Legislative Assembly of Alberta

The 30th Legislature
Second Session

Select Special Committee to Examine Safe Supply

Thursday, February 3, 2022
9 a.m.

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Select Special Committee to Examine Safe Supply

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Select Special Committee to Examine Safe Supply

Participants

Ministry of Health
- Coreen Everington, Executive Director, Addiction and Mental Health
- Deena Hinshaw, Chief Medical Officer of Health
- Kenton Puttick, Director, Legislation and Policy
- Evan Romanow, Assistant Deputy Minister, Health Service Delivery

9 a.m. Thursday, February 3, 2022

[Mr. Jeremy Nixon in the chair]

The Chair: All right. We have 9 o'clock, so we're going to get started here. I'd like to call the meeting to order. Hon. members, at the January 18, 2022, meeting the committee agreed that at the beginning of each meeting we would observe a moment of silent reflection to commemorate the lives lost in Alberta due to drug poisoning, overdoses, and the illness of addiction, so at this time we're going to take that moment.

All right. Thank you. Welcome, members and staff in attendance, to this meeting of the Select Special Committee to Examine Safe Supply.

My name is Jeremy Nixon, and I'm 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.

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

Mr. Stephan: Jason Stephan, MLA, Red Deer-South.

Mr. Amery: Mickey Amery, MLA, Calgary-Cross.

Member Irwin: Janis Irwin, Edmonton-Highlands-Norwood.

Mr. Shepherd: David Shepherd, Edmonton-City Centre.

Ms Robert: Good morning. Nancy Robert, clerk of *Journals* and committees.

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

The Chair: Excellent. Now I'd like those joining us online to introduce themselves, starting with the deputy chair.

Mrs. Allard: Good morning. Tracy Allard, MLA for Grande Prairie.

Mr. Smith: Mark Smith, MLA, Drayton Valley-Devon.

Ms Sigurdson: Good morning. Lori Sigurdson, Edmonton-Riverview.

Ms Ganley: Good morning, everyone. Kathleen Ganley, MLA for Calgary-Mountain View.

Ms Rosin: Good morning. Miranda Rosin, MLA for Banff-Kananaskis.

Mr. Milliken: Good morning, everyone. Nicholas Milliken, MLA, Calgary-Currie.

The Chair: Excellent. Did I miss anybody? I think that's it. Perfect.

I would also like to note for the record the following substitution: Mr. Smith for Mrs. Frey.

I would note for members that masks should be worn in the committee room except when you are speaking. Members are also encouraged to leave an appropriate amount of physical distance between themselves at the table.

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Now we'll move on to the approval of the agenda. I will need somebody to move the motion. Tany Yao will move the motion that the agenda for the February 3, 2022, meeting of the Select Special Committee to Examine Safe Supply be adopted as distributed. Is there any discussion on that?

Excellent. All in favour, please say aye. All opposed? Anybody online in favour, please say aye. Any opposed online? Okay. For the duration of the meeting I'm just going to ask that question once, so everybody online and everybody in the room can respond at the same time.

All right. Up next is the approval of the minutes from the previous meeting. Are there any errors or omissions to note at this time?

Hearing none, would a member move the approval of the minutes? All right. MLA Amery moves that the minutes for the January 18, 2022, meeting of the Select Special Committee to Examine Safe Supply be adopted as distributed. All in favour? Any opposed? Excellent. That is carried.

Technical briefings. First, we have the Ministry of Health and the chief medical officer. At our January 18, 2022, meeting the committee invited officials of the Ministry of Health to provide the committee with a technical briefing pertaining to the committee's mandate as set out in section 2 of Government Motion 115. The committee also invited Dr. Deena Hinshaw, the chief medical officer of health, to provide a technical briefing on the impact of drug poisoning and overdoses on public health.

Today we have with us Dr. Deena Hinshaw, the chief medical officer of health; Mr. Evan Romanow, assistant deputy minister, health service delivery; Ms Coreen Everington, executive director, addiction and mental health branch; and Mr. Kenton Puttick, director of legislation and policy, addiction and mental health branch. I will now invite our guests to provide their technical briefing.

Mr. Romanow: Great. Thank you very much, Chair and committee, for the invitation to be here today. As was mentioned, I'm Evan Romanow, assistant deputy minister of health service delivery within Alberta Health, where the addictions and mental health branch sits within the ministry, and as indicated, I'm joined by colleagues Coreen Everington and Kenton Puttick as well as Dr. Deena Hinshaw.

As you've outlined, Chair, we've been invited here to speak to different topics which are closely related, so we'll be doing so jointly. We do have slides to present, so with the indulgence of the committee we would endeavour to walk through with you if that's all right. Thanks very much for putting those on the screen.

Just on the next slide, please, with the purpose, again, it clarifies the two specific elements that we'll be speaking to today. First, Dr. Hinshaw will be speaking to the motion moved by Mr. Shepherd for a technical briefing on the impacts of drug poisoning and overdoses on public health, and the ministry – my colleagues and I – will follow up, speaking with regard to the committee's mandate as described in section 2 of Government Motion 115.

On to the next slide, please. Again, Dr. Hinshaw will speak to the impacts of drug poisoning. Just to be very clear at the beginning – and it will set the stage for the extent that we're able to comment here today and at this point in time – the Ministry of Health does not have specific in-house expertise related to the concept of safe supply as the context and concept being explored here today. No policy related to safe supply has currently been implemented in Alberta, and absolutely further analysis through the work of this committee will be useful to inform future work.

We have as well – I'll allude to it a little bit later in the presentation – commissioned some work as the committee had requested the ministry to do some further exploration related to the concept of safe supply, but that work is forthcoming. So, just to set the stage a little bit, currently that dedicated policy analysis has not been undertaken up to this point.

Next slide, please. As mentioned, I can hand it over to Dr. Hinshaw to provide her portion of the technical briefing. Thank you.

Dr. Hinshaw: Thank you, ADM Romanow, and I would echo your remarks that I am grateful for the opportunity to speak on this very important topic to you today. I want to just say a few things before I get into the very specific data that I'll be speaking to. One is that all of the numbers that I will be talking about today represent people, and sometimes it's easy to forget, when we're talking numbers, that each of those numbers is a person and that that person is connected to friends and family.

9:10

There are ripple effects of all of these harms that we're going to be speaking about today. The harms go beyond the statistics that I will be sharing today. I'll be speaking specifically about some of the direct harms such as overdose deaths, impact on the health care system, but it's really important to remember that there are other harms such as a child losing a parent, which is an adverse childhood experience that impacts them throughout their life course. There's trauma and grief experienced by those who lose loved ones. There are many other harms beyond the deaths, which are just the tip of the iceberg, so I ask that as I'm speaking about the data and the specific statistics, we all remember, again, that this is just one portion of a much broader group of harms that this particular crisis is causing.

It's really important also that we are considering, as I know we all are passionate about addressing this crisis, the importance of destigmatizing the people who are experiencing these issues that we're talking about today and enabling them to seek help. I just want to share a little bit about the findings. When we did a review of the medical examiner deaths related to opioid poisonings a few years ago, we found that most of the people who died opioid-related deaths were male. They had stable, regular housing. So 75 per cent of the deaths – this was in 2017 – had stable, regular housing, and 84 per cent had at least one family member or friend who knew of the fact that that individual was using drugs. However, 66 per cent of the people who died that year were using alone when they died, and sometimes stigma or negative views about people who use opioids can prevent those individuals from speaking out or seeking supports or treatment. Again, I'm just reminding all of us, as we're going through these numbers, to think about the people behind them and the importance of the work to address the issue.

If you go to the next slide. I'll be speaking about some specific numbers, and you'll note in some of the following slides that the data is in different time frames. We have data publicly available in our dashboard, which is regularly updated. Some of the data, such as our emergency medical service or EMS data, we have access to a little more quickly. Other data, such as our deaths data, our hospital in-patients, and emergency department visits, takes a while to collate and then have access to the validated statistics. In some of the data that I'm going to share, you'll see that for 2021 we only have a partial year of data available. So, again, keep in mind that as you're seeing the graphs that are coming forward, some of it is a full year, like EMS, and some of it is a partial year, like some of the other statistics.

What we've seen over the past several years is that in 2019 we had started to see a decrease in hospitalizations related to all substance use and EMS responses related to opioid use. At the onset of the pandemic those rates started to increase, and this trend has continued into 2021. In 2021, unfortunately, we have seen the highest number of overdose deaths for all substances in a year on record, but we only have 10 months of data available. So it's guaranteed that 2021 will be the worst year so far with respect to deaths related to opioids. This is not unique to Alberta. We have seen this happen in other provinces across Canada, which you'll hear more about later in the department's presentation.

If you go to the next slide. Just a few visuals to emphasize some of these numbers. Now, we know that opioids are only one portion of the problem. There are many substances that contribute to deaths. If we look at hospitalizations related to all substance use – the bar is showing you the counts, and the dotted line shows you the rates, which help us to compare even when for the final year, 2021, we don't have a full year of data yet – you can see that hospitalizations related to all substance use did go up in 2020 and again in 2021 if you're looking at that dotted line of rates.

If you go to the next slide. The next slide looks at EMS, and as I mentioned, we do have that data up to the end of 2021. You can see a dramatic increase in the number of EMS responses and the rates related to opioids in 2020 and 2021.

If you go to the next slide. Emergency department visits: we have all substance use. Again, you can see that when we look at all substance use combined, there was a slight decrease in the rates in 2020, with an increase in 2021 as far as we have the data available. However, if you go to the next slide, you'll see ED visits specifically related to opioids, where you can see that the rates, when we're looking at opioids as that subsection of all substances, did go up in 2020, and again you can see for 2021, year to date, the rates are the highest that they've been in the past several years.

If you go to the next slide. We know that there are very specific substances that are involved in the majority of deaths. In 2021, which, as I mentioned, is unfortunately the worst year to date with respect to the number of opioid deaths, fentanyl has been involved in 80 per cent of overdose deaths. We've also seen an increase in recent years in the number of deaths that have methamphetamine detected in those individuals who have passed away. In 2021 that had risen to 55 per cent. Carfentanil, which is even more powerful than fentanyl, was involved in 17 per cent of overdose deaths in the data that we have so far for 2021, which is an increase from 8 per cent in 2020.

The involvement of prescription opioids has shifted over the years, and there's been a lot of work, for example, with the College of Physicians & Surgeons to look at dispensing of prescription opioids. There has been a reduction in the number of dispensations for opioids in the province. You can see the rates there going from 144.7 per 1,000 population in 2016 to 99.8 per 1,000 in 2021. In a similar time frame, and I'll show you some data later, the rates of drug poisoning deaths that involve prescription opioids have also declined from 2016 to 2021. If you go the next slide.

