Perhaps it's more investments in the social determinants. We need to take a whole-of-society and whole-of-government view of what the federal jurisdictional responsibility is. That begins with a plan.

The Chair: Thank you, Ms. Kennell, and thank you, Mr. Morrice.

[*Translation*]

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

Mr. Luc Thériault: Ms. Eaton, witnesses who specialize in addiction and prevention have told us that 30% to 70% of people struggling with addiction have a primary mental health problem. That is not insignificant. We are also aware of the whole issue of access to mental health care.

What do you recommend so that we can help these people before they get to the point where they are self-medicating to try to relieve their suffering themselves? Would you agree with that statement?

[*English*]

Ms. Margaret Eaton: I'm going to turn to Sarah Kennell in the room to answer this one.

Thank you.

[*Translation*]

Ms. Sarah Kennell: Hello, Mr. Thériault. Thank you very much for the question.

[*English*]

The reality is that millions of Canadians lack access to primary care. The solution can't be solely hiring more family physicians. If we are going to address the health human resources crisis across the country, we need to look at expanding the health professionals who deliver mental health and substance use health to ensure that we are adequately resourced with social workers, occupational therapists and peer support workers. Those are the types of professionals we need in order to fund a robust and comprehensive mental health and substance use health system.

Sadly, many of those professions are being left out of national conversations regarding health human resourcing, coupled with the fact that those professionals, when hired outside of hospitals or doctors' offices, are not adequately paid for their services. In Ontario, for example, they make 20% to 30% less than their colleagues who are in other health industries, resulting in what my colleague, Margaret, spoke to, which is a high level of retention and recruitment issues, and burnout, given the moral distress they are witnessing on the ground.

Our solution is to amend the Canada Health Act, with a view to include those services and health care providers to ensure that they're adequately compensated, and covered within our public universal health care system.

● (1215)

The Chair: Thank you, Ms. Kennell.

Next, we have Mr. Johns, for two and a half minutes, please.

Mr. Gord Johns: Thank you, Mr. Chair.

I've tried to delay tabling motions to get a first hour from witnesses, but I need to move some motions right now. The first motion I put on notice reads:

> That the committee instruct the Chair to write to the Auditor General of Canada to recommend that a performance audit examining the federal government's response to the opioid and toxic drug crisis in Canada, including but not limited to its management of programs identified in the Canadian Drugs and Substances Strategy, be initiated, and conducted on a priority basis.

I would like to briefly speak to the motion.

The Chair: The motion is in order as it relates to the subject matter at hand, so the debate is on the motion.

Is there any debate?

Go ahead, Mr. Johns.

Mr. Gord Johns: Hopefully, we won't spend a lot of time on this motion.

By way of background, in December 2022, I wrote to the Auditor General to recommend that an audit be conducted of the government's response to the toxic drug crisis. At the same time, I received a response stating there was an intention to conduct an audit on the issue, but the work was not envisioned to begin in 2023.

On the Office of the Auditor General's website, there is a list of anticipated reports for 2024-25, which still doesn't include the toxic drug crisis. There have now been 15 Auditor General reports on elements of the government's COVID response, with two more on the way. An audit on the government's response to the toxic drug crisis is overdue. I hope members of the committee will support this motion.

I just want to mention that on Vancouver Island only one riding out of seven got SUAP programming. I know that my friend from the greater Waterloo region, Mr. Morrice, didn't get any. I think it's relevant that we write to the Auditor General, and ask this to be prioritized.

The Chair: Thank you, Mr. Johns.

Go ahead, Dr. Ellis, please.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thanks very much, Chair.

The biggest problem I would have with this motion, of course, is that there's ample opportunity at other times to discuss extending the study on opioids, which, to me, this directly relates to it. We have witnesses here, and our friend from the NDP is bringing this forward now. This is a little ridiculous.

As I said, there is more than ample opportunity to bring this up on many other occasions. I'm not sure why this grandstanding is ongoing at the current time.

The Chair: Mr. Johns.

Mr. Gord Johns: It's not grandstanding. I'm trying to get this motion moved, so we can write to the Auditor General. I just put it on notice last week, so this is just timely. I'm trying to move it, so we can write to the Auditor General. I don't think there should be any objection to this.

The Chair: Is there any further debate on the motion?

Seeing none, are we ready for the question?

The Chair: All those in favour of the motion presented by Mr. Johns, please raise your hand.

