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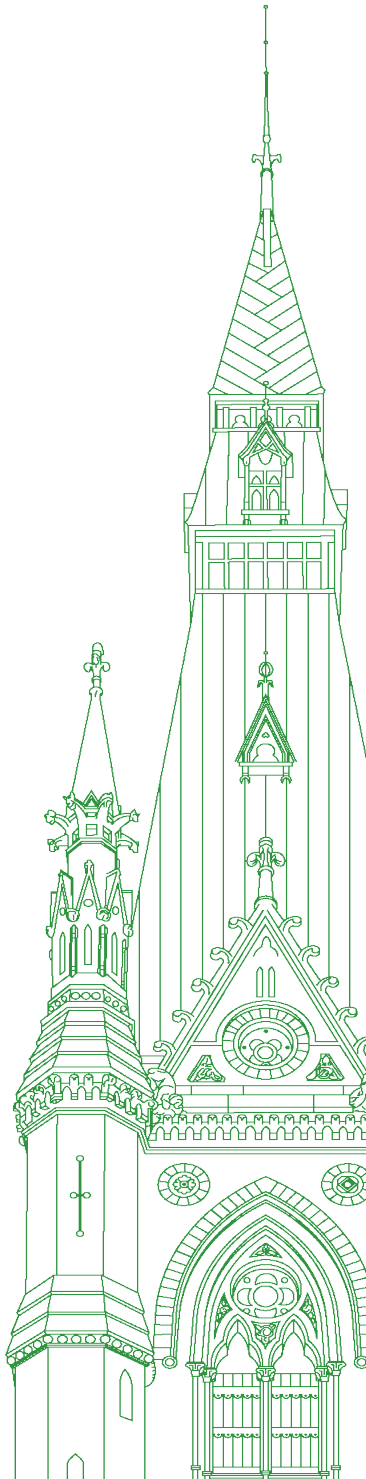

Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, November 26, 2024

● (1105)

[*English*]

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

Welcome to meeting number 141 of the House of Commons Standing Committee on Health.

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

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

I'd like to welcome our panel of witnesses. We have with us in the room Jennifer and John Hedican and, online, Dr. Marc Vogel, chief physician, division of substance use disorders, University of Basel Psychiatric Clinics. Also by video conference, we have Kim Brière-Charest, project director on psychoactive substances for l'Association pour la Santé Publique du Québec, and Marianne Dessureault, attorney and head of legal affairs for the association. Also with us in the room is Thai Truong, chief of police for the London Police Service.

Thanks to all of you for being with us. We're going to begin with your opening statements of up to five minutes in length.

We're going to start with the Hedicans.

Mr. and Mrs. Hedican, welcome to the committee. You have the floor.

Mr. John Hedican (As an Individual): Hello. Thank you for the opportunity to speak here today.

We lost our oldest son, Ryan, when he was 26, and our nephew, Justin, when he was 38, to organized crime's toxic supply of drugs. As hard as it is, try to imagine losing your son or daughter, know that over 47,000 Canadians have died the exact same way, from the same cause, as your loved one, and then have to listen to our political parties choose to not acknowledge that these deaths were preventable if they'd implemented different policies.

Ryan, Justin and the vast majority of Canadians who have died to toxic drugs since 2016 would be alive today if they had been alcoholics or alcohol users, as we provide a government-controlled, safe and legalized source for those substance users. Shame on our federal leadership and elected MPs for choosing to ignore this truth and reality. Shame on those elected politicians who continue to politicize a health crisis, one that has killed more than the Second World War.

All political parties choosing to ignore this reality disrespect and minimize the deaths of Ryan and Justin and our families' grief and the 47,000 lives lost and their families' grief. These mass poisonings would not happen to any other demographic. We would not allow 22 people a day to die to the same cause, year after year, and not acknowledge what would save lives.

The prohibition of drugs is the single biggest contributing factor in all toxic drug deaths. It ensures and supports organized crime as the only supplier in every town and city in our country. We have wasted trillions of tax dollars funding a war on drug users—our family members, our friends and our colleagues. For more than 100 years, it has been an absolute failure. Prohibition can't keep drugs from flourishing in our prisons. Prohibition has directly created and supported a powerful multinational black market for organized crime that supplies and poisons innocent substance users.

The prohibition of drugs is a fantasy policy that is wishing it could keep drugs from entering our communities. The reality is that substance use is a normal neurobiological impulse that will always exist in humans. Legalization is the only policy to directly stop our loved ones from dying from toxic drugs and to address reality, just like legalizing alcohol and marijuana has. For political parties to call for only safer communities, more recovery and mental health beds, and forced and voluntary care, and to not choose to acknowledge all these serious and costly issues, will not change a thing until we address the cause: Organized crime is supplying toxic drugs.

Our son, Ryan, had been in recovery twice. The second time it was for eight months at a facility in New Westminster called Last Door. He returned to work as a third-year electrician. Ryan relapsed shortly after returning to work and died during his lunch break at his job site. Relapse is a normal component of the disease of addiction. When this happens, our federal drug policy forces those who fight a disease back to organized crime to get what their body demands. For what other disease would we allow organized crime to fill a prescription?

The major foundation of most recovery facilities is abstinence only rather than harm reduction. Again, that does not address the reality that addiction is not a choice but rather a disease, with a 92% relapse rate for those using opiates. Recovery played a major part in Ryan's death, as his tolerance was low due to his eight months of sobriety when he relapsed.

Recovery needs to be based on more than a faith-based 12-step program that was introduced over 90 years ago. Science and medical intervention need to be funded to address and cure addiction. What other disease do we treat the same as we did 90 years ago?

The politicians who call for recovery as the be-all and end-all are choosing to ignore the truths and realities of recovery. It does not address, and nor will it stop, the deaths of youth, first-time and recreational users, as they are not addicted. It's like these thousands of people somehow don't exist. Recovery will not save all chronic users for many reasons, just as all alcoholics do not enter into recovery. To not acknowledge these lives is morally wrong, a failing of responsibility, and once again showing that all lives are not equal—or matter—to politicians. Votes are valued over lives.

Dr. Bonnie Henry, our B.C. provincial health officer, stated this summer that prohibition is responsible for the death crisis we are in, and that legalization and regulation minimize harms. As an epidemiologist and health professional, her recommendations are based on evidence and science. Political parties base policy and recommendations on the net gain of votes.

Our son Ryan and 47,000 Canadians have died to toxic drugs supplied by organized crime, which is supported by the prohibition of drugs. What else do you need to know to stop this mass poisoning, these preventable deaths?

Thank you.

The Chair: Thank you, Mr. Hedican.

Please accept my condolences and those of the committee on the tragic loss of your son.

Next, we'll have Dr. Marc Vogel, chief physician, division of substance use disorder, University of Basel.

[*Translation*]

Welcome to the committee, Dr. Vogel. The floor is yours.

● (1110)

[*English*]

Dr. Marc Vogel (Chief physician, Division of Substance Use Disorder, University of Basel Psychiatric Clinics, As an Individual): Thank you very much for the opportunity to appear before the standing committee. It's a particular honour for me because I have a long-standing connection to Canada ever since I spent a high school year in Alberta in the early 1990s.

As an active clinician and researcher, I specialize in opioid and cocaine use and dependence, as well as the treatment of concurrent psychiatric disorders. I currently serve as head physician of the addiction department at the University of Basel Psychiatric Clinics.

Our department provides opioid-assisted treatment to approximately 500 patients. In addition, we offer in-patient treatment, as well as outreach treatment, and we provide medical services at Basel's two supervised consumption sites.

Canada is currently grappling with a severe opioid overdose crisis that is devastating communities across the country. In 2015, I had the opportunity to spend several months as a research fellow at the University of British Columbia, and I was struck by how deeply the opioid crisis is affecting individuals and society as a whole.

Switzerland, too, faced a public health crisis related to opioids in the 1980s and 1990s. Intravenous heroin use was the key driver of the HIV epidemic, which hit Switzerland harder than any other European country. Open drug scenes were visible in all major Swiss cities, and per-capita overdose deaths reached the highest levels in the world.

Switzerland's political system is based on compromise between linguistic regions, urban and rural areas and political parties across the spectrum that have to share governmental responsibilities. Laws are often subject to political referendums. Overall, our political decision-making processes are slow.

However, in the early 1990s, the urgency of the situation was so great that politicians, law enforcement, the treatment system and individuals who use drugs, along with their families, came together to completely overhaul Switzerland's drug policy. The result was the introduction of harm reduction as a fourth pillar of Swiss drug policy alongside prevention, therapy and law enforcement. Harm reduction measures, such as supervised consumption services, needle and syringe dispensing, and low-threshold social initiatives like supported housing, employment and free meals, were implemented on a broad scale. Importantly, this was accompanied by the introduction of patient-centred, low-threshold treatment for opioid dependence. Opioid agonist therapy with methadone became easily accessible, covered by mandatory health insurance and available nationwide, primarily in general practitioners' offices but also in specialized institutions like ours.

Patients have always been involved in decisions regarding their treatment, and most unnecessary regulations and restrictions were abolished. For the majority of patients, take-home methadone was introduced. Despite these measures, it became clear that a portion of the opioid-dependent patients still did not benefit from treatment. This is why Switzerland introduced heroin-assisted treatment in 1994, providing pharmaceutical heroin under medical supervision, embedded in a therapeutic environment that includes addiction and psychiatric care, as well as social support. Heroin is prescribed for injection, as well as in the form of tablets. Currently, we are also investigating the prescription of nasal heroin in a national multicentre study.

It's important to emphasize that heroin-assisted treatment is much more than just dispensing heroin. It's a comprehensive, interdisciplinary and cost-effective treatment approach that also addresses psychiatric comorbidities, such as psychosis, depression or trauma, which often contribute to addiction in the first place. Up to 80% of patients in opioid agonist therapy in Switzerland have such concurrent psychiatric problems. I firmly believe that opioid agonist therapy can only achieve its full potential when these co-occurring issues are also addressed.

All of these measures were implemented on a large scale and were made available across the nation. Switzerland, while smaller than Nova Scotia and with much of it mountainous, now has 16 supervised consumption services and more than 1,800 patients in 24 heroin-assisted treatment centres. Why is this important? We know that only patients receiving treatment can benefit from it. In Switzerland, around 80% of opioid-dependent people are engaged in opioid agonist therapy with a range of medications that they can choose from on any given day.