Again, just to emphasize some of the trends that we've seen over the past couple of years with the pandemic, as I've mentioned, we have seen an increase in the number of individuals who have died. If we look at the same time period in 2020 and compare that to 2021 for the data we have so far, that January to October time period, we've seen a 34 per cent increase in the number of deaths that happened in that portion of the year from one year to the next.

We have been increasing the dispensing of opioid agonist therapy and making treatment available to more individuals for the opioid dependency program as one mechanism for that. We have seen a reduction in supervised consumption service visits over that time period, with a decrease starting in 2020 and continuing to remain low in 2021, although naloxone kit dispensing has increased, so

we've been able to make that available to more people in 2021 as that intervention is critical; again, effective when people are not using alone.

Edmonton in 2021 so far has had the highest number of opioid deaths when we look at the major cities, but Lethbridge has had the highest rate. Again, you can see the numbers there. We have seen that, as I mentioned, the majority of people who have passed away due to opioids have been using in private residences, not in public locations. However, in quarter 3 of 2021 there was a slight increase in the number of deaths that were occurring in public places. If you go to the next slide.

I just wanted to emphasize a couple of the trends that I've talked about but with visuals. You can see here the monthly rate of deaths with any opioid identified in that death, and you can see in the last two years, 2020 and 2021 to date, a dramatic increase from what we had previously seen. You can also see on the bottom the monthly rate of death with the pharmaceutical opioid identified, and you can see that that has been decreasing over time, and 2021 year to date has the lowest monthly rates of deaths with a prescription opioid or pharmaceutical opioid that's identified that that person had used prior to death. If you go the next slide.

It's important to remember that there are communities that are differentially impacted. We have been requested by First Nations chiefs to work with the Alberta First Nations Information Governance Centre to produce a report on the impact of drug poisoning deaths in Indigenous and in First Nations people in Alberta for 2020. It's important to note that similar trends and similar risk factors would be present in those who are Métis and Inuit in Alberta. Some of those specific risk factors include the experience of racism and the impact of that in their willingness to seek support or treatment, treatment modalities that may not have cultural appropriateness. There are many people who live in rural or remote areas, and that can impact services. As a group, Indigenous peoples are more likely to experience trauma in their own lives as well as consequences of historical trauma.

All of those things are risk factors that lead to the rates that are on this slide, where you can see that, again, specific to First Nations people in Alberta we have higher accidental opioid drug overdose deaths disproportionately impacting First Nations people, and rates of emergency department visits and hospitalizations in 2020 were also higher in that particular group. I wanted to underscore that it's critical that, given this data, responses to the crisis include working in partnership with First Nations leaders, Métis leaders, Inuit leaders to address the issue of drug poisoning as well as other health challenges faced by Indigenous Albertans. If you go to the next slide.

9:20

I want to talk a little bit about the epidemiology and what we're seeing in terms of the impacts. As I mentioned earlier, the data that we saw in our medical examiner overview of deaths in 2017 is echoed throughout every year, which is that roughly three quarters of drug poisoning deaths for all substances, and this is also true for opioids, are in men, so the vast majority of these deaths are affecting men. If you go to the next slide. They're affecting young men in particular, and again there is that portion, about a quarter, in women. For both men and women we see the highest frequency of deaths happening in ages 25 to 29. You can see here the different colours representing different years, with green being the year to date 2021, and you can see again the highest frequency in that young adult population. If you go to the next slide.

When we look specifically at that young adult population year over year, you can see here again the increase in terms of mortality rates and how that's impacted the different subgroups, the five-year age bands, where 35 to 39, again, slightly higher, but all of those groups have seen an increase in 2020. Again, year to date 2021: it would be even higher. If you go to the next slide.

It's important to look at how opioids relate to other causes of death, and we know that in young adults there is a substantial impact of suicide, and there certainly are the connections between mental health, substance use, substance use disorder. You can see here in the orange that suicide has been a significant cause of death over the past several years for those who are 25 to 39. However, the drug poisoning is the largest category. You can see that in 2020, which is the latest year that we have complete statistics for in terms of causes of death, 43 per cent of all deaths in those in this age group, men and women, were caused by drug poisoning, so, again, more than all other causes combined if you look at the nonsuicide-related causes of death. If you go to the next slide.

The consequence of the statistics that I have just shared are that the potential years of life lost – this is a very standard public health metric when we look at comparing the impacts of different causes of death. If we assume a life expectancy of 75 years and we look at different causes of death to see how many potential years of life lost they have caused, you can see here, in the blue bars, over 2016 to the portion of the year for which we have data, the impact of acute drug poisonings on the potential years of life lost increasing, particularly over the past two years. In the black lines across the graph you can see the 2019 total years of life lost to several other causes of death. You can see that in all years the impact of acute drug poisonings has exceeded that of suicide. In most years it's exceeded that of circulatory disease, which would be the combined impact of heart attacks and strokes, for example, and other diseases of the circulatory system. You can see that in the last two years the impacts of acute drug poisonings have also been greater than unintentional injury and the significant burden that that particular cause of death has on the population.

At this point I'll turn it over to my colleagues to present the department content. Thank you again for the opportunity.

Mr. Romanow: Great. Thank you, Dr. Hinshaw. As mentioned, we'll speak to the second part with respect to the committee's mandate. Moving to the next slide, please. Just a bit of context and to highlight the broader supports and funding through addictions and mental health that are provided to Albertans. The government of Alberta has provided $1.69 billion towards mental health and addictions services and supports. In Alberta – this was a figure from 2019-20 – this includes $1.16 billion on addiction and mental health related services and supports in addition to $535.5 million on related physician compensation elements.

On the next slide, please. Just some specific elements that do relate directly with the areas the committee is speaking to. Fifty million dollars of the $140 million allocated in Budget 2021 was directly for addiction supports. This is in addition to more than $800 million that Alberta Health Services spends each year on related services. Specifically, and in the context of the COVID pandemic, $53.4 million was allocated early in the pandemic to enhance addiction and mental health supports for Albertans, including virtual supports, to respond to emerging needs.

On to the next slide and to my colleague Coreen Everington, who will speak further.

Ms Everington: Hi. Good morning. Just moving to a slide about crossjurisdictional comparisons here for your information, Alberta is one of several provinces and territories that have seen an increase in the number of overdose deaths since the onset of the COVID-19 pandemic. Just to highlight some of those statistics, between January and June of 2021 90 per cent of all apparent opioid toxicity deaths in Canada, where we have available data, occurred in B.C., Alberta, and Ontario. Historically these have been the three

provinces with the highest numbers of overdose deaths. While not all provinces and territories have the same timelines in terms of their data collection and reporting on overdoses, which makes crossjurisdictional comparisons difficult, we do know that other jurisdictions such as Yukon have also observed record-breaking numbers of overdose deaths.

Some numbers for comparison. In British Columbia there was a total of 1,782 suspected illicit drug deaths between January and October 2021, making it their highest year on record. As well, British Columbia has consistently reported the highest overdose death rates of any province in Canada since 2016. Comparing during the same time for Alberta, 1,372 people died from an overdose. Both Alberta and B.C. have seen increases in the involvement of fentanyl and methamphetamine in overdose deaths in those provinces.

Ontario doesn't have the same information available for the same time period but from January to June of 2021 had 1,014 related overdose deaths. Their overdose death rates also remain higher than prepandemic levels. Ontario has also seen the highest stimulant-related hospitalization rates.

Next slide, please.

The Chair: Did we lose you, Coreen? I think you're muted.

Ms Everington: Oh. Sorry about that.

The Chair: Yeah. That's okay.

Ms Everington: Thanks for letting me know.

In response the government is implementing a recovery-oriented system of care to provide a co-ordinated integrated approach to addiction and mental health services and supports in the province. This includes partnering with our community stakeholders and partners as well as multiple ministries working together, including Children's Services, Community and Social Services, Justice and Solicitor General, Education, Seniors and Housing, among others, as well as with Alberta Health Services.

Some really important features of our ROSC, that are really principles guiding our actions moving forward, are a foundational belief that well-being is achievable for all people, including those with a mental illness or experiencing addiction; that we have measurable meaningful outcomes in seven domains known to impact mental health and addiction, including ensuring that people have access to health services both for their physical as well as addiction and mental health needs; that there are safe housing and healthy environments available to them; that they have support to access employment or training and resolve any legal issues that might be outstanding, ensuring that they're supported to have safe and meaningful family, social, and leisure activities; and that there are peer-based supports available to them as well as an ability to engage with the community and have access to cultural supports.

9:30

Maybe just go on to the next slide there, please. Related to our recovery-oriented response, government is funding several initiatives to help Albertans have greater access to life-saving addiction-related prevention, early intervention treatment, and recovery resources. Some of those key examples are on this slide, but it includes establishing 8,000 new publicly funded treatment spaces per year and eliminating user fees for all publicly funded treatment spaces. It also includes the development of the digital overdose response system, or the DORS app, for people who are using alone and still need to have that supervised support and easy access to emergency services. As well, we have expanded access to our opioid agonist therapy and the virtual opioid dependency program, which allows for treatment on demand, and there is no wait-list currently for that program. We also cover the costs of the injectable opioid treatment drug Sublocade, and we cover this cost through the gap coverage program, which also covers the costs for other OAT medication.

Now I'll turn it over to my colleague Kenton Puttick to talk a bit more about some of the continuum of supports that are available.

Mr. Puttick: Thanks, Coreen. If we can move to the next slide, please. In this context of continuum of supports the government has been working to ensure not only that services are accessible but also that they meet standards of quality, have a core set of policies and procedures in place, have appropriate oversight to ensure safety and consumer protections, and are also set out to be integrated effectively within communities and the broader health care system.

One of the ways the government has done this has been through legislation. At the end of 2018 the government passed the Mental Health Services Protection Act. This legislation came into a place where we had and have a highly regulated health system for most medical needs and, in some cases, really no oversight or even a complete awareness of what was going on within the addiction and mental health system. This act gives us a framework to begin addressing this. Presently two types of services are regulated under the act, residential addiction treatment services, which include detox, as well as supervised consumption services.

As we look to move towards that state of quality, safe, and integrated services, one of the ways government is doing this is by making city-by-city changes to supervised consumption services. What you see there on the slide in the bottom bullet is a reflection of the efforts in each city with an SCS or an OPS to strengthen the services, provide access where it's needed, and embed services into a network of providers to meet the wider needs of the substance-using population, including removing barriers to getting them on a pathway to recovery if and when they're ready.

If you could please move to the next slide.

Mr. Romanow: In our conclusion there are a couple of specific elements under section 2 which we'll respond to in similar direct detail before we invite questions.

Kenton, on the first elements, please.

Mr. Puttick: Okay. Thank you, Evan. If you can move to the next slide as well, please. The first thing I'll note here is that what you see there in the first bullet – and Evan also introed this. We are not and we don't have in-house expertise related to the concept of safe supply. We are at the service of the committee to provide objective and technical information, and we commit to doing so as requested. But when it comes to safe supply, we have engaged with experts to initiate a literature review to illuminate the different elements of the committee's mandate.

