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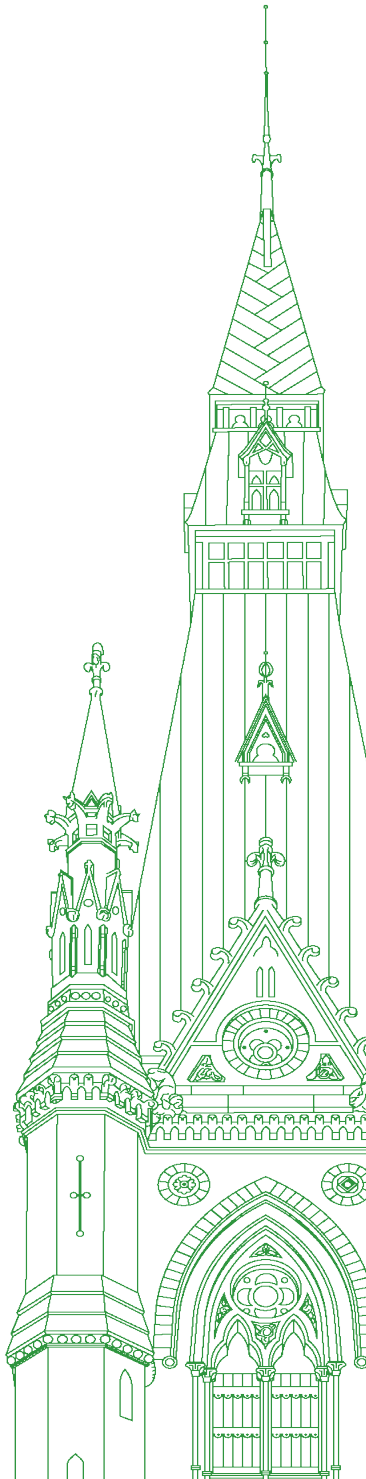

Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, November 5, 2024

● (1105)

[*English*]

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

Welcome to meeting number 137 of the House of Commons Standing Committee on Health.

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

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. Appearing as an individual, we have Shaun Wright, retired RCMP superintendent. On behalf of Blood Ties Four Directions Centre, we have Jill Aalhus, executive director. On behalf of Doctors of the World Canada, we have Pénélope Boudreault, nurse and national operations and strategic development director, who is appearing by video conference. Finally, on behalf of Indwell Community Homes, we have Dr. Steven Rolfe, director of health partnerships, who is also appearing by video conference.

Thank you all for taking the time to be with us today. You will have up to five minutes for an opening statement. We're going to begin with Superintendent Wright.

Welcome to the committee. You have the floor.

Mr. Shaun Wright (Superintendent (Retired), As an Individual): Thank you, committee members, for this opportunity to speak with you today.

I was sworn in as an RCMP officer in 1996. The 28-year career that followed was spent policing in the province of British Columbia.

In August of this year, I retired from the position of officer in charge of the Prince George RCMP detachment, a position I'd held for the previous five years. For committee members who may not be familiar with the geography of northern British Columbia, Prince George is a city with a population of approximately 80,000 people. It is far larger than any other municipality in the northern half of the province and is approximately a six-hour drive from a community of similar size. It is a hub city for goods and services for a large portion of the province. As a result, there is a significant transient population that contributes to social disorder issues.

During my policing career, there were two public policy issues that I observed to have overarching impacts on the area of social disorder in our communities.

The first of those issues was already occurring in the 1990s, when I became a police officer. That was the shift towards treating significant mental health issues in the community rather than in mental health institutions. Unfortunately, the supports provided in the community were either insufficient or inadequate to properly address the complex mental health needs of many individuals. This has contributed to those individuals being involved in criminal activity and incidents of social disorder over the last several decades.

The second issue is the decriminalization of hard drugs introduced in the province of British Columbia in 2023. During the first year of decriminalization, complaints of social disorder in the city increased noticeably. It appears to me that many aspects of this policy mirror the failings of mental health policy, since appropriate resources to facilitate treatment are not in place. There is a significant lack of treatment options available, and the majority of initiatives in this area focus primarily on facilitating the use of drugs, with little focus on prevention or providing assistance to individuals to get out of the cycle of addiction. This is similar to persons with complex mental health needs who are left on their own in society and who are unable to seek out and maintain appropriate care on their own. I have seen very few cases where opioid addicts have made rational decisions to seek treatment to overcome their addiction. There are many services readily available that actively facilitate drug use, but little focus on treatment.

One of the strategies introduced to address opioid addiction is the so-called safe supply of prescribed opioids. The practice of prescribing a quantity of pills for individuals to take away and use at their own discretion is problematic. Many of those prescribed pills are traded in or sold to the illicit drug market by individuals seeking more potent street drugs. This often occurs outside the door of a pharmacy immediately after the prescribed pills are provided to the individual. Those prescribed pills are often seized alongside quantities of street drugs like fentanyl during police investigations.

When I began as a police officer in the 1990s, there was a focus on a four-pillar drug strategy, which consisted of prevention, enforcement, treatment and harm reduction. It is my experience that the only pillar of this strategy now being supported significantly is harm reduction. With decriminalization establishing drug addiction as solely a health care matter, it's my observation that the majority of the resources focus on accepting and facilitating drug addiction and its associated behaviours as a social norm, without a focus on preventing and reducing rates of addiction. As a result, it appears to me that the harms of illicit drugs on society have continued to increase.

Thank you.

The Chair: Thank you, Superintendent Wright.

Next, representing the Blood Ties Four Directions Centre, we have Jill Aalhus.

Welcome to the committee. You have the floor.

Ms. Jill Aalhus (Executive Director, Blood Ties Four Directions Centre): Thank you.

Blood Ties is a small non-profit on the territories of the Kwanlin Dün and Ta'an Kwäch'än Council in Whitehorse, Yukon.

Before our supervised consumption site opened, I was working when I heard a yell. I ran outside and saw the grey skin of the person my co-workers were helping. Their loved ones had brought them to our back alley instead of calling 911 because they were terrified that the RCMP would respond to the call. Our hands cramped from the cold as we filled naloxone vials, did chest compressions and provided rescue breaths in the snow at -20°C in our T-shirts. Thankfully they survived, but this was a regular occurrence. I've had nightmares about this experience and many similar since.

Now that we have a supervised consumption site, this is rare. Overdoses feel more manageable. They are gradual and we catch them early, yet people continue to die in our communities. There's more we need to do. We cannot go backwards.

I would like to share some context for our work as a frontline service organization in the north. The Yukon's land mass is roughly twice the size of the United Kingdom, but this vast territory is home to only 47,000 people, with 30,000 of those in Whitehorse. Eleven of the 14 first nations are self-governing, and four have declared states of emergency due to the toxic drug crisis. Most of our work is in Whitehorse. Since our short-term SUAP project funding ended, we have little funding for rural harm reduction, but we patch together resources to provide outreach and education across Yukon's rural communities.

Last year, we lost 23 people from our small population. This represents a rate of 50.4 per 100,000, which is even higher than B.C.'s already devastating 45.5 per 100,000. One-quarter of people in the Yukon are indigenous, yet they account for up to three-quarters of overdose deaths. In the Yukon's close-knit towns and villages, every loss impacts entire communities. In Yukon first nations, each life is precious not only individually but also for the cultures fighting to survive the ongoing impacts of colonization. Elders tell me of the pain they feel from losing their youth, who are their nations' future and survival. Community care is so strong here, and people look out for each other, but they need better support.

Blood Ties offers programs to meet a range of needs, including youth education, harm reduction, drug checking, supervised consumption, and housing and wellness supports across the spectrum of substance use. We operate one of the only inhalation rooms in the country, which has seen more than 25,000 visits this year alone.

As the Yukon's only harm reduction organization, we are constantly stretched thin. It's not sustainable. High living costs, housing shortages and an emotionally taxing workload make it difficult to recruit and retain staff. We are under-resourced with short-term funding that doesn't allow for long-term planning, but what really wears us down is the politicization and misinformation heaped on our efforts.

In this context, we know what won't work. We can't police our way out of this. Criminalization only drives more harm. Neither can we rely on a one-size-fits-all approach. Not everyone we lose has an opioid dependency, and each person's path to wellness looks different. I think of my friend Maya, who was proudly indigenous, proudly in recovery and a fierce advocate for harm reduction. Her healing journey included residential treatment, yet ultimately her life could only have been saved by a safer drug supply, decriminalization, peer-led supports and a compassionate approach that recognizes each person's inherent worth.

Communities and people with lived experience across the Yukon have told us what they need: a continuum of care that includes harm reduction, recovery, land-based healing, access to regulated non-profit treatment and dignity—policies that see all people as worth saving regardless of where they are on their journey. We need core long-term investments that build on our communities' inherent strengths.

In honour of Maya and all of the loved ones we've lost, I envision a Yukon where everyone, whether they use substances or not, can be well, where community-led, culturally rooted solutions thrive and where each person's dignity is honoured. We have the tools and knowledge to create this future; now we need the commitment and political courage to do so.

Thank you.

● (1110)

The Chair: Thank you, Ms. Aalhus.

Next, from Doctors of the World Canada, we have Pénélope Boudreault. Ms. Boudreault is with us online.

Welcome to the committee. You have the floor.

[*Translation*]

Ms. Pénélope Boudreault (Nurse and National Operations and Strategic Development Director, Doctors of the World Canada): Thank you, Mr. Chair.

Honourable members, thank you for inviting me to participate in your work.

As national operations director at Doctors of the World, I am honoured to bear witness to the realities on the ground experienced by our teams in Canada.

As a nurse by profession, I walked the streets of Montreal in 2006 to provide frontline care to marginalized people and people experiencing or at risk of homelessness. I now accompany a team of nearly 20 health professionals who provide care and community support.

Doctors of the World is an international health organization with a presence in more than 70 countries. It has been here in Canada since 1996. Our mission is to ensure and defend access to health care for people in exclusion, insecurity or crisis situations.

In Montreal, for nearly 30 years, the teams at our mobile clinic and in our mental health program have been working with people who are homeless or at risk of becoming homeless, including urban indigenous populations and people who use licit or illicit psychoactive substances.

Our teams witness growing precariousness on a daily basis, alarming deterioration in living conditions and the harmful consequences of prohibitionist policies on these individuals and communities.

As a health organization, we advocate for a risk and harm reduction approach based on public health considerations and respect for human rights. When it comes to this health and social crisis, our observation is clear: Whether in legislation, policies, care protocols or the practice of health care and social services professionals, we must seek to support these individuals, not punish them, coerce them or further exclude them.

Our teams are concerned that they are seeing more and more people using alone, putting them at increased risk in the event of an overdose or drug poisoning. It is essential to support and design measures that promote safe consumption and, in particular, to provide support where people are not afraid of being judged or repressed. This means maintaining and expanding supervised consumption sites, providing access to naloxone and ensuring safe supply. Every day, our teams witness the positive impact of these interventions on people's health and safety. Beyond these services, we need to provide comprehensive support for people at risk of overdose and drug poisoning, particularly those the traditional system cannot reach.

I want to highlight the role of peers and community-based intervention in preventing and adapting services and approaches to people who use drugs. People with experiential knowledge have a unique ability to build trust with people experiencing substance use problems. They have invaluable life experience to help them identify and prevent crisis situations, such as overdoses and relapses. By adapting to the realities of the people they meet, they share vital information on risk and harm reduction, help people better understand and access essential health services, and guide them through their journey.