In Canada, this proportion is much lower. In our outpatient clinic in Basel alone, we treat over 200 patients with pharmaceutical heroin. If we were to translate this number to Toronto, that would imply approximately 3,000 patients in heroin-assisted treatment. However, when I prepared for this meeting, I reviewed Dr. de Villa's recent statement to the committee. She noted that the only injectable opioid agonist treatment program in Toronto has 35 patients.

The opioid-dependent population in Switzerland is now an aging cohort and new solutions are needed to care for elderly patients.

● (1115)

The number of new opioid users has declined steeply since the 1990s. The provision of heroin-assisted treatment has been confirmed in five popular referendums, and problematic opioid use is viewed as a medical issue, leading to a reduction in stigma around this treatment. We're convinced that this is the result of the broad introduction of harm reduction measures and low-threshold opioid agonist therapy, including injectable options and treatment of concurrent disorders.

Thank you for your attention. I'm happy to answer any questions.

The Chair: Thank you, Dr. Vogel.

[*Translation*]

Next, we'll go to the Association pour la santé publique du Québec, represented by Kim Brière-Charest and Marianne Dessureault, who are with us via video conference.

Welcome to the committee.

You have the floor for five minutes.

Ms. Kim Brière-Charest (Project Director on Psychoactive Substances, Association pour la santé publique du Québec): Thank you, Mr. Chair.

Ladies and gentlemen of the Standing Committee on Health, thank you for including us in this consultation.

Canada is in the midst of a massive public health crisis causes in large part by contaminated unregulated drugs on the illegal market. More than 47,000 people have died in our communities since January 2016. That's more than the number of Canadian soldiers killed during the Second World War. The scale of the problem indicates the need for an urgent, adapted, nationwide response.

Members of the Global Commission on Drug Policy identified Canada as a country that stands out thanks to its bold pursuit of policies infused with a human rights and public health approach. However, existing solutions are no longer an adequate response to the scale of the needs and cannot attenuate the crisis. We need to do more to prevent premature, avoidable deaths, expand access to voluntary treatment, enhance prevention, ensure a regulated supply and reduce the burden on the judicial system.

The overdose crisis has been less severe in Quebec than in other provinces, but it is present nonetheless. Many indicators suggest it is getting worse. The province's approach to addiction is a continuum involving prevention, research, harm reduction and treatment. The social safety net has certainly contributed to reducing the prevalence of overdose and avoiding additional pressure on the health and social services system. Acting on the social determinants of this crisis is crucial. The lack of social housing and resources in certain sectors exacerbates health and social coexistence problems.

In addition to tackling aggravating factors, the toxic drug supply and the immediate on-the-ground response, we need to enhance upstream prevention. We need to stop the bleeding and manage emergencies.

Criminalization aggravates stigmatization, which leads to hidden consumption and delays access to resources and treatment. It increases pressure on the judicial system without truly tackling drug toxicity. In 2020, criminal justice costs related to the use of drugs other than alcohol, tobacco and cannabis exceeded $10 billion.

The Association pour la santé publique du Québec believes that recent political debates across the country threaten the continuity of harm reduction resources. Sometimes, these resources are a person's last link to care and treatment, a pivotal role for people with no access to health care resources. Sometimes, there's no other way to reach those people.

Brain lesions due to oxygen deprivation during overdose can aggravate mental health and addiction problems and make people less likely to access supervised consumption services. Not only will that increase the death toll, but it may also result in more permanent health complications.

Supervised consumption services are crucial to making a safe, clean, legal structure available. Detox and therapy are essential, but they have to be part of a continuum of resources. There is no evidence that forced treatment is effective, and it exposes people to a higher risk of overdose. We need to start by making treatment accessible, free, adapted and universally available to ensure geographic equality for all.

Prescribing regulated substances significantly reduces the risk of accidental death. However, given the potency of substances on the illegal market, available medications are no longer able to ease withdrawal symptoms. Access to regulated substances is crucial to reducing the effects of drug toxicity. Let's not forget that overdose is typically caused by contaminated drugs, not prescribed drugs.

Addressing overdose is complex. There are no simple solutions. According to a report by the UN High Commissioner for Human Rights, the war on drugs is having a disproportionate impact on the poor and on vulnerable groups. This public health crisis calls for a cross-party approach based on scientific evidence so people don't play politics with problems related to overdose.

I'll let my colleague, Marianne Dessureault, finish our presentation.

● (1120)

Ms. Marianne Dessureault (Attorney and Head of Legal Affairs, Association pour la santé publique du Québec): I'll wrap up with a few words about the legal aspect.

The Canadian Constitution is based on a legal foundation that informs how we approach the opioid crisis. Drug laws and policies must be consistent with the Canadian Charter of Rights and Freedoms, but also with provincial legislation, such as the Quebec Charter of Human Rights and Freedoms. The right to life, safety, integrity and freedom, which consent to care derives from, is a fundamental principle enshrined in our framework. All policies and legislation must take these founding principles into account and align with them.

The Chair: Thank you.

[*English*]

Last but not least, from the London Police Service, we have Chief Thai Truong.

Welcome to the committee, Chief Truong. You have the floor.

Chief Thai Truong (Chief of Police, London Police Service): Good morning, Mr. Chair and members of the Standing Committee on Health. Thank you for the opportunity to appear before you today to discuss the opioid epidemic and the challenges we face in London, Ontario, with respect to the safe supply program and its unintended consequences.

London has garnered significant attention in recent months regarding the safe supply program. While the program is well intentioned, we are seeing concerning outcomes related to the diversion of safe supply medications. The diversion of regulated medications, including hydromorphone, is a growing concern. These diverted drugs are being resold within our community, trafficked to other jurisdictions and even used as currency to obtain fentanyl, perpetuating the illegal drug trade. Specifically, we are seeing significant increases in the availability of diverted Dilaudid eight-milligram tablets, which are often prescribed as part of safe supply initiatives. Vulnerable individuals are being targeted by criminals who exchange these prescriptions for fentanyl, exacerbating addiction and community harm. This issue is not isolated to individuals experiencing substance use challenges. It also impacts the safety and well-being of our entire community.

The human cost of the opioid crisis is devastating. In 2019, 73 individuals in London lost their lives due to drug overdoses. That number spiked to 123 in 2020 and reached 142 in 2021. While fatalities have slightly declined since then to 123 in 2023, we remain far above prepandemic levels. Tragically, over 80% of opioid-related overdose deaths in London are linked to fentanyl.

Our enforcement data emphasizes the growing issue of diverted medications. Hydromorphone seizures have increased substantially over the past five years. In 2019, we seized 847 pills, 75 of which were eight-milligram Dilaudid. By 2023, seizures ballooned to over 30,000 pills, with nearly 50% being eight-milligram Dilaudid. These increases cannot be attributed to pharmacy thefts, as London has had only one pharmacy robbery since 2019. Our police service is working diligently to disrupt the trafficking of fentanyl and diverted safe supply medications. We are targeting individuals and organized crime groups that exploit vulnerable populations and fuel the drug trade.

However, enforcement alone is not sufficient. We are collaborating with community health partners to address the systemic issues contributing to diversion. These efforts must be holistic, integrating prevention, harm reduction and treatment. I'm not here to criticize the safe supply program but to address the serious challenges associated with its diversion. We need innovation to mitigate risks. We need robust enforcement to hold traffickers accountable. We need continued collaboration among health, social service and public safety sectors to effectively respond to this crisis. This is a complex issue requiring collective action. I want to acknowledge the challenging efforts of health and social service partners working on the front lines of prevention, harm reduction and treatment in response to this opioid crisis. However, it will require strong collaboration and strong enforcement to face this crisis.

Thank you for your time. I welcome your questions.

● (1125)

The Chair: We will now begin with rounds of questions starting with the Conservatives for six minutes.

Mrs. Goodridge, you have the floor.

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

I want to thank all the witnesses for coming here today.

To the Hedicans, I'm sorry for the loss of your children.

Chief Truong, you said that there were clearly unintended consequences from this radical new policy of safe supply that was brought in and piloted in your community of London.

When you put out your press conference and talked about safe supply, how confident were you that the drugs that you were seizing were from these safe supply programs?

Chief Thai Truong: We had direct evidence linking the seizures of eight-milligram Dilaudid specifically to the safe supply program.

Mrs. Laila Goodridge: Is enough being done to prevent the diversion of these pills?

Chief Thai Truong: There needs to be more. Obviously, we are seeing the diversion of safe supply in London. That's why it's very important that we work together in the community with our partners to ensure that regulations are in place and that we do our part with enforcement.

Mrs. Laila Goodridge: We had one doctor here from London, Ontario, Dr. Sereda. When we asked her about diversion, she talked about the fact that there were some compassionate reasons behind it, indicating that it wasn't just all bad. She works for London InterCommunity Health Centre, which puts into question whether they have enough protocols in place to prevent diversion from happening in their clinic.

Do you believe that all the clinics in London that allow safe supply to continue have enough protocols in place?

Chief Thai Truong: We've been working very closely with the executive director, Mr. Courtice, of London InterCommunity Health Centre. A strong relationship with them is very important. They've recognized that working together with us and tightening up their standard operating procedures are things that we need to look at.

We're working very closely not only with London InterCommunity Health Centre, but also with other partners and stakeholders within the community to see how we can mitigate this diversion.

Mrs. Laila Goodridge: Would it not be easier if this program were to end? Not only is it clearly creating harms in the community of London, but there are ripple effects all across southern Ontario.

Chief Thai Truong: Decisions regarding medical efficacy and public impacts of safe supply or harm reduction strategies are best left with medical experts and medical professionals.

My role as the chief of police is specifically law enforcement and the efficacy of addressing the criminal aspects that coincide with diversion.

Mrs. Laila Goodridge: What is the street price of diverted safe supply in London?

Chief Thai Truong: In London, the prices fluctuate. Obviously, it's unregulated. Our last intelligence information and evidence of Dilaudid eight milligram is that they're being being sold for between two dollars and five dollars per tablet.