All those opposed?

(Motion agreed to)

The Chair: Mr. Johns, you still have two minutes and 23 seconds.

Mr. Gord Johns: Thank you.

Ms. Eaton, you talked about the fact that there's no plan.

Mr. Stephen Ellis: I have a point of order, Chair.

The Chair: I have Dr. Ellis on a point of order.

Mr. Stephen Ellis: I know I just arrived, and I apologize. Was he on a five-minute round? How could he still have time left? I thought our convention at this committee was that any time you used to bring forward a motion was actually lost time.

The Chair: No. The clock stops. I'm sure Ms. Goodridge would be able to confirm that.

Mrs. Laila Goodridge: That is correct—only if it's at the end.

Mr. Stephen Ellis: Okay, very well.

The Chair: Go ahead, Mr. Johns.

Mr. Gord Johns: Thank you.

Ms. Eaton, you talked earlier about the fact that there's no plan. It's something that we've also been calling for. The government has had a high-level meeting around auto theft, and I'm not saying that's not an important issue, but they still have not had a summit on the toxic drug crisis. They have put forward a plan, but there's no timeline and there are no resources attached to that timeline.

Can you talk to and speak a bit about how critical it is that the government put forward a plan with resources and a timeline to implement that to respond to the toxic drug crisis and the mental health crisis happening in Canada?

● (1220)

Ms. Margaret Eaton: Thank you so much, Mr. Johns.

Absolutely: We would thoroughly support a summit to address this crisis.

The death toll is great across the country, and we can't sit idly by. We will soon be releasing some really interesting information about the fact that provinces have actually reduced the amount of money they are spending on mental health and substance use care. It is lower than the percentage that they were spending even 10 or 15 years ago.

We are really interested in the government looking closely at this issue and at what legislative means they can use to actually change this situation to save lives. We would absolutely encourage a plan and a summit.

Mr. Gord Johns: Do you think that expanding coverage under the Canada Health Act is the best path forward to the challenges we're facing with mental health and substance use care? What would that solve?

Ms. Margaret Eaton: We absolutely believe that a change to the Canada Health Act is necessary. We see provinces not being held accountable for actually investing in mental health and substance use care. We don't have national standards. We don't have the ability for someone to use their provincial health card to get the essential services we need.

Also, we see this patchwork quilt of funding across the country, which means that rural regions are remarkably unserved, even by the existing services of the Canada Health Act—like doctors and psychiatrists—let alone mental health and substance use health services.

We absolutely see the Canada Health Act as a remedy.

The Chair: Thank you, Mr. Johns.

Next is Mr. Steinley, please, for five minutes.

Mr. Warren Steinley (Regina—Lewvan, CPC): Thank you very much.

This is for Dr. Conrod.

We have done the so-called safe supply experiment for about nine years now, and I was wondering about the before and after. Do you have the numbers of overall deaths before safe supply started, for approximately those 10 years, and for the nine years after safe supply had been introduced into the Canadian public by this NDP-Liberal government? Have there been numbers?

Could you say and extrapolate some information between how many more overdoses we have had in our country before and after this what they call “safe supply”—which I don't agree with—experiment?

Dr. Patricia Conrod: I'm afraid I can't directly answer your question. I don't know if the data that exists right now could even answer that question. There are a number of different factors that have changed over the past decade and two decades that have contributed to where we are at right now.

I do want to just clarify one thing. This notion of safe supply is kind of a mixed bag of treatment services and possibilities. I know that there are some researchers from the CRISM network who intend on producing some material that might be helpful to the Canadian government and communities across the country, to better just unpack what is meant by safe supply, what practices are safe and what might actually have unintended consequences for the broader population.

We need a lot more work and clarity around some of these practices.

Mr. Warren Steinley: I appreciate that very much.

Mr. Sword, thank you for being here.

I had a conversation with a constituent who came to my office. His son had overdosed as well. His conversation was very similar. The ease with which his son.... He overdosed, and this gentleman's grandson was sitting there when his father overdosed. He was sitting in front of the TV when his grandfather came and found his son dead. He said that the biggest thing that he could not do was to stop the ease with which his son was getting drugs. He was getting them online and delivered right to his door. It was very similar to Snapchat. He was accessing the drugs online.