Community organizations, on the other hand, play an invaluable role by providing a support and solidarity framework for people in precarious situations. These organizations are often the first points of contact for people in crisis. They provide basic services, such as meals, shelter and clothing, but above all they provide a safe and non-judgmental space where people can get support.

Finally, a diversity of tailored approaches and services is critical. Substance use involves individuals of all backgrounds and gender identities, as well as all ages and socio-economic status. Every life course and every consumption experience is unique, which requires a great deal of flexibility and tailoring of interventions to be effective. A rigid or one-sided approach will not meet the complex needs of these individuals.

For example, our work with urban indigenous communities has shown us that standard services do not always suit their reality. We are working closely with the Indigenous Community Network in Montreal, because the solutions to this crisis must be determined, designed and put in place by those who are living and experiencing the direct impact of repressive policies.

In summary, we need to prioritize risk and harm reduction measures, because they save lives. Collaboration among peers, community organizations and health systems must be funded and encouraged to reach those who traditional services cannot reach.

We advocate for a diverse strategy that promotes dignity, respect and support. It's important to support these individuals, not punish them.

Thank you.

● (1115)

[*English*]

The Chair: Thank you, Ms. Boudreault.

Finally, representing Indwell Community Homes, we have Dr. Steven Rolfe appearing online.

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

Mr. Steven Rolfe (Director of Health Partnerships, Indwell Community Homes): Thank you, Mr. Chair. As a point of correction, I'm not a doctor yet. I'm still a mister. I apologize for the error on that form, but I am a Ph.D. student.

Thank you for this opportunity to speak.

My name is Steven Rolfe. I am the director of health partnerships at Indwell. We are a supportive housing charity in southwest Ontario specializing in creating deeply affordable housing, combined with access to mental health and addiction services. We currently provide services to over 1,200 people.

Our tenants all come to Indwell programs with two core needs. These are the need for stable and deeply affordable housing, and the desire to access supports that foster health, wellness and belonging. While everyone's journey toward health is varied in the complexity and time to achieve goals, there is a commonality: Our tenants have experienced lives of precarity and instability, they seek space to heal and they have no interest in returning to lives of instability.

Our tenants come to us from hospitals, shelters and states of homelessness with a range of complex needs. In some of our programs, the rates of concurrent or primary substance use disorder challenges are eight out of every 10 tenants. Each comes to us with the hope for change that comes with finding a place of safety to live.

My professional background is in nursing. I have spent 37 years focusing my practice on the care of people experiencing profound health and social challenges arising from mental health and addiction. I am confident that I cannot recall a period where the availability and lethality of chemicals has had such an impact on the people I am privileged to serve. Vulnerable people beset with a multitude of challenges arising out of chronic disease, disadvantage and poverty are subject to the offer of inexpensive drugs amid hopelessness.

Today I want to share two key thoughts in relation to opioids and the toxic drug supply. The first is to state that the proliferation of opioids and toxic drugs, including methamphetamine, fentanyl and derivatives, has exacted a terrible toll of death and disease in our communities over the last six years.

The second is to highlight the value of meaningful responses to loneliness, illness and houselessness through safe housing, care and connection that restore hope and build health and wellness. Tangible responses of supportive housing that people choose to live in are the foundation of recovery and can mitigate the impact of toxic drugs.

Few Indwell communities have been spared the loss of a neighbour to overdose or drug poisoning within the last six years. In 2022, from my recollection, we had an average of one memorial service a week. This is across eight or nine different sites.

The years of the COVID-19 pandemic and associated public health measures seemed to accelerate the proliferation of drugs in our communities, with an increase in the number of overdose occurrences and, sadly, deaths related to drug use. Evaluation of this period provides us with some insights into correlates of toxic drugs and community impact. One is the loss of physical connection and contact with positive community events, the loss of communal meals and social events, and the reduction of human contact to virtual or distant and short contacts, which creates loneliness. Another is limited access to mental health and addiction programming in hospitals and community mental health agencies. Another is the loss of community cohesion, which allows for an increased presence of people taking advantage of vulnerable tenants by offering drugs.

Indwell's response to this built on the strengths of the supportive housing model to restore housing as a place of safety and healing. This response included tenant-led development of guest management policies that included the implementation of overnight security. The lifting of public health measures led to the swift reimplementation of social gatherings, understanding that healthy community connection is the building block of resilience. Finally, there was the implementation of a blend of life-saving measures—which would include the issuance of harm reduction supplies and the presence of naloxone, both staff- and tenant-led—with a sharp focus on accessing addiction treatment.

As an example, in 2022, we opened a new, 15-unit supportive housing program in St. Thomas, Ontario, where we offered people who were living in encampments the choice to live in housing with access to supports. Every person who accepted the offer had significant challenges with substance use, including opioids and other toxic drugs. For these individuals, supportive housing became a catalyst for their respective journeys toward wellness.

● (1120)

Some common touchstones of their experiences included a desire for personal security and freedom from people offering drugs, interest in developing mutually beneficial guest management policies that facilitate a reduction in the availability of substances, engagement with staff and a reduction in the necessity for emergency overdose intervention. This was a program where daily overdose occurrences were happening. As we began introducing addiction medicine into the facility and bringing in primary care doctors and addiction medicine doctors, we watched the number of overdose occurrences go from daily to zero in six months.

In general, it's about a shift in attitude from survival to a focus on health and wellness. When you provide basic necessities, people are better able to focus on the things that are going to keep them well.

The Chair: Thank you. I'll get you to wrap up, Mr. Rolfe. You'll have lots of chances to expand on those points during the question and answer session.

Mr. Steven Rolfe: I'm on my last paragraph, sir.

The Chair: Thank you.

Mr. Steven Rolfe: If I have one message to offer today, it is that out of the solutions for addressing the terrible costs of addiction arising from the unprecedented proliferation of toxic drugs, offering practical solutions based on choice and accepting a person's basic needs for care are among the most effective. When people have access to things that bring a true sense of security, health and stability, they're better able to leave what is unhealthy behind. Supportive housing, access to health care from places of stability and the presence of a positive community are hope-instilling and resilience-building responses.

Thank you for your time.

● (1125)

The Chair: Thank you.

We'll now proceed to rounds of questions, beginning with the Conservatives.

Mr. Doherty, you have six minutes.

Mr. Todd Doherty (Cariboo—Prince George, CPC): Thank you, Mr. Chair.

I want to start by thanking our witnesses for being here. In particular, I want to thank our friend from Prince George, retired superintendent Shaun Wright, who served our community and province.

Mr. Wright, earlier this year, you called B.C.'s drug decriminalization experiment “one of the biggest public policy disasters” in our province's history. Can you expand on that a bit?

Mr. Shaun Wright: Basically, my experience was that it led to a marked increase in incidents of public disorder within the community I was policing at the time. It had significant negative effects in that regard, resulting in a lot of complaints from the community—both community residents and business owners—and it made it very difficult for the police to intervene in behaviours of open drug use and disorder.

Mr. Todd Doherty: How have our communities changed over the last, say, eight years?

Mr. Shaun Wright: I would say there's been what I would describe as a dark turn with regard to disorder on the streets. As a case in point, approximately eight years ago, when I arrived in Prince George, a lot more of the public disorder was fuelled by alcohol consumption. While that's still not great, things definitely have taken a darker turn over the last couple of years, as the primary agitator causing a lot of public disorder incidents is now illicit drug use, opioids in particular. It's much more pervasive and has a darker and more threatening tone.

Mr. Todd Doherty: Can those who are struggling with addiction make informed decisions?

Mr. Shaun Wright: It's been my experience that no, they can't. In general, they make poor decisions. Many of them are homeless, living in very poor conditions, and it's evident that they are not capable of making informed decisions for their own best benefit.

Mr. Todd Doherty: There's been a lot of talk in our province about this. Premier Eby, John Rustad and our leader have talked about providing those who are addicted with two streams...involuntary care. In your opinion, would that work?

Mr. Shaun Wright: I believe that's definitely an additional tool that would be very useful, as previously discussed. I think a lot of people under the influence of opioids and other drugs are not in a position to determine which path they truly want to go down.

Mr. Todd Doherty: We've had witnesses, even here tonight, who have talked about criminalization and perpetuating stigma. Is that your opinion as well?

Mr. Shaun Wright: I'm sorry; could you rephrase that?

Mr. Todd Doherty: Do you believe involuntary care and walking back decriminalization would contribute to the stigma of those who are struggling with addiction?

Mr. Shaun Wright: To be honest, even prior to the introduction of decriminalization, among a large proportion of the population, it was my experience that there wasn't a tremendous amount of stigma.

Mr. Todd Doherty: Should safe supply drugs have markers for traceability?

Mr. Shaun Wright: I think that would be very useful for police and government agencies when tracing them if they're diverted from their intended use.

Mr. Todd Doherty: You are here essentially bringing the voices of thousands of men and women who serve our communities all across our nation. Can you speak to whether officers on the ground have had reservations about decriminalization and safe supply? The message we are getting from our frontline officers is that there was significant concern with that, yet we still went down that path.

Mr. Shaun Wright: From my experience in my community, it's an accurate depiction that the front line was not particularly supportive. However, they're not always supportive of policies implemented from management.

I would say that it's a fair characterization that frontline officers were not particularly supportive.

● (1130)

Mr. Todd Doherty: Is safe supply being diverted and trafficked by organized crime?

Mr. Shaun Wright: In my experience, yes.

Mr. Todd Doherty: Do northern and rural communities like Prince George have the resources to curb the flow of fentanyl and other deadly illegal drugs coming into our communities?

Mr. Shaun Wright: It's very problematic, and the example I'll provide is the community of Prince George. It's a municipality of approximately 75,000 to 80,000 people. The vast majority of resources we have are municipally funded, and they provide enough policing service to maintain law and order and conduct criminal investigations, but doing large, proactive drug-trafficking investigations is extremely problematic for communities of that size in a remote area.

Mr. Todd Doherty: What are the flaws in how safe supply has been implemented?

Mr. Shaun Wright: It's my observation that the biggest flaw with the program is that individuals are provided up to several dozen pills and are allowed to proceed out the door with them. There is no mechanism to determine or ensure that they are used appropriately by that individual and not diverted elsewhere.

The Chair: Thank you, Superintendent Wright.

[*Translation*]

Mrs. Brière, you have the floor for six minutes.

[*English*]

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

Thank you to all our witnesses for joining us today.

[*Translation*]

Dr. Boudreault, you mentioned that laws, policies and protocols should seek to help, not punish. You also say that we need to adopt an approach that offers diverse and adapted services to better respond to the reality on the ground.

As you said, your teams see what's happening on the streets in Montreal on a daily basis.

What do you think of the comments you just heard in response to the first questions that were asked?

Ms. Pénélope Boudreault: Thank you very much for the question.

First of all, I have to make a correction. I'm not a doctor either, I'm a nurse.

It's been said that repressive policies, such as forcibly taking a person to a supervised consumption site or giving them medication like naloxone, encourage people to use.

That's already going too far. People use for a variety of reasons. They need to be in contact with people, to have access to information, to not be further stigmatized, because they already have to hide in order to be able to consume. I talked about consumption—

The Chair: Excuse me, Ms. Boudreault.

There is no interpretation at the moment. So we're going to take a break to resolve the situation, and then we'll continue.

● (1130)

_____(Pause)_____

● (1145)

[*English*]

The Chair: I call the meeting back to order.

Thank you to our technical team for resolving those problems.

[*Translation*]

Ms. Boudreault, do you remember the question that was asked, or would you like to hear it again?

Ms. Pénélope Boudreault: I think I was asked what I thought of the comments made earlier about the ongoing repression.