Mrs. Laila Goodridge: That's a substantial decrease from what it initially had been. Is that correct?

● (1130)

Chief Thai Truong: In other areas of the province and across the country, including communities in remote areas, that price is significantly higher, the street value.

Mrs. Laila Goodridge: To what extent is organized crime involved in the trafficking of these government-fuelled opioids?

Chief Thai Truong: Organized crime is involved.

Mrs. Laila Goodridge: You said that the safe supply is being distributed into other communities. Which communities are they?

Chief Thai Truong: They're outlying communities. We know from information that remote communities in northern Ontario are seeing prices that are much higher than two-dollar or five-dollar tablets.

Mrs. Laila Goodridge: At your press conference, you said that this has been occurring for a while. Approximately in what month and year did you guys first start seeing the diversion of these government-funded opioids?

Chief Thai Truong: I can tell you that it became very concerning and prevalent last year. We looked at our data for the last five years, and the data I shared with you with respect to the seizures from 2023, when thousands of hydromorphone pills were seized in our city, showed that 50% of those seizures were specifically eight-milligram Dilaudid pills.

Mrs. Laila Goodridge: We also had Dr. Sharon Koivu, another London doctor, who said she saw vulnerable women patients who were being pressured to secure safe supply, and then they were basically being pimped out for these drugs. Is this something the London Police Service has also seen?

Chief Thai Truong: Yes, that's the information we have as well.

Mrs. Laila Goodridge: Does it concern you that vulnerable people are being made more vulnerable by the use of government-funded drugs?

Chief Thai Truong: Our concern is the victimization of all individuals in the community. Vulnerable and marginalized people are extremely at risk. This is a complex issue. This is one area where we see the exploitation that members in our community are unfortunately experiencing.

The Chair: Thank you, Chief Truong.

Thank you, Mrs. Goodridge.

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

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

I'd also like to thank our witnesses for being here today.

I extend my deepest condolences to the Hedican family for the loss of their son and their nephew.

Earlier, you talked about the politicization of the issue. Do you think we can find a path forward when the noise is very political right now? What advice would you give to get past the politicization so that we can continue to honour the lives of those who have died?

Ms. Jennifer Hedican (As an Individual): I'm sorry. It was hard to hear you.

Ms. Arielle Kayabaga: I apologize.

I was asking about your thoughts on the politicization that you talked about earlier and what your advice would be to get above the noise so that we can actually do the work that continues to save lives.

Ms. Jennifer Hedican: I believe we all have to come at it from a human perspective. You can make different choices if you want, as a government. We've seen it multiple times.

There's accurate reporting, telling the whole story, understanding that it's not only people who are unhoused who use substances, being accurate in reporting all types of substance users and acknowledging that our first nations individuals are seven times more likely to die. If we report all of the information, I believe people will have a better understanding of it.

If I can talk to what Laila Goodridge and Chief Truong talked about, I wondered—

Ms. Arielle Kayabaga: I apologize, but please be really quick.

Ms. Jennifer Hedican: I wondered if they asked themselves why these people have to sell safe supply. Is it because the other supplies are so toxic?

I believe we have to look at it holistically and we have to stop 10-year-olds from dying from poisoned sources.

Ms. Arielle Kayabaga: That's interesting. Thank you.

Mr. John Hedican: Can I make just one quick comment?

Ms. Arielle Kayabaga: Quickly, yes.

Mr. John Hedican: When we talk about politicizing it, I just had to listen to Mrs. Goodridge use the word “radical”. I don't know why we need the word “radical” when this harm reduction is brought by health professionals. It's similar to when a federal leader uses the term “drug dens” when he's talking about safe consumption sites.

It just covers people fighting a disease in shame and stigma. Shame on that language because it doesn't need to be used and it does no good.

● (1135)

Ms. Arielle Kayabaga: Thank you so much.

Let's go back to what some of our other witnesses have said, which is that we cannot ignore evidence-based....

I'm going to the chief now.

Chief, thank you so much for being here.

On October 16, you made a comment in The London Free Press. You said, “We know we can’t arrest our way out of this...[but] there are times when it is appropriate to make arrests when individuals are openly using dangerous drugs in the community.”

Can you comment on who the appropriate person would be to make these arrests for public drug use? What kind of law enforcement services do you think are needed to adequately respond to this overdose crisis in our community, especially in London and given the context and collaborations that have happened across different practices?

Chief Thai Truong: Thank you for the question.

Chair, through you, with respect to the question about the open drug use, police officers need to have the ability to intervene. When you talk about public drug use and consumption in open spaces, there has to be perspective and a balance between the actual circumstance of that individual using in public and the impact to the community.

Ms. Arielle Kayabaga: Do you think that the police services right now are equipped to do that?

Chief Thai Truong: I think we need collaboration and partnership. We need support from health and social agencies.

Ms. Arielle Kayabaga: Is that the collaboration of community services?

Chief Thai Truong: That's correct.

Ms. Arielle Kayabaga: Are you currently working with community services to address the opioid crisis in the city of London?

Chief Thai Truong: We're currently working with our community and community partners to address the open drug use that is occurring in the city, specifically in the downtown core at this moment.

Ms. Arielle Kayabaga: Chief, when was the last time your police officers received training to be able to respond to an overdose crisis?

Chief Thai Truong: It's part of their ongoing training and annual training. Police officers go through in-service training on an annual basis. Part of that ongoing training involves just that. We continue to work with our partners and medical professionals to help us perform our duties.

Ms. Arielle Kayabaga: You talked about the collaboration that has to happen with the community services that are actually trained to help people with mental health and all the other things that are involved in a drug use situation. Do you think that police officers are the only appropriate people to be at that call, or are you suggesting that there should be other partners at the call?

Chief Thai Truong: Let me just state that when I'm speaking about police intervention, as I've said numerous times, it's only when appropriate, because there will be times when it is appropriate for police to intervene and uphold the law.

The Chair: Thank you.

[*Translation*]

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

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

I'm going to take advantage of the fact that we have people here who are coming at this from completely different perspectives. Some focus on implementing the strategy, others on law enforcement and others on harm reduction. Some are the people on the front lines, and some are bereaved parents.

My first question is for Ms. Brière-Charest and Mr. Vogel. Please keep your answer brief.

In your opinion, would the toxic drug crisis be more or less severe without safe supply? What can be done about safe supply drugs being diverted?

Please share your views quickly.

Then I'll go to Chief Truong and Mr. and Ms. Hedican.

Ms. Kim Brière-Charest: By far, most of the overdoses in Canada are attributable to contaminated drugs on the illicit market, as has been pointed out. Eighty-four per cent of accidental substance-related acute toxicity deaths in Canada between January and March 2024 involved non-pharmaceutical opioids. That's a pretty high number. That's why we need regulated drug treatment programs to address a health crisis that, at the end of the day, is caused primarily by drug toxicity.

One way to address diversion is to make sure that everyone has access to treatment. Currently, many people are waiting for detox, therapy or medical treatment. People might wait several weeks or even months. The first thing to do is make treatment available everywhere in Canada.

● (1140)

Mr. Luc Thériault: Dr. Vogel, what are your thoughts on that?

[*English*]

Dr. Marc Vogel: First of all, I want to point out that it's not really clear what's meant by safe supply. There are very different programs, as far as I am aware, for what safe supply means. Sometimes it can be just a prescription for hydromorphone and nothing else, and I'm not convinced that this will work.

It can also be almost like a treatment setting and this is where it leads me. I think we should offer medication with opioids as a prescription inside of a therapy setting. This means controlled. This means regularly overseen by a doctor. This means a therapeutic context. This means a relationship with patients and providers. I think it should not be apart from therapy.

I heard that hydromorphone is used as currency to get fentanyl. Ms. Hedican was saying that these people are forced to sell hydromorphone, and this is exactly the point. They are selling hydromorphone because they're looking for fentanyl. If you want to take the analogy of heroin-assisted treatment in Switzerland, why not treat these people with fentanyl in a really intensive, therapeutic setting so they get the substance they are looking for and probably the substance they need at this point in time?

I cannot comment on your question of whether the crisis would be worse or better.

[*Translation*]

Mr. Luc Thériault: Thank you. That answers my question.

You're saying that one solution would be to prescribe what these people are looking for, but in a controlled way.

Mr. Truong, without safe supply, how do you see the toxic drug crisis evolving? Will there be more or fewer deaths in London?

[*English*]

Chief Thai Truong: Chair, through you, as I stated previously, the medical efficacy and the public health impacts of safe supply and harm reduction strategies are, for me, best left with medical professionals and public health experts.

My concern, in my role in the safe supply diversion, involves just what we spoke about. One issue is that individuals in the program—

[*Translation*]

Mr. Luc Thériault: We understand that part. We've heard from other witnesses before you.

Would you be for or against what Dr. Vogel just proposed? According to him, there would be no safe supply diversion if people got prescriptions for what they're looking for in the first place. Would you be opposed to controlled fentanyl prescription?

[*English*]

Chief Thai Truong: Thank you for the question.

That decision, for me, is best left with the medical experts. That's not a question I feel I should be answering, where my role is public safety and the impacts of criminality involved in the diversion of safe supplies.

[*Translation*]

Mr. Luc Thériault: Thank you.

I would like to hear from Mr. or Ms. Hedican.

[*English*]

Mr. John Hedican: Thank you.

Safe supply saves lives. To refer to the doctor, if our alcohol system was still being supplied by organized crime and our alcohol stream was toxic and killing people, we would have to have a safe source for our alcoholics. If we were prescribing 0.5% alcohol and somebody's looking for a 40% shot of rye, it's not going to work. That's what we're doing with our safe supply. We have to prescribe what's needed.

At the end of the day, we're losing sight of what's causing what we're talking about. It's toxic drugs supplied by organized crime. That's what we need to focus on.

● (1145)

The Chair: Thank you, Mr. Hedican.

[*Translation*]

Thank you, Mr. Thériault.

[*English*]

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

Mr. Gord Johns (Courtenay—Alberni, NDP): Thanks to all the witnesses for being here.

I definitely want to thank John and Jennifer for making the trip from home on Vancouver Island.

Again, my condolences for your loss of Ryan.