I think Dr. Conrod has done some research on the ease with which people can get drugs online now. It's something that—for me as a father—terrifies me. I have three kids. They are 7, 9 and 11, and it terrifies me that with a click of a button, a 12-year-old could get drugs to their doorstep.

Do you have some data that says what we could do as legislators to help with that and to try to curb the ease of these kids and adults getting drugs online?

● (1225)

Dr. Patricia Conrod: Is that question directed to me?

Mr. Warren Steinley: Yes, ma'am.

Dr. Patricia Conrod: There's a lot to say here, but it's important that we recognize that young people are using digital media and, therefore, digital media must be designed for young people's use, and it's not right now. There are all kinds of privacy features, for example, and defaults that assume that the user is an adult, when we know that a very large portion of the users of social media and other digital platforms are not. They're minors. We can force industry to change some of their default features so that, for example, young people are less likely to be solicited by a stranger online. That could go a long way to protecting young people. We could also monitor environments in which young people meet online.

Mr. Warren Steinley: Thank you very much.

Actually, Mr. Sword, I'd like to leave you with the last word. If there's one thing you could ask us as legislators to do, how do you think we could help to make sure that what happened to your beautiful daughter doesn't happen to anyone else? What is the best advice we could have from you, sir?

Mr. Gregory Sword: It pretty much comes down to funding. Invest in the mental health of our children. It's our future that we are throwing away. Most kids now are looking at a grim future with the prices and the way the economy is going. They're not dumb anymore and they're looking for escapism. Some kids are turning to drugs to forget about the problems, while others are turning to video games. Neither one is mentally healthy for them.

We need to actually invest in our future and get the funding they need so they can get the help they need before they become true addicts.

Mr. Warren Steinley: They need some hope.

Mr. Gregory Sword: Yes. They need a light at the end of the tunnel. All they see is darkness.

The Chair: Thank you, Mr. Sword and Mr. Steinley.

Next, Ms. Kayabaga, go ahead for five minutes, please.

Ms. Arielle Kayabaga: Thank you, Chair.

I would also like to thank our witnesses for being here today, especially you, Mr. Sword, for sharing your heart-wrenching testimony. My thoughts are with you and your family as you continue to navigate this.

Perhaps I would like to start with Dr. Judson.

Dr. Judson, I'm sure a lot of things have changed since you started practising. I'm curious to know if methadone or Suboxone can be diverted. Besides maybe an injectable formulation, do you think there's a medication that can be diverted? Do you agree that zero diversion is almost impossible when we're talking about prescribed drugs or even some non-prescribed ones?

Dr. Martyn Judson: There is no such thing as zero diversion. When methadone programs first started in the early nineties, protocols were set in place to minimize that diversion, which required patients who were just recently initiated on methadone to attend the pharmacy every day and consume a witnessed dose of methadone. They weren't able to take any doses of their methadone home until they had achieved evidence of significant stability. That usually required a period of over three months.

After three months of a patient's denying use of substances, substantiated by witnessed negative drug screens, in which the patient had to produce a urine sample under witness conditions, if those twice-weekly urine samples remained negative over a period of three months, then a patient would be able to take one dose of methadone home a week, and after a month that increased to two. It would take six months—nine months really—to get all of their take-home doses, otherwise known as “carries”. Even that didn't prevent diversion, but it certainly reduced it.

Compare that with what is happening in safe supply clinics, particularly in London. You could go to a clinic in London and say that you had a problem with opioids. Chances are significant that you would walk out of that doctor's office with a prescription for Dilaudid—enough to last a whole week. You might have to have one witnessed dose in front of the pharmacist, and you would get the rest of your doses to take home. If it didn't happen immediately, it would happen certainly after about two or three weeks that you would be getting maybe 50 or 60 tablets to take home. That's far more than a patient who has just had abdominal surgery would require for the management of their pain. That is just tantamount to negligence. It's just incomprehensible. It's unconscionable that someone who is active in their disease of addiction would be trusted to take that amount of an opioid home.

● (1230)

Ms. Arielle Kayabaga: Thank you.

There haven't been a lot of conversations around the socio-economic impact on people who become patients with drug-use disorders.

I'm curious to know, Ms. Kennell, what perhaps your thoughts are on some of the comments that the Conservatives have been really pushing on making treatment forced. I'll give just a small example. Some communities have lower income. The median income is much lower than perhaps in some of our colleagues' ridings. What are your thoughts on the socio-economic impacts and these forced treatments? Obviously, we've seen some research that this hasn't worked.