The Chair: Okay.

Your answer was not interpreted. I would ask you to start from the beginning.

Ms. Pénélope Boudreault: The Doctors of the World teams in Montreal work close to people on the ground. There are a number of organizations in Montreal that welcome these individuals, such as supervised consumption sites and day centres. There are also people who all these organizations can't help at all, because they live on the fringes, on the street, and because they're homeless.

As I was saying earlier, every person we see has their own story and their own needs. We focus a lot on stopping drug and alcohol use, and we forget to look at the reasons why people use drugs. So we need to put in place a whole social fabric, interventions, training, awareness and safe spaces where individuals feel free to go and meet with people who will be with them, instead of being forced to hide and be further stigmatized, which puts them at even greater risk.

We focus on reducing risks and harms, not on repression, to adapt our response to each person's reality.

Mrs. Élisabeth Brière: Thank you very much.

Would you say, then, that the harm reduction efforts being made make it easier to build those trusting relationships and sometimes help people stop using?

Ms. Pénélope Boudreault: Yes, that's exactly it. You have to reach out to people if you want to help them.

Of course, overdoses do occur in Quebec and Canada almost every day, and Montreal is no exception. There were two overdose deaths this past weekend. These are individuals who are known in the community, who are still in hiding and whom we need to get in touch with. They come from certain communities or minorities, and they still feel very stigmatized. It's harder to get in touch with them, and we're not going to get there with a model of repression and involuntary cessation of use. It's more about reaching out to them and building all those trust relationships.

We work a lot with peers who have experiential knowledge. They have had problems with their own use and have weaned themselves off drugs, or they are able to manage their use.

So it's possible.

Mrs. Élisabeth Brière: Thank you very much.

[*English*]

Law enforcement said the following to this committee:

> However, we strongly support the notion of not trying to arrest ourselves out of this crisis. That is not going to save lives. In fact, it does quite a bit of harm if it's somebody with a significant addiction that they need medical help with or somebody who needs support. The last thing they need is to be introduced into the criminal justice system.

Do you agree with that statement?

● (1150)

Mr. Shaun Wright: There's definitely some merit to the statement that we can't arrest ourselves out of this problem. I wouldn't suggest this is an appropriate course of action. What I do believe, though, is that police and the legal system have a role to play with regard to some of the behaviours within communities that are acceptable. However, absolutely drug addiction will be defeated eventually through intervention on the medical side.

Mrs. Élisabeth Brière: You've heard the testimony of Madame Aalhus and Madame Boudreault. What is your opinion on their testimony?

Mr. Shaun Wright: We three individuals probably have some differing viewpoints. However, as I said in my opening remarks, I went through all of my career in policing believing in the four-pillar model, which includes enforcement, prevention, harm reduction and treatment. I really think that all four of those components need to be there for a system to be successful.

Mrs. Élisabeth Brière: Thank you.

Ms. Aalhus, if it's okay, I'll ask a question in French.

[*Translation*]

In your presentation, you talked about the value of having a continuum of care to help people maintain a certain level of dignity, to ensure a presence with them and to treat them with respect. You said that you had the tools and knowledge to help these individuals, but that you needed a commitment.

What do you think that commitment should be to give you a leg up so you can continue to do the work you're doing and save lives?

[*English*]

Ms. Jill Aalhus: We really need our responses to be evidence-based and community-led. They will look different in every community. As I said in my opening remarks, we need to continue to uphold the dignity of people who use substances. We cannot police our way out of this. We cannot rely on a one-size-fits-all approach. Not everyone we lose has an opioid dependency, and each person's path to wellness looks different. We need a range of options to meet people where they are.

One thing that makes this work feel unsustainable is the politicization of our efforts. The lack of support only heaps on top of the sometimes traumatic toll of the work. We need more support, less criticism and more long-term commitments of funding to support work in harm reduction, including in rural and remote contexts and in the north.

The Chair: Thank you, Ms. Aalhus.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you, Mr. Chair.

Ms. Boudreault, we are facing an overdose and toxic drug crisis. It's a very complex problem. It's not as simple as what Portugal experienced at one time, when they only had heroin and a substitute for heroin. We have drugs today that are killing people. One capsule kills. So we had to intervene based on the overdoses and the resulting mortality.

In terms of the four pillars of the drug strategy, do you believe that harm reduction, including safe supply, is more effective in an overdose crisis than enforcement and prohibition?

Ms. Pénélope Boudreault: Thank you very much for the question.

I believe so.

I think that risk and harm reduction has a proven track record in Montreal. A recent newspaper article reported that there were no fatal overdoses at the supervised consumption site featured in the story. I've been working on the ground in the streets of Montreal for nearly 20 years. In the past, we didn't have access to naloxone. Today, more and more people, including the general public, are obtaining naloxone because they feel it's important to be able to save lives. It does save lives. People administer naloxone in the event of an unfortunate overdose or drug poisoning.

As you say, it's not always people who use opiates who are poisoned. Some drugs are contaminated, hence the need for safe supply programs where people who use drugs at least have access to clean or less dangerous drugs.

When I worked in detox, I saw the results of the repressive approach, such as forcing someone to stop using. People would avoid jail time by coming to detox. They would do their time, and then they would go back to using.

The detox approach works very well when people are ready to stop using, when they've made the decision to do so, when they've reached that point. They will probably go through difficult times and relapses, hence the importance of intervention groups being close to these individuals to support and guide them without judgment.

● (1155)

Mr. Luc Thériault: One of the four pillars of the strategy is enforcement. Don't you think that, given the current crisis, that pillar is the least effective?

Ms. Pénélope Boudreault: Yes, I'm afraid so. When laws are repressive, it forces people to hide. Drug use has always existed, and it probably won't go away. Again, there are reasons why people use. Some do it for pleasure, and we can't judge them.

As most of the witnesses have said, there are multiple types of drugs and users, and there are multiple reasons to use. However, preventing people from using or telling them that it's wrong is certainly not the approach that works. Imposing prison sentences or forcing people into detox treatment doesn't work.

People who use drugs still have judgment, and they're able to make decisions with full knowledge of the facts. It's just that they get to a point where they run out of options. If groups and peers with experiential knowledge are there to listen to them and recognize that they are worth helping, these individuals will be able to benefit from an environment that will enable them to make smarter choices, choices that will be better for their health and well-being.

Mr. Luc Thériault: Mr. Wright, in your 28 years with the RCMP and in the last few years, how many organized crime illicit drug rings have you been able to dismantle?

[*English*]

Mr. Shaun Wright: Particularly over the last couple of years, the officers under my command were quite successful in many enforcement efforts against drug suppliers. We don't target individual users.

[*Translation*]

Mr. Luc Thériault: Why is it that we're grappling with such a massive toxic drug crisis and mortality rate?

Is that due to the ineffectiveness of the enforcement pillar or to safe supply and harm reduction, as you claim?

[*English*]

Mr. Shaun Wright: There is a lack of resources on the enforcement side, and that could certainly be addressed. I would say the greatest key factor in lethality, as I think you stated, sir, is that we're dealing with fentanyl now, not simply the heroin of decades ago, and it's much more potent.

[*Translation*]

Mr. Luc Thériault: Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

Next up is Mr. Johns, please, for six minutes.

Mr. Gord Johns (Courtenay—Alberni, NDP): First, I want to thank all the witnesses for their testimony. I'd especially like to congratulate Superintendent Wright on his retirement. Thank you for your service to Canada.

I'll start with my questions.

In 2016 in British Columbia, a public health emergency was declared due to the significant increase in drug-related overdoses and deaths. We know that fentanyl and synthetic opioids have been the driving force in the crisis. In fact, the B.C. coroner says that 79% of deaths related to toxic overdoses are caused by fentanyl—fentanyl is found in them.

Retired Superintendent Wright, there was the recent bust of a superlab up in your neighbourhood in Prince George that prevented 95 million hits of fentanyl from hitting the streets, which is significant. Can you speak about why you think law enforcement has been unable to stop the flow of fentanyl and the harm it has caused to communities despite the significant investment in resources? Why can't police really stop fentanyl superlabs? How many do you think there are out there?

● (1200)

Mr. Shaun Wright: I'm not in a position to comment. I don't have information on how many superlabs there may be.

With regard to my personal experience and opinion as to the persistence of fentanyl trafficking and the continued flow of it, I would say the simplest explanation is that there is a market for it. There is an appetite for it. Someone will always find a way to feed that appetite, just as there's a drive to accommodate any sort of illicit product. I think that's why there has been a heavy focus on fentanyl in the last, probably, five or so years. It's small and very profitable.

Mr. Gord Johns: The Northern Health authority has the highest death rate per capita in the province of British Columbia. It has the lowest uptake of safer supply. Overall in British Columbia, we've seen the number of deaths per capita drop since the decriminalization pilot was brought in. These are just facts, according to the chief coroner of British Columbia.

We had Superintendent Dwayne McDonald here, and he called for more safe consumption sites, as did the president of the B.C. Association of Chiefs of Police, Fiona Wilson. Do you agree that we need more safe consumption sites?

Mr. Shaun Wright: It's my opinion that we need to focus on reducing the demand rather than facilitating the usage.

Mr. Gord Johns: I think we need to do both, for sure—

Mr. Shaun Wright: Yes, for sure.

Mr. Gord Johns: —but do you recognize the importance of safe consumption sites for saving lives and limiting public drug use?

Mr. Shaun Wright: I agree there is a place for that. As I expressed previously, I believe that the four-pillar approach, which would include some harm reduction initiatives, is appropriate.

Mr. Gord Johns: We saw the toxic drug deaths in Alaska go up 45% year over year. Last year, their drug death rate was worse than British Columbia's. In Lethbridge, it's triple that of British Columbia. They have no safe consumption site. Regina has no safe consumption site and has a death rate 50% greater than British Columbia's. Baltimore's death rate is over four times, 400%, greater than British Columbia's. You can go to Philadelphia or Tennessee, and there's open drug use. It has skyrocketed over the last eight years, which you talked about. In all of those places, there's no decriminalization and no safe supply.

Maybe you can tell us why it's skyrocketing across North America in places where there aren't policies like decriminalization and safer supply.

Mr. Shaun Wright: I wouldn't be enough of an authority to speak in those general terms outside of jurisdictions where I've worked. What I can say is that, in my opinion, correlation does not necessarily equal cause. With regard to safe consumption sites, or overdose prevention sites, we have one in the community of Prince George. As pointed out, there's been no overdose deaths there since it's been open, similar to most overdose prevention sites. However, we have had overdose deaths on the sidewalk out front where lots of people gather around.

I think it may be one piece of the puzzle, but I don't think it's the silver bullet to fixing everything.

Mr. Gord Johns: I agree with you.

We've heard from the chiefs of police, from the First Nations Health Authority, from the chief coroner of B.C. and from the chief medical health officers right across the province that we need to scale up treatment, recovery, prevention and education, and of course replace toxic street drugs with safer supply and stop criminalizing people who use substances. That's what we've heard straight up from those organizations.

Fiona Wilson, the president of the B.C. Association of Chiefs of Police, talked about the diversion of safe supply. She said that the diversion of pharmaceuticals—toxic street drugs and street drugs in general—is nominal at best. She said that hydromorphone made up a fraction of them, that it was fentanyl that was killing people and that organized crime was replicating hydromorphone and pushing it out on the street—that was a lot of the hydromorphone they were finding—along with other pharmaceuticals.

Would you agree that it's fentanyl that's killing people on the street?

● (1205)

Mr. Shaun Wright: I would agree that, as stated from the coroner's report, fentanyl is definitely present in the vast majority of overdose deaths, yes.