Can you tell this committee about your son Ryan? Can you maybe speak about what your lives have been like without Ryan?

Mr. John Hedican: Ryan was our oldest son. He loved his family. He loved life. He was athletic.

The Chair: Excuse me, Mr. Hedican.

Ms. Hedican, it pains me to do this, but the rules of Parliament prohibit the use of demonstrative evidence or what we call props. I'm sorry.

Mr. Todd Doherty (Cariboo—Prince George, CPC): I have a point of order.

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

Mr. Todd Doherty: Mr. Chair, with all due respect, as someone who has lost loved ones to overdose, I'm going to ask for some leniency today. I understand completely their anger, their frustration and their loss. I don't think we should penalize anybody for doing that.

Ms. Arielle Kayabaga: I support it.

The Chair: It appears that your view has some but not unanimous support in the room.

I'm sorry for the interruption, Mr. Hedican and Ms. Hedican. Please go ahead.

Mr. John Hedican: Ryan was our family's IT guy. Ryan hated his disease. He felt shame, stigma and remorse. Our political system—the prohibition of drugs—put that on Ryan.

When he tried to fight his disease, he fought hard through recovery. His second time was for eight months. You don't stay in recovery for eight months if it's not something you want in your life. At the end of the day, Ryan relapsed shortly after eight months, doing a job that he loved. He had dreams. To have that taken away from him, when he should be alive today....

As I've said, if he were an alcoholic, he'd be here today, because he would have had a chance to go to a safe legal source to get what he wanted and get back on that horse again. He would have beat it, but we never gave him another chance, because the prohibition of drugs sends those who relapse and fight a disease right to organized crime: They have nowhere else to go. We don't acknowledge that, and it's wrong on so many levels. When I talk about “politicizing”, that's what happens. We don't acknowledge the truths and realities.

One hundred and fifty youths in B.C. have died, from 2018 to 2023, and the vast majority of these kids are not addicted. They make a mistake when they try the gateway drug—alcohol—and they die, and we don't talk about what has killed them.

If you two could quit talking when I'm talking up here.... It's rude. I'm talking about the death of my son and the 150 youths who have died in our province and who would be alive today if they would have had a source that came from a legalized clean source.

Those 150 parents would be disgusted.

I'm sorry. I lost track of the question.

Mr. Gord Johns: I'm going to follow up with a bit more so you can speak to it.

Over the course of the study, we've heard from many of the parents who have lost a child, the parents you talked about, or who have a child struggling with addiction. They've shared differing views on whether we need to scale up or scale back measures like safe supply. Have your views on how to address the crisis evolved since you lost Ryan? What do you think are the most critical actions that the federal government needs to take?

Ms. Jennifer Hedican: When you bring a child home from the hospital, you can't look at them with the thought that they're going to battle something you won't be able to help them through. I heard the honourable member talking about her children having strep throat. I understand that, because my son had been sick, as well. When they move to the use of substances that they battle.... Our other children have used substances, as well, but they don't battle them.

Gord asked a question. I'll go quickly.

My view has completely changed. John, as an alcoholic, has been sober for 38 years. We talked openly about what substance use is like. I was certain our children were not going to follow that same hard path. I really fought against Ryan using substances, even though I was the mother who would pick him up if he'd had too much to drink, then not admonish him, because my siblings and cousins had all done this in their adolescent phase, as well. I now know that substance use, when it becomes chronic, is not a choice. The number of people we met in recovery facilities Ryan had been to.... People talked about it being their eighth time there. That's the heartache people went through. It's not the fault of the person, even though it feels like it when we put that judgment on them.

I really wish we didn't use the word “overdose”, because it's not an overdose. When Ryan was 16 and went to a New Year's Eve party, he ended up with alcohol poisoning. It's called “alcohol poisoning”, but everything else is called an “overdose”. We had the coroner change Ryan's death certificate to say that he died from toxicity due to a substance. You can't call it an overdose, because people are not ingesting what they think they are ingesting. The amount of toxicity in the drugs is so high and inconsistent that users don't know what they're putting in their bodies. I hear the word “fentanyl”. Fentanyl is not the only drug being put in that is killing our loved ones.

The drug toxicity is also impacting people who are unhoused, because they are constantly in a state of withdrawal from drug sickness. If the coffee you drank today had not had the right level of caffeine, which was replaced by other substances that made you ill, your body would still crave that caffeine. You would probably need more instances of it throughout the day, which is what is happening with drug toxicity now.

● (1150)

The Chair: Thank you. We're over time. I expect you'll have other opportunities to expand on that.

Next, we're going to Mr. Moore for five minutes.

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

Thank you to all of the witnesses for their testimony today.

Chief Truong, I have some questions for you about organized crime.

It's something affecting all Canadians, in both urban centres and rural areas across this country, and in every province. It was astonishing to look at a release from the London Police Service guns and gangs section recently, laying 62 charges. Items seized were a Smith & Wesson nine-millimetre handgun, a Glock handgun, a loaded Glock handgun, another Glock handgun, oxycodone tablets, cocaine and crystal meth. We see how, in Canada, gun deaths have increased by 116% since 2015, and gang-related homicides have increased by 78%. We are facing a crisis related to organized crime.

In your testimony, you mentioned the diversion of so-called safe supply by organized crime. I'm wondering if you could expand a bit on the willingness of someone to divert the safe supply they've received. I use the expression “so-called safe supply” because of the testimony we've heard at this committee. The way this supply is being abused is resulting in more crime and chaos. As we all know, there have been over 40,000 overdose deaths since 2015.

Could you speak in practical terms about how this diversion, in your experience, plays out in your own community?

● (1155)

Chief Thai Truong: I'll give you one example. Not every participant in the safe supply program is involved in diversion. There are instances where individuals who are participants in the safe supply program are unhoused, have very little money or currency and are addicted to fentanyl.

As users, these particular individuals, in these circumstances, have no money to purchase fentanyl, but they're part of the safe supply program. If they are engaged in the program, and receive a supply of Dilaudid eights, that now acts as currency that they never had previously. Because they're prescribed a quantity of hydromorphone, they now are able to obtain fentanyl. They will trade or sell that medication to obtain fentanyl. That is one example of what is occurring.

Hon. Rob Moore: Thank you for that explanation.

In 2022, Bill C-5 passed. It eliminated mandatory jail time. I'm not speaking here about those who were addicted to any substance, but those involved in organized crime, those convicted of producing, importing or exporting schedule one drugs like fentanyl, meth, heroin and cocaine. The result of the elimination of mandatory jail time for those involved in this organized crime was that it made available the possibility of serving your sentence within the comfort of your own home on conditional or house arrest, rather than a period of incarceration.

Coupled with that, in 2019, Bill C-75 came into effect. It has been known as a catch-and-release system whereby judges have become increasingly likely.... It's all but a rubber stamp for someone charged with serious drug offences, including gang and gun offences, to be back out on the street to revictimize their fellow Canadians.

Can you speak a bit to the impact of the passage of that legislation and your organization's ability to disrupt the illicit drug trade?

The Chair: Please provide a very brief response.

Chief Thai Truong: As a chief of police, laws are very important. Specific laws that are created to ensure that this community is safe and laws pertaining to individuals involved in organized crime and the exploitation of individuals in our society are very important to me as a chief and to many police leaders.

There were a number of perspectives and objectives with Bill C-75, many of which were not fully mentioned. The application of the law is not for me to dictate. That is for the courts to dictate and apply.

The Chair: Thank you, Chief.

Thank you, Mr. Moore.

[*Translation*]

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

[*English*]

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Mr. Chair, and thank you to all our witnesses for joining us today.

Mr. and Mrs. Hedican, please accept my condolences on the death of your son, Ryan.

When you hear the Conservatives say that they will stop the safe supply and shut down the safe consumption sites, what are your reactions? Do you think it's important to have harm reduction services available for those struggling with addiction?

● (1200)

Mr. John Hedican: I'll be very quick.

I'm disgusted when I hear that. It's a gut punch. Deaths will only increase if that occurs, and policy that increases deaths is one hundred per cent wrong for so many reasons. It is disgusting. To have recovery, which is what they call for, as the be-all and end-all is a fantasy. They're in a fantasy world. There's a 92% chance that people will relapse. That's the be-all and end-all. When that happens, as I said, they have to go to organized crime.

Until we address the reality of toxic drugs being supplied by organized crime, you can have this meeting for years to come, the police chief can keep putting people in jail—there will always be people to put in jail—we'll just keep spending billions of tax dollars, and our kids will keep dying.

Ms. Jennifer Hedican: I wanted to thank you for your question.

I'm hearing people say that nobody is happy about organized crime supplying toxic drugs. You really have two choices. One is that you leave it in the hands of organized crime. They have been supplying the drugs forever. I could ask all of you and/or your parents the same thing: Did you ever use any illicit drugs as you were growing up? Did you ever try any of the things that were illicit? Yes? They were supplied by organized crime.

You really have two choices, Mr. Moore. You can leave it in the hands of organized criminals or you can regulate it and make sure that it's a safe supply so that people don't die from it. Then you will be able to talk about all the other things. Until then, you are wasting money and you are wasting lives.

Mrs. Élisabeth Brière: Thank you so much for your answer.

[*Translation*]

My next question is for you, Ms. Brière-Charest. If we had more time, I'd try to figure out if we're related, but I'm going to ask you another question instead.

During your opening remarks, you mentioned the importance of evaluating and analyzing the social determinants and aggravating factors. You also recommended clarifying the social determinants of health and the social and health inequalities specific to the use of psychoactive substances and the overdose crisis, taking into account provincial, regional and local distinctions.

Can you elaborate on that for us?

Ms. Kim Brière-Charest: Yes, the social determinants of health are closely linked to several aspects of the overdose crisis. For example, research is starting to show links to difficult socio-economic conditions. Housing is one thing that's hugely problematic across Canada right now, as you know. There are also links to poverty and mental and physical illness. These factors combine to exacerbate substance use problems.

Many factors are involved. In Quebec, the Comité Maison de chambres de Québec, a last bastion against homelessness for some, can no longer meet the need. Unfortunately, various social coexistence issues may have more to do with these social determinants than with drug use per se. That's on top of the shortage of spaces in places that house these people.

