Legislative Assembly of Alberta

The 30th Legislature
Third Session

Select Special Committee to Examine Safe Supply

Stakeholder Presentations

Friday, March 25, 2022
9 a.m.

Transcript No. 30-3-1

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Transcript produced by *Alberta Hansard*

Select Special Committee to Examine Safe Supply

Participants

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9 a.m. Friday, March 25, 2022

[Mr. Jeremy Nixon in the chair]

The Chair: All right. Well, I'd like to call this meeting to order. Perfect. Okay. Thank you.

Hon. members, at the committee's January 18, 2022, meeting the committee agreed that at the beginning of each meeting we would observe a moment of silent reflection and commemorate the lives lost in Alberta due to drug poisoning, overdoses, and the illness of addiction, so we will do that now.

Okay. Thank you.

Welcome to members and staff in attendance at this meeting of the Select Special Committee to Examine Safe Supply. My name is Jeremy Nixon, and I am the MLA for Calgary-Klein and the chair of this committee. I'd ask members and those joining the committee at the table to introduce themselves for the record, starting to my right with our deputy chair.

Mrs. Allard: Good morning. Tracy Allard, MLA for Grande Prairie and deputy chair of the committee.

Mr. Yao: Tany Yao, Fort McMurray-Wood Buffalo.

Mr. Milliken: Nicholas Milliken, MLA, Calgary-Currie.

Mr. Roth: Good morning. Aaron Roth, committee clerk.

The Chair: All right. Now I'd like for those joining us online to introduce themselves. I see MLA Rosin. Ms Rosin, can you introduce yourself for the record?

Ms Rosin: Sorry. I was on mute. This is Miranda Rosin, MLA, Banff-Kananaskis.

The Chair: Thank you.

Ms Rosin: Is my connection funny?

The Chair: Nope. Well, it seems fine to us here.

All right. I see MLA Amery. Can you introduce yourself for the record? You are muted if you're trying to talk MLA Amery.

All right. We will just keep going, then. I'd like to note for the record the following substitutions: none. Well, that's amazing. Great work. Please note that the microphones are operated by *Hansard* staff, and committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV. The audio- and videostream and transcripts of the meeting can be accessed via the Legislative Assembly website. Those participating by videoconference are encouraged to please turn on your camera while you are speaking and mute your microphone when you are not speaking. Members participating virtually who wish to be placed on the speakers list are asked to e-mail or send a message in the group chat to the committee clerk, and members in the room are asked to please signal the chair. Please let your cellphones and other devices be set to silent for the duration of our meeting.

We will move on to the approval of the agenda. Can I get a motion to approve the agenda? Excellent. MLA Yao moves that the agenda for the March 25, 2022, meeting of the Select Special Committee to Examine Safe Supply be adopted as distributed. Any discussion about that?

Hearing and seeing none, all in favour, please say aye. Any online in favour, please say aye. Any opposed, please say no. Okay. From now on I'll just ask that question collectively, so if you're online, say aye when I ask it or when I ask the people in person here. Now I'll move on to approval of – sorry. That was carried. Thank you. It's Friday morning.

Up next is the approval of the minutes for the three previous meetings, February 15, 16, and 17, 2022. Are there any errors or omissions to note in relation to the minutes of February 15, 2022?

All right. If not, would there be a member willing to move the approval of the minutes? Excellent. MLA Milliken moves that the minutes for the February 15, 2022, meeting of the Select Special Committee to Examine Safe Supply be adopted as distributed. All in favour, please say aye. Excellent. Any opposed? This motion is carried. Thank you.

Are there any errors or omissions to note in relation to the minutes of February 16, 2022?

All right. Seeing none, would a member move the approval of the minutes? Excellent. MLA Yao moves that the minutes of the February 16, 2022, meeting of the Select Special Committee to Examine Safe Supply be adopted as distributed. All in favour, please say aye. Excellent. Any opposed, please say no. That motion is carried.

Are there any errors or omissions to note in relation to the minutes for February 17, 2022?

Hearing none, would a member move the approval of the minutes? Excellent. MLA Yao moves that the minutes for the February 17, 2022, meeting of the Select Special Committee to Examine Safe Supply be adopted as distributed. Thank you, MLA Yao. All in favour, please say aye. Any opposed, please say no. That motion is carried.

Okay. Now we get to go on to the good part, oral presentations. Hon. members, at our February 17, 2022, meeting the committee agreed to invite additional stakeholder presentations in relation to the matters referred to us by the Legislative Assembly. Our first presenter today is Dr. João Goulão – I apologize if I got that wrong – the drugs and alcohol national co-ordinator in Portugal and director general of the Intervention on Addictive Behaviours and Dependencies General-Directorate. Dr. Goulão, thank you so much for your time today and for joining us. Please proceed with your presentation.

João Goulão

Dr. Goulão: Hello. Good morning. Good morning to all. Thank you, Mr. Chair, for this timely presentation. I am very happy to join you in this discussion even if I am not an expert on safe supply, because we do not have the experience. Anyway, in Portugal we faced a similar situation to the one you are now dealing with, with a huge number of overdoses there. It's a huge problem connected mostly to heroin some two decades ago. I would like to share with you some views about how we dealt with those problems and make myself available for any queries that you might have.

If you'll allow me, I will share my screen to share a presentation. Okay. It's there.

As I said, we faced a catastrophic situation back in the '80s and the '90s in Portugal, mostly connected to heroin. What I want to share with you is the way that we dealt with those problems. By the end of the '90s drugs and drug addiction were the main concern of the Portuguese population. We had 1 per cent at least of the population affected by drug problems. That means 100,000 problematic users, 98 per cent of which were heroin users, 48 per cent of them using the IV route. They contributed almost 56 per cent of the new HIV infections that happened in the country. We had around 350 overdose deaths a year.

The response that was organized by our state was a new strategy that was approved in '99, a new paradigm, the Law 30/2000, the law of decriminalization, probably the most known aspect of our

policy. The creation of national co-ordination: national co-ordination means co-ordination between different ministries that have something to do with the drug problem, the creation of a national network of strategies for intervention, building what we call the integrated model, building very close co-operation between the several components of the responses.

9:10

The first Portuguese national strategy had two components, two main components, the supply reduction part and the demand reduction, both based on the principles of humanism and pragmatism. The traditional components of the demand reduction: site work, harm reduction, treatment, prevention, social reintegration. But on top of these, assuming that we were dealing with a health and social condition rather than a criminal one, the proposal was in the sense of decriminalization of every drug. We called this, the bridge between the supply and demand side, the integrated approach. Evaluation is a crucial part of all the systems.

Starting with the dissuasion model, the subject of decriminalization, I would like to say that the Law 30/2000, the law of decriminalization, only changed one article of the drugs law of '93, a law that still stands, mostly, and the article that was changed is the one that refers to personal use and possession for use. It says, "The consumption, acquisition, and possession for own consumption of plants, substances, or preparations . . . constitute an administrative offence." Possession cannot exceed the quantity previewed for individual use for a 10-day period. Exceeding this quantity, criminal procedures take place. This means that the drug user is considered a person in need of health and social care. This dissuasion intervention provides an opportunity for an early, specific, and integrated interface with the users. We consider it as an indicate prevention tool, and it is aimed and targeted to the drug user's characteristics and individual needs.

It's important to stress that in Portugal the use of drugs is still forbidden. However, unlike models from other countries where drug courts were created with streamlined procedures under the ministry of justice, the commissions for the dissuasion of drug addiction privilege the health approach. They are bodies under the custody of the Ministry of Health.

Of course, it only works if co-ordination between services is present, all services who may have any kind of responsibilities in this area, from employment and training services, addiction treatment centres, health centres, welfare services, prisons, and so on, schools, police authorities. There's a network that is needed to make this system work.

As I said, using drugs is still forbidden, and there is a long list of administrative sanctions that might be applied to people who use drugs or people caught in possession of drugs. However, it never happens, to have a criminal record, which has clear benefits in the stigma and allowing people to recover normal life. A criminal record is usually something that impedes people to access credit, to get a job. There are a lot of difficulties that occur as a consequence of having a criminal record. As this list is a long one with many possibilities of administrative sanctions, it is possible to define sanctions according with the personal lifestyle and conditions. I would like to note that a monetary fee is never applied to addictive persons.