What would happen to people who would be forced into treatments, treatments sort of offered as jails? What are your thoughts on this?

Ms. Sarah Kennell: Thank you very much, Ms. Kayabaga.

Your question, I would say, has two parts. The first is the socio-economic context that people struggling with substance use disorders and mental illness face. We know, for example, that 25% to 50% of people who are homeless or facing housing insecurity have a mental health or a substance use health concern.

The correlation there is unignorable; therefore, it requires us to be thinking cross-jurisdictionally and cross-sectorally to come up with solutions that truly address the crises and the intersectional nature of the crises that we're facing. The creation of the Canada disability benefit that came online this summer is an example of the type of federal intervention that can reduce the strain that poverty has on people dealing with mental health crises and substance use disorders.

In regard to the issue of involuntary treatment, I would encourage the committee to focus on interventions that are squarely within the federal jurisdictional purview. We know that every province and territory in Canada has a mental health act. We know that apprehensions under those acts are rising in the face of threat to public safety and threat to harms at the individual level; therefore, we know that there are legislative options that are being utilized provincially and territorially.

They are not perfect, and we need to acknowledge the incredible amounts of trauma and harm caused when we involuntarily detain individuals, which can be long-lasting, while also prioritizing the voices of people with lived and living experience who interact with the system every single day. We must ensure that we are responding to their needs and their experiences with the system when developing legislative amendments to those acts or considering new legislative options.

The Chair: Thank you, Ms. Kennell.

Next we have Ms. Goodridge, please, for five minutes.

Mrs. Laila Goodridge: Thank you.

I'm going to start my questions with Dr. Judson.

We've had people come here from London, people who are prescribers of the highly potent opioids. They say that the diversion can sometimes be seen as compassionate. What concerns do you have as someone who lives and works in London, Ontario, when it comes to diversion of these highly potent, government-funded opioids?

Dr. Martyn Judson: Diversion must be minimized, and that has to be a priority. I am not opposed to pharmaceutical-grade opioids being prescribed, but is it appropriate to be prescribing short-acting opioids? No. I've already stated that it is counterproductive. Giving take-home doses prematurely when a patient is not stable in their recovery—they've not engaged in their psychotherapy counselling—is not appropriate. For someone who is actively suffering from addiction to be given these short-acting opioids is just something that will deter them from engaging in lifestyle changes.

There must be some approach that encourages engagement with the patient and the therapist. The purpose of the opioid replacement therapy is to avoid the patient going into withdrawal or suffering from overwhelming cravings. Once those symptoms are eradicated, the patient is stable and more likely to be able to engage in the psychotherapeutic medium that is provided.

● (1235)

Mrs. Laila Goodridge: Thank you.

Dr. Conrod, what are your concerns when it relates to youth, specifically, and to the very well-documented diversion that is happening of these government-funded, potent opioids that are flooding the streets from coast to coast to coast?

Dr. Patricia Conrod: All substances that young people use are being diverted in some way. A small portion of them would have been prescribed directly to them by a psychiatrist or by a family physician. The literature suggests that most young people are actually getting them from friends and from family members. They're not getting them directly from government; they're getting them from actors in their communities. These people could be better educated. They could be assisted, as Dr. Judson described, in having access to safer supplies of opioids for whatever reason they are being prescribed, either for pain management or for opioid substitution therapies.

I do want to add one more thing to the discussion. We need to understand that mental health is a very big part of addiction. We're seeing, in the safe supply and opioid substitution clinics across the country, fewer and fewer resources available to deliver the mental health and counselling services that Dr. Judson just described. There are fewer funds and fewer people delivering those. On the evidence for opioid substitution therapies, we know that they're effective in conjunction with mental health services and counselling.

Mrs. Laila Goodridge: Do you believe that more needs to be done to prevent opioids and a variety of different substances from being accessed by youth?

Dr. Patricia Conrod: I absolutely agree with your statement. More needs to be done on both sides: on the supply side and on the demand side amongst young people.

Mrs. Laila Goodridge: Specifically on the demand side, I think that's a great space. Has your organization been able to access federal government funding to help with funding your PreVenture program?

Dr. Patricia Conrod: There are three ways. One is through research, through CIHR. CIHR has rather consistently been through the clinical trials and the committees supporting research on it. It's been very well reviewed and supported in that way. It's a lot of work, and it's a long timeline to do research in schools.