It's important to address all these aspects of the problem to get a comprehensive understanding of the crisis. Witnesses have said as much today. People's basic needs must be met, and there has to be access to treatment and follow-up, as well as ongoing research on that.

Mrs. Élisabeth Brière: You also mentioned that the social safety net has definitely helped mitigate the overdose crisis in Quebec. How would you characterize access to those community services?

● (1205)

Ms. Kim Brière-Charest: This is about access to essential services. Supervised consumption services in Canada reversed over 60,000 overdoses between January 2017 and August 2024. That's a big deal. Those lives probably would have been lost otherwise.

The government must ensure that the health care system and organizations can create spaces to respond immediately in an emergency. That's in addition to prevention, which needs to be enhanced across the country.

The Chair: Thank you very much, Mrs. Brière and Ms. Brière-Charest.

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

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

Ms. Brière-Charest, some people think that the harm reduction approach, specifically safe supply and supervised consumption sites, normalizes addiction to hard drugs and keeps people addicted.

What are your thoughts on that?

Ms. Kim Brière-Charest: The fact is, the people who deliver harm reduction services are there to support people who use drugs. They can refer them to treatment or detox centres. Users who want to cut back or stop using altogether build trust with the front-line workers they interact with on a daily basis.

This is a suite of services designed to ensure the health and safety of these people and to keep them alive, given the number of deaths we are currently seeing.

Our basic assumption is that people have been using drugs for millennia. There's also the human face to this, which Mr. and Ms. Hedican talked about. My condolences to them. Unfortunately, programs based on abstinence, whether they target drug use or sexual health, have shortcomings and are not effective. They can even have the opposite of the desired effect.

Mr. Luc Thériault: Do you think statements like that contribute to stigmatization?

Ms. Kim Brière-Charest: Absolutely. In fact, stigmatization has also been identified as one of the social determinants of health associated with the overdose crisis.

Stigmatization is also present in various health care establishments and institutions, and it leads to discrimination in access to care and treatment.

That's why we have to tackle judgment and prejudice not only in the general population, but also among health care professionals.

The Chair: Thank you, Mr. Thériault.

[*English*]

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

Mr. Gord Johns: I had a chance to visit London and go out with COAST, your community outreach and support team. I want to commend you on the work they're doing, the mental health collaboration work that you're doing on the ground.

You talked about evidence-based policies, and you support a medical health-based approach. The chief coroner and the chief medical health officers all say that people aren't dying from a safer supply of drugs. They're dying from fentanyl, and as Mr. Hedican talked about, it's a concoction of fentanyl, meth, cocaine and MDMA. That's what they're finding. Eighty per cent of the people who die show up with fentanyl in their bloodstream.

Do you agree that's what's killing people?

Chief Thai Truong: I would agree that it's the toxic drug supply that is killing people.

Mr. Gord Johns: Given that, today you're talking about safer supply of substances and the concerns around that. We've seen Alaska. Their death rate went up 45% last year. Baltimore's is about five times the death rate of what's going on in London, Ontario. The price of fentanyl has crashed. It's so cheap in those places.

Why can't they stop substance use and the death rate going up in those places? How can you compare that to what's going on in London?

Chief Thai Truong: That's a good question. I can't comment about those jurisdictions. I'm not aware of the criminality and the issues that are happening in those jurisdictions.

● (1210)

Mr. Gord Johns: We know that the war on drugs is a North American-wide issue, and that it's failed drug policy. That's clearly evident.

We heard from the B.C. Chiefs of Police. We heard from the deputy commissioner of the RCMP. They said that there is diversion of pharmaceuticals, that hydromorphone and safer supply is just a fraction of what they're finding on the street compared to fentanyl. They cited that toxic drugs are killing people. They advocated for more safe consumption sites, more safe supply, and, of course, scaling up treatment, recovery, prevention and education.

Do you not agree with their analysis?

Chief Thai Truong: As I've already stated, I am in full support of scaling up prevention, in full support of scaling up treatment and in full support of scaling up harm reduction. I'm also in full support of scaling up enforcement efforts.

This is a complex issue, as you know, sir. With respect to what is happening, I am focusing not specifically on the safe supply program. I am focusing on the criminality as a result of the diversion that is occurring, and it is impacting our community here in London.

The Chair: Thank you, Chief.

Next is Mr. Doherty.

Go ahead for five minutes, please.

Mr. Todd Doherty: Thank you, Chair.

I first want to thank our witnesses for being here.

Mr. and Mrs. Hedican, I know our condolences are little comfort to you, but please know that they come from.... I share your anger. I share your frustration as someone who has witnessed my brother on the street for far too long gripped in this crisis. I lost a brother-in-law to overdose.

While we may differ in our views, I can tell you that my frustration lies with the billions of dollars that have been spent, yet we still continue to lose people like my brother-in-law, your son and nephew. I just want you to know that I share your anger and frustration. I think that we should be doing this in a better way.

I will direct my questions to Chief Truong.

Chief Truong, British Columbia has walked back their decriminalization experiment. We had retired RCMP superintendent Wright here a couple of weeks ago. He said that the decriminalization experiment was the worst public policy decision in B.C.'s history when it comes to crime and disorder. Would you agree with that?

Would you agree that if London were to go forward with decriminalization, it would increase crime and disorder in your community?

Chief Thai Truong: Chair, through you, as the police chief of London, Ontario, I am not in support of the decriminalization of drugs in our community. I am in support of the discretion of our officers to have the ability to intervene when appropriate. I'm in support of working together with health professionals and social service agencies to address the root causes of crime, specifically, the consumption of drugs and opiates.

I will also tell you that, when we are talking about the proliferation of public consumption of dangerous drugs in the community, there's a balance that needs to be considered as a whole to the community and not just to that individual. You have to look at every individual case by itself through the lens of the social determinants of what is happening.

We cannot take away tools and the ability for police to intervene when appropriate. There are times when it is appropriate to address situations of open drug use that impact the safety and well-being of the collective community.

Mr. Todd Doherty: Thank you, Chief, for that answer.

In your view, in London and perhaps working with your colleagues across our country, would you say that we are powerless to stop illicit drugs from flowing through our borders and into our communities?

● (1215)

Chief Thai Truong: Sir, I missed that last word you used.

Mr. Todd Doherty: Are we powerless to stop illicit and deadly drugs such as fentanyl from flowing into our communities and our country?

Chief Thai Truong: Chair, through you, I don't think we are powerless. I think more needs to be done.

Mr. Todd Doherty: Would you say that police forces have the resources needed to make an impact?

Chief Thai Truong: I would say that, from an enforcement perspective, police services, particularly those that are experiencing a prevalence of organized crime occurring in their communities, require full support and more resources to address organized crime and the crime that is occurring in their communities.

It is not just enforcement. Police have to involve prevention as part of the response. Again, the pillars are prevention, treatment, harm reduction and enforcement. I'm in support of all of that.

Mr. Todd Doherty: In your opinion, for crime and disorder and what have you, in your community in London, which is what you're aware of, would safe supply be helping fuel fentanyl use, deaths and crime?

Chief Thai Truong: That is not a question where one single answer can be stated. As I've stated before, there's one issue of safe supply that is impacting the community that I am responsible for, and that is the diversion of safe supply.

The Chair: Thank you, Chief Truong.

Thank you, Mr. Doherty.

Next is Dr. Powlowski.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Dr. Vogel, I'm so glad you're here. I've been wanting to have somebody come and talk about the Swiss model for a long time.

I think what we're observing in this room today is a microcosm of the debate about safe supply, where we have the Hedicans passionately advocating for safe supply because it's a toxic drug supply that's killing people, and on the other hand, we have Chief Truong talking about diversion and the concern that diversion creates this very cheap supply of narcotics that may be the entry-level narcotics.

I've certainly heard this, for example, from B.C. psychiatrists who deal with the population on the streets. I asked them why kids start on Dilaudid, and they said, “Well, they're cheap.” The price went from $20 at one time, and after safe supply came in, it was one dollar, whereas a joint is five dollars on the street. What are you going to get, the joint or the Dilaudid?

You start on Dilaudid. No, Dilaudid doesn't kill you, but the problem with narcotics is you get used to them and you have to go to something stronger. That's what's happening, and the concern is people are selling the Dilaudid and then using fentanyl, and it's the fentanyl that kills people.

What's the answer to balance these? I think, in large part, it's what the Swiss do.

Dr. Vogel, do you agree that the whole basis of the Swiss model is observed treatment? For the vast majority of people who are on stronger drugs like heroin, they're not going to be okay with oral pills anyhow, so you give them an injectable, but they have to come in and take it there. The vast majority of the HAT program is observed treatment. Is that correct?

Dr. Marc Vogel: Yes and no.

Most people who enter heroin-assisted treatment will receive an injectable, which is a treatment under supervision, meaning they will have to come in two to five times a day to inject the pharmaceutical heroin. There is no take home at the beginning of the treatment, but this can actually change if the patient stabilizes enough in treatment after a certain period of time. We have relaxed regulations in the past years, so there is now take home for up to a week. We offer pharmaceutical heroin for injectable purposes but also as tablets.

Mr. Marcus Powlowski: I think, when we talked about this previously, you're quite careful, though, when you do it, because you are concerned about the possibility of diversion and you have to have a therapeutic relationship.

How long does the doctor have to be in a relationship with the patient before they start doing this?

Dr. Marc Vogel: The federal regulations for heroin-assisted treatment state that it has to be six months, but for oral opioids such as methadone or buprenorphine, there's no such period, so it's up to the discretion of the prescribing physician.

You're absolutely right. There's time to build up a relationship between nurses and doctors and the patients, and then, when the patient is sufficiently stable, we provide them with take home. At the start of treatment, it's always supervised.

Mr. Marcus Powlowski: Can you talk a bit about what happened as a result of starting heroin-assisted treatment in Switzerland? My understanding is that before this there were drug parks in—I don't know; was it Geneva or Bern? There was a big problem with the open consumption of drugs and needles in the park, the same kind of thing we're actually witnessing here.

My understanding is with the Swiss model you basically eliminated the drug parks and you greatly decreased the public consumption and use of drugs. Am I right?