Just briefly, I would like to show some outputs of this system. From 2001 to 2020 we had around 150,000 offenders, from which 82,000 were assessed as nonproblematic drug users, occasional recreational users, even though after the interaction with the health professionals it was possible to refer most of them, 44,000, for specialized support such as health support for other subjects or for social or psychological support in any case. From the 15,000 problematic drug users that were assessed, 12,000 were accepted to be referred to treatment centres, treatment teams, and almost 10,000 actually initiated treatment in the centres starting to various responses. So it's a supplementary gateway for the system of treatment or to indicate prevention related to substances.

In the beginning, when this law was approved, we faced some difficulties with the United Nations bodies, and it took some years until it was recognized that it was a good move. However, in 2016 at the UNGASS in New York the president of the International Narcotics Control Board, the guardian of the treaties, stated that the Portuguese approach is a model of best practices fully committed to the principles of the drug control conventions, putting health and welfare in the centre, applying a balanced, comprehensive, and integrated approach, and based on the principle of proportionality and respect for human rights. Since then we feel much more comfortable with our approach, and somehow we opened the space for other countries to follow the same view if they wish.

Our policy is based upon five pillars: dissuasion – and they anchor all the others – prevention, harm reduction, reintegration, and treatment. We have a quite solid public network of services for treatment that is complemented by regulated NGO and private responses. We have a high range of different models for intervention. They are complementary, and they allow a choice between the models to be followed or to be addressed by the clients and by the professionals.

Along with this, we developed a set of strategies and programs in terms of harm reduction, from low-threshold methadone administration to opioid substitution therapy and other dependent treatments, naloxone distribution, needle and syringe exchange programs, counselling, diagnosis, and referral to treatment of their addiction and of other physical diseases, information, education, and communication on the street level. We're using peer education, the party scene, for instance. Recently we started the installation of safer use sites. We develop policies inside detention settings, prisons or youngsters' detention sites, and we are developing recently, as well, policy related to drug-checking to assess what actually circulates on the street.

9:20

I would like to take this opportunity to share with you some – well, those are some of the structures: street teams, refuges/shelters, contact information points, drop-in centres, mobile outreach teams for the prevention of infectious diseases, cabinet sort of psychosocial support, and, as I said, supervised drug consumption sites.

With this, we have some important results that I would like to briefly share with you. One of them relates to the evolution of HIV infection that was really catastrophic in the mid-90s. This is the line of new HIV infections amongst people who use drugs. Since 2003-2004 it dropped under the level of new infections amongst heterosexuals or homo- or bisexuals. Nowadays it's the contagion that is less represented in the new HIV infections in our country.

On the other side we have – as I said, by the late '90s we used to have around 350 overdose deaths a year. Now there isn't a year in this graph – we have since 2013: 2013, 22 overdoses; 2014, 33; 2019, 63. There is an increase in the last years. We are trying to work on it, but in any case we have the lowest number of overdose deaths among the European countries.

To new users that seek treatment in the ambulatory public network, it evolved a lot like this. In 2011 we had 51 per cent of heroin users. It dropped to 16 per cent in 2019. Cocaine has been more or less stable from 15 per cent in 2019 to 26 per cent. There's a slow increase in figures of cocaine. Nowadays the last highest number of new treatment commenced relates to cannabis users. As you can see, new psychoactive substances of all the others

demanding very low levels, around 5 per cent of new treatment commenced.

Comparing that with the situation in 1998, as I said, we had 1 per cent of the population affected by drug problems. Nowadays we estimate that we may have .33 per cent of the population. From the 100,000 problematic users we estimate we might have 33,000 problematic users nowadays. From the heroin users, 98 per cent in '98, we estimate that nowadays we have 16 per cent of all the users using heroin. From the 48 per cent using the IV route, nowadays we have 2 per cent of people injecting drugs. From the new HIV infections, from 56 per cent, we're down to 3 per cent amongst drug users, and from the . . .

The Chair: Sorry, Doctor. Sorry. That concluded our time, but I see that you just have a couple of more slides, so I think we all agree we'd like to see you finish. Thank you. Sorry to interrupt.

Dr. Goulão: Sorry, Chair. Just to finish, next steps: we are just in the process of approving a new strategic plan. We will have next week a new government, and we already presented a new plan that is based on three pillars: protect, care, and empower. Discussions on legalizing regulated cannabis for nonmedical purposes are already on the table. The issue that relates to safe supply has something to do with: what about the other substances and regulating of other substances?

Thank you, Chair.

The Chair: No, thank you so much, Doctor, for that presentation and taking the time with us today to jump across the Atlantic and spend some time with us today. We really do appreciate that.

We're going to dive into questions and answers with the members here, but before we do that, if MLA Stephan can introduce himself for the record.

Mr. Stephan: Hi there. MLA Jason Stephan, Red Deer-South. Thanks for your presentation.

Dr. Goulão: Thank you.

The Chair: Excellent. Thank you, MLA Stephan.

We have MLA Amery up with the first question.

Mr. Amery: Hello, Dr. Goulão, and thank you very much for your presentation. I wanted to wish you a good morning, but I know that it's probably the afternoon where you are. I appreciate you spending the time and presenting to us about this model in Portugal, which is sort of the gold standard, I think, when it comes to the type of discussion that we're having here this morning, the types of information that we're looking to extrapolate from this committee, from the presenters.

Doctor, I want to talk a little bit about the process of change when it came to Portugal's decision to move with this model to deal with contemporary addiction and drug issues. I know that the system that you described in your presentation, from what we heard in our other presentations, involves or incorporates a number of different agencies and organizations that are all working together to try to accomplish a common goal, and that is to deal with the contemporary addiction and drug issues that all nations, essentially, face. I also know, from the description that you provided to us, that this system includes co-operation between the judicial system, police organizations, and health care systems and whatnot to help work together and try to focus on the common goals that you described in your presentation with respect to the five pillars.

I'm wondering if you can help us with a question that I have, and that is really with respect to police involvement, police enforcement. I want to know if you can describe to our committee what role the police have in the Portuguese system, I guess. What sort of involvement, what sort of integration do the police have with respect to the model?

Dr. Goulão: Thank you, sir, for your question. The police authorities are key in dealing with people who use drugs. We articulate very closely with them our strategy in trying to bring to the presence of the commission for the dissuasion of drug addiction the target groups that we choose together, and their activity is key to providing the health system the opportunity to interact directly with those people who use drugs. They have a quite friendly, I would say, attitude, but in any case there is still – as I said, using drugs in Portugal is still forbidden – enforcement without being in any way violent, respecting the rights of the people. They address and give us the opportunity to interact with those drug users and to better identify the needs that they might have either in terms of treatment or other kinds of interventions such as social support or others. It's important to say that in our model the co-ordination bodies are key. The responsibility for drug policies in Portugal stands on the Minister for Health, and on his behalf there is a national co-ordinator on the case, the general director of SICAD. They work closely with personal representatives of 11 ministers on an almost daily basis so we can establish and define priorities together.

9:30

The Chair: Next up we have MLA Milliken.

Mr. Milliken: Thank you very much, Chair and Dr. Goulão. I think I'm actually going to build a little bit off what MLA Amery mentioned. He sort of got into it a little bit with regard to police and the idea of illegality of drugs in Portugal and decriminalization. I just want to be clear that when I talk to people here in Canada and we talk about Portugal and decriminalization, a lot of people just assume that it means that people in Portugal are essentially free to use personal use drugs. A lot of people just take that as sort of what it means. I think that it's fair to say that, clearly, in Portugal drugs are illegal and prohibited. Again, the word that I think they used was "forbidden." So given that, that means that if a police officer does catch somebody who is in possession of drugs, no matter the amount, that individual can be arrested and brought to the police station. Is that correct? Yes?

Dr. Goulão: Yes.

Mr. Milliken: Thank you, sir. Can you then do me a favour and describe the process of what happens to that individual as they then go to the police station? What's the process once they go through those doors?