The second way is through the SUAP. I've partnered with one group in northwest Ontario that had a SUAP grant...or a PHAC grant. I'm sorry. They did an implementation, in their community, of PreVenture to great success. It was very well received.

The third pathway has been through provincial governments. There's a big initiative in Ontario right now, through the health ministry in Ontario, to deliver PreVenture across all schools in the province. We have reached a point where we've trained over 1,000 community-based and school-based professionals in the delivery of the program. There are a number of challenges to this project, but the objective is to deliver this to 30,000 young people over the next two years.

The Chair: Thank you, Ms. Conrod.

Thank you, Ms. Goodridge.

Next is Ms. Sidhu for five minutes, please.

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

Thank you to all the witnesses.

Thank you, Mr. Sword, for sharing your pain and your story. My heart goes to Kamilah. I'm a mother of two daughters, and I know how you feel.

Thanks for all the work all the organizations are doing on the ground.

My question is for Dr. Conrod.

Dr. Conrod, you talked about the prevention professionals who are going to be there. We know that youth born after 2010 have social media, technology and screens all around them. We hear more and more experts talking about overexposure to technology and about a clear link to the impact on mental health.

To what degree do you see the impact of suffering from addiction? What are some other factors in the environment of today's youth that impact them? I know there's a question.... What, immediately, is the change you're seeing?

● (1240)

Dr. Patricia Conrod: The situation is not as unhopeful as we all might think in the sense that alcohol, cocaine and tobacco use amongst young people has consistently declined since the seventies. There's quite a lot that we have managed to do around protecting young people from other substances.

The one substance that is showing an opposite trend is opioids, so we really need to focus on this particular behaviour. Young people's opioid use is increasing despite declining rates of substance use in other forms and it's an extremely dangerous substance for young people to be using. We need to take this very seriously.

All the trends are suggesting that there will be many more deaths of young people in this country from opioids.

Ms. Sonia Sidhu: My next question is for Dr. Eaton.

It's good to see you once again. Your team in Brampton is doing incredible work on the ground.

My first question is about the youth who struggling with addiction, which is now a crisis situation. Recently, we made a distress line equity fund announcement in Peel to expand the crisis line services provided by CMHA and your partners.

Can you provide some numbers to this committee on the number of young people who are accessing the CMHA distress lines?

Ms. Margaret Eaton: Thank you so much.

I do not have those numbers at hand, but we would be happy to find that information and report back.

We do know, generally and anecdotally, that the numbers are up for youth trying to access services. This is a post-pandemic response even though COVID has ended.

We know that for those youth that developed things like eating disorders and substance use disorders, none of that went away even though the pandemic stopped. I know that kids help phone numbers are up and usage of 988 has been consistently what was expected across the country.

I'd be happy to get back to you with those solid numbers.

Ms. Sonia Sidhu: Mr. Chair, I want to share the rest of the time with Dr. Powlowski.

The Chair: Dr. Powlowski, you have a little over a minute.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Dr. Judson, do you still work at Clinic 528? I believe that's in London and I believe it uses OAT or opioid agonist treatment with either methadone or Suboxone. I take it from your testimony, but I wasn't quite sure.

You were saying that you think the usage of that clinic and OAT has decreased because of the ready availability of safe supply and safe supply of Dilaudid in London.

Do you think that's the case? Is there is there any evidence that this is the case?

Thanks.

Dr. Martyn Judson: Yes, I do still work at Clinic 528.

As I said earlier, we originally had 1400 patients in 2004. Now we're down to about 600 patients. We used to have two or three admissions per day, Monday through Saturday. That has dropped down to one or two per week at the very most.

Most patients who are wanting treatment for their opioid dependence gravitate to safe supply clinics. Why? It's because fewer questions, seemingly, are asked. There is less screening and there is ready availability of take-home doses for the patients before they've been stabilized and established in a comprehensive recovery program.

● (1245)

The Chair: Thank you, Dr. Judson and Dr. Powlowski.

[*Translation*]

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

Mr. Luc Thériault: Dr. Conrod, you talked about the importance of prevention. We have seen prevention efforts, particularly with regard to tobacco use among young people. There is a new phenomenon, however, which is nicotine addiction through vaping and products such as Zonnic nicotine packets, which offer a pure and accessible nicotine product to young people. This creates a serious addiction. What do you intend to do about that?