● (1220)

Dr. Marc Vogel: You are completely right. There are no open drug scenes anymore. Last year, they really opened up because of crack cocaine, but this is a different issue.

In terms of heroin and opioids, we do not have an open drug scene. We have no public use, so this is not a problem. I think this is attributable to heroin-assisted treatment and the massive scale of heroin-assisted treatment that I hinted at in my opening statement.

The other thing is we also introduced other services such as supervised consumption services, housing and things like that. There are several measures, but I want to point out that with all of these measures, it's a complex issue. We heard that today and we have to come together.

One major part of it, as a physician, I think, is treatment.

The Chair: Thank you, Dr. Vogel.

Thank you, Dr. Powlowski.

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

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

I'd like to continue on the route that Dr. Powlowski was on. I think it's important to correct some misconceptions that we've heard here in this committee.

For instance, opioid agonist therapy and witness dosing, as Dr. Powlowski talked about, obviously is not the same thing as not having a therapeutic relationship with an individual who uses drugs and simply sending them home with 30 tablets of eight-milligram Dilaudid.

Dr. Vogel, I'll start with you, sir, if I may.

During your time in participation in the Swiss model, was that type of safe supply ever trialed in Switzerland, just giving patients eight-milligram tablets of Dilaudid in significant quantities?

Dr. Marc Vogel: No. As I pointed out, we have the possibility of treatment and we have the possibility of doing take home to patients that we, as physicians, deem stable enough, but I also have to point out that these take homes are actually what the majority of patients receive in Switzerland now. I want to also make clear that it's part of a treatment. It's part of regular and scheduled contacts with a physician, and it's not outside of treatment.

Mr. Stephen Ellis: Clearly, Dr. Vogel, these patients would have more than just a prescription or free and very potent opioids. They would have access to therapy, housing and other supports, as you mentioned previously.

Dr. Marc Vogel: I would say that it's a spectrum of therapy that is available, and on the very basic end of opioid agonist therapy is the provision of medication, but as I pointed out, I think a lot more has to be offered in this therapy, like you said, housing, but also psychiatric treatment, treatment of concurrent psychiatric disorders and other options.

I want to make clear. I know that you're a physician, right? You're a general physician.

Mr. Stephen Ellis: Yes.

Dr. Marc Vogel: A lot of the treatments here are done by general physicians, but those are the more stable patients. They have a long and ongoing relationship with their GP. That works fine. You can do take-home for most of them. It will work fine.

We also have specialized institutions that are responsible for, let's say, the patients with more problems, with the psychiatric problems and with comorbidities. We also have a large scale of these institutions that treat about 45% of patients. The rest are treated in GP practices.

● (1225)

Mr. Stephen Ellis: Thank you very much, Dr. Vogel.

I think it's important out there that Canadians understand that those treatment beds and those other supports do not exist in Canada. I think the other important point is, that, as I said, simply giving people who are actively struggling with addiction Dilaudid eight-milligram tablets—30 of those at a time—realistically amounts to palliative care: “Please go out and use those as you wish or sell them in a diversion manner.” We also know that that's not terribly helpful.

Certainly, the model you're talking about, in the parlance here in Canada historically with methadone, we would understand that people develop a therapeutic relationship with practitioners and then have that ability for, as we call it here, “carries” or take-home doses, when they become more stable in their addiction and have that therapeutic relationship.

I think one of the other things—and certainly I know you'll correct me if I'm wrong—is that fentanyl has not been a significant problem in Europe. Is that a true statement, Dr. Vogel?

Dr. Marc Vogel: I wouldn't say for all of Europe. There are countries where it's a problem.

In Switzerland, it hasn't been a problem yet. We have nitazenes just arriving on the scene, which are similarly potent to fentanyl or more potent. We will have to adjust our treatment.

This is what I pointed out in my last comment. I think that where there's no evidence, you have to collect evidence. This is something that the Swiss did as well. They did a large study on heroin-assisted treatment, which showed that it worked and was cost-effective.

This is probably something that we would do if the nitazenes arrive on a larger scale. It's that we would start treating with higher potency opioids like fentanyl, because we know that methadone is not a good medication for many patients, and patients need to be able to choose from a variety of available substances. Heroin—pharmaceutical heroin—is among them and it's very strong. You can inject it, but for patients with fentanyl use, maybe even this is not enough and we have to provide fentanyl for these patients in the context of a treatment.

The Chair: Thank you, Dr. Vogel.

Thank you, Dr. Ellis.

Next, we have Ms. Sidhu for five minutes.

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

Thank you to all of the witnesses.

I offer my sincere condolences to you, Mr. and Ms. Hedican, on the loss of your son.

My first question is for you.

Can you talk about the stigma around those struggling with addiction? What kinds of programs do you think could be run that are designed around awareness? Then, if someone has a problem, how can they use the pathway of harm reduction?

Mr. John Hedican: First, I'll say that, as long as the words “illegal” and “criminal” are tied to substance use and addiction, we will always have stigma. It can never be removed.

We need to start educating our kids better about the harms of substance use and to start acknowledging that the gateway drug, alcohol, opens that path. As a recovering alcoholic, I never would have tried cocaine if I hadn't been drunk out of my mind. All of my friends who did hard drugs were drunk first. However, we don't acknowledge alcohol as the gateway drug.

Go ahead, sweetie.

Ms. Jennifer Hedican: I wish I had written down the question.

Can you ask it again, please, Sonia?

Ms. Sonia Sidhu: It was about stigma. Also, how can we raise awareness before they use a drug? Do you think it should be done in the schools and maybe in social organizations? What needs to be done?

Ms. Jennifer Hedican: There are two things I'm very passionate about.

I believe there has not been enough research looking into neurobiological components and treatment methods. Research for addiction has been very low. As we said in our speech, the model for AA is based on “just don't use”. However, we would never say to anybody who has cancer or diabetes, “Just don't eat the sugar. Then you won't have a problem.” We look at all the different ways. I would say that research really needs to be improved.

We have shared Ryan's story in a PowerPoint with schools, nurses and all sorts of people so they understand it's not a choice. It's about educating people and reducing the stigma over consuming a substance. It does not mean you are a bad person. People who smoke cigarettes are addicted. Nicotine is highly addictive. Some treatment methods are medical, but nobody ever—now—shames people who smoke. If we can present it from a medical perspective with the neurobiological components of what's happening, and let people know that substance use is a normal thing that happens....

How do you have a healthy relationship with yourself? How do you acknowledge that your consumption of whatever you choose is not healthy, then understand where to go to get help? Our doctor was not able to provide help to Ryan when he needed it, so it's not just about educating users. It's also the education of people who provide support so they understand people don't choose to be addicted.

However, I also want to say that I feel the media portrays people who use substances as causing difficulties, since they are very visible right now when unhoused. That's not the math. That's not the vast majority of substance users. Those users cannot support the billion-dollar industry that organized crime has. There are so many other substance users, and we don't acknowledge that.

● (1230)

Ms. Sonia Sidhu: Thank you, Ms. Hedican. I'm sorry. I have to go to Chief Truong.

Chief Truong, you talked about collaboration among health services, social services and public safety as a pathway to care for individuals with substance dependence. You emphasized the need for resources to attract people to treatment.

How many arrests do the police make for public drug use?

Chief Thai Truong: Chair, through you, I can tell you that in our jurisdiction the charge of possession of a controlled substance for the last few years has whittled down to nearly a fraction of what previous years have seen. Although we haven't decriminalized the possession of controlled substances, specifically individuals using open spaces, by not engaging, not arresting and not engaging when appropriate, we have seen a de facto decriminalization of possession of a controlled substance.

We see the impact that is having in our community right now in London. If we don't address it, then we're causing some serious harm and it's impacting businesses, communities and the greater community as a whole.

Ma'am, you're citing comments that I've made in the community before our police service board and before city council. I will just reaffirm to you that we've listened to the community and it's about balance. We need to ensure that we have balance. When appropriate to do so, especially in the context of impacting the greater community as a whole, police officers have to have the ability to engage. We're looking at engaging in an effective way with our community.

The Chair: Thank you. We're well past time.

[*Translation*]

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

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

I have a question for Ms. Brière-Charest, but before I get to that, I'd like to pick up on something I just heard from Chief Truong that's bothering me.

Mr. Truong, you answered a question earlier about decriminalization. You're a law enforcement expert, so I'm assuming that you're not confusing legalization, decriminalization and diversion. However, you said that, when people use drugs in an inappropriate place, there's no municipal bylaw that allows you to intervene, because of decriminalization. However, decriminalization is only about simple possession. It means a person won't be taken to the police station and put through the judicial process. That doesn't stop you from enforcing the basic rules of order in your city.

Don't you have that power, contrary to what you just said?

● (1235)

[*English*]

Chief Thai Truong: Thank you for the question, sir.

Chair, through you, I missed some of that translation. I apologize, sir.

If I understand you correctly, what I actually said was that in Ontario and in London, it is still illegal to possess and use controlled substances in our community. However, by de facto, our police service has not been engaging individuals who are using in open spaces because we have taken a position of compassion. We've taken a position with the principles of the changes in the Controlled Drugs and Substances Act where officers are looking at alternatives to arrest.

[*Translation*]

Mr. Luc Thériault: I understand that, but I want to clarify one thing.

You're implementing a kind of diversion, but I don't understand why a police chief can't tell his officers that they have to intervene when someone breaks the basic rules of order in a city. It has nothing to do with diversion, decriminalization or compassion. It is strictly a matter of respect and decorum that everyone must exhibit in a public place. If I drink a bottle of champagne and smoke a pack of cigarettes outside the entrance to a hospital, the police or security services will intervene. It has nothing to do with the issue before us.

Why don't police officers intervene to enforce the basic rules of order when they see problems involving people struggling with addiction? You have that power. Why aren't you using it in cities?

[*English*]

The Chair: Can you give a brief response, please? He's well past time.

Chief Thai Truong: That's not what I'm saying, sir. What I'm saying is, as in previous years, our officers have not been engaging and they've been taking a compassionate approach. What I've stated publicly is that we've listened to the community.

It is still illegal to use controlled substances in public, and we are looking to enforce our position of arrest when appropriate.

The Chair: Thank you, Chief.

Next is Mr. Johns for two and a half minutes.