Mr. Gord Johns: Do you believe substance use disorders should be treated as a health issue? Do you agree with public health leaders that there are significant harms associated with criminalizing people who use drugs?

The Chair: Thank you, Mr. Johns. That's your time.

Mrs. Goodridge, please go ahead for five minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

I want to thank the witnesses for being here.

Just to follow up on some of the questions that have come so far, back in April or March 2024, Prince George came out saying that you guys had found safe supply pills in your region. I'm wondering how you can confidently say that the drugs seized in Prince George were in fact government, taxpayer-funded safe supply drugs.

Mr. Shaun Wright: With regard to the initial media release, that was our belief because they were similar to and believed to be from safe supply or prescribed supply. However, we conducted further investigations and made observations that determined that safer supply was indeed being diverted into the illicit market.

Mrs. Laila Goodridge: It's not that you guys just went out and decided that they were these drugs because they looked like them. You actually did a series of investigations on this.

Mr. Shaun Wright: That's correct. We had received complaints of diversion prior to that as well.

Mrs. Laila Goodridge: I want to go back a bit. What did you see in the aftermath of British Columbia's disastrous move towards the legalization of hard drugs in your community of Prince George?

Mr. Shaun Wright: I would say the most significant impact was a noticeable increase in crimes of public disorder, particularly in the downtown core and in other areas of the city. They reduced the livability of the community for many people, who experienced an environment of increased public drug use. In particular, individuals, perhaps with their children, no longer wanted to shop at particular stores because there were persons openly smoking drugs on the sidewalk nearby.

Mrs. Laila Goodridge: I'm a mom of young kids, and I've had many moms reach out to me to share stories they have about children's playgrounds being littered with drug paraphernalia, people using drugs in public parks and playgrounds, and people disrupting their paths of travel.

How did the community of Prince George specifically react to the disastrous legalization project?

Mr. Shaun Wright: It's very similar. We've received quite a number of complaints. I received complaints, personally, on a daily basis from business leaders and members of the community with regard to those issues.

Mrs. Laila Goodridge: At the same time that you saw this massive policy shift towards making it legal for people to possess and use up to 2.5 grams of fentanyl, crack, cocaine and a number of other drugs, did you see any increases in your community in treatment and recovery supports?

Mr. Shaun Wright: No, I did not.

Mrs. Laila Goodridge: That seems like a bit of a struggle, if you're going to make a massive policy change, remove tools from law enforcement and then, in turn, not provide any supports on the other side.

Did this normalize drug use in the community?

Mr. Shaun Wright: I would say that's a fair characterization. Open drug use was certainly normalized. There were issues prior to that, but it made it commonplace.

Mrs. Laila Goodridge: Thank you.

I'm going to move over very quickly to Mr. Rolfe.

I'm wondering how many lives have been saved in your housing program through the use of evidence-based opioid agonist therapy medications like methadone or Suboxone.

● (1210)

Mr. Steven Rolfe: It's a difficult number to track. It's more along the lines of who is using Suboxone. Really, it comes down to the availability of prescribers coming into the program and the availability of primary care.

Mrs. Laila Goodridge: Are you guys not able to track which people living in your facilities are using these opioid agonist therapies?

Mr. Steven Rolfe: Yes, we can. It would be possible to come up with the number of people on Suboxone.

Mrs. Laila Goodridge: How important is it to have access to qualified, addiction-specializing prescribers so that people looking for those off-ramps can get that treatment?

Mr. Steven Rolfe: It's critical. As I said in my remarks, I think supportive housing is key in that it creates a place of stability where treatment can begin. People have an address, which means they can get linked to primary care and can get referrals to where they need to go.

The Chair: Thank you, Mr. Rolfe and Mrs. Goodridge.

Dr. Hanley, go ahead, please, for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): I want to thank all of the witnesses for appearing today.

Thank you, Superintendent Wright, for your long years of service.

I'll give a special thanks to Ms. Aalhus, who made the effort to travel from the Yukon to be here.

It's so important that we draw upon experience, expertise and evidence for this study and try to leave our personal biases behind.

Superintendent Wright, you expressed an opinion about an emphasis on harm reduction to the exclusion of the other pillars, but facts from Health Canada about overall spending over the five years from 2017 to 2021 show that 58% of spending was on enforcement, 18% was on prevention, 13% was on treatment, 8% was on harm reduction and 3% was on research. It seems like we're spending an awful lot on enforcement. As important as that is, I'd love to see documentation on how successful we are in winning that war.

Ms. Aalhus, your fellow witness described harm reduction as something that facilitates drug use. Is that how you see it as a harm reduction expert?

Ms. Jill Aalhus: It is not. People have used substances in all cultures for millennia. We're not going to stop that through involuntary treatment or criminalization.

It's difficult to listen to lengthy debates about the less than 2% of overdoses attributed to pharmaceuticals, when many of us are on the front lines of this crisis. Really, what it comes down to is stigma. Criminalization creates stigma. It forces people to use in the shadows and to hide their use from family, friends and loved ones. I think that takes away from what we're trying to do as a community, which is end the toxic drug crisis.

Mr. Brendan Hanley: Do you feel that individuals using substances are not able to make the right decisions for themselves, as suggested by your fellow witnesses?

Ms. Jill Aalhus: I completely disagree. I think it is a huge human rights violation to suggest that people who use substances are unable to consent and make their own decisions.

Every day I see people who use substances administering naloxone to each other, administering rescue breaths and saving each other's lives. Our supervised consumption site is often a very positive space of community support, where people are letting staff know if they see someone who needs support and assistance.

People who use drugs are on the front lines of this crisis. To suggest that they don't have the ability to participate in a solution or care for themselves and each other is disrespectful and removes their dignity.

Mr. Brendan Hanley: Thank you.

The First Nations Health Authority of B.C. submitted a brief, where they described the following in their text: “The politicization of the toxic drug crisis threatens progress, especially as the backlash against proven, evidence-based harm-reduction measures that save lives hits First Nations people the hardest, deepening existing inequities.”

You mentioned something similar in your opening remarks. What do you see as under threat here? Can you comment on this area?

Ms. Jill Aalhus: These are our loved ones across the country. There was a two-week period where we lost four young mothers in the Yukon. These are people who deserve dignity.

Cracking down on substance use and closing harm reduction centres contribute to stigma and shame and increase the likelihood of people using alone without support. They also increase the risk of fatal overdose.

There are many years of evidence backing up supervised consumption and harm reduction as life-saving approaches. The solution to the crisis is to bring these discussions into the open to provide support, to facilitate safe spaces for people and to reduce stigma.

● (1215)

Mr. Brendan Hanley: We have about 30 seconds left.

You mentioned how the lack of support from SUAP funding has affected your operations, particularly with regard to rural harm reduction. I'm going to give you some time to elaborate on that.

Ms. Jill Aalhus: I think sustainability is a huge challenge for harm reduction organizations, particularly now with the politicization. We were fortunate to receive short-term funding through SUAP, but right now we are struggling to recruit and retain staff to compete with other employers in the north. It's hard to afford that.

We're really patching things together with duct tape, trying to use limited funding to meet the communities' needs. We have many requests from communities for work that we're unable to support them with because we don't have funding. We have very limited funding for rural harm reduction.

The Chair: Thank you.

[*Translation*]

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

Mr. Luc Thériault: Ms. Boudreault, in your experience, do you think it's impossible to establish an addict's decision-making capacity?

Ms. Pénélope Boudreault: It's absolutely not impossible.

The people who are using are adults. As other witnesses have said, you'd be surprised at the degree to which there is a spirit of co-operation and solidarity on the street, even when it comes to overcoming all the realities these individuals have to deal with. This is especially the case for the homeless people we're trying to reach. They need to figure out how to find something to eat.

These individuals are able to make choices. The problem that arises is often related to the lack of choice or the lack of resources that would enable them to make choices tailored to their reality and needs.

Mr. Luc Thériault: Thank you.

In your conclusion, you say that you advocate for a diverse strategy that promotes dignity, respect and support.

Could you elaborate on each of those terms?

Ms. Pénélope Boudreault: Our focus is on really being there for people. I'll say it again, there are reasons why people use. We want to talk about drugs, with a focus on stopping drug use.

People use for a number of reasons. However, some people don't have a social safety net, a family network or a guaranteed income. They might not have much schooling. Therefore, multiple approaches are needed to address these diverse needs. People sometimes need to feel heard and to be supported. They need access to services tailored to their reality, to organizations that can provide them with good support and advice.

This work is needed. There are multiple realities that have to be considered. We talked about repression and other similar approaches. I can tell you that we have established collaborative ties with various community stakeholders in Montreal, including police forces. Some police officers prefer to accompany people they encounter on the street to a supervised consumption site or a community organization. They know that people will receive services and that they will be listened to and supported.

Some people will feel comfortable going to supervised consumption sites. Others will prefer to go to detoxification centres. Some will decide to stop using.

So we have to take a number of realities into account and be able to offer a variety of services. We also need to structure our intervention services.

The Chair: Thank you, Ms. Boudreault.

[*English*]

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

Mr. Gord Johns: Thank you.

I'll go back to you, Retired Superintendent Wright. Do you believe substance use disorders should be treated as a health issue? Do you agree with public health leaders that there are significant harms associated with criminalizing people who use substances?

Mr. Shaun Wright: Yes, I agree that the health system is the appropriate way to address opioid disorder. However, for some of the ancillary issues that arise with regard to behaviour and public disorder, I think we need a mechanism and tools to deal with them.

Mr. Gord Johns: In term of your concerns about the decriminalization pilot in British Columbia, you obviously made it clear that you didn't believe appropriate supports were put in place in advance. What types of supports would you like to see? If you were to design a decriminalization model, what would it look like?

● (1220)

Mr. Shaun Wright: It would be very similar to the tenets of the four pillars. Education should have been rolled out strongly from the beginning, knowing that small children were going to see more of this in the street as a result. On harm reduction, in my opinion, plenty of resources should be added. With regard to enforcement, there should be additional enforcement with regard to fentanyl in particular. Most critical, I think, is recovery and treatment. Even if people are ready for it, it's not readily available on demand. I think that was a key missing component.

Mr. Gord Johns: I was just going to go there, actually. In Canada right now, on average, provinces and territories spend about 5% of their health care budgets on mental health and treating substance use disorder. In the OECD it's around 12% to 14%. B.C. is at around 7%, building toward 9% with their new commitments.

In responding to the toxic drug crisis, we spent 1% of what we spent on COVID. Do you believe it's because of stigma? Do you believe Canada needs to create parity within the Canada Health Act for mental and physical health?

Mr. Shaun Wright: I would agree that steps definitely need to be taken to include further mental health supports. In my opening comments, I said that one of the most significant negative effects I saw on communities was the shift from organized mental health treatment to disaggregated mental health treatment in communities without adequate support.

Yes, I would agree.

The Chair: Thank you, Mr. Wright and Mr. Johns.

Next we have Mr. Moore, please, for five minutes.

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

Mr. Wright, as a retired RCMP superintendent with 28 years on the front line of policing, you've seen the impact of changes that have been made by federal governments over the years in your community. I found your testimony very instructive and persuasive. You've been on the front line so you see these changes in real time.

We also have the benefit of Statistics Canada, which tracks crime statistics, among other things. Over the last nine years, we know that violent crime is up 50% in Canada, homicides are up 28%, sexual assaults are up 75%, auto theft is up 46% and violent firearms offences are up 116%. Those are Statistics Canada numbers.