If you can move to the next slide, I'll talk a bit more about that. Upon receiving a request from the committee, we sought support from the most qualified and experienced experts in Canada, the Centre for Applied Research in Mental Health & Addiction – they go by CARMHA – out of Simon Fraser University, and we asked them to perform an evidence review. When you look at the credentials and experience of their investigators, what we see is that no other applied research team in Canada has the equivalent body of pragmatic work over 30 years, spanning harm reduction to recovery.

We believe the committee will be really well served with this work. Intermediate results will be available to the committee as early as February 15. However, to that end, we don't want to be presumptuous. We were the ones invited here, so as an extension of our own briefing to you today we would recommend that the

committee invite Dr. Julian Somers from CARMHA to present the evidence gathered on each of the elements of the committee's mandate and speak to their work at that time.

Mr. Romanow: Thanks. Moving on to the next slide, related to section 2(a). There are no standard definitions of safe supply that are clearly in front of us. Opioids are drugs with pain-relieving properties that are used primarily to treat pain. Opioids can also induce euphoria, or feeling high, which gives them the potential to be used improperly. The concept is not associated with treating substance use disorder, but models absolutely appear to differ across different jurisdictions. Again, to re-emphasize, Alberta does not have a formal safe supply program though it is possible that some Alberta physicians are prescribing medications for these off-label purposes.

Next slide, please. As you see, there could be some elements – and I think the literature review will point to this a little bit more. Some of the elements within a potential medical system related to the concept of safe supply may include physician-prescribed or access to additional public health programming and resources, which could include drug cost, dispensing, clinical oversight, and supervision. Or, on the other end, elements of the concept of safe supply in more of a nonmedical system may include no physician or medical assessment, unsupervised dosing, no facilitated access to health or ancillary supports. Risks associated would be risk of diversion or health consequences associated with those nonsupervised practices.

On our next slide, related to our assessment in looking at some of the other jurisdictions, at a very initial stance and just for the awareness of the committee, beginning in 2019, Health Canada amended legislation to enable safe supply options and has been funding a growing number of pilot projects in Canada. At least 14 safe supply initiatives have been funded in four provinces through Health Canada's substance use and addictions program: one operates across three provinces – British Columbia, Nova Scotia, and Ontario – and the other programs are located in British Columbia, so five programs there; New Brunswick, one program; and Ontario with seven programs. The longest running program was initiated in January 2019, and the majority have only been established within the last year.

Some initial literature in front of us points to issues in communities with safe supply programs, including increased availability of illicit, diverted hydromorphone, serious infections in patients receiving safe supply medications and, concerning requests for safe supply medications, with less interest in the evidence-based opioid agonist therapy model of care. Again, more information can be presented through the literature.

On to the next slide. Specifically related to section 2(d), Dr. Hinshaw alluded to this, but again just to present the differences on the historical evidence regarding overprescribing, prior to synthetic opioids such as fentanyl entering the drug supply around 2013-2014, opioid poisoning deaths were significantly lower despite the highest opioid dispensing rates. As fentanyl entered the drug supply, opioid deaths began to increase, and the proportion of these deaths attributed to nonpharmaceutical opioids such as fentanyl quickly increased, with a proportion of these deaths attributable to pharmaceutical opioids. Again, typically prescribed opioids were decreasing. At the same time dispensing rates for prescription opioids decreased and have reached one of the lowest rates in 10 years, as Dr. Hinshaw mentioned.

On to the next and final slide, which concludes our presentation and technical briefing. The Ministry of Health absolutely welcomes the dialogue and the findings from this committee, and we look forward to the evidence to help inform work that the Ministry of Health undertakes in the future to inform policies to support Albertans.

Thank you very much, Chair and committee, for your time.

9:40

The Chair: Thank you for your presentation and for taking the time to share this information with us, especially Dr. Hinshaw's words about just remembering that these statistics represent friends, family, and loved ones. I think that's important to frame our conversation.

We're going to open it up for Q and A, and we're going to start with MLA Sigurdson.

Ms Sigurdson: Well, thank you so much, Mr. Chair. Can I just have a point of clarification first? We've heard two presentations. There are two distinct presentations on our agenda. I just want to ask about the time allotment. Are we going to have the standard amount of time for each one?

The Chair: Yeah. We actually didn't schedule a specific amount of time. I want you guys to be able to have as much time with the presenters as we can today, so we're going to take as much time as we can to ask those questions provided we can get the rest of the work of the committee done before noon if that's fair.

Ms Sigurdson: Okay. So it's not specific. All right.

My first question is for ADM Romanow from the Ministry of Health, if I could speak to him. Of course, we know that we're in this very difficult situation of an opiate poisoning crisis here in Alberta. I mean, obviously, we don't have all the numbers yet for last year, but we know it's going to be the highest ever. Up to October more than 1,300 people have died, and it's a horrible situation. When the government was elected, the UCP government, back in 2019, they did recognize this at that time, when it was even less severe than it is now, and did appoint a Mental Health and Addiction Advisory Council. I believe – well, I know – that the chair of that committee is the chair of this committee's father, Pat Nixon. We were supposed to have a final report in the summer of 2020. You know, people were on that committee working to that, and I understand it was extended to the end of December 2020, but we still haven't heard anything about that, yet the ministry obviously is making decisions about the direction of their policy. Is that informing it at all? When will we see that report?

Mr. Romanow: Yeah. Thank you for the question, MLA Sigurdson. Absolutely, as you alluded to, there was extensive work with the committee, that was chaired by experts and physicians from across the addictions and mental health system. The committee absolutely was mandated to build on existing work that was in place such as initiatives with valuing mental health and really look at initiatives to enhance addiction recovery related supports across the province. As you did reference, that work was under way.

Government in the last year did receive a final copy of that report, would specifically highlight that within the context of COVID and the specific responses that the Ministry of Health – and certainly, Dr. Hinshaw can comment more on other elements about the broader response. That report, that work, and that dialogue with experts and community leaders have been informing work. As alluded to, a recovery-oriented system of care and initiatives and public commitments that government has made in budget, in the business plan, and other areas have pointed to those recommendations. There has been an interest to be looking at the releasing of the broader set of recommendations and action plan initiatives; however, we are confirming the timing for that broader release and update on how that work is informing government's actions moving forward.

Ms Sigurdson: Okay. Thank you for that. It's just that it's not, you know, a transparent process, I guess. We don't know what that committee came up with, what the direction was. I believe this

committee would benefit from knowing that. Do you know when that report will be released, if it's going to be released?

Mr. Romanow: Again, I think the dialogue within the committee, which has informed budget allocations, which has informed business planning – those elements which very much have been in front of the Legislature, in the public domain have been steering government priorities for the Ministry of Health's allocations of resources in community. Absolutely, there have been elements informed by the work of that committee which are helping to steer policy. With respect to those specific elements, again, government is confirming the timing. There have been complications within the COVID context, with changing scenarios over the last number of months, where there had been interest to be able to move forward but needing to pull back on that, but we will hopefully be able to confirm in the not-too-distant future what timing looks like for more direct communication on those points, MLA Sigurdson.

Ms Sigurdson: Yeah. It's unfortunate because it is being, guiding anyway, the policies of government, and we don't know what that committee has done.

Maybe I need your direction, Mr. Chair, on this. I do have further questions, but are we going to go back and forth? I just want to be respectful of the process, which is a bit unclear.

The Chair: For sure. We're taking a list here, and we'll do like we normally do, go back and forth between opposition and government. So next up we actually have MLA Yao.

Mr. Yao: My question might be more for the committee and the chair. I noticed in the presentation that they said that the lit review could be done by February 15, which I think is earlier than what we anticipated. My question is: could they present on the 15th? Would anyone object to that? I think having access to that literature earlier would do us all well so that we could review that much earlier.

The Chair: Yes. I would recommend that we deal with this topic later under other business.

Mr. Yao: Okay. Fair enough.

The Chair: Anybody from the government side that has a question?

Mr. Yao: A follow-up question?

The Chair: MLA Yao. Yes.

Mr. Yao: Thank you very much. As a former paramedic in the late '90s into the 2000s, we dealt with the OxyContin crisis, and I'm just wondering if our chief medical officer or anyone who is presenting to us today can explain a little bit about that era and what our learnings were from that, and what are the perspectives on that in relation to this current crisis that we're currently experiencing?

Dr. Hinshaw: Thank you for the question. We do know, if we look at the North American experience with opioids, that we have seen what some describe as three waves of opioid overdose impacts. As you reference, in the 1990s there were increasing opioid prescriptions and the rise in prescription opioid deaths; in the early 2010 era there was a surge of deaths related to heroin; and then, beginning in about 2013, we saw the beginnings of the impacts of fentanyl.

Now, I think it's important to flag that this particular surge, which, again, we've been in for almost a decade at this point, given the beginnings in that early 2013 time frame, has been the worst in terms of the absolute impact, in terms of the length of time that it has lasted, and there are, I think, with every wave very specific contextual factors that need to be considered.

It's clear that when I went to medical school, the training at that time was very focused on the importance of providing adequate pain relief, which continues to be a very important goal, and at that time the prescription of opioids, with fewer checks and balances than we have today, was a part of the issue. However, again, the College of Physicians & Surgeons has done a lot of work, again partly informed by what we've learned from the previous waves and, of course, from early in the wave that's involved fentanyl, carfentanil, and other substances, to make sure that people are able to access pain control, are able to access the medications that they need but in ways that are informed by a view of that patient, of their risk factors, and of the things that they need for their particular context.

Again, there are others who would have a much deeper background in addictions treatment and response who would be able to speak in more detail, but from the kind of overall public health perspective, again I would say that there are things that have been done. As you saw in the slide that was presented earlier, the deaths that involve prescription opioids have dropped dramatically in part due to, again, working to make sure that the prescribers are using that whole-person assessment, making sure people have access to the medication they need while, at the same time, ensuring that people that may have risk factors have access to other types of treatment.

Mr. Yao: Can I have a follow-up, please?

The Chair: Yeah.

Mr. Yao: Thank you so much, Dr. Hinshaw. Following up on that, you talked about the overprescribing by physicians and whatnot. Can you give us a general layout of what the education is that physicians do learn about opioids as well as the addictions related to that? My assumption is that that education has increased because we do see a trend in less prescribing of opioids, but can we get an overall picture of that physician education, please?

9:50

Dr. Hinshaw: If the committee is interested in the details on current education at all levels, so medical school, residency, and then the ongoing continuing medical education that physicians receive through the college and other providers, that's something that we can certainly take away and get back to this committee on with the details. In general there certainly has been a concerted effort by the College of Physicians & Surgeons to provide information, education, and also to provide physicians with their own prescribing profile and how it relates to peers and colleagues. There are various aspects of the work that, again, I wouldn't be able to speak to in detail since those are pieces that are being done by other organizations, but certainly that's something that we could take away and bring back in more detail.