Mr. Gord Johns: I'm going back to Mr. and Mrs. Hedican.

Can you speak about your advocacy for evidence-informed policy approaches to the toxic drug crisis and what motivates you to speak out about this increasingly politicalized issue?

I'm going to add a second question here because I have only two and a half minutes. I'll give you time to respond.

Has witnessing the incremental approach that all levels of government have taken and the increasing politicization of the toxic drug crisis made your grief journey even more challenging?

Mr. John Hedican: That question gets bigger with each day because there isn't anybody here talking about the people who aren't addicted. There are kids who are dying. It's like they don't exist. It's the people who aren't ever going to go to recovery who are dying and don't exist to you. I don't understand how you can ignore these lives that are being lost in the thousands and will continue to be lost. It's like they don't exist to you.

You're failing in your responsibility to protect all Canadians. It's a gut punch every day to know there are five to seven in B.C. and 22 in our country. You're not dealing with the majority of them. You're not acknowledging it. It's a gut punch.

Our government is failing in its responsibility. We need to quit talking about atrocities in other countries because there's one in our goddamn country. There are 22 people who are going to die today, and the majority of them are not addicted. They're not talking about safe supply, and you're not acknowledging it.

Until we deal with the toxic drugs supplied by organized crime, you're failing in your responsibility to protect all Canadians. Do your jobs.

● (1240)

Ms. Jennifer Hedican: I don't know if this would be the time, but I actually wonder if Dr. Vogel had a toxic drug supply problem when they implemented their policies.

Mr. Gord Johns: Sure.

Dr. Marc Vogel: When we implemented our policies, there was illegal heroin sold on the streets, which was our toxic drug supply. We didn't have medication opioid toxic drug supplies like we do now, but it was in principle the same illegal heroin being sold.

There were young people getting addicted, having an overdose and dying, like Mr. Hedican rightly pointed out. We had that, and with the treatment and all of these harm reduction pillars that we offered, I think we had a medicalization of the problem as well. It was very well known also with Swiss kids and adolescents that if you start taking heroin, you'll end up in treatment. You'll have to go to the doctor, and it's very unattractive to go to the doctor.

The Chair: Thank you, Dr. Vogel.

Next is Mrs. Goodridge, please, for five minutes.

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

Chief Truong, you said what you've seen in London is that the so-called safe supply created a currency for people who were addicted so that they could sell it to get the drugs they were actually after. Would your job be easier if this so-called safe supply flooding the streets with potent opioids wasn't on the streets in London?

Chief Thai Truong: Again, I will state through the chair that I rely on the medical professionals and experts to provide their commentary on the efficacy of safe supply. What we are working toward with our community partners in London is making sure there is mitigation of diverted hydromorphone.

Mrs. Laila Goodridge: If fewer drugs were being diverted onto the streets in London, would it be easier or harder for you to do your job?

Chief Thai Truong: That's what we are aiming for, that there is no diversion of hydromorphone into the community.

Mrs. Laila Goodridge: You talked about there being a de facto decriminalization, because you guys were not engaging with people who were using drugs in open spaces. Has the London police now started to engage with people using drugs in open spaces?

Chief Thai Truong: Our police service is looking at a comprehensive strategy with community, with health professionals, with social services to look at a stronger initiative and strategy to deal with open drug use in the community.

In previous years, officers were looking and understanding that drug consumption is a health issue and a health concern. They were using their discretion accordingly. We have seen the results of that. We have seen and heard from the community, and we're seeing impacts on the community as a whole. We're looking at a different strategy to engage when appropriate.

Mrs. Laila Goodridge: I went to London—I was about seven months pregnant—back in April 2023. I was shocked by the amount of open drug use that was so visible in downtown London. In fact, I watched a drug deal happen in front of the CBC headquarters, which then told me that perhaps I wasn't in a safe part of London, just to find out that it probably had been safe nine years ago.

What have you guys changed from a policing standpoint or what barriers are in the way from a policing standpoint for you to deal with the open drug use in London?

● (1245)

Chief Thai Truong: Some of the challenges are that we understand drug addiction is a health problem and a health concern, and there are determinants that are creating this environment for people to be in this space—

Mrs. Laila Goodridge: Are you allowed to charge for simple possession of drugs?

Chief Thai Truong: Absolutely, we are.

Mrs. Laila Goodridge: Do you charge for simple possession of drugs?

Chief Thai Truong: This is what I've been saying. In the last few years, ma'am, our officers have dramatically reduced their enforcement efforts with possession, because we understand that it is a health problem. We are listening to the community. We are also abiding by the principles of the Controlled Drugs and Substances Act, making sure that, if we arrest, it is because there's a public risk.

Mrs. Laila Goodridge: I fully agree. It is a public health concern and needs to be dealt with as such.

Have you seen any increase in the amount of detox available in the city of London?

Chief Thai Truong: I have not.

Mrs. Laila Goodridge: Have you seen an increase in the amount of addiction treatment available in the city of London?

The government decided to roll out a dramatic new program, and you haven't seen any increase in detox. Have you at least seen some increase in treatment?

Chief Thai Truong: London, like many other municipalities, requires support and funding for treatment options.

Mrs. Laila Goodridge: Do you think the federal government failed in rolling out a radical new program and not providing any support for the medical side?

Chief Thai Truong: Again, I'm not going to answer that question.

Mrs. Laila Goodridge: That's fair enough.

There's no new detox, and there's no new treatment. If you were to arrest someone with simple possession for open drug use, what would happen?

Chief Thai Truong: Right now, if we were to arrest based on the circumstances, our officers have the availability to arrest, seize the drugs and release unconditionally.

The second option our officers have is to arrest and charge when appropriate, seize those drugs according to evidence and put those individuals or that individual before the courts.

We recognize that we only want to put them before the court when it is appropriate and, in some circumstances, it is necessary to put them before the courts. In some cases, putting them before the courts is an opportunity for them to receive care in that capacity. A lot of the times when our officers are engaging—we are looking at this right now—are there other options for community to be involved and engaged and to support that individual?

There are circumstances where our officers have to engage for public safety purposes, and circumstances will dictate either court or other avenues of care.

The Chair: Thank you, Chief Truong.

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

Mr. Brendan Hanley (Yukon, Lib.): I want to thank all the witnesses today for some really important testimony.

Dr. Vogel, I would like to start with you. I would guess that you're familiar with the 2008 NAOMI trial, which attempted to assess who would be the best candidates for heroin-assisted treatment in the Canadian context. Briefly, that study quoted that "long-term, chronic opioid injectors with severe health and social problems, and several previous addiction treatment attempts" would be among those candidates. It also pointed out that the participants are largely "polydrug users with cocaine being the second most popular drug of choice, after heroin."

That was in 2008, so times have changed, but I would venture that this remains, as I think you suggested, an underused treatment in Canada. It's a struggle to get funding and general support for this treatment as well as local production, as in the case of Fair Price Pharma in the Downtown Eastside.

Does this patient description match who is accessing treatment in Switzerland? What do you think we are missing in our approach, apart from perhaps a massive scale-up in this treatment?

Dr. Marc Vogel: That's pretty much the same kind of clients or patients we have here. The reason for this is that the Swiss did a trial on this. The inclusion criteria of the trial we did 30 years ago was basically replicated in every other trial and every other setting without ever asking whether or not this made sense.

There was one trial that looked at patients who did not fulfill the criteria—they had not failed previous treatments and they had not had methadone before—and it worked equally well. That was a German trial. So that works equally well.

There's no evidence for what I'm saying, but I'm absolutely sure that every patient with an opioid dependence has the possibility to benefit from heroin-assisted treatment, regardless of whether or not they failed treatments before.

● (1250)

Mr. Brendan Hanley: Thank you.

You did mention buprenorphine, or Suboxone, in passing in answering previous questions. I wonder if you could elaborate a little bit on where Suboxone is in your treatment regimen in the Swiss context.

Dr. Marc Vogel: Buprenorphine is available here. It's available not in combination with naloxone, because that was never prescribed and never used. It was taken from the market. We use it in approximately 10% of patients. The reason for this is that patients can choose from a variety of different substances. They will more often than not opt for a substance other than buprenorphine. Buprenorphine is a so-called partial agonist. It does not have the full effect. Most patients are not looking for this effect in their treatment.

They are not treated adequately, in my personal experience, with buprenorphine. If you look at the evidence, the randomized controlled trials say different, but this is not real-world evidence, I think.

Mr. Brendan Hanley: Thanks. That's very helpful.

Very briefly, with regard to inhalable heroin, you mentioned oral and injectable. Is there an inhalable agent that's available in Switzerland?

Dr. Marc Vogel: We're currently investigating nasal pharmaceutical heroin, which is atomized into the nose. We're doing that because we have people who do not inject but are severely addicted. We also want to offer a reduced-risk option for receiving pharmaceutical heroin.

There is inhalable heroin, so-called smokable heroin, in the Netherlands. It works fine. It's another option. As I said, you need to have a range of substances, but you also need to have a range of routes of administration in order for treatment to reach maximum efficacy.

Mr. Brendan Hanley: I have only a minute left, but to the Hedicans, I want to add my condolences for the loss of not just your son, Ryan, but also your nephew, Justin. I'd love to learn more about their lives and what their losses among thousands of others have meant for our families and our communities.

I'm not sure if you've seen some of the testimony from previous meetings where other parents with equally tragic losses have come with completely different views. When you hear aggrieved parents who share your anger, but who direct their testimony to a completely different place, how do you think we should treat this testimony as committee members?

Mr. John Hedican: We're not talking about the people who aren't addicted who are dying. I don't understand that. How do we save the people who aren't addicted, the first-time users? Nobody is asking that question, and I don't understand that. There hasn't been one question on that.

The only way to do it is to address the toxic supply of drugs. Shame on all of you for not asking that question. Kids, first-time recreational users, are dying, and you're not asking how we save them. You're talking about a small percentage of chronic users. Honestly, I'm disgusted. It's.... Sorry.

The Chair: Thank you, Mr. Hedican.

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

Mr. Stephen Ellis: Thanks very much, Chair.

I'd like to talk to you, Dr. Vogel, about what Mr. Hedican is maybe referring to. I think there may be another way to look at those so-called first-time users. Realistically, we haven't discussed prevention much in this committee.