In addition, could you send us all the literature that you have mentioned? You say that we can intervene preventively, and that is what must be done. We understand very well that it is important to engage in prevention. However, while we are doing that, people are going to die from overdoses because poor-quality drugs are being peddled on the streets. We have to amend the act in addition to working on preventive and long-term measures. It remains, however, that a toxic drug crisis is killing people on the streets. I would like you to send us all the relevant literature, because I absolutely want to read it.

Social media plays two roles in this crisis. The first is providing an avenue for dealers to connect with young people with the intention of selling drugs. The second is contributing to addiction and mental health issues.

[*English*]

Dr. Patricia Conrod: I'm not entirely sure what the exact question is, but I reinforce all of your comments. I agree with all of them.

We absolutely need to direct resources to indicated interventions for young people who have started to experiment with substances. We need to reduce their use of substances and absolutely prioritize interventions that are going to help them not transition to more regular and harmful use of very high-risk substances. We need upstream solutions as well, and we need solutions that will provide people living with substance use disorders and substance dependence with mental health services. They get caught in this revolving door.

I think the committee needs to realize that it's difficult enough to assess someone with a mental health problem. It's also very difficult to assist someone with a substance use disorder, and when you put those two things together it becomes a very complicated mix of symptoms that mutually influence each other. There's this notion called "telescoping". It causes difficulties to rapidly accelerate, and it makes it very difficult to intervene.That is why we advocate for much earlier intervention around the concurrent substance use and mental health problems. What research has shown from large cohort studies is that there are risk factors that will predict who is likely to experience co-occurring mental health and substance use problems. We've even identified some of the common underlying factors that will lead to these problems, and that is where the interventions are targeted.

The Chair: Thank you, Dr. Conrod.

Next, we have Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: Thank you, Mr. Chair.

The only time I can table motions is during this committee time, so I hate to do it, but I have to. Mr. Chair. I move:

> That, pursuant to Standing Order 108(2), given the increasing prevalence of privatized health care across the country and the difficulty Canadians face in getting the health care they need, the committee undertake a study of at least four meetings on protecting Canada’s public health care system against for-profit corporations, and that the committee invite the Chief Executive Officer of for-profit health care providers like Loblaw Companies Limited to testify

I'd like to speak to the motion, if I could.

The Chair: Okay, the motion was put on notice more than 48 hours ago, so it is therefore in order.

Dr. Hanley, go ahead.

● (1250)

Mr. Brendan Hanley: Thank you, Mr. Chair.

The Chair: I'm sorry, but Mr. Johns wanted to speak to the motion.

Mr. Johns, you still have the floor, and then you have the floor, Dr. Hanley.

Mr. Gord Johns: I think it's important. We heard today about the for-profit health care and mental health care straight from CMHA. We need to force the CEOs of these for-profit companies that are literally trying to replace the Canada medicare system with a cash-for-care model, and they need to come to Ottawa and explain their plans. That's the goal of this motion. We're seeing doctors and nurses in our hospitals being poached by private facilities. These are doctors and nurses we need to help with the toxic drug crisis and the mental health crisis. They're also impacting our hospital operating rooms, which are sitting empty. Emergency rooms are overrun and understaffed. These for-profit corporations are already starting to bill people. The message that families are getting right now is to pay up or wait at the back of the line. I believe that Canadians, and certainly the NDP, believe in free public universal health care. We believe that people and their families deserve the best care no matter how much is in their bank account. CEOs like that of Loblaws need to come to tell Canadians why they're working to ruin that. We need some answers.

The Chair: Thank you, Mr. Johns.

We have Dr. Hanley, please.

Mr. Brendan Hanley: Thank you.

Recognizing the time and that we still have witnesses, even though a few minutes remain, I think it's an important topic.

I want to recognize that there is currently, of course, a contribution from the private sector in our health care system today. The Canadian Medical Association has done some excellent recent work on the role of the private sector, including the options, as it were, and pros and cons.

In that spirit, I propose an amendment, and the amendment enlarges the scope of the motion somewhat. It reads:

> That pursuant to Standing Order 108(2), given the increasing prevalence of privatized health care across the country and the difficulty Canadians face in getting the health care they need, the committee undertake a study of at least four meetings on the role of the private sector in Canada's public health care system, including the need to protect Canadians against for-profit corporations, and that the committee invite the chief executive officer of for-profit health care providers like Loblaw Companies Limited to testify.