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

Mr. Shepherd: Thank you, Mr. Chair. I appreciate the opportunity. Thank you to both Dr. Hinshaw and the folks in the ministry for their presentations. I did have some questions for Mr. Romanow regarding the presentation from the ministry and specifically, I guess, the safe supply evidence review. Mr. Romanow, I think you're aware that in the mandate for the committee there was presented a particular definition of safe supply, that is:

> examining the concept of "safe supply," defined as the provision of pharmaceutical opioids, heroin, crystal methamphetamine, cocaine, or other substances to people who are addicted to or dependent on these substances.

There was some discussion. There have been some critiques expressed about that choice of definition. It's rather broad. In the safe supply evidence review that you are requesting from CARMHA, is that the definition that's being put forward to them, or are we asking them in this case to conduct a review of the policies that are actually in practice amongst various provinces? Are we asking them to conduct this review based on this broader definition?

Mr. Romanow: No. Correct, MLA Shepherd. We've absolutely been a conduit, as the committee and the Legislative Assembly has requested of us, providing those exact directions and language to CARMHA for their assessment to be able to provide that support. Just to reiterate the Ministry of Health's commitment to support the work of this committee, you know, with subsequent work as it's required, that was the additional direction for the Legislative Assembly and the ministry to be able to provide that support. It was directly based on the language provided.

Mr. Shepherd: Thank you, Mr. Romanow.

In regard to CARMHA I appreciate what you've said about their expertise. Certainly, a quick review online does show that indeed they have done quite a bit of research in this area and have some knowledge to bring to the table. I guess I have a couple of things I just want to ask about that. First of all, was there consideration of any others that might fulfill this role and provide this review? Secondly, the selection of Dr. Julian Somers, or the recommendation, rather, from the ministry. Dr. Somers, as you say, is one of the researchers there, but I would note in an article from January 13, 2021, in the *Vancouver Sun*, entitled Addiction, Homelessness and Evidence to Build Back Better, Dr. Somers expresses some very clear opinions on the concept of safe supply. I'll read into the record a couple of quotes.

> Effective assistance often costs the public less than leaving people homeless, which in B.C. has been shown to cost around $50,000 per person per year. But rather than expanding effective services that promote agency and human dignity, our leaders contemplate vacuous practices like giving homeless people more drugs.

The second quote:

> The primary limiter of change is the availability of a life worth living. No amount of "safe supply" can provide that.

Mr. Romanow, I certainly would agree with Dr. Somers on some points. Certainly, the provision of housing and other supports and certainly supportive housing in particular indeed reduces costs and is an essential part, but I do have some concerns that a recommendation of the gentleman to present what should be unbiased evidence to this committee on such a review is on the record having just given a very particular view and using some, I think, more than academic language in expressing that view. Do you have concerns with these positions taken by Dr. Somers and being the one, then, to present this?

Mr. Romanow: Just in response to that concern, to be clear, the ministry has not engaged CARMHA nor this researcher for their views on this topic. It is a literature review that was requested of the Legislative Assembly and the ministry to undertake. That presentation of their literature review and the assessment from the broader medical and research community is the information that will be provided. It is not the specific views of that researcher or CARMHA that are the topic of focus with what was requested.

The Chair: Mr. Stephan.

Mr. Stephan: Sure. Thank you. I just had a question about slide 19 in the presentation. I just want to reference it because I want to help define the problem relative to drug overdose issues. I noted that in slide 19 it says that suicide fell during 2020 and that drug poisoning deaths increased in 2020. I know that sometimes, unfortunately, individuals do commit suicide through drug overdoses. So just in making your determination of whether someone has died of a drug overdose or by suicide, how do those statistics that you provided in slide 19 differentiate between someone committing suicide with drugs and someone dying from drugs?

Dr. Hinshaw: I think this is something I can speak to. Then, Evan, if you have anything to add, please feel free. The assessment of which death is a suicide is made by the medical examiner's office. They look at the circumstances of that death and the evidence that's available and whether or not that death appears to be intentional or not. The suicide deaths – again, I would have to go back and confirm this because this is based on previous involvement with the file. My understanding is that when a death is a suicide, it is classified as a suicide, whether the cause is intentional ingestion of a substance or any other cause of suicide. The way that we in Alberta classify the opioid poisonings is the unintentional opioid poisoning separate from the intentional. We'll take that away and confirm that. That's the way that we have historically categorized, but I just want to make sure there hasn't been a shift in recent years.

I see Evan nodding. I'm not sure, Evan, if you can confirm that that is our current approach.

Mr. Romanow: Yes. That's consistent. We would need to take that away. As you referenced earlier, Dr. Hinshaw, I think that the lag and even reporting for the assessment of cause of death is a factor through the medical examiner's office, for confirmation of that. We could further clarify if there was a desire, but our understanding is consistent with yours, Dr. Hinshaw.

The Chair: Did you have a supplemental, Mr. Stephan?

Mr. Stephan: No. They answered my question. Thank you.

The Chair: Perfect. MLA Ganley.

Ms Ganley: Hello. Thank you, Mr. Chair. My question is for Dr. Hinshaw. I think, you know, as we're addressing this, it's good to know what it is we're dealing with. I'm just wondering: with respect to the unintentional opioid deaths that are being categorized that way, is there evidence that all of those people were suffering from an addiction?

Dr. Hinshaw: What I can speak to is the data that was available in the detailed review that was published in July 2019 of medical examiner reviewed deaths that happened in 2017. To be clear, it's not possible without a very detailed analysis to be able to see exactly what those trends are. But in that particular review of the medical examiner data, not all individuals who died from opioid poisoning had a diagnosis of substance use disorder. It was common in that group but not necessarily universal, and there are several reasons for that. Certainly, there are people who may have substance use disorder that is not diagnosed, but there are also people who may die of unintentional opioid poisoning who may not meet the criteria for substance use disorder. Both of those things are potentially some components of that, but again the lack of a diagnosis would not necessarily mean that person did not have that diagnosis criteria. It just means they hadn't sought care and then had that diagnosis in the system.

10:00

Mr. Romanow: Dr. Hinshaw, if I may supplement. MLA Ganley, I think you raised a significant point related to the tracking and identification of the needs of individuals from a health system perspective. Members of the committee will be quite familiar, I

would expect, related to recent discussions about the use of a personal health number within supervised consumption services and overdose prevention systems and facilities and being able to have an understanding of individual clients and users from different parts of a system, be it children in care, the corrections system, or broader health facilities. It's critically important to understand the needs of individuals to be able to respond to some more of those root cause issues as opposed to just the symptoms that might show up in the most unfortunate ways, through fatalities, emergency department visits, et cetera.

That's very specifically the intent, to respond to exactly the point you are raising about the need to have integrated sharing of information to be able to provide health system responses.

Ms Ganley: Yeah. Thank you. I appreciate that that is your view, Mr. Romanow, but what I'm trying to get at here is sort of the underlying kind of: what is the problem that we are dealing with? I think, Dr. Hinshaw, what I heard you saying is that there is no definitive evidence that in 100 per cent of cases the individuals were suffering from addiction. That is, there may be circumstances in which an individual died from an unintentional drug poisoning and they wouldn't meet the diagnostic criteria for an addiction.

Dr. Hinshaw: That's accurate. So the data that we have, again, from that analysis, that comprehensive analysis of all deaths, indicated that in 2017 71 per cent of the individuals who died from opioid poisoning in that year had a previous diagnosed substance use disorder. It is important, though – and, again, some of this relates back to stigma and other issues. The 29 per cent of those individuals who died: some of those individuals likely would have had a diagnosable disorder that they simply hadn't sought treatment for, but it's not possible to specifically characterize of that 29 per cent what proportion would have had the substance use disorder criteria but simply hadn't been diagnosed at that time.

The Chair: Excellent. MLA Milliken, you're up next.

Mr. Milliken: Thank you, Chair. I think that ultimately this question may go to Mr. Romanow or Dr. Hinshaw. Forgive me. I've been scrambling to take down notes throughout this whole process, and I do want to just pre-empt this with a statement that ultimately I'm coming to these questions not with any kind of a preconceived expectation of what sort of decisions should be taken or anything along those lines, but I think it's fair to say that, based on our mandate, we're kind of focused or zeroed in on the idea of contemplating safe supply.

I'm trying to just focus on some of the data that was provided in your presentation and then also just kind of – if we're taking data points, I recognize that B.C. is just one other jurisdiction, but sometimes crossjurisdictional comparisons can be valuable, and it almost seems like there is a bit of a test case in the sense that I think that B.C. implemented a safe supply system, in some respects at least, in 2020. Feel free to jump in and correct me if that's wrong, anybody, because that's a premise to this question. Okay. Hearing none . . .

Mr. Romanow: Within the last year. Correct.

Mr. Milliken: Sorry. Last year? Because we're in 2022 now.

Mr. Romanow: Yeah. Starting in 2019 but I think taking effect through 2020, and launching July 2021 I think is where there was more direct service. But, yes, within this kind of last year time frame related to the provincial policy work.

Mr. Milliken: Okay. So starting in 2019. Does that just mean localized? Sorry. I'm now taking it off track. Does that mean just in local areas there was safe supply available and that then in July 2021 it was ramped up to be province-wide?

Mr. Romanow: I would have to confirm specifics about where elements began. One very direct element to point to is the B.C. Ministry of Health policy release. This was in July 2021. There was a policy that is out that is related called Access to Prescribed Safer Supply in British Columbia: Policy Direction. There was a policy statement, some specific initiatives funded and enabled through the federal government in and around that time frame. Specifics: we would need to come back to confirm an exact time frame in more detail.

Mr. Milliken: Okay. I'm still going to try to stick with the data on this. It helps me make an even more kind of direct question in the sense that looking at I believe it was slide 22 – and some of this will actually be, I think, verbatim. I don't have it in front of me, but I think it was stated that B.C. has seen similar increases in the involvement of fentanyl and meth in overdose deaths. I believe this is all relative to Alberta. B.C. has the highest year on record in 2021 with regard to opioid deaths, I think tracking, then, similar to Alberta.

All I'm asking is that I think this has to be based on the data post, just because I don't think we're too clear with regard to prior to July 2021 with regard to the availability. That could be a question that might come up should we find out what was available prior to July 2021. Post July 2021 can it be said, based on the data, like, that B.C.'s safe supply system has objectively helped with their drug poisoning death crisis? Again, based on data, I guess, since July 2021. Does that show through in the numbers?

Mr. Romanow: I'm sorry. I don't think we could say one way or another what the data is suggesting. We're hopeful that through the literature review there will be evidence to point to. We have not as a ministry performed that analysis. I'm sorry; we couldn't comment.

Mr. Milliken: Okay. Fair enough.