Some of this is as a direct result of changes that have been made with bail—for example, the catch-and-release bail in Bill C-75—where we see those who probably should be in custody after committing an offence out on the street reoffending. How have you seen catch-and-release impact the ability of police to disrupt the illicit drug trade in British Columbia?

Mr. Shaun Wright: I would say the most significant manner in which it impacts the illicit drug trade is that persons charged with violent offences are often now released on bail. My experience 10 or 20 years ago was that this wouldn't have been the case. While they're out on bail, they reoffend and continue to commit further violent crime. Much of our violent crime, at least in the community where I worked, was directly related to the illicit drug trade.

Hon. Rob Moore: I noticed that in your remarks you used the term “so-called” safe supply—which I've heard used before at this committee—because of the interplay between so-called safe supply and the illicit drug trade. We heard from a previous witness about individuals selling their safe supply in order to get harder drugs. That safe supply is getting into our schools and getting to students.

What's your experience with that? Is that accurate in terms of what's happening, in your experience?

Mr. Shaun Wright: It's my experience that a quantity of the prescribed supply is making its way into the community and into the illicit market. Unfortunately, as it comes packaged as a prescribed pharmaceutical, it gives the impression that it's safer than a street drug, but it's still an opioid. I think it could have—or does have—disastrous effects for some individuals, particularly those experimenting.

● (1225)

Hon. Rob Moore: You talked in an interview about the failed policy—I think we should all agree that it's been a failed policy—of drug decriminalization, which led to a proliferation of open drug trafficking in the downtown core, and much more than you had seen previously. What do you see as the long-term impact of an entire year where decriminalization was in effect and how it normalized the otherwise illicit drug trade?

Mr. Shaun Wright: Basically, open drug use, drug trafficking and incidents of disorder in the community still exist. It's very hard to put that genie back in the bottle because the mindset has shifted and it has become a norm among many people there. It's definitely an uphill battle to try to roll that clock back.

Hon. Rob Moore: Do I still have some time, Mr. Chair?

The Chair: You have one minute, Mr. Moore.

Hon. Rob Moore: You would know that just last week—and I'm sure some former colleagues of yours were there—we saw the RCMP in British Columbia dismantle the largest and most sophisticated superlab in Canada. The police seized 54 kilograms of fentanyl and 390 kilograms of meth from this lab, not to mention 89 guns, some of which were loaded and ready to use.

You'll know that the government's Bill C-5 allows for house arrest for those producing, importing and exporting schedule I drugs. Previously, if someone was convicted, that would have required a jail sentence. Now someone convicted could indeed serve their sentence from home.

What message do you think that sends to the community about those who are involved in this very harmful activity?

Mr. Shaun Wright: It definitely lessens the deterrence of a sentence if that's how it rolls out. In particular, electronic monitoring, with the expansion of it here recently over the last several years, has been problematic, as even on electronic monitoring, many individuals continue to commit offences in the community, including very serious violent offences.

Hon. Rob Moore: Thank you.

The Chair: Thank you.

Ms. Sidhu, you have five minutes.

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

Thank you to all the witnesses for being with us.

Ms. Aalhus, I know that you're working hard in the Yukon. My colleague is always talking about you and the work you are doing there helping the community. Thank you.

You talked about the compassionate approach. You also said that sometimes people are afraid to call the RCMP or an ambulance in the event of an overdose. Can you elaborate on why they're scared and on compassionate support and why they need that?

Ms. Jill Aalhus: The Good Samaritan Drug Overdose Act was meant to protect bystanders, but loopholes allow criminal charges for probation violations, no-contact orders and low-level trafficking.

In our small communities, people die surrounded by others who fear the consequences of calling for help. This needs to change. We need to follow up on epidemiologist Dr. Jane Buxton's recommendation to this committee in 2016 and review the RCMP's approach to 911 calls for overdoses. We also need to decriminalize and address stigma so that people can feel safe accessing support. We need that support to be compassionate. We need it to be available when people are looking for support. We also really need to centre those we're trying to support in these conversations.

Ms. Sonia Sidhu: We have heard a few times about the importance of safe and affordable housing for vulnerable people dealing with substance use. Could you tell us about how your housing programs help to meet that need?

Ms. Jill Aalhus: We operate low-barrier housing programs. What we are able to do currently without funding is provide a tiny house community for people who are at various points on the substance use spectrum so they have a safe and affordable place to live.

I think adding five units has been an inadequate solution to the housing crisis in the Yukon. As we've been working on this issue, we've seen it worsen. Often we have people tenting into the fall, in very cold seasons. They're being moved by bylaw and RCMP, so it's hard to reach those people when we're trying to do outreach and provide support.

I think addressing housing and providing safe, low-barrier, supportive housing is the solution.

● (1230)

Ms. Sonia Sidhu: Thank you.

Mr. Rolfe, you spoke earlier about what sounds like a particularly promising housing program in St. Thomas, Ontario. You also mentioned that when support services were introduced, overdoses in the community declined to zero.

Is there any more data on this program that you can share with this committee?

Mr. Steven Rolfe: I don't have current data. I do know that a Western University study is starting on that program and that's an evaluation piece, so it will be forthcoming.

One bit of information I can share is some of the conversations we had with St. Thomas police when the program was implemented. Police involvement, special constable involvement, with the residents of this particular program was important to folks settling in. It helped them achieve what they wanted to achieve with their goals.

We also noticed that police calls in the community in the downtown core of St. Thomas were reduced, and that corresponded to when these individuals accessed housing. It speaks to what you see when you respond to community need with compassion and create physical spaces for people to live in securely, spaces where relationships can be fostered and people can access care. That is a preferable approach, and our police colleagues certainly agreed with that.

Ms. Sonia Sidhu: Can you tell us more about the role of tenant-led development in mitigating harm and healing communities?

Mr. Steven Rolfe: We firmly believe that tenant-led responses are much more preferable to imposed responses. They're about engaging tenants and setting goals around what kind of a community they want. These are single-site, supportive housing communities with multiresidential buildings, so when tenants gather, they talk about the agreed-upon approach when they have guests and what kind of community they want.

Largely, people come up with ideas. There are certain things that aren't talked about or aren't done in communal areas. What people do in their own apartment is a matter of discussion, but on the whole, it's also about how to respond to people knocking on their doors at two o'clock in the morning. How do they want to respond to people who are ringing all of the buttons at the front door? What's the agreed-upon response that they want? That's critical, because most people will say that it's easier to sleep at night when somebody is not knocking on their door at two o'clock in the morning trying to tell them things.

I hope that was helpful.

The Chair: Thank you, Mr. Rolfe.

Next we have Mr. Doherty, please, for five minutes.

Mr. Todd Doherty: Mr. Wright, I want to again thank you for your service. I almost want to say that you deserve a medal for being here today and listening to some of the comments that are going on.

I want to go with the same line of questioning as my colleague Mr. Moore. This has to do with—and I'm going to be very blunt about it—the hug-a-thug policies we have seen under the Liberal government.

November 25, 2021, is a date that you're very familiar with, Mr. Wright. It's when Paul Nicholas Russell terrorized the community of Vanderhoof and hunted RCMP officers. He shot dozens of high-velocity rounds into an RCMP detachment, narrowly missing both enlisted and civilian members before taking to the streets. Last week, his sentence was reduced from 10 years to five years. That's one example.

Three weeks ago, my constituent Bob Hubbard returned to his house on Upper Mud River Road when it was being looted by a group of drug addicts—criminals. He tried to stop them. He was run over, severely injured and airlifted to a hospital in Vancouver, where he remains today. He almost lost his arm. Facial reconstructive surgery had to be done. He had numerous injuries. He'll have to have numerous surgeries as he moves forward. Mr. Hubbard is a senior.

Mr. Wright, this revolving door that you and your frontline officers have to face each and every day must be demoralizing. This is an opportunity. You are here representing thousands of frontline officers. I would like to hear in your own words how demoralizing these types of policies are. We see it with drugs, and we're hearing it today. It's not all whistles and glow sticks that we hear from our colleagues. You and your officers deal with life and death decisions each and every day. You don't want to see anybody die from an overdose. Your testimony today has been very valuable, but I feel that it's been under attack.

The remaining time is for you to share how these hug-a-thug policies have demoralized your frontline staff.

● (1235)

Mr. Shaun Wright: Yes, that's a very good description. It is demoralizing. I would say that for some of the fresh, young recruits, it's actually soul-crushing to see. It's not hyperbole that quite often these individuals are released back out into the community, even after violent crimes, prior to the paperwork being completed by the officer.

Mr. Todd Doherty: I should add that the criminals who were found in the case of Mr. Hubbard were released back onto the streets within 24 hours.

Mr. Shaun Wright: That's very typical nowadays. It's different from my experience of a couple of decades ago. With a serious offence like that, those individuals would probably have been held in custody for some time, if not until their trial. It is commonplace now for individuals to be released back into the community.

I know there's a lot of reasoning behind that given how being in custody may impact the individual, but I think there's a wider argument about the harms that society as a whole faces when some of those individuals—particularly career violent criminals who for decades have committed severe violent acts—are released into the community again. The next victim will suffer potentially life-altering injuries trying to protect their property or when they're minding their own business.

It's extremely disheartening. Definitely, over my almost 30-year career, it's the most disheartening thing I've seen—and not because I want to see people locked up. It's because I want to see society protected from people who actively want to do harm and ill against other individuals. From my personal perspective, it seems like a lot of the tools and processes that used to protect many in society have been reduced or stripped away.

Mr. Todd Doherty: I appreciate that.

The Chair: Thank you, Mr. Doherty.

Next is Ms. Kayabaga, please, for five minutes.

Ms. Arielle Kayabaga (London West, Lib.): Thank you, Chair.

I would like to go to Mr. Rolfe.

I want to start by making a comment about Indwell in the city of London. When it first came and expanded to London from Hamilton, I was a city councillor. The conversations community members in London were having then are quite different from the conversations we're having now.

Can you touch on the change you've seen since 2018 and 2019, since extending Indwell services within the community of London? How has everybody reacted to that, even in the business community? Also, we have some collaborations with Indwell in the downtown core. Have you seen a shift in conversations about people who are experiencing and living with drug addiction as a disease?

Mr. Steven Rolfe: In London, we are really pleased to be part of a growing movement of building larger community solutions around housing and integrating health care with housing.

If we look at London, the current situation remains particularly difficult. Being able to offer people some hope by introducing quality housing programs—places where people want to live and can actually afford to live—is a values-based approach where you're looking at treating people with some dignity and inviting people into places where they want to live and want to participate. They would prefer to live in a community and are willing to engage in the hard work.

One thing that often isn't talked about is how hard the work is for tenants when they move in and the label of homelessness gets dropped aside or the challenge of addiction becomes something else. It's a lot of work for those individuals to work toward their health and engage. It's not an easy road for any of them.

For the whole London community, I think we've been able to demonstrate that if you link municipal programming with hospital programming and supportive housing, you create a system of care that is able to start teasing apart what is really a complex situation. The challenge that remains before us is the scale.

In London in particular, we know we don't have enough supportive housing. We know we don't have enough affordable housing. There's no easy path to integrating affordable housing with access to services. It really comes down to saying, “Here's a way forward. This can work, but let's figure out how to make it work better.” How do we increase investment in mental health and addiction services and housing?

● (1240)

Ms. Arielle Kayabaga: You touched on something that I think is very important: having supportive housing. Indwell came into the city back in 2018. I remember it very well because I was a city councillor at the time. We very much understood the importance of having it work together with wraparound services. It's about making sure housing is available to people and that they have the supports they need to establish themselves in the community.