In your experience in Switzerland, or perhaps in Europe in general, have you had any opportunity to look at that specifically?

Dr. Marc Vogel: Well, I'm not an expert on prevention. I'm an expert on treatment.

In Switzerland, we have very few young people initiating opioid use. We think part of it, and I tried to explain that before, is that the scale-up of treatment has made it very clear that it's quite dangerous to use opioids. There's a high risk you'll overdose, and you'll get addicted. There is also a high risk that you will end up in treatment.

I'm not sure whether that can be said for Canada with the treatment option I'm aware of, but in Switzerland, it's very clear. If you have an opioid addiction, you have to go into treatment. This is very unattractive. We are sure that this is part of what has been preventive. What has also been preventive is that, obviously, less opioids are being sold on the streets, because we provide more effective treatment than is done in other places.

● (1255)

I also think that most adolescents are aware of the dangers. They could probably get codeine, things like that, but it's harder to get, for example, pharmaceutical heroin on the streets. That's clear.

Mr. Stephen Ellis: I realize it's not your area of expertise, but are precursor drugs for the creation of things like fentanyl, etc., legal or illegal in Switzerland?

Dr. Marc Vogel: Most precursor drugs are illegalized once they pop up. That's the way. Once the system recognizes the substances, they are scheduled.

Mr. Stephen Ellis: Do you have any idea how long it takes to make precursor drugs illegal?

Dr. Marc Vogel: I do not.

Mr. Stephen Ellis: Thanks very much for that.

One of the interesting things, of course, is, as we talk a bit about the fact that in Switzerland, fentanyl is really not a so-called drug of choice, it does make the Canadian environment a little bit different. I think that bears repeating.

The other things that are incredibly important are that the scientific studies that have been done with respect to treatment are all really based on witness dosing, or at the minimum, opioid agonist therapy. Certainly, your idea that there are requirements for a multitude of different substances will help tailor treatment uniquely to the individual. Here in Canada, certainly methadone has fallen out of favour, although it's been used in treatment for a very long time.

As we look at, and as Mr. Hedican talked about, the NDP-Liberal government is failing at its job here having presented safe supply without any supports to go with it. It's a travesty. As we begin to potentially look to form the next government, we really need to look at other things in terms of prevention, resilience, continued disruption and quality rehab. Those kinds of things, coupled obviously with housing, are what Canadians need to wrap their minds around in looking at how we can make the system better in Canada.

Dr. Vogel, do you have any final words on how we might improve things here in Canada? If you're not familiar enough with the system here to comment on that, that's fine.

Dr. Marc Vogel: I heard a lot about witness dosing, and yes, witness dosing has its place. However, I also want to point out that it's very hard to keep up a life, manage a family and keep a job if you have to appear at the treatment centre two to five times a day, 6,000 times a year. I want to point out that take homes are very important. The majority of patients here receive take homes. It's actually quite a liberal treatment.

I would advise Canada to abolish unnecessary rules and regulations, and put more responsibilities in the hands of physicians and people who use.

The Chair: Thank you, Dr. Vogel.

We'll go to the Liberals next.

Ms. Kayabaga, go ahead, please.

Ms. Arielle Kayabaga: Thank you, Chair.

I'm going to go straight to the chief.

This is based on some of the questions that you've received in our committee, as well as the comment that you made around not being able to arrest our way through the crisis, and the context of our community, the city of London, which has experienced many of these overdoses over the last decade, even in places like the jails.

I'm curious to know, if we were to remove the current crisis of toxic drug use from the streets today, do you think there would be other drugs that would pop up on the streets?

● (1300)

Chief Thai Truong: Thank you for that question.

Chair, through you, yes, I do. With organized crime, it's about profit. It's about exploiting individuals for gain and profit. There's no question that there would be additional drugs and that the war on drugs would continue.

Ms. Arielle Kayabaga: I heard you say that you are willing to continue to collaborate with the services that are available in London.

Chief Thai Truong: That is correct. They're very important.

Ms. Arielle Kayabaga: Chair, I just want to put this on the record as well. Someone mentioned earlier that the beds are a federal responsibility. They're not. I just want to make sure people know that it's a provincial responsibility.

I'll give my time to Mr. Powlowski.

The Chair: Dr. Powlowski, please go ahead.

Mr. Marcus Powlowski: Appropriately, given Mr. Hedican's remarks, I'm going to go where he wants to go, which is the casual user. We haven't been addressing that. Yes, we're talking about long-term addicts, but how about the very many people—which sounds like your son—who use on and off? You also hear stories about one pill and a kid or someone like a hockey player. There's one pill and they die.

I think that's really hard to deal with and to find a solution for. I think it has to be one of our reports, but....

What you're seemingly suggesting, Mr. Hedican, is legalizing safe supply. You go and buy your booze and you buy some narcotics there, too, but it would have to be cheap enough. With marijuana, there's still a black market for marijuana because it's cheaper on the street than it is in the marijuana stores. Similarly, with narcotics, there would be a black market, so you'd have to make it cheap. Then wouldn't you run the risk of people, like my kids, who are going to buy beer, so maybe they'll buy some narcotics, then they get addicted to the narcotics and it's created a bigger social problem with this large population of addicted people?

I don't know. I mean, if you have suggestions, this is a really important topic, so I give you the floor and probably the last few minutes.

Mr. John Hedican: One hundred per cent that's reality. We don't have a choice whether we want drugs in our community. The only choice we have is who controls it, government or organized crime.

Yes, someone may try another substance because it's for sale next door to the liquor store. It's the gateway drug that we put on every corner. People are always going to try drugs and the vast majority is after they've drank. That's just reality and we're not addressing reality.

The reality is that as long as we have alcohol—and people use substances and alcohol for different reasons—people are going to try drugs. I'm repeating myself. It's either organized crime or government.

We can see today—we have over 80 years of evidence—how it's working out with organized crime. It's never going to change.

Mr. Marcus Powlowski: I agree with you. I have sons. They go to parties and there's alcohol. I always tell them that if there's drinking and people have drugs, just leave, because after a few drinks, you're going to be tempted to do it.

Do you have any other suggestions with that combination?

Yes, I think a lot of times people first try it when they're drinking. They say, “Everyone is taking it, so I'm going to take it.” The next thing you know, they're overdosing.

Mr. John Hedican: And they die.

Mr. Marcus Powlowski: How do we educate kids about drinking and drugs?

Mr. John Hedican: + As I said earlier, it has to start at a young age. It has to start in elementary school. It has to be on a regular basis. It has to be by, I believe, people like myself, people with lived experience. We put alcohol in shiny stores. We have commercials, and we glorify it. We've normalized it, but we have to acknowledge that it is the danger drug, 100%.

● (1305)

Ms. Jennifer Hedican: There are more people with alcohol problems than there are with cancer according to the U.S. Surgeon General. One of the things I'll go back to is the question of what we need to do. We need to talk about realities.

In 2016, when Ryan was waiting to get into the Last Door, we needed to find him heroin until he could be able to detox. There were about 43 drug houses in our community that the police had said.... You don't see it, so you think it's not there. Because it's there doesn't mean you have to use it. It is already there. It's in all of your neighbourhoods. It's not in just what you think of as a drug house. It goes all the way through society.

That's where my heart started. I didn't want any of my children to use substances, ever. That's not reality. Even the stigma of, “I saw a drug deal,” how about, “I saw somebody get what they need.” There's no stigma, move on. Rather than, “I saw two people holding hands who were the same sex,” move on. Educate yourselves.

The Chair: Thank you, Ms. Hedican.

We're at the appointed hour. Mr. Johns has asked for one final question, so I'd like to extend that courtesy to Mr. Thériault and Mr. Johns, and then we'll seek a motion for adjournment.

[*Translation*]

Mr. Thériault, you have the floor for a question.

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

Ms. Brière-Charest, can you tell us about the concept of a continuum of addiction services and why that's important?

Ms. Kim Brière-Charest: Yes, I'd be happy to.

In Quebec, the addiction services network is well established. I would even say that a consensus is emerging among all the people and organizations working on the front lines, as well as in terms of prevention, research and treatment. The general idea is to focus on making a range of resources available.

I want to build on the comments about harm reduction services and give you a personal example. The last time I dealt with an overdose, the person was not addicted to opiates, but still needed three doses of naloxone. The individual was informed of the risks, but still needed our support, without which they would probably have died in the middle of the night in an alley.

Maintaining all these services for all these at-risk people is therefore essential. We also need to radically increase prevention measures alongside those interventions.

The Chair: Thank you, Mr. Thériault and Ms. Brière-Charest.

[*English*]

The last question goes to Mr. Johns, please.

Mr. Gord Johns: Mr. Vogel, the Hedicans spoke about their son losing his life when he relapsed after eight months of sobriety. We know that for people who have substance use disorder, it's a relapsing and recurring disorder.

In Switzerland, how do you ensure that people get drug replacement therapy and...what substances they get when they do relapse, when they decide they're going to use? I know you're not going to be able to answer about first-time users because you're an addictions doctor, but could you speak to that and maybe provide some advice to us on what we're dealing with in Canada and how to respond?

Dr. Marc Vogel: I didn't get the first part of the question because it was cut off, but if someone relapses or uses in general, we would try to react. We would try to offer treatment, first of all. We know that abstinence-based treatment is not working for 95% of the people, so opioid agonist therapy is the best we have right now, and we would offer that.

If people relapse on opioid agonist therapy, I would offer them an improvement in therapy. I would try to offer dose increases. I would try to offer a different substance or a different route of administration. If I notice that a patient relapsed, for example, on methadone or buprenorphine again and again, I will offer, for example, heroin-assisted treatment as a more intensive and better treatment offer than I had tried before. I will also see that what I have been offering right now is still failing the patient and that I have to improve, and together with the patient, we will find something that is acceptable and works.

The Chair: Thank you, Dr. Vogel and Mr. Johns.

Thank you to all of our witnesses for being with us today. The variety of lived experience and expertise has made for an exceptionally interesting meeting. That testimony will be extremely valuable to us in our report back to the House.

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

Some hon. members: Agreed.

The Chair: We're adjourned.