I guess what I'll do, then, is just a bit of a follow-up. I was listening to – and I couldn't see the number of the slide, but I think it was the second-last slide. This may just be obvious, but I'm not a hundred per cent sure what correlation you were getting at with regard to the dip. Can you just explain that slide again for me?

Mr. Romanow: Sure. I'd invite Dr. Hinshaw to weigh in as well. It relates to the prescribing rates and historical evidence of overprescribing from a physician perspective. It was a comparison or assessment of the deaths overall that are seen from nonprescribed. Pharmaceutical opioid-related deaths starting in the earlier years: that slide was showing that the vast majority of opioid-related deaths were pharmaceutical based or based from prescriptions as opposed to increasing in recent years, and now the vast majority of deaths are nonpharmaceutical-based opioid deaths. The dip that you saw on the curve – and certainly the committee clerk could bring that up if it's helpful to see that again on slide 32. It shows the prescribing rate decreasing, which correlates with a decrease in pharmaceutical opioid deaths. However, it's the nonpharmaceutical opioid deaths which are increasing relative to that rate.

Dr. Hinshaw, anything else to add?

Dr. Hinshaw: I'm not sure if the dip being referenced is the lower numbers in 2019. MLA Milliken, is that what you're referencing in terms of the dip on that second-last slide?

Mr. Milliken: Now that I see it, I'm seeing a trend line, basically, right? "Dip" would be the wrong word now that I'm seeing it again; trend line going down. Just for clarity, then, what we're saying is: as fewer pharmaceutical opioids are being prescribed, then we have fewer overdose deaths attributed to those who are receiving the pharmaceutical opioids, but we are seeing an increase generally with regard to nonprescribed?

10:10

Dr. Hinshaw: In terms of the time trend, yes, the dotted line is the time trend of the rates of prescription opioids, so opioid dispensing rate per 1,000. You can see that that has been decreasing since 2016, and certainly in 2019, 2020, 2021: some drops there. You can see that the pharmaceutical opioid deaths have been decreasing, again, since beginning that decrease in 2017, continuing to decrease throughout the subsequent years. I would just say that there's not a direct correlation and that we had similar opioid dispensing rates in 2020 and 2021, with different death rates due to pharmaceutical opioids. So, again, it's not a 1 to 1 ratio, but certainly the trend line – again, as you say, there's a trend line that correlates.

Mr. Milliken: Okay. So we have a general . . .

The Chair: Sorry, Nick. MLA Milliken, you've had several supplementals, so we're just going to give the opposition a chance to ask a question. We can put you back in the queue if you'd like.

MLA Irwin.

Member Irwin: Thank you. Yeah. And thank you to Dr. Hinshaw and to all the presenters. You know, this is a very important conversation to me as I've seen first-hand the impact of drug poisoning on the communities that I represent in Edmonton-Highlands-Norwood, and I know that there are people watching this committee meeting who have lost loved ones to drug poisoning and to the opioid crisis. I'm sending my love to them. Also, a shout-out to those on the front lines who are working in health care and harm reduction.

Dr. Hinshaw, can I just ask you to expand on what factors have led to the last two years being the deadliest on record regarding drug poisonings in Alberta? As we see in the data, you know, the numbers are highest here in Edmonton in 2021. Can you expand perhaps on the role that the toxicity of drugs plays?

Dr. Hinshaw: This is a really important question, and unfortunately it's one that we don't have all of the answers to. There was so much that changed in 2020 and 2021 as we responded to the pandemic. I think it is going to be a topic of, I hope, much research and investigation to help us understand what all of those intersecting factors are. Certainly, there is a component of the increase in deaths that, again, aligns with when we had to respond to COVID-19 through public health measures. There are potential implications to that in terms of the flow of illicit drugs and what supply is available.

There's a correlation with respect to isolation and people potentially being more likely to use alone if the public health restrictions were in place. We know, again, that the majority of opioid-related deaths occur in someone's own home, so whether or not there's a correlation between people who were more likely to be isolated and therefore not have someone who could intervene. There's a correlation between the – certainly, in the early days some of the restrictions that were put in place impacted service availability. We did try very hard as quickly as we could to mitigate the impact of direct public health restrictions on service availability.

I believe that there's no single factor with respect to driving the increase in deaths. I believe there are multiple factors, including the illicit supply, including service availability, including social factors such as isolation, and that all of those things are likely partially contributing to this, but I don't believe that anyone has been able to demonstrate definitively what the relative proportions are or how all of those factors have intersected.

Member Irwin: Thank you. I'm quite keen to dig a little bit more into those factors. You know, I do wonder. You pointed just now to the point that a lot of folks are using alone and dying alone, which – again, from my local perspective, I see the value that supervised consumption sites play in saving lives and giving folks a place to use safely.

You also mentioned, Dr. Hinshaw, the increase in naloxone use, and I wonder: could you perhaps expand on the role that these harm reduction supports play in ensuring that people have access to the health care system in its entirety, which, of course, you know, includes treatment services?

Dr. Hinshaw: In public health we talk about the spectrum of prevention from primary prevention, where you work to prevent an adverse outcome from happening at the root causes. You're trying to prevent people from progressing down a road to having a poor health outcome. Secondary prevention is where you're screening to find people who are at an early stage of whatever that health outcome is and intervening quickly on minimizing the chance that it could progress to a later stage. And tertiary prevention is where someone has developed a health issue and they need a variety of services from harm reduction to treatment to recovery in order to be able to maximize their full health potential. I would say with respect to the opioid poisoning issue, with respect to how that relates to substance use disorder, I think that it's critical to use a wide variety of tools to have that full spectrum of supports from primary to tertiary prevention.

In the tertiary prevention category, everything from harm reduction to treatment to recovery, I think that, again, we tend perhaps sometimes in public discourse to imagine we might know what a person who would be at risk of an opioid death would look like, but I think that there's not one single snapshot of what people look like. It's across all ages. It's across all genders. It's across all social strata that we see people who are at risk. So I think we need diverse options to be able to meet people where they're at, to move them along to achieving their full health potential.

It's important to note with naloxone in particular that in 2021, as was noted in the presentation and as you referenced, we had high dispensing rates of having naloxone given to people. Of course, it's challenging to know how many of those doses were used. Naloxone is, of course, going to be beneficial when someone uses when other people are present. When using alone, naloxone will not help to intervene.

Again, I think that the critical piece is having a broad spectrum of supports available, working to destigmatize so people who are in situations of risk feel that they can reach out, that they can let people know, that they can access the services that are available. There's no single approach that will work for everyone.

The Chair: Excellent. MLA Yao.

Mr. Yao: Thank you so much. I think it's important for committee members to understand the evolution of the rehabilitation that's happened. Dr. Hinshaw, I'd just like you to clarify a lot of that, but from my perspective, historically there was only rehabilitation available. It was a very black-and-white approach to addictions. Someone along the way identified that it was really inhumane to be rehabilitated cold turkey. We saw that in mainstream media and stuff like that, through movies like *Trainspotting*, where they show someone drying out and the pain and suffering that they went through.

You listed off a long list of therapy and supports that are available, from recovery coaching, opioid agonist therapy, virtual opioid dependency programs, digital overdose response systems. We've added 8,000 new treatment beds on top of what was already available. We have Narcan kits available, drug courts, safe injection sites. Is it safe to say that we have many options now to support treatments for individuals based on their willingness and need? I guess, what's your perspective on that? Do we provide a lot of options that enable anyone, regardless of where they are on the spectrum of addiction, to have some support and help and to support their recovery?

Thank you.

Dr. Hinshaw: I would just say a couple of things. One is that when people have a dependence on a substance, whether that's alcohol or opioids, it can be life-threatening to go into withdrawal. So it is really important that the physiological impacts of – again, for someone who's physiologically dependent on a substance, it would be dangerous for them to be not using that substance that their body is dependent on without some kind of treatment to be able to safely, if that's the course that they're on, transition out of that dependence. So that's really important to recognize, that there is a physiological risk.

10:20

I think the other piece – it's difficult for me to answer the question whether our current system of supports is adequate for every individual who may be using illicit drugs or have substance use disorder. I think that, again, as I mentioned earlier, there is a wide variety of people who use drugs. There's a wide variety of people who experience substance use disorder, and it's really important – one of the things that I think is important is that we understand the barriers that differing individuals experience to accessing services. Without having that data, which I know has been a little difficult to access in different time periods, it would be hard for me to say with confidence that our current suite of services is adequate for every individual.

Again, my perspective is that in order to support individuals who are in different contexts and different places, we need to consider a broad range of services across the primary to secondary to tertiary prevention, as I mentioned, and within that tertiary prevention is considering everything from harm reduction to treatment to recovery. I'm sorry. I don't feel like I can give you a definitive yes or no answer. I would just emphasize that a broad variety of supports is critical because there are many different people who are experiencing challenges related to this topic.

The Chair: MLA Sigurdson is up next.

Ms Sigurdson: Thank you again. Yeah. I'm just going to direct this question to ADM Romanow again. Hello. I'd like to talk – I mean, obviously, we all know that this government has made pretty bold statements about this recovery model that they want to use, and they talk about, you know, treatment beds, treatment spaces, detox beds. Some are publicly funded; some are not. Recently there was an announcement that these had actually been doubled. It's just kind of a quagmire, you know? It's just, like, understanding exactly what is being counted, when, and some of them used to be in the Ministry of Community and Social Services. Anyway, it's a big confusion.

Certainly, my understanding when I was talking to stakeholders was that they don't understand how it's all, you know, identified. So I would really appreciate your help in this. To be frank, it probably would be great to have some kind of a written explanation just to give us the details of that. If you could just perhaps start, Mr. Romanow, speaking about what is being counted here so that we understand.

Mr. Romanow: Thank you for the question and comment. I absolutely recognize that what you're also referring to is: what's that broader suite of supports across the whole system so that it actually functions as a system and those individual pieces? We absolutely, MLA Sigurdson, could share the specific numbers of what's being counted in those residential addiction treatment spaces and what the 8,000 refers to. It's not, you know, 8,000 beds that are just all appearing at the same time. What it specifically is counting is the spaces of treatment over the span of a year, the number of individuals that can go through the system, and to emphasize in a public way, with no cost barriers, the number of individuals in the span of a year who can access free treatment supports. They're all across the province. It's leveraging some existing capacity, additional capacity across both nonprofit, community, and public settings and additional dollars to support those spaces. We would happily submit to the committee, if there was a desire, that list of what is counted there.

Again, that's not counting anything in the shelter space or group homes or continuing care, but I think, again, to part of your earlier question, it's very important to look at the pathways of supports and referrals between those different types of services and supports so that there's that integration. But with the specific counting, we would absolutely be able to share. There was a public release, and I can confirm the timing of that with those numbers, but we can share those specific details.

Ms Sigurdson: Thank you. I'll do a follow-up.

I just do want to ask: has that funding model changed for treatment spaces, and would these spaces have been, you know, funded previously but now, because it's this new model, they're being counted even though they existed before?