Could you speak about the role that supportive housing plays in giving people the motivation they need to escape the cycle of substance abuse? Before you do, I would like to note a comment from a family I know in my community. They had a family member who experienced drug abuse. When he was finally put into an Indwell home, the family said he expressed that it was the first time in his 30-something years of life that he had been able to feel like a human.

Could you touch on the importance of housing in establishing and stabilizing people so they can get to the other side of their struggle?

Mr. Steven Rolfe: Thank you for that comment. I really appreciate it. It reinforces what we do.

It's absolutely critical. I can give you an example. We recently opened a program in London. The city created the housing and we're providing the support. We're talking about permanent housing. People live in their own unit, and they can access nursing and addiction care. It's an interdisciplinary service that's available.

Everybody came straight off the by-name priority list for homelessness. Most people had either a major mental health issue or a substance use issue. For 50% of the people who came into that building, the primary daily need was wound care, and quite often the wound arose from illicit drug use. You're talking about people emerging from situations of incredible difficulty and complexity.

What supportive housing does is offer an opportunity for people to stabilize. For many of our tenants, it's the first place they've been able to call home in their adult life. That ability to access housing and care is critical to people's survival.

The Chair: Thank you, Mr. Rolfe.

[*Translation*]

Mr. Thériault, you have the floor for two minutes.

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

Mr. Wright, let's talk about the diversion of safe supply. After the drug bust in Prince George, British Columbia, RCMP Assistant Commissioner John Brewer said that there was no evidence of widespread diversion of safe supply drugs in British Columbia. The Minister of Public Safety and Solicitor General of British Columbia claimed the same thing.

However, Fiona Wilson said the following before the committee on April 15, 2024:

> My biggest concern when it comes to pills is the number of organized crime groups that are producing counterfeit pills. I saw a photo of this just last week, and you could not distinguish the counterfeit pill from the real prescription pill. The problem is that we have no idea what's in the counterfeit pill, and it could absolutely be deadly.

If the pills aren't in their original dispensing bottles, we can't determine where they come from.

Do you agree with those officials, such as the Minister of Public Safety and Solicitor General of British Columbia, who say that there is no evidence of widespread diversion of drugs in the province?

Or do you object to those statements?

● (1245)

[*English*]

Mr. Shaun Wright: I agree with your point about counterfeit pills being more deadly, as they tend to contain fentanyl. That is definitely an extreme concern.

I believe the statement you referred to was by Assistant Commissioner Brewer, who said there is no proof of widespread diversion. At that time, I was still working for the RCMP, and there was no mechanism to track diverted safe supply. That data collection has now been implemented.

I can tell you from my experience that, once we started receiving complaints about diverted safe supply, we conducted investigations and observed diversion to the illicit market done by individuals. We confirmed that. It was significant. I would say that it was 25% or more.

The Chair: Thank you, Mr. Wright.

We'll go to Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: Ms. Aalhus, the B.C. chief coroner, through her report, cited that 79% of people that die from a fatal overdose have fentanyl in their toxicology results. It's 51% with cocaine, 4% with meth and about 3% with hydromorphone. The coroner, the chief of police, the B.C. chief medical health officer and and First Nations Health Authority say it's fentanyl that's killing people. People are not dying from hydromorphone and safer supply.

I understand that you operate a drug-checking service. Can you tell us about the nature of the drug supply in the Yukon? What's killing people in the Yukon? Lastly, how easy it is to get deadly fentanyl and other drugs in the Yukon?

Ms. Jill Aalhus: The unregulated drug supply in the Yukon is volatile and highly toxic. Sometimes when a new supply arrives, we see waves of overdoses as people encounter unexpected levels of fentanyl, benzodiazepines and, more recently, xylazine.

Our drug-checking data demonstrates that our supply is very similar to B.C.'s, but even more volatile with fewer suppliers. It is highly vulnerable to disruption. When there's a police drug bust, the supply is immediately disrupted, and another supplier moves in to fill the gap in the market, sometimes with a more toxic supply of fentanyl.

We are definitely seeing fentanyl increasingly contaminated with benzodiazepines and xylazine. I'd say a combination of the three is the terrifying thing we're seeing lately that is leading to deaths.

Mr. Gord Johns: How easy is it to access the fentanyl? Your neighbour Alaska had its death rate go up 45% last year alone. Its death rate is now worse than British Columbia's. There is no safe supply and no decriminalization.

When you hear politicians blame the skyrocketing death rate, which is spreading like an epidemic right across North America, on those two policies, what are your thoughts on that?

Ms. Jill Aalhus: We definitely see a lot of people whose drug of choice is fentanyl. However, fentanyl being used intentionally is highly stigmatized in the Yukon and across the country.

I'm concerned when I hear those conversations. Fentanyl is available. People are purchasing it. They're bringing it to us to test and asking what concentration of fentanyl is there. We see a range from below 5% up to 90% to 100% fentanyl. That's like having a drink and not knowing if it's one drink or 20.

● (1250)

The Chair: Thank you.

Mr. Doherty, you have five minutes, please.

Mr. Todd Doherty: Mr. Wright, earlier this year, Dr. Bonnie Henry testified to the committee that she was in favour of legalizing hard drugs like fentanyl, meth, cocaine and heroin. In your opinion, would that make the crisis worse?

Mr. Shaun Wright: Absolutely.

Mr. Todd Doherty: Did the province inform RCMP leaders in B.C. about the metrics they were using to determine whether decriminalization was working?

Mr. Shaun Wright: I was not privy to those communications, but I would imagine so. I don't have specific information.

Mr. Todd Doherty: Thank you.

I'll cede my time to my colleague.

Mrs. Laila Goodridge: Thank you.

I just want to go back. You said there was no mechanism to track diversion of safe supply in British Columbia prior to you guys finding it in Prince George when doing all the investigations. That means when the RCMP said there was no widespread diversion, they didn't actually know if there was widespread diversion. Is that correct?

Mr. Shaun Wright: That may indeed be the case.

Mrs. Laila Goodridge: To me, it's exceptionally troubling that there was no mechanism to track this massive change in policy of providing highly potent opioids to people who are struggling with addiction—giving them large quantities of it and sending them home. There was no process to track whether it was being trafficked into our communities.

Mr. Shaun Wright: Yes, I would agree that it is troubling.

With regard to my experience with the health sector and decriminalization, I'll go back to when marijuana was introduced for medical purposes. Health Canada had the lead on that, but there was little appetite or ability to conduct enforcement. I see a similar occurrence in this case, where Health Canada rolls out policies but doesn't have the inclination or resources to adequately police it on the back end.

Mrs. Laila Goodridge: In my home province of Alberta, police officers have been told for a number of years not to charge for simple possession. How long had law enforcement in British Columbia been told not to charge for simple possessions prior to this legalization pilot project coming out?

Mr. Shaun Wright: It's probably been about 20 years since it was common practice to charge individuals for simple possession.

Mrs. Laila Goodridge: When did you guys use the tool of charging someone for simple possession when it was part of your tool kit?

Mr. Shaun Wright: It was a useful tool for gathering evidence toward larger drug trafficking investigations. Against drug trafficking networks and that sort of thing, it was a particularly useful tool.

Mrs. Laila Goodridge: Effectively, when the government decided to embark on this lunatic process of legalizing hard drugs in British Columbia, they removed tools, not allowing you to do your job as well.

Mr. Shaun Wright: That's correct.

Mrs. Laila Goodridge: One thing you said earlier was that decriminalization noticeably increased the number of complaints of social disorder. Do you know why that happened? What were the observations you had on that?

Mr. Shaun Wright: My opinion is that it normalized behaviours in public spaces that were previously not acceptable. Smoking meth on the sidewalk in front of a business was not typically something that occurred before. There was drug use, for sure, in some open areas, but it became more predominant. That led to an increase in calls on open drug use and that sort of thing, which we were really powerless to address at that point in time.

Mrs. Laila Goodridge: You said that you guys witnessed this so-called safe supply being trafficked into community and diverted to people. Did you see that fuelling fentanyl use and crime in your community?

Mr. Shaun Wright: Yes. We saw individuals who were prescribed so-called safer supply who would immediately either trade it directly for fentanyl or sell it in order to seek stronger street drugs elsewhere.

Mrs. Laila Goodridge: Effectively, the government became the drug dealer.

Mr. Shaun Wright: That would be one perspective, yes. It adds to the supply, to some degree.

Mrs. Laila Goodridge: That is incredibly frustrating.

We had a mom here who said that the government became the “drug lord” when her son was prescribed this so-called safe supply. Do you agree with that statement?

● (1255)

Mr. Shaun Wright: I might not choose those words, but yes, I do.

The Chair: Thank you, Mr. Wright and Mrs. Goodridge.

Next we have Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley: Thank you.

I'll go back to you, Ms. Aalhus. You mentioned the inhalation room at Blood Ties. I've had the opportunity to visit there a few times. I find it quite disturbing that, as you mentioned, it's one of only a few inhalation rooms in the country. Can you tell me more specifically about its initial set-up and what you've seen in the increasing demand for services there?

Ms. Jill Aalhus: We knew from our work in the Yukon over the last 30 years that inhalation is the primary form of consumption in the Yukon. It was really important for us to consider this context and ensure that inhalation was available at our facility. I think it has been key to our success within the program. In the first eight months of our supervised consumption site, we had only 220 visits to the site. In June, when the inhalation room opened, we had over 170 visits in that month alone. We now see 3,200 visits a month, and 95% of the consumption at our site is by inhalation.

When I share this data, keep in mind that our population in Whitehorse is only 30,000. If we didn't have inhalation, I don't think we would see even the 5% of people who are consuming by injection. People come with their friends who consume, or they often smoke and inject at the facility. I think it's been a life-saving part of the service.

Mr. Brendan Hanley: We have seen, I believe, an increasing pattern of drug use through inhalation around the country. At the same time, we've seen an increasing trend, in most jurisdictions, that threatens the existence of supervised consumption. Fortunately, that has not been the case in the Yukon.

If this were a threat in the Yukon, what would you see as the consequences of an impending closure of that site?

Ms. Jill Aalhus: Even though this isn't being discussed currently in the Yukon, the political rhetoric around the country has concerned me for several years, and more so increasingly. I'm not trying to be dramatic when I say that I'm having nightmares now because I'm afraid we're going to lose our service and lose more lives.

We've reversed over 100 overdoses at our site. That's 100 times that people could have passed away in our community. We see so many losses. We would see so many more. I don't want to go back to the days of reviving people in the snow and, yes, it frankly terrifies me.

Mr. Brendan Hanley: The Yukon government, the minister of health, has declared a substance use emergency, and it has for some years.

How do you feel we're doing? Are we getting somewhere? What would you see as the most urgent next steps?

Ms. Jill Aalhus: The supervised consumption site has been more successful than any of us envisioned. There are still a lot of barriers for people in the community, particularly people living outside of Whitehorse. Remote and northern work has unique challenges, but there are community members who are contacting us and really wanting to do this work. There's a team of grandmothers in Old Crow, a fly-in community in the heart of Vuntut Gwitchin territory, who are going door to door to distribute harm reduction to the youth.

I think the Yukon needs to look at exploring those community-led solutions and working with knowledge keepers, elders and people with lived experience to provide these services outside of Whitehorse. We're making progress, but people continue to die. We need more.

Mr. Brendan Hanley: Particularly with a northern lens in mind, hopefully in the coming weeks, we will be getting to the report stage of this study, considering a report and recommendations for what more we can and should be doing, particularly at a federal level.

What reflections would you have? What would you like to see in terms of recommendations, particularly reflecting the northern reality?