Dr. Goulão: Okay. Thank you. Well, the person who's caught by the police authorities using drugs or in possession of drugs is conducted to the police station, where the substance or substances are apprehended. They are weighed by the officials, and if the amount is superior to the one that is calculated on the basis of personal use for 10 days – there's a table with different amounts for different substances – if the person has more than that, he undergoes criminal procedures, as before. He is sent for the criminal justice system, as before. It's up to the trial of the judicial system to produce evidence that he or she is trafficking or dealing drugs in any way.

But if the person has less than that amount of substances, it's just intimated by the police. It just gets a piece of paper intimating the person to present at the commission for the dissuasion of drug addiction, which is an administrative body under the Ministry of Health. They must present with three days' delay. At the same time the police officer sends a copy of that intimation to the commission so that the commission already knows that the citizen is going to show up. If he doesn't, there's a communication to the police authorities again saying, "Oh, this person did not appear at the commission." This is the process to come there.

The Chair: Did you have a follow-up?

Mr. Milliken: No. I have an unrelated question, so maybe I'll just . . .

The Chair: Okay. Next up we have MLA Stephan.

Mr. Stephan: Great. So I just want to learn a little bit more about the commission for the dissuasion of drug addiction. We don't have anything like that here in Canada. I understand that under Portugal's system – just correct me if I'm wrong – if you're arrested for possession of drugs but you possess an amount that is low that would be for personal use, as you've described, then they are required to attend this commission. Is that correct?

Dr. Goulão: Yes. Yes, it is.

Mr. Stephan: Okay. And just a quick question: is this commission unique to any other jurisdiction that you're aware of?

Dr. Goulão: No. Those commissions: we have one of those bodies in each district capital. We have 18 in Portugal. That includes one in Azores and another in Madeira. Those commissions were created specifically for this endeavour. They are composed of three members. They act under the Ministry of Health. Those three members are typically a jurist, someone who knows about laws, a psychologist, and a social worker. They have a team of support, a technical team, that interviews, collects a history of consumption, a social and family history. They may use some diagnostic tools in order to score if there is an addiction or just an occasional recreational use of substances. They produce a report that is presented to the members of the commission. That interview is initiated.

This is quite a destressed environment, I'd say. It's not a court. It's not a formal audition, I would say. The main goal for that audition is to identify: what kind of needs does this person have? Is he or she addicted and in need of treatment? It is discussed: "Would you like to undergo a treatment? Have you ever tried to approach a treatment facility?" "Yes, I thought about that, but it's so difficult, so complicated." "You think so? Would you like to start tomorrow? We can have a phone call and have an appointment for you tomorrow or the day after tomorrow." And I would say that most of them accept to have that appointment. I'm not saying that they are going to be successful the first time, but at least they have a face, they know they have a referral that is active, and from now on it's easier to undergo and search for treatment if they need it.

Mr. Stephan: That sounds excellent. Thanks.

Dr. Goulão: The vast majority of people we've presented to those commissions are not addicted people; they're just occasional recreational users. But even then the commission tries to identify any kinds of factors that, along with drug use, may be present in the citizens' lives and may benefit from some kind of supports, some kind of help, either from the social or health services to which he or she might be referred at this point. This is the same mechanism, I'd say. "Okay; I have no problem with drugs. I smoke a joint with my friends on weekends. But in any case, my parents are divorcing. My father just lost his job. Myself, I am facing some psychological difficulties. I am unbalanced with my gender choices or whatever." And, I mean: "Would you like to discuss it with a psychologist? Would you like to have an appointment with a social worker that may help your family?" So the aim is to interrupt a career that may lead to more problematic use later on.

The Chair: Perfect. Thank you for that response.

Next up we have MLA Allard.

Mrs. Allard: Yes. Thank you, Chair, and thank you, Dr. Goulão. Your last comments were the perfect segue into where my head was going. In your presentation you had a slide that had about 150,000, maybe 148,000, people, and of that 148,000 just over 82,000 were identified to be nonproblematic users and about 15,000 problematic. I'm just curious, especially given your last comment: is there a statistic showing how many of the nonproblematic are repeat, back into the commission? And is there a trend to become problematic over time?

9:40

Dr. Goulão: Thank you for your question. Yes, there are statistics. I don't know them by heart, but most of the nonproblematic drug users come back in the next year at least, and in the second time they appear at the commission, the use of administrative sanctions may start.

Mrs. Allard: That's helpful. That's helpful.

That leads me to my next question. I wanted to know – you explained the general process of the commission. What I wanted to know is: can you describe for our committee today the type of sanctions that can be rendered if a person refuses to participate in the commission process?

Dr. Goulão: Well, the person may refuse, may not appear at the commission as scheduled. In that case, the commission refers the absence of the person to the police authorities, again, and they may prosecute the person for disobedience. It is not for drug use but for disobeying an order, so they may incur other kinds of penalties not related to and not applied by the commission.

Mrs. Allard: Thank you.

The Chair: Next we have MLA Yao.

Mr. Yao: Thank you so much, Chair. Dr. Goulão, thank you so much for taking the time to speak with us. We greatly appreciate your time, experience, and expertise in this matter. My question to you, sir, is – we know that Portugal built a significant recovery-oriented system of care for people with addiction so that they can stop using drugs and begin to heal. Portugal's system includes therapeutic communities, opioid agonist therapy, and other forms of counselling and treatment. In your opinion, would the Portuguese model work without this commitment to a recovery-oriented system of care? As an example, in British Columbia they seem to just offer the prescriptions and the opioids but not necessarily hold the people accountable when they accept these drugs.

Dr. Goulão: No. I would say that one of the main characteristics of our system is the broad range of options that are offered to people who use drugs and to their therapists as well. We have a wide range of models of therapeutic communities, for instance, that work under different models, and we have the capacity to address the person

according to the main difficulties that he or she faces in their lives. We are dealing with a chronic, relapsing disease, so it's possible that the first attempt, the first system to be used is not the most adequate for that person, so we have the opportunity, if things don't work on the first attempt, to try again. We never give up on that person in any case.

Mr. Yao: Thank you. Just to clarify, in your opinion, if Portugal were to have simply decriminalized drugs without having the recovery-oriented system of care that Portugal provides, do you think your nation's strategy in combatting opioid use would be as successful as it is today?

Dr. Goulão: No, sir. I don't believe we would have the success. Success comes exactly because of this integrated set of responses. Decriminalization has had its virtues. The most important, in my view, is turning everything much more coherent with the idea that we are dealing with a health condition rather than a criminal one. That's why decriminalization is important, and also the practical way that we have put it in place allows us to consider those commissions I described as a tool for prevention, for indicating prevention. But it's important to have the referral network to which we can refer people and that easily can find responses if they wish to treat themselves or to rebalance their lives by means of harm reduction facilities, for instance.

The Chair: Excellent.

Ms Rosin: Thank you so much, Doctor, for joining us today. Technology is amazing. You're over in Portugal, and we are all here in real time. I'm so grateful that we were able to connect because Portugal is a world-renowned success story.

The one question that I do have will sort of go along the same avenue that Member Yao was on. I'm just wondering if you or your government has any data anywhere or if you're aware of any data to suggest that decriminalization of drugs on its own, without any recovery-oriented supports around it, has any positive effect on reducing overdoses.

Dr. Goulão: Thank you, Member, for your question. It's impossible to establish decriminalization as an independent variable. We cannot say: we decriminalized and we got those results. It's the whole system with the complete package that led us to this improvement in situation. It's impossible to say that it came from decriminalization. What we feel is that altogether those different components of our policy worked and are still working quite well nowadays, but as an independent variable it's not possible. We tried, but we could not find it.

Ms Rosin: Okay. Thank you.

The Chair: Excellent. MLA, did you have a quick follow-up?

Ms Rosin: No. I'm good. I think between myself and Member Yao we covered most of the questions. I think both of us got what we had around decriminalization, so thank you.

The Chair: Okay. I know we just ran out of time, but I had one more question on the list. MLA Allard, did you want to get that in now?