I also just want to say that, yes, absolutely, I am requesting that these questions and what you're responding to and the details of that be in writing to us as a committee. That would be fabulous.

The Chair: Excellent.

Oh, sorry. Did you have a response? I apologize.

Mr. Romanow: Yes, I absolutely do have a response, just for clarity. The process that has been under way: these are contracted spaces through Alberta Health Services. That has been part of the effort to provide that funding for Alberta Health Services to oversee, in some cases administer, but contract out with third parties. The main important piece is that these are spaces that, in some cases, might have come with a fee for Albertans to access. These are spaces with the new allocation of resources so that finances are not a barrier to be able to access them. That's the broader suite of supports that are layered on.

Absolutely, you're right. Prior to this commitment of 4,000 spaces and the delivery of 8,000 spaces that were previously available, they were free spaces, but it's this commitment to enhance the overall numbers that are available. Really, as part of a standardized model and to make sure that there's that predictable and sustainable funding as part of the overall system going forward – I don't know if it's appropriate, but I'll just share the news release that outlines the specifics there so you have it in real time, but we would be happy to share additional details. But, MLA Sigurdson, some of the very specific numbers, just to point to how that calculation was arrived at and what that definition is, I'll just share that for the committee's awareness.

Ms Sigurdson: Thank you so much.

The Chair: Thank you.

MLA Stephan, you're up next.

Mr. Stephan: Sure. Thanks a lot. My question is actually a bit more basic. I want to talk about the concept of safe supply. I'm not really sure

where that term originated from. My understanding is that drug poisoning, death, injury can occur with prescribed medications in the form of a safe supply. My understanding is that individuals who suffer from these addictions will seek a high and that if they take enough of so-called safe supply medications, they can die. My question is: is the term "safe supply" misleading? Are these prescribed medications actually safe?

Mr. Romanow: I can start to respond, and, Dr. Hinshaw, please feel free to supplement. I think as part of our presentation, as we outlined, there is no clear definition of safe supply that's directly in front of us. Multiple models or interpretations of what that may look like have been applied in other jurisdictions. I think you point to an element related to opioids and elements to relieve pain. But there's no standard definition.

That's precisely the point, I think, of the request that the committee made of the ministry and the Legislative Assembly to do that literature review, to identify some of the specifics about the concept of safe supply, and that's what will hopefully be able to inform this discussion in front of you and certainly in front of the ministry going forward.

Dr. Hinshaw, anything to supplement?

Mr. Stephan: Sorry. Can I just intervene with that? The committee has been given a mandated definition of safe supply. So as it is defined within our mandate, is safe supply actually safe?

Mr. Romanow: That certainly is not any analysis that has been extensively, well, I would say, undertaken to this point and certainly not extensively by the ministry to determine based on the definition that the committee has provided. Is it safe or not? I think there are many variables. What are we specifically referring to? What type of program? Those elements have not been defined. I understand and certainly see in the mandate of the committee how it is defined, but I think the question to study "Is it safe?" – we would need to understand: how is it being delivered, in which contexts or jurisdictions? That would require further analysis.

10:30

Dr. Hinshaw: And, ADM Romanow, if I could just add to that, the parameters of the program, as you say, and the literature review, I think, will be important to determine that question of "Is it safer than illicit drugs?" which I think is the question that the lit review is being asked to answer.

Just from a physiological perspective, the only other thing I would add is to say that any opioid, independent of what type, can cause death. It's also true that an individual who has been using an opioid for a long period of time develops a tolerance just physiologically in terms of the amount of an opioid substance that would be considered to be dangerous or not for that person. So different strengths of opioid could be taken without causing death, depending on that person's tolerance level, which is a function of what substances they've been taking over the preceding weeks and months.

The challenge is, of course, that there's no single dose of opioid of any kind that will always be safe or will always be dangerous. It really depends on the individual as to what that tolerance level is. Part of the challenge with illicit supply is that any particular amount in an illicit supply is not regulated, so it's not consistent from one batch to another how much of the active ingredient would be in that, and therefore it's less predictable. Pharmaceutical opioids are more predictable in terms of the volume or the strength of the opioid in a particular dose. So the main difference between illicit supplies and prescription supplies is the predictability of the substance.

Again, the question of safety or not is contextual both based on program elements, as ADM Romanow has described, as well as, from an individual perspective, what that tolerance level is and what a toxic dose would be, what for them would be a toxic dose.

Mr. Stephan: Can I just clarify, then, what you just said? So an unillicit drug supply can be unsafe?

Dr. Hinshaw: Any medication can be unsafe, depending on how it's used. Again, in the context of opioids, the difference between prescribed and pharmaceutical medications and illicit is the consistency and predictability of the dose. That is the difference. Of course, any medication can be unsafe, depending on how it's used.

The Chair: Excellent. Thank you, Member, and thank you, Dr. Hinshaw.

MLA Shepherd, you're up next.

Mr. Shepherd: Thank you, Mr. Chair. Mr. Romanow, on slide 31 you talked about how, beginning in 2019, Health Canada amended legislation to enable safe supply options and has been funding a number of pilot projects in Canada. I just wanted to clarify to begin. You also spoke in your presentation that to date, or at least currently, there is no expertise within the Ministry of Health regarding the concept of safe supply. Just to clarify, up until this point there has been no research done, there has been no outside expertise sought, or are you simply saying that nobody within the department has that expertise as opposed to that you have not to this point consulted any outside expertise on that topic?

Mr. Romanow: I think it would be fair to say – and Dr. Hinshaw can certainly add more – that whereas the ministry and the chief medical officer of health's team would have epidemiologists or other experts in particular fields, there is not that type of expertise related to this concept of safe supply, again, however that might be defined. Then in the deeper analysis, of course, at various points with any concepts in the public health domain there's awareness, and certainly this concept has been discussed previously in the ministry. But I think that on some of the specific questions, in the mandate of the committee, asked of the ministry – what is the evidence that's been provided related to proposed safe supply as a concept? – we do not have that extensive evidence to be able to provide that. So, yes, you're correct in that regard.

Mr. Shepherd: Did Dr. Hinshaw have any comment?

Dr. Hinshaw: I wasn't sure if the member wanted me to address that. I would agree and just say that as a medical professional I have a specific area of expertise in public health but rely on my colleagues across multiple other areas of medicine to provide their specific expertise such as addiction medicine, which is not my specialty.

Mr. Shepherd: I understand. Thank you.

If I may follow up, Mr. Chair – and this would be to Mr. Romanow – I appreciate that clarification. I was just asking because we know that, as you stated, there has been the federal program, and indeed there was a decision made within government to move against a program that was being negotiated with community groups to potentially access funding.

Now, we know from an article in the *Globe and Mail* in February 2021 that there was $44.2 million that had been committed by the federal government to work with a number of provinces. As they state in the article:

> But provincial conservative governments have balked . . . [and] Alberta's United Conservative government quietly shut down community-based efforts to launch [such a] program.

According to the *Globe* they learned that there was a group that was partnered with Alberta Health Services. If I may quote:

> When it was approved, staffers from the province's Ministry of Mental Health and Addictions "pressured" the groups to withdraw their application, according to two people with direct knowledge of the dealings.

Given that the government appears to have made a policy decision at that time but there has not been, as you said, the actual expertise within the department, is that something that was discussed with you as department officials, and if so, what was the policy based on if we do not have that expertise in-house?

Mr. Romanow: The details of that specific case: MLA Shepherd, absolutely, I'd have to go back and look. I'm not directly familiar with the specifics of what's being referred to or what communication there may or may not have been with community groups. I should say, just to clarify, that there absolutely is expertise in elements across the mental health and addiction space within Alberta Health Services and community. But as it relates to particular program and policy decisions in areas like safe supply, there has not been an explicit stance, as we have seen, where there are formal policy documents or strategies put out in those regards one way or another related to safe supply in Alberta. Again, the specifics of that case and particular program funding that may be coming from another order of government: I am just not familiar to comment on that piece. I apologize.

The Chair: Excellent. MLA Milliken, you're back up.

Mr. Milliken: Well, thanks. I didn't have a hand up or anything like that. I think the point that was made through the questions was adequately done.

Thanks.

The Chair: Perfect. MLA Amery, then.

Mr. Amery: Thank you very much, Chair. Thank you to Dr. Hinshaw and Mr. Romanow for your presentations here this morning.

I want to go back a little bit to some of the points that you raised in your presentation with respect to the B.C. program. We know that from the discussions here today, from the information that we see available, the province of B.C. has implemented a safe supply program as of spring of 2020 with the goal of reducing opioid-related deaths and other adverse effects. I note from the data that you have provided to us, however, that opioid-related deaths continue to increase despite the implementation of that program.

I think it's important for us as a committee and as this province to have information available to us from other jurisdictions for the benefit of our own analysis. I think that if we're about to embark upon this analysis of a safe supply program, one of the best ways to do so would be to consider the effectiveness of this particular initiative from our neighbours to the west. I also place, I think, a significant emphasis on crossjurisdictional analysis of other Canadian provinces as they share many similarities with our province.

Now, to the extent that you can provide some background and with that preamble in place, what specifically are you guys seeing in B.C. that would explain this increase in opioid-related deaths despite having the safe supply program in place for now nearly two years?

Mr. Romanow: Thank you. I do just want to reiterate, I think, some earlier comments. Absolutely understanding the context and the question, we are just not in a position to be able to drill into the specifics related to the parameters of programs that are delivered in B.C. or, importantly, in other jurisdictions. As you highlight, there is much to be learned in research and evidence related to the delivery and outcomes.

10:40

I think, as Dr. Hinshaw alluded to, there are many variables that relate to trends that we are seeing, as was referenced, and I think the data that you're referring to is the increase in deaths in British Columbia related to opioids, as we've seen increases in many jurisdictions, Alberta included, and significant increases over the last two years, which are deeply alarming. However, to specifically point to a correlation one way or attribute it to a particular program: that analysis has not been done, so I couldn't comment one way or another on specific variables related to B.C. programs.

Again, we're hopeful that in this process under way some of the assessment of literature and research will help to uncover that. Absolutely, the ministry is focusing attention as all of you elected officials are squarely pointing to this as a priority to help inform decision-making, but we just aren't in a position to comment one way or another. I apologize.

The Chair: A supplemental question?

Mr. Amery: Yeah. Thank you for that. I understand the position that you've mentioned and perhaps some of the information that may not yet be available to you, but I'm going to continue and maybe suggest or, hopefully, put something to your mind to consider going forward in the future. Now, I think the increase, that you mentioned earlier, that is evident in B.C., Alberta, and many other jurisdictions may be in part related to pandemic-related obstacles, some of which are fairly obvious, I think, to most people: reduced access to treatment facilities, physicians, support services, and that kind of thing.