Ms. Jill Aalhus: Northern, remote, indigenous and rural communities are disproportionately impacted by this crisis. I think we know that in small places our strength is our people, our communities and the care people have for each other.

In this rural and remote context especially in the north, we need to use that strength. That could look like exploring peer- and community-led models, and really centring the voices of communities and, hopefully, addressing this crisis so that we can stop this devastation.

● (1300)

Mr. Brendan Hanley: Thank you.

The Chair: Thank you, both.

Dr. Ellis, please go ahead for five minutes.

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

I'll add my voice to thanking the witnesses for being here.

One of the things we haven't talked much about, Mr. Wright, is related to drugs coming into this country or drugs being manufactured here. We certainly heard recently about the massive drug bust that happened. Guns and quantities of cash, etc., were seized at the same time. Obviously, part of your jurisdiction is some parts of B.C.

Can you tell the committee if you have had experience with drugs coming into this country, precursor drugs perhaps? Also, are these illicit drugs being made here in Canada?

Mr. Shaun Wright: Thanks for the question.

I don't have a particular amount of experience with regard to the transnational and international nature of it. However, over several years, really when the fentanyl crisis started, the majority was being imported. It's now my understanding that much of it is actually being manufactured in Canada as a source country now.

I would say a lot of that has to do with what is my understanding of fairly lax controls around precursor chemicals in this country as opposed to some other countries, such as the United States.

Mr. Stephen Ellis: Perhaps even the U.K., which makes those precursor substances illegal until they are made legal. Is that not the case?

Mr. Shaun Wright: I don't have knowledge of that, but I would agree with that, yes.

Mr. Stephen Ellis: Thanks very much.

Mr. Chair, I am going to move a motion that I brought forward on Friday. I apologize to the witnesses, although this is certainly germane. The concern from the Conservative side is that there's much more to be learned about this particular topic. As I said, that motion was tabled on Friday, November 1.

I'll just read the motion if that's appropriate:

> That, pursuant to Standing Order 108(2), given recent reports from the British Columbia coroner service that the death rate from illicit drugs among women and girls is up 60% from four years ago, the committee extend its study on the opioid epidemic and toxic drug crisis in Canada for three additional meetings to deal specifically with the dramatic impact of the opioids crisis on women and children.

Mr. Chair, obviously this is another extension of this meeting. It's very clear to Canadians who are paying attention to this committee and hearing the testimony that's been presented that the NDP-Liberal experiment related to opioids and providing the so-called "safe supply" and illicit drug dens is not helping the situation.

I find it odd, too, that often what we hear from interested parties is that it's now necessary to provide evidence as to why these practices should be stopped when, indeed, there was no evidence that they should have been started in the beginning, except for ideological purposes.

That being said, I'm continuing to hear from people who have worked on the front lines and have seen the devastation wrought on communities, specifically with regard to women and girls. I think that it's time we continue this study.

Thank you.

The Chair: Thank you, Dr. Ellis.

The motion is in order, so the debate is now on the motion.

I have Dr. Powlowski and Mr. Johns on the speaking list.

Dr. Powlowski.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I would like to preface my remarks by saying that my understanding is that Planet Youth will most likely be at the next meeting, the one existing meeting that we have on the opioid crisis.

That being said, I'd like to propose an amendment to the Conservative motion, which would then read as follows: "That, pursuant to Standing Order 108(2), the committee extend its study on the opioid epidemic and toxic drug crisis in Canada for up to three additional meetings to deal specifically with the dramatic impact of the opioid crisis on women and children, the role of drug courts in addressing addiction and the use of mandatory treatment for mixed substance use in mental disorder cases."

● (1305)

The Chair: Thank you, Dr. Powlowski.

I think what you just did was read the motion as amended.

If I understand it correctly, you are proposing to delete the words "given recent reports from the British Columbia coroner service that the death rate from illicit drugs among women and girls is up 60% from four years ago," and to add, at the end of the motion proposed by Dr. Ellis, "the role of drug courts in addressing addiction and the use of mandatory treatment for mixed substance use and mental disorder cases".

Mr. Marcus Powlowski: I think the other change has been to change it to "for up to three additional meetings". I don't know if that was in the original motion.

The Chair: I thought it was.

Mr. Marcus Powlowski: Was it in the original motion?

The Chair: You're adding the words "up to".

The amendment is in order. I hope that everyone is clear on the amendment. The debate now is on the amendment.

I have Mr. Johns and then Mrs. Goodridge.

Mr. Gord Johns: First, obviously, there is so much that we haven't even come close to exploring in this study, and it is such an important study. I'm concerned about our not getting a report done. That is something I'm very concerned about.

Certainly, when it comes to children, not one of us around this table wants to see a child die from toxic drugs. I want some facts to be brought into this. There has been a 35% drop in British Columbia, year over year, in the death rate for youth under 18, according to the chief coroner of B.C. That's still not good enough. We have to look deeper into this. This has to be something that we have depth on.

There are areas I feel that we've neglected when it comes to indigenous peoples, who are disproportionately impacted by the toxic drug crisis. We can look to Alberta, where 22% of deaths due to toxic drugs are indigenous people and first nations people. That's 8.4 times the death rate for non-indigenous people. In British Columbia, despite the fact that only 3% of the population is indigenous, they make up 17.7% of the deaths that are happening in British Columbia. That's six times the rate for the non-indigenous population, yet this committee has not focused and done specific studies, despite the fact that I raised this previously, on indigenous peoples.

If we're going to amend this and further amend it and look at future studies, I think we need to have a more in-depth conversation. I don't know if we're going to get through that today, but if we are going to do that, we need to also look at where the population is that is dying. I think indigenous peoples also need to be a significant focus.

I will say this in credit to the original motion, that when it comes to women, indigenous women are 11 times more likely to die of a toxic overdose. In centring it around indigenous people as well, if we're going to extend this, I think there need to be dedicated meetings for this. We heard from the B.C. First Nations Health Authority. I was really disappointed that the chief medical officer never got a single question from the Conservative bench during the whole meeting she was here to testify, despite the fact that the Conservatives have three members on this committee and the fact that the death rate of indigenous people is skyrocketing and is much more than that of the non-indigenous population.

Mr. Todd Doherty: I have a point of order, Mr. Chair.

The Chair: We have a point of order from Mr. Doherty.

Please go ahead.

Mr. Todd Doherty: Mr. Chair, that is categorically false. I am on record as requesting time for indigenous—

The Chair: Mr. Doherty, that's not a point of order. You're engaging in debate.

Mr. Todd Doherty: He's misleading the committee and making misleading statements.

The Chair: You're on the speakers list, so you'll have a chance to rebut.

Mr. Johns, go ahead.

Mr. Gord Johns: It's fact. They did not ask a single question of the First Nations Health Authority's chief medical officer despite the fact that they want to centre this new extension on British Columbia. I mean, the fact of the matter is they ignored her when she was a witness here, and her testimony is important. Indigenous people and their voices matter, especially when it comes to the enormous death rate that they have compared to non-indigenous people.

I want this committee to consider that, if we're going to continue debating this amendment to the motion today, unless we delay until Thursday and have a more fulsome conversation on this.... I think if we're going to look at extending meetings on this, we need to have some in-depth consultations and listen to indigenous voices.

● (1310)

The Chair: Thank you, Mr. Johns.

There are two more people on the speakers list. We're not going to get back to the witnesses at this hour, so is the committee okay with dismissing the witnesses and continuing our discussion on the motion? Is everyone okay with that?

To our witnesses, thank you so much for being with us. What is happening here is entirely within the rules and is appropriate. Dr. Ellis quite rightly waited until the end of the meeting to raise this so that we could maximize our time with you.

We're grateful to you for being here and for the expertise and lived experience you've been able to share with us. It will be of significant value to this study. As you can tell, it's a study with which the committee is completely seized. We are very grateful to you for being with us. You're welcome to stay, but you're free to leave.

We'll continue debate on the amendment with Mrs. Goodridge, please.

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

I rarely find myself in a position where I have agreed with almost every statement that has been made by my colleagues up to this point.

I agree strongly with what Mr. Johns said, that we have not adequately studied the impacts on indigenous peoples and specifically indigenous women. This is precisely why, when I was discussing this motion and stuff that I wanted to see, I wanted to bring forward the impact specifically on women and children, because it is very clear to me that this is something that we have not looked at in this space.

In looking at women and children, I believe you will very naturally see the impact on indigenous women and specifically on kids. The leading cause of death in British Columbia in 10- to 18-year-olds is drugs. That is an important fact that needs to be recognized and needs to be addressed. The leading cause of death in British Columbia youth aged 10 to 18 years is drugs.

This is something that we have very briefly scratched the surface of in this committee. We could be adding a number of additional meetings to continue looking at how the addiction crisis is impacting a variety of different segments of the community. I know that we had conversations earlier on about potentially adding more meetings specifically from an indigenous lens. That motion hasn't come up in debate up to this point.

Considering all of this, I would propose subamending the motion to add “four additional meetings”. Remove “up to three”, and have four. At the very end of the motion, add “on indigenous peoples”.

If it's as important as everyone around the table says it is, I think that's very reasonable space to have a look on three spaces where we haven't looked at as in-depth as I think we could. Four meetings would give us an opportunity to refocus slightly but still have time to have a report come to fruition fairly quickly.

Thank you.

● (1315)

The Chair: Thank you, Mrs. Goodridge.

The subamendment is in order.

The subamendment calls for precisely four meetings, not “up to four meetings”. It calls for an addition at the end of the motion for inclusion of the effects “on indigenous peoples”.

The debate is on the subamendment.

Next on the speakers list is Mr. Doherty.

Mr. Todd Doherty: Thank you, Mr. Chair.

I originally put my hand up in response to the amendment that Dr. Powlowski had put forth. I wanted to ask the chair or perhaps the clerk something.

This was brought up, specifically about the impacts of the opioid crisis on our indigenous communities. I thought we had already agreed to at least one meeting and possibly more. It is important, as has been stated by many.

Where I disagree with the our colleague, Mr. Johns, as he stepped down off his soapbox, is that this has been brought up by others, not necessarily him. Again, it's typical NDP fashion in being late to the game on this. It might even have been Dr. Powlowski who brought it up initially and I echoed it.

We had Takla First Nation in my office earlier on talking about their band council resolutions. They are oftentimes left to deal with this, the significant gap in resources and policing on their first nations, and how challenging it is to enforce a dry community or what have you. We're talking about safe supply going into these communities and how that impacts our first nations.

I know this has been brought up. Through you, Mr. Chair, perhaps the clerk could us tell us if we had already scheduled at least one or two meetings on this.

If not, then I'm in full agreement. I just don't know whether four meetings is enough for what we need to get through, but I'm okay with the convention that, as we've been going along, should we go through those four meetings and feel the need for further meetings, we can go forward with that.

I know that this issue has been brought up and it is an important issue. We need to be able to bring the appropriate people here—first nations in our ridings—who can actually explain what's happening on the ground in their communities and how important it is to have their voices heard.

The Chair: The original motion that gave rise to this study was the following:

> That, pursuant to Standing Order 108(2), the committee undertake a study of the opioid epidemic and toxic drug crisis in Canada and specifically look at the impacts of measures that are being taken, and additional measures which could be taken, to address the toxic drug crisis, reduce harm, and save lives; that the committee hold a minimum of eight meetings on this study, including one meeting with an explicit focus on the toxic drug crisis in Indigenous, rural, northern, and remote communities, and that at least two meetings be conducted after September 30, 2023, to allow for the committee to hear evidence related to British Columbia's drug decriminalization experiment; that the committee present its findings and recommendations to the House and that the committee request a comprehensive response to the report by the government.