Mrs. Allard: If I may, Chair. Again, thank you, Dr. Goulão, for being here. I have actually one follow-up from my previous and then one additional question. I had asked you about penalties for those at the commission or consequences for those sanctions. But I'm wondering: what happens to those that are identified as problematic users? If they refuse to participate in treatment, what kind of sanctions do they experience?

Dr. Goulão: It's up to them. We have no compulsory treatment. We invite, we try to persuade them to accept treatment, but they are free to refuse. They may say: no way; I'm not interested. Okay. Go in peace. Please do not come back to this commission, let's say, in the next six months; otherwise, I will have to apply to you a penalty as well as to the nonaddicted person that we spoke of before. In the first contact usually there's no penalty, time to think, but if they wish and if they reconsider, they may come and ask to be addressed for treatment facility meanwhile.

Mrs. Allard: It's my understanding, then, with respect to the dissuasion process that if somebody is a repeat offender and they're identified as problematic, those penalties can escalate and become quite severe, no?

Dr. Goulão: Yes, they may. Most of the penalties are soft to increment the follow-up, to permit the follow-up of the person. For instance, one of the penalties – let's imagine someone who is HIV positive and is missing his consultations at the hospital and follow-up. One of the penalties of the commission can be: "Okay. You must retake your consultations and bring me the evidence, a piece of paper showing that you are attending your consultations again. You must come here every two months, bringing the evidence that you are seeing your doctor for this endeavour." This is a sanction, and this is something that may be used. That's why I said that the vast list of penalties that may be applied may be adapted to the lifestyle and to the personal conditions of each of the citizens.

9:50

Mrs. Allard: Thank you so much. I know we're really pushing it for time, so this is my last question, with your indulgence, Chair. Is that okay?

The Chair: Have at 'er.

Mrs. Allard: Okay. Activists in Canada are advocating for the government to provide prescription opioids and stimulants to those that want to use drugs free of charge and without a prescription in the form of take-home kits. Is this something that Portugal ever considered or would ever consider?

Dr. Goulão: No. We have not considered it yet, but we completely understand that this is a discussion going on. I'm thinking it's not easy, particularly with the international environment and all of the treaties and everything that we have agreed upon at the international level. Anyway, treaties are not written in stone. Those treaties consider that, well, the nonmedical use of such and such substances is forbidden. Nowhere says that it must be criminalized, but it's forbidden. But how to consider that prescribing substances to those who are dependent, who have a substance abuse disorder, prescribing them the substance they are dependent on: is it a medical use for substances or not? This is a question that, I think, deserves to be considered.

The Chair: Excellent.

Mr. Milliken: Mr. Chair, with your indulgence.

The Chair: Yes. Sorry. If it's about the committee, you'll have one more question. It seems to be we will allow one more question if we can keep it tight because we do have a presenter waiting.

Mr. Milliken: Yes. Absolutely. Thank you. I should have started my last question, actually, Dr. Goulão, with just a couple of comments. I know from your background that you're a doctor, and I know that in 1997 you became the national director of the network of drug treatment centres in Portugal. That was '97, and then your presentation with regard to the new strategy, the integrated-model approach, kind of brought us to 1999, so a couple of years in. You were part and parcel with regard to creating the strategy in Portugal, which I think Member Amery might have called the gold standard. I would agree with him. It's a model of best practices, or at least people view it that way, almost universally so. Again, thank you very much. It's my honour to have the opportunity. That's why I had to jump in for another question, so thank you to the chair.

Going back to that, when you were breaking down the original new strategy, 1999 and moving forward – I'm not sure exactly what slide it was, but you mentioned two of the sort of pillars. I'm not sure that was the word, but two of the main focuses were demand reduction – if I remember correctly – and then supply reduction. I sometimes ask the really, really obvious question. My question might be too obvious sometimes, but here it is: why supply reduction? What's the point? What was your goal with regard to supply reduction?

Dr. Goulão: It was to reduce the availability of substances circulating on the market. I don't know. There are some historical reasons in Portugal. We had an explosion in drug use, very sudden, after our democratic revolution back in '74. Prior to that and during the Salazar regime, drugs were not an issue in our country, but after the revolution there was an explosion, mostly related to the return of soldiers and settlers from our Asian colonies. Suddenly it was almost impossible to find a Portuguese family that had no problems related to drugs. At the first moment there was a sudden availability of cannabis all over the country, brought back from the colonies and distributed freely for free for relatives and family and so on, but shortly after some branches of international organizations introduced in our market all the other substances. Suddenly we had everything: plenty of cannabis, heroin, cocaine, LSD, you name it.

One of the concerns was to attempt to avoid those branches installed in Portugal becoming solid and completely established, mostly dealing, also providing the access to drugs to other parts of Europe. We are very exposed in terms of our coast, and it proceeded to enter the country. One of the concerns was exactly to try to avoid those organizations consolidating in our country. In fact, after decriminalization since the police authorities got somehow free of all the tasks related to mere users, they could concentrate their efforts and their means, their capacity, on big criminal organizations instead of dealing only with the mere users or the street traffickers. By the end of the year nowadays instead of seizing grams or kilos at street level, they seize tonnes in open seas, in big shipments, in containers. Of course, they had to change their way of acting. They improved a lot the co-operation with international counterparts, but nowadays they are much more efficient than before in countering the boat trafficking.

The Chair: Excellent. Thank you so much, Doctor, for joining us here today and taking that much extra time with us to indulge our questions. We certainly appreciate your efforts and your presentation. We wish you a good day, and again thank you.

Dr. Goulão: Thank you, sir. It was a pleasure. Thank you for having me.

The Chair: All right. Next our presenter is Ms Amber Fort, the executive director of Pastew Place Detox Centre in Fort McMurray, Alberta. Ms Fort, thank you for being with us today. I apologize for the delay in getting to your presentation. Without further ado, I will turn it over to you.

Amber Fort

Ms Fort: Well, thank you, Chair. Can everybody see me?

The Chair: No. We can't see you.

Ms Fort: My camera is not working. I apologize for that.

I just want to thank you for this opportunity to have a conversation with you about safe supply and just share our thoughts about what that would mean for a front-line agency like Pastew Place. We are a 16-bed facility in Fort McMurray that provides various programs to individuals in early recovery. Our detox program, pretreatment program, posttreatment program, and day program are all designed to foster change. We work every single day hands on with people suffering with addiction, and we have developed a good understanding of what works and what doesn't to help our clients on their path to recovery.

I'd like to start off the presentation by explaining the process for a person with opioid addiction who is accessing our services and what that would look like in the course of their stay with us. Ninety-four per cent of our clients are self-referral, meaning they are calling us on their own behalf for a bed to go through the withdrawal process. When they call, our staff will complete a brief assessment and provide the client with a time to come in for intake. During the intake more in-depth information is gathered about the client's usage, previous detoxes, medical issues, as well as any mental health concerns. This is when clients will disclose that they have been using opioids.

Oftentimes their addictions started with a prescription for pain meds like OxyContin. The very first question staff will ask the client is if they are connected to the opioid dependency program here in Fort McMurray or to the virtual opioid dependency program. If they are, staff would immediately call their clinic to get the process going with regard to Suboxone, methadone, Sublocade, whichever they were on. If not, staff will talk to the client about the benefits of these medications and connect them to ODP or VODP if they are interested. Clients are typically initiated on Suboxone though we expect more and more will choose Sublocade now that it's available.

10:00

Pretty soon after their initiation we see clients start to feel better and assessments indicate withdrawal is starting to subside. This is the moment where we have the ability to help facilitate change. We encourage them to participate in our day program. The day program is a five-day facilitated group program designed to educate people on addiction: why they are continuing to do what they are doing, why they just can't stop, and what they can do about it.

Clients are not always eager to participate in the program at first, but something happens when they do. Often people are isolated in their addiction and feel entirely alone in their thoughts and feelings. There's a tremendous amount of relief when they realize that other people are going through or have gone through similar things as them. Sometimes we hear from almost every client as they progress through the program that they do not want to use drugs and alcohol anymore due to the fact that it has ruined their lives and the lives of their family. They talk about deep shame and feeling worthless.