Now, this may be something that requires a subsequent follow-up, and I appreciate that you may not have that information with you today, but it doesn't necessarily relate to a specific analysis of the B.C. safe supply program but more to a general question about opioid-related deaths throughout Canada, including specifically with focus on B.C. Have we seen a measurable increase, decrease, or a similar proportionality as it relates to opioid-related deaths in B.C. when compared to Alberta and other jurisdictions that do not have a safe supply program?

Mr. Romanow: I just don't think, to talk about the proportionality, that I could explicitly comment, you know, certainly, with a degree of detail. That is what the evidence review is directly targeted with, with the questions asked of the committee, to bring forward that information, as we've outlined, as early as February 15. Initial findings from that evidence review will be able to be presented to the committee, and subsequently, as there are opportunities to drill into that, I think there will be an opportunity for more assessment. I believe that there has probably been that type of assessment in community and through evidence-based research. We just couldn't talk about that correlation of rates at this time.

The Chair: Excellent. Thank you, Member.

Next we have up MLA Ganley.

Ms Ganley: Thank you very much, Mr. Chair. I think this question is likely for Dr. Hinshaw, but I'll let anyone jump in. I mean, it's generally my understanding that when someone receives sort of treatment for an ongoing addiction, there is a pretty high risk of relapse. In fact, my understanding is that it's often the case that someone will relapse sort of multiple times on their path to

recovery. With the increasing toxicity of the drug supply, which I think we can all agree on, what is sort of the risk in terms of people relapsing? What is the risk of relapse in the sort of context, I guess, of that increasingly toxic supply?

Dr. Hinshaw: Again, I think this is a critical question, and I think that certainly the risk of relapse is high for somebody who is in treatment for a substance use disorder. I don't have the specific statistics at hand in terms of the proportion of people in treatment that may go on to have a relapse, but it is absolutely a consideration. It's true that if an individual is in treatment for a substance use disorder related to opioids – and I mentioned before the concept of tolerance. If somebody has been using opioids and has built up a tolerance to a particular level or dose of opioids and then they are in a program and they're not using opioids, if they do go back and use the same amount they used before, that would put them at substantial risk of overdose. As I mentioned before, certainly the main difference between prescribed or pharmaceutical opioids and illicit opioids is just that lack of consistency.

Those are kind of general concepts. I think that if you wanted a lot more detail with respect to the data about the proportion of people who experience relapse or some of the specifics of those kinds of risk, probably – I don't know if there's going to be an addictions medicine specialist who is speaking to this committee, but they would likely have that more detailed kind of clinical, granular, patient-specific look. But at a broad-based concept certainly those are all things that are accurate in terms of the level of tolerance and then that risk of relapse, of a severe outcome.

The Chair: A supplemental?

Ms Ganley: Yeah.

The Chair: Go for it.

Ms Ganley: Sorry. Was that me? Okay.

The Chair: Yeah.

Ms Ganley: Very confusing on the video sometimes.

Yeah. I think my follow-up on that would just be – would you suggest, then, that in addition to, like, even in a situation where you're sort of treating on the basis of steering everyone towards recovery, which I think is, I mean, ultimately the goal, given that sort of tendency towards relapse and given the sort of uncontrolled nature of the illicit supply, I guess what I'm asking is: what role do you think harm reduction type practices would need to play in terms of recovery?

Dr. Hinshaw: Again, it's challenging. People have many different paths through any kind of health issue, including substance use, so I think it's very difficult to say exactly what is needed. Every person will need the services that are appropriate to their circumstances. I think it is important to – and I'll just kind of go back to what I talked about before in terms of thinking about that entire spectrum, prevention to recovery – within, again, that kind of tertiary prevention concept, really think about all of the different interventions and have a broad spectrum of services that are available. I think that the more that we understand the barriers that people experience and the service needs that they have, the more we can make sure to have a variety of services that people can access at any point along the way. But what specifically is the right mix would be very challenging to say.

Mr. Romanow: If I may, Dr. Hinshaw, I could supplement. I think the literature and evidence review will help to supplement because a lot of those questions are quite specific related to addiction medicine. I think there would be opportunities for addiction medicine specialists, of which there are many within Alberta Health Services, and, more broadly, expertise, for example from the virtual opioid dependency program, a service delivered through Alberta Health Services that connects with Albertans whether they're calling in directly or referred through a physician – I think there would be a better assessment with that pool of expertise, amongst others, to identify and respond to those technical questions. We could certainly support the committee if there's a desire with some of those types of experts who might be able to respond to those technical medical questions.

The Chair: Excellent. Thank you.

I'm just going to suggest that we come to the end of our question period. We're going to take a question from either side and then move on as we do have a number of other agenda items we need to address today and keeping in mind that the Ministry of Health will still be available to this committee as we continue.

Is there any final question from the government side?

Seeing none, MLA Irwin.

10:50

Member Irwin: Perfect. Thank you. Okay. So in studying and evaluating safe supply policies in Canada, I wonder: have any of you had the opportunity to read the recently released report from the London InterCommunity Health Centre – London, Ontario – about their findings of safe supply there? It's quite interesting, including findings that over a third of the people who used the program stopped using intravenous drugs; reductions in overdose, overdose risk; increased access to health, social services like housing; reductions in emergency department visits, hospitalizations, which we know have been quite high here, particularly in Edmonton; and reductions in crime. I'm just curious if any of the guests would have thoughts on those findings, if they've read the report.

Mr. Romanow: I can jump in. Dr. Hinshaw certainly can respond. I haven't personally had the opportunity to read that particular article. I think that's exactly the scope of that and other evidence-based approaches that would be able to be captured in that evidence and literature review.

Dr. Hinshaw, I don't know if you or others may have a specific awareness on that piece referenced by the MLA.

Dr. Hinshaw: Regrettably, I have not had a lot of time aside from COVID lately, so unfortunately I have not read that specific report.

Member Irwin: Okay. Thank you. I can't imagine what's been keeping you busy, Dr. Hinshaw.

Thank you. Thanks again for presenting today.

Now, Dr. Hinshaw, I do wonder how much or how often you are able to connect with your provincial counterparts and, of course, your federal counterpart, because I know with certainty that Dr. Bonnie Henry in B.C. and Dr. Theresa Tam have both, you know, explored the research and the evidence, of course, and they've both spoken favourably about safe supply programs. Have you been able to consult with your counterparts, and if so, can you share a little bit about those conversations?

Dr. Hinshaw: This is absolutely a topic of conversation at the Council of Chief Medical Officers of Health meetings, where we recognize collectively the impact that this is having on our communities, families. Obviously, the death toll is substantial and urgent, so that has been discussed, and ultimately the consensus is that, of course, we need to employ all tools at our disposal to have that wide spectrum of services that are available for people who are at risk of having an overdose or, again, along that primary-secondary-tertiary prevention pathway. I

wouldn't say that there has been any kind of single path that has been concluded at those meetings, but it is something that all of us agree is a very, very important topic that needs additional research to find the best way forward.

I think you'd asked earlier about how exactly the pandemic has contributed to this increase, and those kinds of questions are exactly the things that we are trying to find answers to through the available data, but it's just very difficult. Again, there's no one single thing. We need to have multiple interventions. Again, I would characterize our conversations at that level as being wide ranging and covering a multitude of topics and a multitude of interventions.

The Chair: Excellent. Thank you, hon. members. That does conclude our time for question and answer period with our invited guests, and I would like to thank them for coming to our committee today and answering all of our questions.

As a reminder, the committee did pass a motion at our January 18, 2022, meeting to request that officials from the Ministry of Health work in conjunction with the Legislative Assembly Office staff, as requested, to support the committee during the course of the committee's work and that officials attend committee meetings and participate when requested in order to provide technical expertise, so we will have an opportunity to connect and ask further questions later.

At this time, before we move on in our agenda, I'm going to suggest that we take a five-minute break and reconvene here shortly.

[The committee adjourned from 10:54 a.m. to 11:01 a.m.]

The Chair: All right. We are going to move on to the subcommittee report. Hon. members, the subcommittee on committee business met on Thursday, January 27, 2022, to discuss two matters. The first of these was to make recommendations in relation to stakeholders from whom the committee would hear oral presentations.

Before we move into this discussion, I would ask the chair of the subcommittee to briefly present the subcommittee's report to the committee. Mr. Milliken.

Mr. Milliken: Thank you, Chair. Hon. members, the subcommittee on committee business met on January 27, 2022, and considered two matters in relation to its terms of reference, recommending stakeholders to the committee for hearing oral presentations and timelines for a possible workflow for the committee. The report of the subcommittee has been provided to committee members. I would like to also genuinely thank all subcommittee members for their work on these matters.

Thanks.

The Chair: Thank you, Mr. Milliken.

I would now like to open the floor for any comments, questions, or motions pertaining to the question of inviting stakeholders to make oral presentations to the committee. Tracy. I mean MLA Allard.

Mrs. Allard: Thank you. I respond to both, so thank you for that. If it's appropriate at this time, I would like to propose a motion, Mr. Chair. Is that okay?

The Chair: Yes, it's appropriate.

Mrs. Allard: Perfect. I would like to move that

> the Select Special Committee to Examine Safe Supply invite the following individuals and organizations to make oral presentations to the committee commencing February 15, 2022, and concluding no later than March 4, 2022, subject to the standing orders of the Legislative Assembly and the committee's availability to meet: . . .

Before I read them all into the record, I just want to confirm: do I need to read them all into the record, or do we have that already done?

The Chair: You do need to read them all into the record.

Mrs. Allard: Okay. No problem.

> . . . Dr. Sharon Koivu, MD; Earl Thiessen, executive director, Oxford House Foundation; Dr. Nick Mathew, MD; Dr. Vincent Lam, MD; Dr. Jennifer Melamed . . .

And I apologize for name pronunciation.

> . . . Dr. Launette Rieb; Dr. Maire Durnin-Goodman; Gerald Posner, author; Chief Dale McFee, representative for the Alberta Association of Chiefs of Police; Dr. Anna Lembke; Dr. Kevin A. Sabet; Chief Eric Shirt, Saddle Lake Cree Nation; Dr. Keith Humphreys, PhD; Chief Leonard Standingontheroad, Montana First Nation; Dr. Bertha K. Madras, PhD; Dr. Elaine Hyshka . . .

I'm going to skip most of the letters. I think you have this all in writing anyways, but let me know if I need to expand on anything.

> . . . Dr. David Best; Dr. Ginetta Salvalaggio; Michael Shellenberger; Moms Stop the Harm; Dr. Rob Tanguay; Each+Every; Dr. Nathaniel Day; Dr. Kathryn Dong; Dr. Meldon Kahan; Alberta Medical Association; and Dr. Jeremy Devine.

That concludes my motion.