Thank you.

The Chair: Dr. Hanley, I think what you just read was the motion as amended.

Can you specify exactly what the nature of the amendment is? That's because we now have to proceed with debate on the amendment.

Mr. Brendan Hanley: I certainly can.

The addition is adding the words, “on the role of the private sector in Canada's public health care system, including”....

Mr. Gord Johns: I have a point of order, Mr. Chair.

The Chair: Mr. Johns.

Mr. Gord Johns: Can I accept that as a friendly amendment, so we can proceed on the main motion?

The Chair: No, I don't think you can. We're going to debate the amendment, then the motion as amended.

The debate now is on the amendment.

I have Dr. Ellis and Mrs. Goodridge.

Mr. Stephen Ellis: Thank you very much, Chair.

Once again, we see the political grandstanding of the NDP-Liberal coalition, which had the opportunity for nine years, on behalf of Canadians, to make the health care system better. Here we are talking about an absolutely incredible and important initiative.

Goodness gracious, colleagues, we have a gentleman here whose daughter died from this opioid scourge, but the two of you want to go on talking about something you had nine years to fix. Shame on you. This is absolutely unacceptable and ridiculous. For Mr. Johns to say that he didn't have another time to bring this forward.... In the vernacular, give me a break. That's absolutely untrue. This is foolishness. We have a system falling apart, with seven million Canadians without access to primary care. Both of these individuals brought forward an amendment to a motion they had the opportunity to address over nine years. They think they have to do it now. On behalf of Canadians, I say this is wrong.

In that spirit, Chair, I move to adjourn debate, so we can get back to the important matter we have at hand.

● (1255)

The Chair: A motion to adjourn debate is a dilatory motion on which there is no debate. We go straight to a vote.

I will ask for a show of hands.

All those in favour of adjourning....

Mr. Stephen Ellis: I request a recorded division, Chair.

The Chair: We'll have a recorded division as to whether the debate should now be adjourned.

(Motion agreed to: yeas 6; nays 5)

The Chair: The motion is adopted. The debate on the motion is therefore adjourned.

You have two and a half minutes, Mr. Johns.

Mr. Gord Johns: I will make sure that it is clear that the Conservatives have, many times, tabled motions during very critical testimony on this study, which I believe we should extend, as well.

I'll go back to Dr. Conrod.

What do you think is behind increasing opioid use in youth? Can you explain some of the factors that put youth at risk for substance-use harms? By contrast, what are the factors that reduce risk?

I'm sorry, but there is one more: What can the government do to reduce risks and increase protective factors?

Dr. Patricia Conrod: As I outlined in my brief, I think the first thing that needs to happen is government supporting a registry of evidence-based programs and helping communities review the evidence on what works and what doesn't. It's important to realize that some programs can actually do harm. We should only be supporting programs that, through rigorous research, have been demonstrated to protect young people. We should make those programs available. Then communities that indicate a readiness and desire to implement such programs could be supported in doing so.

I've outlined a number of steps that could facilitate the delivery and implementation of evidence-based programs to communities, ones that could be done very quickly.

Mr. Gord Johns: I asked you earlier, too, about this. Do you have an idea? You stated that Canada is underinvesting in prevention. I think we can all agree with that around this table. Do you have an estimate of the scale of investment required to implement a universal prevention program across Canada for youth?

Dr. Patricia Conrod: I would have to get back to you about that. It's minimal relative to the cost of substance abuse and the cost of lives lost to the addiction crisis so far. There's a report by Dr. Jürgen Rehm from 2006, which has been revised more recently, suggesting that implementing prevention is a very small fraction—around 0.1%—of the cost to society of substance misuse. I'd have to get back to you with an economic model if you needed one, but those can very easily be developed.

The Chair: Thank you, Mr. Johns.

To all of our witnesses, thank you so much for being with us.

Mr. Sword, please allow me to add my condolences for the loss of your daughter and my sincere thanks to you for your courage in coming forward in a public forum like this. It's my hope that the expertise from the other members of the panel and your courage today will all serve to ensure that fewer people have to experience what you have.

Is it the will of the committee to adjourn the meeting?

Some hon. members: It is.

The Chair: We're adjourned.

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