For anyone who has ever looked into the eyes of a person who is in this place, I don't think those words fully describe it. That is why we believe in them until they learn to trust and believe in themselves. Until they develop a little bit of hope, we will continue to try to empower and motivate our clients to see that they

absolutely can live a life free of substances. This is when a lot of our clients start to think about treatment and they decide it may be the best option for them. They make the decision to pursue recovery.

At that point, they start working with our client co-ordinator, who gets them connected to treatment facilities in the province that are best suited for them. We've helped many people transition into treatment centres over the years, but it has been challenging. There are often long waiting times for treatment centres across the province. We would lose people because they couldn't wait. Another barrier to treatment was financial. Clients couldn't afford the costs of treatment. In 2008 in response to wait times we developed our pretreatment program. Clients who plan to go to treatment can stay with us at no cost until they transition there. Even with our pretreatment program it has been hard. We feel people should be able to access treatment when they are ready, and it should be free.

That is why we are beyond grateful that our provincial government is transforming the system of care to make this a reality. The recent announcement that a recovery community is being developed north of Edmonton is a game changer for us. Having the ability to transfer our clients direct from detox to long-term treatment with no cost to the client will help us save many lives and get our clients on the path to recovery.

What will not work in recovery is safe supply. At Pastew Place we have some real concerns that implementing a safe supply would be counterproductive to all of the things that we are trying to achieve in what we do. One of the bigger concerns would be that people who are at the point of considering entering into detox would choose to stay active in their addiction by utilizing prescribed safe supply, thinking that it will help them. Often addiction is a symptom of an underlying issue. The majority of the time that issue is trauma, and individuals are using substances as a way of coping with trauma that they have experienced at some point throughout their life. We know that in order to really, truly heal, individuals must sort through and deal with the feelings and emotions of those past experiences.

This is why treatment is vital, but they need to get there. I've heard time and time again from many clients that one small dose of their drug of choice instantly sends them into addictive obsession and impossible-to-resist cravings. From that point they are totally preoccupied with how they are going to get their next hit. If they're enabled in this perpetual state of addiction by making access to these substances easier by prescribing them, then the concern would be that people won't even make it through our doors to learn that they can live another way.

There are many concerns that previous presenters to this committee have warned about such as people continuing to utilize street drugs while receiving safe supply, selling the safe supply to get the street drugs, diversion, adding to the opioid crisis by creating easier access to opioids, and causing more addiction where there maybe wouldn't have been to begin with. I worry that offering a safe supply of opiates will start a practice of offering other substances like cocaine and methamphetamines.

I'm very concerned about the messaging that our youth will receive around government providing a supply of drugs. As a mother of three I've had many open conversations with my children about the impact and consequences of using drugs. They know that if they decide to use drugs, they can die from it. They know that alcohol causes the most harm, including death, even though it's legal. I question what message our youth will pick up from legalizing and normalizing opioid use.

One of the things we need to put more effort into is looking into long-term prevention strategies. We need to get our youth and educate them, put more supports in place now so that our doors are a lot slower in 10 to 15 years down the road. We also cannot give up on people struggling with addiction now, which is the message that safe supply gives. Every single person who walks through our doors and asks for our help needs to understand that they can change and that without a shadow of a doubt we believe in them. If we prescribe an addict their supply rather than actually believing in them and showing them that there's a better way to live, they're going to get the message that we gave up. That would be a huge injustice to those suffering in addiction.

I've had the opportunity recently to have conversations with some of the people who have gone through our programs. I have asked a few individuals what a safe, free, or even cheaper supply of their drug of concern would have meant to their recovery. Unanimously they all agreed that there would be no recovery. I have permission to share some of those words and thoughts with the committee.

One former client who just reached nine years of sobriety said:

> In my active addiction, if I was able to have a safe supply of my drug of choice, I would never be recovered. I would have less incentive to get well, and it most likely would have kept me using drugs for longer. I was a street-level drug addict who was homeless 12 months of the year at the end of my active addiction. If the government gave me a supply, I would have likely used it in between seeing the dealer or literally sell the government supply to get a fix on the streets. If I had to guess, I would be in prison or dead by now. I needed detox, treatment, complete abstinence from all alcohol and mind-altering substances. I needed a 12-step program and a fellowship to be part of. Quite simply, I would not have ever wanted to quit if it was easy access to a free and so-called safe drug.

Another former client who is about to reach 11 years sobriety said:

> In my addiction, once I used, the craving would kick off, and I couldn't stop. Every time I used, it gave me a temporary relief from my emotional unrest and kept me in obsession for more. I couldn't imagine my life without alcohol until I picked up crack, and then I was easily able to put alcohol out of my mind. It didn't matter what it was, whatever gave me the relief of my life problems. It worked. I had to look at life with a sound, reasonable, rational-thinking mind. I find it hard to imagine that I would have found recovery if I was prescribed a substance that allowed me not to feel. I believe more in feeling reality with sound support like I got through detox and treatment, working through a program. To me, a safe supply would mean a death sentence, and I would never recover. I now use different solutions to deal with my emotions and was able to learn that by taking the drugs and alcohol out of my life. You can't work on a solution until you understand the problem. You have to create a new life, and I believe not only that you need support living, but you need supported living that holds you accountable. Being an addict in recovery, I see too many reasons why not to have a so-called safe supply program. I can see a lot of people coming to their bottom and reaching out for help and then: "Oh, wait. Free drugs? I'll stop later."

The last client was one of our posttreatment clients. His desire to help those who are struggling like he used to is nothing that I have ever seen before. A few days after he had sent me those words, he was at the centre participating in a morning meeting. Afterwards he came to my office, and he asked me one simple question: "What about me? Does my recovery not matter?" He said, "The way I was in my active addiction, a program like safe supply would have kept me in my altered state of mind and my obsession, and I would not be where I am today. So does my life not matter?" His life absolutely matters.

I want to end by thanking the government for everything that you are doing to implement a recovery-oriented system of care. The

system that is being created in this province is not only going to save lives; it's going to give people their lives back and reconnect families, leading to stronger communities and a stronger province.

The Chair: Excellent. Thank you, Ms Fort. Certainly, the personal stories are very touching, very helpful. We appreciate you sharing with us today.

I will now open it up to questions with the members.

Mr. Yao: Ms Fort, thank you so much for taking the time to speak with us today. I believe, when we look at all of our presenters, who all have front-line experience with treating addictions and opioid abuse, that you're certainly just the one currently that's closest to the front lines right now, and we really appreciate that, especially the fact that you're based here in Alberta. The clinic that you work at, Pastew Place, is a small and very intimate but very effective clinic, so I want to thank you for your services there.

Ms Fort, the activists that promote safe supply concepts argue that treatment beds and addiction treatments are not the only ways to support addicts. Quite honestly, you might have answered this question already in your introduction, but they talk about there being an entire spectrum of addiction and that we should be accommodating those who are not necessarily ready for traditional treatment. To that effect, how do you deal with people who might fit that description, that they might be on the far end of the spectrum in regard to being prepared for treatment? Do you have options available? I wonder if you can answer that question.

10:10

Ms Fort: Yeah. One of the things that I would say to that is that there are people that are more ready for treatment than other people. We see it every single day.

One of the things that we try to do in our centre and what I think is a vital piece that should absolutely be implemented through treatment across the province is – there's a piece between detox and treatment. That is an area where – say a client comes in, and they're not feeling the greatest, and they start to feel better, and then they start taking our day program. The day program is implemented to educate them on why they're doing what they're doing and why they can't stop doing it. For myself I wouldn't ever make a life-changing decision without knowing the ins and outs of why I should be making that choice. If we can get to people and explain to them, "You know, this is what addiction is doing, and this is what you can do about it," then sometimes they say, "Maybe I do have this issue, and maybe I do need help."

The other thing that we do is that we do work really closely with the ODP clinic and the virtual ODP clinic.

With regard to a spectrum, everyone that comes into our building is treated on an individual basis. We meet them where they are at, and we try to support them in that stage of their recovery, whatever that is.