Your memory serves you correctly, Mr. Doherty. The motion that gave rise to this study in the first place did make specific reference to that.

That brings us to Mr. Thériault, please.

[*Translation*]

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

In December, we will have been studying this issue for a year. We have held well over eight meetings, and every time we discussed the possibility of holding more meetings on the issue, I was one of those who wanted us to be able to do so. However, we still have an obligation. We can't do this work without making recommendations, which is the end goal.

It doesn't matter whether everyone on both sides of the table agrees or not. What would be unacceptable is for us not to table a report and recommendations in the House after hearing testimony from so many people, experts and citizens.

In this regard, I share my colleague's concern that we have to be realistic about the time spent on this study. We must not do what we did during the pandemic. Marcus remembers. We studied the pandemic for three years and, at the end of the day, no report or recommendations were produced by our committee. To me, that's unacceptable.

That said, if we're talking about women, it's important to talk about all women. According to the coroner's office's statistics for the 2019-2023 period, we saw an initial drop in mortality rates in 2019 and then sky-high mortality rates due to the pandemic. Oddly enough, in British Columbia, in January 2023, we began to see a dramatic drop in the overdose mortality rate for males, which fell from 2,200 deaths to fewer than 1,000 deaths in 2024.

The rate has always been much lower for females than for males. We might ask ourselves why that is. By January 2023, mortality rates for women were almost back to pre-pandemic levels. I would say that we need to talk about that as well and find out why. Those are the facts. This is not my interpretation or personal view on the reality of the overdose crisis. It’s based on the number of deaths indicated to us by the coroner's office.

I'm fine with adding three meetings. However, in my opinion, if we adopt this motion, it amounts to saying that we don't want a report. You know what our committee does in terms of producing reports. That work goes on behind the scenes, but it remains important. Out of respect for all those who have died, for their families and for all those who are struggling with addiction issues, we need to come up with a report. We owe it to all who are suffering from this overdose crisis.

When we started this study, that's what we were talking about. We said that we had to postpone all the other studies planned, because people were dying. We were seeing six, 10 or 12 fatalities a day. Right now, people are still dying from overdoses.

What can we attribute the sharp drop in the number of overdose deaths to? We can always speculate, but such a drop occurred from 2023 to 2024.

● (1320)

I don't mind if we add more meetings, but what I'm saying is that we can't extend this study indefinitely. I do want us to address the issue of overdoses among women, including indigenous women.

I don't see why we should be talking about overdose deaths of indigenous women separately from the overdose deaths of women in Canada. Indigenous women are Canadian women. They fall into the category of females for statistics purposes. If there is indeed a specific problem in that regard, I think it should be raised as part of the same study. Then we can have a better understanding of how these women live.

We talked about the determinants of addiction, such as health, and what should be done. We talked about quality of life, which should be the same for everyone. All of these things are going to come out of the study, and I don't see why we should treat them as separate issues. We have to stop making distinctions. I think we have to treat the problems of indigenous women the same way we do for all women and use the same lens.

Having said that, I think three meetings is enough. We have to move on. That doesn't mean we're going to agree, but we've heard from enough witnesses. I think we should move to the stage of pooling our ideas and making recommendations.

● (1325)

The Chair: Thank you, Mr. Thériault.

[*English*]

Mr. Johns, go ahead, please.

Mr. Gord Johns: I'm trying to get some clarity on how many meetings we're talking about having. I mean, there are so many areas that, as I said, we haven't even touched. We have so many witnesses on our list that we haven't even gotten close to. I think it's pretty clear that we need the expert task force so that they can do this very work, get into the depths of it, and respond properly from a government perspective, but it would be a disservice and be disrespectful to the grieving parents who came to this committee. We've had parents come here and testify. We've had women and different groups come here. If we don't get a report done, it will be disrespectful to them.

That is what I believe. I think we need to get to that report soon. I share that with Mr. Thériault. I disagree about not having at least one session on indigenous women in particular, because the death rate is elevenfold, but I do agree with Mr. Thériault about the need to get this study done.

I know that Mr. Doherty wants to say that I'm on a soapbox here. I'm not, but I do get a lot of criticism from that side. I'll say this: They're bringing forward a motion on looking at deaths of children when their party leader is the only leader that won't meet with Moms Stop the Harm—the only leader. I'm going to point that out. That's a fact.

[*Translation*]

The Chair: Mrs. Brière, you have the floor.

Mrs. Élisabeth Brière: Thank you, Mr. Chair.

The point I wanted to mention has been raised. The original motion sought to focus on indigenous communities. It was therefore up to the parties to call witnesses on this subject.

I tend to agree with Mr. Thériault's position.

[*English*]

The Chair: Thank you.

Dr. Ellis.

Mr. Stephen Ellis: Thanks very much, Mr. Chair.

Those of us on this side of the House are not afraid of not getting a report done. It would appear that we have a whole year to do this. I would suggest that we should be able to get this done in a year, unless our friends know something that we don't know, which of course is very possible.

It would also appear that, much to the chagrin of many Canadians, and behind the back of Conservatives, the Liberals and NDP are once again teaming up to move the fixed election date by one week so that many people can get their pensions who perhaps are not even deserving of one—present company notwithstanding, maybe.

That being said, should we do an incomplete study because we're afraid that there may or may not be an election? My goodness, we on this side of the House have been hoping for an election for two years at least—probably three years, to be honest—but we still haven't had one on behalf of Canadians.

However, enough of that. I'm certainly ready to vote on the motion. I know that our team is as well.

[*Translation*]

The Chair: Mr. Thériault, you have the floor.

Mr. Luc Thériault: Mr. Chair, the issue is not whether or not we are afraid of an election. It's a matter of making sure that we have the time we need to do our work properly. We've been working on this for a year.

Do we think that the discussions and work that the committee must do in camera on this report will be done quickly?

Do we have an idea of the number of meetings we will have to hold before agreeing? We will also have to take into account the fact that other bills will require studies, which will be added to the committee's agenda as the work in the House of Commons progresses.

That said, if, as we begin our work, we realize that we need to explore the subject further, we can do so, because the committee is the master of its own domain. At least we'll have done the spadework and made some progress.

When I was on the Special Joint Committee on Medical Assistance in Dying, we produced an interim report. We came to the conclusion that we would run out of time and that we would need to produce an interim report. However, it was because we did the spadework that we were able to realize that an interim report was necessary.

Once we roll up our sleeves and get going, nothing prevents the committee from producing an interim report and holding follow-up consultations with witnesses on certain aspects. However, we have to get cracking if we don't want to repeat what happened with the pandemic study. The committee will have toiled away for nothing because an election is called. Even if an election is called in the fall of 2025, that's only a year away. Between now and then, we'll have the end-of-year break and then the summer recess. Unfortunately, we don't have as many meetings left as we might think to be able to produce a report, even by the fall of 2025. This is a very important topic, and we have to take into account the breadth of opinion that may be expressed around the table.

We have to be realistic and serious when we undertake a study. I didn't become a politician to play petty politics. I'm not casting aspersions on anyone. I'm just saying that we have to take things seriously. I do have some expertise in the field of methodology, so I know we have to have the time to do the work, especially on such a thorny subject, when the views around the table are polarized.

If I disagree with my Conservative colleagues, I would never tell them that all they have to do is write a dissenting report. Instead, I would seek to arrive at recommendations that will achieve as much consensus as possible around the table. I still believe in the idea that we all share the same goal on this issue around the table. That's why we have to get cracking.

I think three meetings is enough. It's not because I am indifferent to what indigenous women are going through. Absolutely not. I am talking about this precisely because they are overrepresented statistically in the overdose mortality rates. This is why I want us to treat their situation as part of female mortality trends. That's what this study is about. Why should it be a separate topic of study when we can just insert that aspect of the issue into this study?

What matters to me, in terms of female mortality rates, is understanding why indigenous women are overrepresented.

● (1330)

[*English*]

The Chair: Mr. Johns, go ahead, please.

Mr. Gord Johns: I guess we need to decide. Right now, we have one more meeting on the books.

Could you clarify that, Mr. Chair?

The Chair: Yes, there is one more meeting with witnesses on November 26.

Mr. Gord Johns: I want to make sure I'm clear on Mr. Thériault's suggestion, because I like it. We move, right after that meeting, to an interim report, then have other meetings and continue after that.

However, I think we need to get to a report. We don't know what this is going to look like. I agree with Mr. Thériault that there are enough things around the table we can all agree on. Despite our differences on some of the issues, we've heard enough things that we have to figure out.

Mrs. Laila Goodridge: I have a point of order.

The Chair: There's a point of order by Mrs. Goodridge.

Mrs. Laila Goodridge: First, we had a motion, then an amended motion. Now we have a subamended motion.

The current conversation, while pertinent to the overall conversation, is not on the subamendment. If we want to try to get to a vote before question period, I think we need to deal with the subamendment at hand.

The Chair: Go ahead, Mr. Johns. However, if you're going to propose an interim report, we need to deal with the amendments in front of us and perhaps introduce a new motion.

This is part and parcel to the discussion as to how we proceed, so it's not really out of order.

However, if we're going to deal with it, we'll need a motion outside of the one we're talking about now.

● (1335)

Mr. Gord Johns: I'm going to move a subamendment.

The Chair: No. The appropriate way to go, if that's what you want to do, is to vote down what's in front of us and move something new. You can't subamend a subamendment, and that's where we are now. The debate is on the subamendment.

Mr. Gord Johns: Okay. I will talk about the subamendment. The reason I want to talk about that is, if we defeat the subamendment, Mr. Chair, and we move a subamendment that we support the motion after we do an interim report, that gives us a pathway to getting started on an interim report, and then we go to meetings and come back to the main report after. I will support defeating the amendment so that we can get to that.

The Chair: The speakers list is now exhausted. No, it's not. I'm the one who's exhausted.

Dr. Powlowski, go ahead.

Mr. Marcus Powlowski: I'd like to get to a vote.

I don't like the idea of an interim report. I do think we need to come to a conclusion of this study. There are other things to study, for example, the cancer study, which I know a lot of people in the cancer community are really waiting for.

Anyhow, I'd like to get to the vote.

The Chair: There's no one else on the speakers list, so the question for the committee is on the subamendment. The subamendment proposes to fix the number of additional meetings at four and to specifically include a reference to indigenous peoples. Are we clear on the subamendment?

(Subamendment negatived)

The Chair: The debate is now on the amendment proposed by Dr. Powlowski.

The amendment proposed by Dr. Powlowski is to delete the words “given recent reports from the British Columbia coroner service that the death rate from illicit drugs among women and girls is up 60% from four years ago”; to add, before the words “three”, “up to”, so that it's “up to three”; and then to add, at the end of Dr. Ellis's motion, the other topics, which are “the role of drug courts in addressing addiction and the use of mandatory treatment for mixed substance use in mental disorder cases”.

Are we clear on the amendment? The vote is on the amendment.

(Amendment agreed to)

The Chair: The question is now on the main motion as amended. Do you need that read?

Some hon. members: No.

The Chair: You're clear on the main motion as amended.

(Motion as amended agreed to [*See Minutes of Proceedings*])

The Chair: Before I let you go, you received a supplementary budget for the opioid study. As luck would have it, this budget is probably sufficient to allow for the motion that was just adopted because it presumes 10 working meals.

Is it the will of the committee to adopt the supplementary project budget, as presented?

(Motion agreed to)

The Chair: Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: The meeting is adjourned.