Mr. Yao: Thank you so much for that answer. If you can expand more on those words you just said. One of our previous presenters, Chief Shirt, stated that safe supply does not address the fundamental addiction and mental health challenges that these victims are facing. To that effect, can you expand more on your comments, that you just said, about meeting people in their place, where they currently are at, and supporting them?

Ms Fort: Yeah, for sure. The second client that had spoken with me: he talked about how he needed to have a sound, rational-thinking mind in order to understand what was going on. If we are giving people, you know, these drugs that are keeping them in this state of mind-altering processes, then they're never going to be able to have the chance to come in and actually have that rational thinking. Does that answer your question?

Mr. Yao: A little bit. I mean, basically, just emphasize that there are options available for people who aren't quite ready, and that does involve you and your services as well as some proactive treatment, I guess, if you will, whether it's a therapy of some sort or helping them with some underlying issues.

Ms Fort: Yeah. What we do is that if those issues are outside of our scope, we refer them to the addictions office, or we refer them to mental health offices or, like I said, the ODP clinic or things like that. We have a network of other agencies and other service providers in our community and actually throughout the province that we refer people to.

The Chair: Excellent. Next up we have MLA Milliken.

Mr. Milliken: Thank you, Ms Fort, for being here today. I also want to thank you for the work that you do on the front lines. I know from speaking to Tany as well that I've gotten more information on the work that you do, so again thank you very much for that. Pastew Place seems to be, from what I've heard, an area where, for lack of a better word, there's been some success there, so thanks for that.

I know that within – correct me if I'm wrong – Pastew Place there are different availabilities for individuals at different stages of addiction, et cetera, and things of that nature, whether it's detox, day programs, pretreatment, posttreatment. I think just in your most recent answer you mentioned the potential of sending people to other agencies or other options that might be available that may not be at Pastew Place. In your experience, what is the most effective way that you've seen with regard to dealing with an individual's addiction? I say that knowing that, like, we've kind of already covered the fact that addiction can come in different ways or can have different factors. People are unique. I'm assuming that individual addictions are unique, et cetera, but what, I guess if there was, would be sort of the most effective – and I'll have a follow-up to this, too. What would be the most effective way, by your estimation, to treat addictions?

Ms Fort: Treatment.

Mr. Milliken: Treatment. Okay.

Ms Fort: Without a doubt, treatment. There's a small percentage – a very small percentage – of individuals who can recover without implementing or going to a treatment program. You know, we see people come in thinking they don't need treatment all the time, and we kind of say: "Okay. Yeah. You know, maybe treatment is not an option today, but if it ever is, come back." The majority of the time they come back, and we end up sending them to treatment facilities.

Mr. Milliken: Okay. Just a quick follow-up.

The Chair: Yes, sir.

Mr. Milliken: Yeah. Prior to your presentation, having seen some of the background on Pastew Place and things of that nature, a lot of people historically – and you kind of touched on this in your presentation as well. A lot of people consider or think of the beginning of the treatment process to often be when somebody hits – a lot of people use a word like "rock bottom" and things of that nature. I guess what I'm trying to get at is that for my previous question I talked about how addiction can be different, and you mentioned that people can be on a different spectrum with regard to addiction at any given time, et cetera. Like I said, a lot of people

see it as rock bottom when people then finally become open to the decision to say, "Hey, you know what? I'm ready now" and things of that nature. Is it also possible, though, that individuals along any part of a spectrum or as they go further into addiction: would there be potential for off-ramps at all stages like beginning? Would it be like intervention or something along those lines?

Taking into account the fact that, if anything, within Pastew Place you've got, say, day programs and all those other kinds of detox, you know, are there other options that are effective for people within the spectrum of addiction, not just necessarily when somebody finally comes in, completely having broken their family or something along that nature, finally saying: "Okay. Now I'm ready, because I'm at rock bottom." Are there other off-ramps at different stages?

Ms Fort: You know, I think that everybody's bottom line is different. I don't think anyone has the same bottom line. From what we see, the majority of people that are coming into the detox centre, you know, their life is hard. That's what we see, and a lot of the times those people don't even know how to do the changes that they need to do, which is why we educate them.

I think I'm struggling answering your question because I'm not too sure what you're trying to say in that.

Mr. Milliken: Okay. Let me try to rephrase it, then. I'm happy to do that. Somebody who would be – okay. Yeah. I'm struggling to, then – I would say, like, rock bottom. I guess what you said is that rock bottom can be something different to a lot of people. A lot of people historically look at, say, somebody who is potentially going to receive safe supply being that person who is maybe on the street and things of that nature. Are there opportunities for people at, you know, say, if somebody has just started or somebody has – yeah. You're right. It's tough for me to kind of – I was trying to see if, like, as somebody progresses down a spiral of addiction, are there off-ramps throughout that process that might be able to lead towards recovery without having to, then, only see them when they are at that stage where they come to you to say, "Hey, I need help"?

10:20

Ms Fort: Yeah. But those services need to be there. That support needs to be there.

Mr. Milliken: Okay.

Ms Fort: For instance, yesterday we were at the centre, had a client come in who had gone through our program two years ago. She went to treatment for approximately a year. The last few weeks she's been using crack every few days. She came in very upset, crying, didn't want to slip back into where she was previously. We called the treatment centre next door to us, Fort McMurray recovery centre, and we're getting her into the treatment centre on Tuesday. This is something that the client knew she needed to do in order to get clean and sober.

I believe that there are many ways that we can kind of interject and kind of, you know, stop someone from maybe hitting what we would perceive as a rock bottom. But those supports and those things need to be there, and people need to be aware of them.

Mr. Milliken: Thanks.

The Chair: Excellent.

Mrs. Allard: That's a great segue. Thank you for being here this morning. I'm from Grande Prairie, and one of the things that I've noted – and I think you've touched on it – is the gap between detox and treatment. There are times when a client can come in to detox – and I think you were just talking about one. You're getting them in on Tuesday, but today is Friday. What happens to that client in those few days? I guess my question, bigger picture, is: what tools do you need to better serve your clients to get them into a path of recovery?

Ms Fort: What happens to that client is that we had a bed available, so we brought her in on our pretreatment program, and she's currently in day program, talking with the facilitator and a group of her peers. Really, we're trying to just build up that confidence again for when she transitions into treatment on Tuesday. You know, when this woman came in yesterday, it broke everybody's heart because she had tried so hard, and I'm just really proud that she caught herself at a time and then asked for the extra help.

The second part of your question, you know, day program and pretreatment program: when we developed all these programs, it was because we'd seen the need in it. For someone to go into a detox centre and sit for five to seven days, or whatever their withdrawal process takes, and just lay in bed and eat and feel better isn't enough. We need to use that time. We need to get to people when they're not feeling good, and we need to explain to them that we know a way where you never have to feel like that again, and the only way we're going to do that is through educating people. And that's why I say, like, you don't know until you know, and you can't change something that you know nothing about. Implementing these programs has really created this little mini continuum of care in our tiny little facility, and it's worked out really, really well; 90 per cent of our people that admit into pretreatment transition into treatment centres across the province.

One of the things that we struggle with is the funding of these programs that we know work. We look for funding for day program yearly. We've gone to foundations, industry partners, things like that, to fund it, and then United Way Fort McMurray and Wood Buffalo funds our pretreatment program, but those are on a yearly basis. Every year these programs are at risk of ending. Financially, that's one of the barriers to adding these programs.

Mrs. Allard: If I can have a follow-up?

The Chair: Yes.

Mrs. Allard: That statistic is exceptional, 90 per cent.

I guess I wanted to summarize what I heard you saying earlier about safe supply, that in your experience as a professional in the field you've seen people unable to make a healthy decision for themselves because – and I think these were your words, and forgive me if I'm misquoting you – they're not in their right mind because they are in a mind-altered state from their drug use. Is that correct?

Ms Fort: If you look at the words from the second client that I talked about, as soon as he got a taste for his drug of concern, that is all he thought about, how he was going to get his next use, how he was going to be able to remain in that way. If we put people in a position where all they're thinking about is how they're going to do this, how they're going to get high, they're not going to be thinking about the solution part and what life would be like without having to use that substance. They're just going to continue to try to find that.

Mrs. Allard: Okay. Thank you.

I am not an expert in this field at all. This committee has undertaken an exploration, a posture of curiosity, if you will, to understand from the front line, from those that are working in the field, what are truly the best practices in service to the people.

We're concerned, obviously, about the rate of overdoses, and we're also concerned about the growing issue with respect to drug use and drug abuse. I heard you say earlier, in a number of those testimonials, that it is a disservice, so, in my words, it's not a kindness to give the addict another hit. Can you give us an alternative to safe supply, then? I mean, I heard you say "treatment" repeatedly. Are there other tools that we should be looking at as a committee? Again, I don't want to purport that I have this figured out. I'm trying to understand, from your perspective, what would serve those clients better to reduce the number of overdoses and to get people truly on a path of recovery.

Ms Fort: I think those are already available with Suboxone, methadone, and Sublocade. Those medications. You know, when we have clients that come in, the withdrawal from opioids is terrible. It's not nice. It's not pretty. People are really, really sick. You hear people describe it like it's a flu. I would say that it's nothing like a flu. They are in pain. Their joints are sore.

I had one female client, and this client was actually the first time that I and our client co-ordinator have ever seen somebody dose on Suboxone. She came in, and she was in her mid-20s. She was just in so much pain that she couldn't even communicate how bad she felt. So we called the ODP clinic in Fort McMurray, and we got her there. They dosed her. Within two hours she was up out of bed, talking to staff and doing her hair and washing her face. A detox that would usually take days was shortened because of this medication, and then, in that, she was able to withdrawal quicker. She was able to enter into our day program quicker, where she was educated and she learned about her addiction. Then she was able to transition into a treatment centre after that. So there are substitutions out there that aren't going to keep people in active use.

Mrs. Allard: Thank you so much for answering my questions. I don't have any more. I guess I would just say that what I just heard you say was that instead of a taste for their drug of concern you're giving them a taste of success and what their life could look like without that drug of concern.

Ms Fort: Correct.

The Chair: Excellent. Any other members that have a question? MLA Yao.

Mr. Yao: First off, Chair, we have about a minute left. I'm looking for permission to extend this by just a few minutes?

The Chair: Sure. For your question.

Mr. Yao: Thank you so much. Ms Fort, you're in a unique position working up in Fort McMurray. Here in Alberta we have a large Indigenous population, particularly in Fort McMurray. We also have the most successful First Nations in the nation: they have demonstrated their entrepreneurial acumen, they're all business people, they're considered the wealthiest First Nations. I just want to refer to some comments made by some of our previous presenters.

I just wanted to know your perspective of understanding – and this is the question – whether safe supply will disproportionately affect a certain segment of our population, particularly First Nations. One of the previous presenters, Dr. Mogus with the AMA – he was, I believe, from the section of addictive medicines – mentioned that we need to study this here, that we need to have safe supply here, and we need to do a pilot project here, despite being reminded that there are pilot projects or full on safe supply endeavours happening in British Columbia and in Ontario, as an example. Following him was Chief Eric Shirt, and he stated that the issues around safe supply will disproportionately affect First Nations. He stated that many of the people who are on the street are Indigenous, and if I can find the quote, he basically stated that these are experiments on First Nations people. Yeah. He stated that they should not be "doing experiments on us," as in First Nations people.

10:30

Currently in the Legislature we have a private member's bill coming forward from the New Democrats, from the opposition. They're asking that our government identify race in all the various issues that we are addressing so that we could help perhaps identify underlying issues that affect these people that might be race based. Again, just to clarify my question: do you believe that if we were to allow safe supply, it would disproportionately affect our First Nations peoples?

Ms Fort: You know, first off, 60 per cent of our clientele that we see coming through our centre are Indigenous. I'm a firm believer in Indigenous people having a voice and being able to advocate for themselves. I believe that safe supply with regard to Indigenous people will impact – safe supply is going to impact everybody the same way. Every single addict will be impacted the same way. The underlying issues as to why addicts come in and why addicts use drugs as coping mechanisms are different for everybody. Do I believe it would be disproportionate based on our statistics in our centre? We'd probably have an increase to people using opioids who are Indigenous coming in. Yeah.

Mr. Yao: Thank you very much for that.

No further questions.

The Chair: Thank you, MLA.

Thank you, Ms Fort, for joining us today for your presentation and for all of your work that you're doing up north in helping people recover from addictions. We really appreciate you and your time and your presentation and hope you have a good day.

Ms Fort: Thank you.

The Chair: All right. Next we have up research services. Hon. members, on January 18, 2022, the committee directed the Legislative Assembly Office research services to prepare a crossjurisdictional scan of safe supply in Canada. The document was posted to the committee's internal website on February 11, 2022. I would now like to ask Dr. Amato from the Legislative Assembly Office research services to provide an overview of the crossjurisdictional scan.

Dr. Amato, I will turn it over to you.

Dr. Amato: Good morning. Oh, I have an echo. One sec. Okay. I hope you can hear me.

The Chair: Yes, we can. You sound great.

Dr. Amato: You can? Okay.

I hope you have the copy of the crossjurisdictional document. It endeavours to provide some information on safe supply across Canada, and it begins by defining the term. It notes that most jurisdictions, in fact, use the term "safer supply," but safe supply and safer supply can be used interchangeably.

As explained on page 3 of the document, prescribing safe supply requires exemption from the federal Controlled Drugs and Substances Act. The Controlled Drugs and Substances Act prohibits activities with controlled substances across Canada. Activities with controlled substances are only allowed by exemption from the act. Most organizations across Canada offering

safe supply do so by application to the federal government. If approved, organizations receive funding through the federal substance use and addictions program. There appear to be 14 organizations offering safe supply services across Canada, and these are listed on the table on pages 7 and 8 of the document. Also, in the footnote on the bottom of page 8 you'll find a link to an interactive map showing various organizations providing services that are responding to overdose crises across Canada. That's just for your information, if you'd like to explore that map.

Organizations offering safe supply are currently located in British Columbia, Ontario, New Brunswick, and also, most recently, in Yukon. British Columbia is the only jurisdiction to make safe supply a provincial policy and became the first jurisdiction in Canada to expand access to safer supply in July of 2021. In October of 2021 Yukon also announced its intention to expand access to medically prescribed safer supply of opioids. In January of 2022 it announced expansion of safer supply in and outside Whitehorse.

I'm just going to say a couple of words about the appendices. Appendix A discusses supervised consumption services. Supervised consumption services are authorized by exemption under section 56.1 of the Controlled Drugs and Substances Act. The text of section 56.1 is quoted for you in appendix B. Appendix C is the text of the class exemption issued under section 56(1) that permits safer supply in Canada. I'll also perhaps, as I draw your attention to the footnotes throughout the document – I've tried to provide hyperlinks to all of the sources that I've used. That's just for your information should you wish to look at those sources yourself.

Thank you very much.

The Chair: Perfect. Thank you, Doctor.

I'll now open it up for questions from members. Are there any questions from members? All right. MLA Allard.

Mrs. Allard: Yes. Good morning. Thank you. This is extensive work. I'm sure you've been very, very busy getting this prepared for us, so thank you so much for doing that.

We just got the document yesterday, so admittedly I've skimmed, but I haven't read through the whole thing yet. I just wanted to know: in your research did you determine if there are a number of other jurisdictions looking at this issue at the present time? Was that part of the work that you did or no?

Dr. Amato: Let me say that I only found information with respect to that pertaining to Yukon, so that's why that is there. They issued a number of press releases and notices in October of 2021 and then again as I was finishing the document in January, so things appeared to be in motion there. I did not find corresponding information in other jurisdictions. That's not to say that it doesn't exist; it's just that I didn't find it.

Mrs. Allard: Perfect. Thank you very much.

I guess I'm just wondering: of the jurisdictions that are offering safer supply, is British Columbia the one that's been doing it for the longest?

Dr. Amato: No. Well, I suppose. But we should be maybe careful about what we say, what we define as long. The citations I have from the federal government and the class exemption, 56(1), date from 2020. So none of this was – I mean, I defer to you in terms of what you would define as long, but this is all fairly recent, in my view. The British Columbia policy dates from July of 2021, and the policy document that I cite there describes a policy that is being implemented in three phases. I believe I state this in the section on British Columbia in the document, but the first phase is 18 to 24 months. So if that started in July of 2021, they're still in that first phase.

Everything here is very new. Referring to the last question that I just answered, I believe, you know, Yukon is still in the very, very first stages of this.

Mrs. Allard: Yes. That's very helpful. I guess the point I'm getting at, or where I'm going as I think about this, is that we don't really have a longitudinal jurisdiction in Canada from which to draw conclusions about: what worked, what didn't, what were the societal impacts? As government you often have to think about: what are the unintended consequences of policies that you put into place? Sometimes we don't know that for a decade. We don't have a jurisdiction with that longevity.

I will read this more thoroughly. Thank you so much again for your research.

That's all I have, Chair.

10:40

Mr. Yao: Thank you so much to you and your team's work in finding us some of this information. I just want to clarify one of the columns that you have as you reviewed the projects across the nation that received the federal funding. Jeez. I'm just shocked that there's almost $40 million worth of federal funding on this. Are there any other funding sources that you identified, or was it specific to the federal funding?

Dr. Amato: That is all the information that I have.

The Chair: Excellent. Did you have a follow-up, MLA?

Mr. Yao: No, just a comment that $40 million is a substantial amount of money to be providing in our nation for a so-called safe supply of pharmaceuticals. I find that disturbing.

Thank you.

The Chair: Thank you, MLA.

Any other questions from members for Dr. Amato? No?

I see none, so thank you, Doctor, for joining us and for putting this together for us. We will now move on to written submissions.

Hon. members, a summary of written submissions received by the committee was posted to the committee's internal website on March 24, 2022. I would now like to invite Dr. Amato to please provide an overview of the document. Welcome back, Doctor. I'll pass it over to you.

Dr. Amato: I believe this is actually the document that was just posted yesterday, so I hope you do have it. It's just a summary of the submissions that were received by the committee, and I'll provide just a very, very high-level overview.

The committee received 76 written submissions in response to its call. Four of those submissions were from invited stakeholders. The breakdown of the submissions is that 30 were in opposition to the provision of safe supply in Alberta, 30 were in favour of the provision of safe supply in Alberta, 12 were neutral on the subject and simply sought to provide the committee with information, and – hopefully, my math is correct – four additional submissions were other comments and did not address at all the topic at hand, which is safe supply or the opioid crisis.

Perhaps I'll just say a word about the contents of the submission, again, a high-level overview. For those expressing opposition to safe supply in Alberta, the one stakeholder who commented talked about the present medical literature. With respect to public submissions opposing safe supply, they expressed a variety of views such as opposition to using tax dollars to pay for safe supply;

safe supply could encourage use of illicit drugs; public funds would be better spent on treatment, rehab facilities, inner-city organizations, and/or safe consumption sites; concerns about where safe supply might be provided; and experience with addiction.

Of those submissions that expressed support for the provision of safe supply in Alberta, two were from invited stakeholders. Invited stakeholders made recommendations to the committee on the introduction of safe supply and also made recommendations with respect to consultation with other stakeholders. Public submissions also expressed a variety of views. Some of them made recommendations on implementation. Some expressed the view that safe supply prevents overdoses and saves lives, reduces medical costs, reduces criminality. Some expressed the view that safe supply would provide a solution to the unpredictable toxicity of the illicit drug supply, and others discussed the need for safe supply as part of a continuum of care, including mental health supports and other social services. Still, others discussed experience with addiction.

The 12 neutral submissions, as I said, sought to provide the committee with information, so they urged the committee to consider certain perspectives in its deliberations. Some of them advocated for safe consumption sites, and some of them expressed views about the committee's proceedings.

I think that's a summary of it, and I'm ready to answer questions. Thank you.

The Chair: Perfect. I will now open up to members for any questions.

All right. Hearing and seeing none, we will move on. Thank you, Dr. Amato, for the work done here.

We will move on to 6, committee decisions for consideration, matters relating to written submissions. At our February 3, 2022, meeting the committee invited written submissions from the public to be received by March 4, 2022. The committee received 75 submissions prior to the deadline. Submission 69 was received after the established deadline. Submission 75 was originally received prior to the deadline, but the submitter requested that a revised version be accepted by the committee the day after the March 4 deadline. Additionally, I would like to note that Dr. Perry Kendall made a submission to the committee prior to the established deadline but provided supplemental written information to the committee approximately one week after the March 4 deadline. I would note that Dr. Kendall was one of the invited stakeholders who was unable to make a presentation to the committee today.

At this time I would like to open the floor to any comments or motions in relation to how the committee would like to handle these late submissions. Are there any comments or thoughts on this?

Mr. Yao: In the event that there are late submissions, I think that we should accept them. I think that's fair.

The Chair: Okay. Perfect.

MLA Milliken.

Mr. Milliken: Yeah. I would actually just concur with what MLA Yao just said. I think that we should probably – I think it's reasonable to accept them, definitely.

The Chair: Excellent. We would entertain a motion that the Select Special Committee to Examine Safe Supply receive all written submissions made to the committee prior to March 14, 2022. Would somebody like to move that motion? Excellent. MLA Milliken moves that

> the Select Special Committee to Examine Safe Supply receive all written submissions made to the committee prior to March 14, 2022.

Is there any further discussion on this motion?

All right. Hearing and seeing none, all in favour, please say aye. Any opposed, please say no.

> That motion is carried.

Hon. members, those who made written submissions to the committee were advised that their submissions and their names may be made public. At this time I would like to open discussion as to whether the committee wishes to make the written submissions public on the committee website. Is there any discussion on that?

Mr. Yao: I believe in a transparent and open process. I believe that we should accept all submissions as well as put them online for purview.

The Chair: Excellent. Would you be moving a motion that the Select Special Committee to Examine Safe Supply direct that written submissions received be made public with the exception of personal contact information and confidential third-party information?

Mr. Yao: Yes.

The Chair: Excellent. MLA Yao moves that

> the Select Special Committee to Examine Safe Supply direct that written submissions received be made public with the exception of personal contact information and confidential third-party information.

Is there any further discussion on that?

Hearing and seeing none, I will call the question. All in favour, please say aye. Any opposed? Hearing none,

> that motion is carried.

All right. Section (b), request for an issues and proposals document. Hon. members, we have now arrived at the point in our committee's work where we begin to turn our attention to deliberating and making recommendations that will make up our report to the Legislative Assembly. The committee has heard technical briefings from the Ministry of Health and the Ministry of Justice, oral presentations from identified stakeholders, and has received written submissions. It is common for committees to request an issues and proposals document to be prepared by the Legislative Assembly Office research services to aid committee members in their deliberations.

At this time I would like to open the floor for any comments, questions, or motions on this topic. Are there any comments, questions, or motions? We'd be looking for a motion that could read like this, that the Select Special Committee to Examine Safe Supply direct research services to prepare a summary document of issues and proposals identified through written submissions and oral presentations to the committee pertaining to matters relating to its mandate.

10:50

Mrs. Allard: So moved.

The Chair: Excellent. MLA Allard moves that

> the Select Special Committee to Examine Safe Supply direct research services to prepare a summary document of issues and proposals identified through written submissions and oral presentations to the committee pertaining to matters relating to its mandate.

Any further discussion on this?

Hearing and seeing none, I'll call the question. All in favour, please say aye. Any opposed, say no.

> That motion is carried.

That moves us on to other business. Is there any other business that members wish to discuss?

Hearing and seeing none, the date of the next meeting. The next meeting will be at the call of the chair.

If there is nothing else for the committee's consideration, I will call for a motion to adjourn.

Mrs. Allard: So moved.

The Chair: MLA Allard moves that the March 25, 2022, meeting of the Select Special Committee to Examine Safe Supply be adjourned. All in favour, please say aye. Any opposed? That is carried.

[The committee adjourned at 10:51 a.m.]

Published under the Authority of the Speaker
of the Legislative Assembly of Alberta