I just wanted to say that I believe this is a comprehensive list of stakeholders who are experts in their field, and it's important that the committee has a firm understanding of this topic. As I said in subcommittee, I have no preconceived notion about the outcomes or the conclusions the committee will make. I've adopted a posture of curiosity, and I'm very interested to hear. I think, you know, having the opportunity to ask questions of these key experts will really help inform the fact-finding mission that this committee is on and really inform the work in service to all Albertans.

With that, Mr. Chair, I'll turn it back, having made the motion.

The Chair: Yes. Just one clarification on the motion, that Dr. Devine is with the Alberta Medical Association. Or is that a separate presenter?

Mrs. Allard: The way I read it, it looks like he's part of the AMA, but I could be wrong. Does anybody want to clarify that?

Member Irwin: They're separate. It started a new . . .

The Chair: Excellent. Okay. Clarifying that they're separate. Thank you.

All right. Thank you. I think you did a better job at pronunciations than I would have done, so I appreciate that.

We'll now open it up for discussion. I have MLA Ganley up first.

Ms Ganley: Thank you very much, Mr. Chair. I will be voting against the motion to adopt the subcommittee process for stakeholders. I think it's worth sort of outlining the reasons for that. First off – and I think I've stated this on the record, but it's worth saying it again – I do believe that Albertans have the right to see us do our work, and having a lot of this important work sort of punted to a subcommittee which is off the record, that people in Alberta can't listen to, is extremely problematic.

I also think it's pretty clear from the general literature and evidence and media coverage of this area that there is, shall we say, a debate amongst experts in terms of what the best approach is. Now, it's been made, I think, abundantly clear that the Premier and the minister in this instance have a certain perspective. That perspective is not generally supportive of harm reduction measures at all, up to and including safe supply. I think the concern here is

that in a lot of instances in committees like this the general process would be to either receive written submissions first and from that sort of draw oral presentations, maybe have research services kind of draft a list of experts so you get kind of a nonpartisan lens on that, and I think that's not what we see here. I have significant concerns with the process. I mean, this happens in court, too – they call it sort of the war of the experts – where, you know, kind of people are brought in from certain perspectives. I think that in terms of adopting a posture of curiosity, that's fine, but if the evidence to be laid before the committee comes from a certain perspective only or primarily from a certain perspective, I think that kind of gives us a skewed view of what reality is.

I continue to be troubled that this is the process. I don't think it has been the process in other cases. I think moving this kind of discussion to a subcommittee where Albertans can't see or hear what is going on continues, in my view, to be extremely problematic. I think the way in which this list was ultimately arrived at and drafted was problematic and is kind of designed to lead the committee to a certain conclusion, and I think that that is unfortunate because I think we had a real opportunity here, and I don't think that this takes advantage of that.

Those are my reasons. Thank you.

The Chair: Thank you, Member.

MLA Yao.

11:10

Mr. Yao: Thank you so much. I'd just like to respond to Member Ganley on this issue. I'd like to challenge that premise that the subcommittee wasn't accountable to Albertans simply because they couldn't see and hear it. Certainly, that's why members of the opposition are on such a committee. The committee's basic mandate was to provide a list of stakeholders to present to this main committee, and both sides, opposition and government, had an equal opportunity to provide lists and names of people who they felt would be adequate for this stakeholder list. If the opposition is acknowledging that they were unprepared for this, I would certainly like to understand and hear more of that, but they were given the same opportunities as the government side. I feel that this list is very comprehensive, very proper. These are not illegitimate people, anywhere on this list, at all. I mean, the opposition even provides two advocacy groups which may or may not have actually any professional background in dictating their opinions on this issue, but we accept them. So I challenge that premise that this wasn't a transparent and accountable process, and I believe this list is fair.

Thank you.

The Chair: MLA Allard.

Mrs. Allard: Thank you, Mr. Chair. MLA Yao essentially stole my thunder. I was just going to say that I believe the process has been equal and fair, that there was ample opportunity to bring forward experts, and that all experts that were brought forward to the subcommittee were, I believe, accepted. So I don't see a problem with that, nor do I see a problem with hearing what the experts have to say. We don't know what the experts are going to say, and this list is substantive in nature.

Thank you, Mr. Chair.

The Chair: Excellent.

Any further discussion on the motion?

All right. Hearing and seeing none, I will ask the question. All in favour of the motion, please say aye. Any opposed to the motion, please say no. All right.

I believe that motion is carried.

All right. We will move on to item (b), discussion on the draft timeline. Hon. members, the subcommittee report also contained two proposed timelines for the committee's consideration. Before opening the floor to discussion of the proposed timelines, I would like to state that there are no motions that are required to adopt these timelines. They are discussion items to provide a general framework for the work of the committee. Are there any comments in relation to the timeline that was presented? MLA Yao.

Mr. Yao: Hi. I would just like to clarify, as I said earlier, that there's a list of literature that was recommended and that we will be able to receive that as soon as it is compiled by the health authority.

Thank you.

The Chair: Yeah. To clarify, once the health authority has that literature available, it'll be made available to the committee.

Mr. Yao: Thank you.

The Chair: Any further discussion on the timeline?

Mr. Stephan: Sorry. Just a point of clarification. There are two proposals on the timeline, as I understand it, one proposal being February 28 to March 4 and a second proposal as it relates to February 15 and then skipping over to February 28 to March 4. Are we able to speak in favour of either of those proposals at this time?

The Chair: I think that would be ideal to be able . . .

Mr. Stephan: Sure.

The Chair: The oral presentation motion that we just did already put in a rough timeline, so that basically decided the parameters which we're going to be able to meet within. Does that make sense?

Mr. Stephan: So we'll be starting the process on February 15 in terms of kind of working through the number of speakers and making sure that we move towards completion of our mandate in the time that we've been given. Is that correct?

The Chair: Yes, that's correct.

Mr. Stephan: Excellent. Thanks.

The Chair: Excellent. Any further comments or questions about the timeline? All right.

We're going to move on to other committee decision items, decisions on written submissions. Hon. members, at our previous meeting members did inquire about written submissions to the committee as part of conducting its work. I would point out that terms of reference for the subcommittee on committee business did not include dealing with written submissions. I would like to now open the floor to discussion about whether to solicit written submissions. I believe MLA Irwin is up.

Member Irwin: Yeah. I mean, as noted, we would like to, I guess, move the motion. I can see as well, and I maybe just need a point of clarification from you, Chair, that the UCP side – have they also proposed a motion? Am I reading that correctly?

The Chair: Yes. There are two motions proposed.

Member Irwin: Okay. Would you like for me to formally move? Just a point of clarification here.

The Chair: It's a good question. If you're ready to and, yeah, if you still want to.

Member Irwin: Yeah. Sorry. I just wasn't sure about process when we have two similar motions in front of me, I believe. Yeah. Well, then I would like to move my motion that

> the Select Special Committee to Examine Safe Supply solicit written submissions from the public related to matters within the committee's mandate to be received by March 4, 2022, and advising those who make a submission that their name and submission may be made public.

The Chair: All right. Hearing the motion, is there any discussion on this motion? All right. I see MLA Milliken.

Mr. Milliken: Sure. Happy to chime in. I would just recognize that Member Irwin's motion is, from what I can see, essentially exactly – or at least it provides the same result as a motion that I was going to try to get my hand up to put forth. I won't be, then, putting forward another motion. I would just ask that all members consider the motion as proposed by Member Irwin since it's my – and I'm just double-checking – estimation that I think that both provide the exact same result. As such, I would hope that all members support this motion.

Thank you.

The Chair: Perfect. Any other discussion on the motion?

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

That motion is carried.

All right. Hon. members, the committee has decided now to move ahead to solicit written submissions in relation to its mandate. Common practice once that decision is made is to ask the Legislative Assembly Office corporate communications to draft a communications plan proposal to solicit those submissions. At this time I would like to invite Janet Laurie from the LAO to provide an overview of the process. Ms Laurie. Is she on? There she is. Oh, you're muted.

Ms Laurie: Pardon me. Thank you very much, Mr. Chair. Thank you for the opportunity to present to the committee. Now that the committee has gone forward with the decision to proceed with written submissions, we would typically prepare a communications plan, as you indicated, that would include no-cost, low-cost, and paid advertising options to engage in the campaign. Communications services will proceed based on the direction of the committee in terms of which of those options you'd like to include in a communications plan. I'm happy to answer any questions that committee members may have today.

The Chair: Excellent. Are there any questions for Ms Laurie? All right.

Hearing and seeing none, would a member entertain a possible motion to . . .

Mr. Yao: I accept.

The Chair: Perfect. Can we put that up for folks if they want to see it? I will read it out. Member Yao moved that

> the Select Special Committee to Examine Safe Supply direct Legislative Assembly Office corporate communications to prepare a low-cost or no-cost communication plan to support soliciting written submissions from the public in relation to the committee's mandate to be approved by the chair after the draft plan has been circulated to the committee members for review.

Does that sound right, Member Yao?

11:20

Mr. Yao: Yes.

The Chair: Perfect.

Any further discussion about the motion before us?

All right. Hearing and seeing none, I will ask the question. All in favour, please say yes. Any opposed, please say no. All right.

That is carried.

We will now move on to other matters. Hon. members, are there any other comments, questions, or motions in relation to other matters that the committee may wish to consider in proceeding with this work? MLA Stephan.

Mr. Stephan: Yeah. I would like to just move a motion from the floor in respect of the lit review. I just want to make sure that we have this. The department had offered to have Julian Somers provide a summary presentation on that lit review, and I would like to take them up on that offer so that they can provide a summary of that literature review.

I don't know if I need to make a motion or if I can just make that motion now, but that's what I'd like to see occur.

The Chair: Okay. We first need to vote on whether or not we're going to accept the motion. We'll do that first.

I'll ask the question, if we're willing to accept the motion. All in favour, please say aye. Any opposed? Okay. That is passed.

All right. So now – oh. Mr. Shepherd.

Mr. Shepherd: I just wanted to clarify if that requires unanimous consent or if that just simply requires a majority.

The Chair: It just required a majority.

Mr. Shepherd: Thank you, Mr. Chair.

The Chair: All right. Now does he present his motion? Perfect. We're going to get that written up to clarify.

If you could clarify your motion, please.

Mr. Stephan: Sure. As I understand it, the department offered that when they provide the literature review summary on the 15th, they also said that they would have Julian Somers provide a summary of that lit review. That's what I am moving, that we have that occur.

The Chair: Okay. MLA Shepherd.

Mr. Shepherd: Thank you, Mr. Chair. I just want to reiterate the concern I raised earlier. I had the opportunity to speak with the department to seek, I guess, clarity on this particular recommendation that was made in regard to Dr. Somers. Again, for the record, I will note that Dr. Somers published an article in the *Vancouver Sun* on January 13, 2021, expressing a specific opinion on the question that we're asking to consider and that we are asking for a presentation of the literature review on. His view, that he expressed, was that safe supply, in his view, was a "vacuous practice[s] . . . giving homeless people more drugs." He went on to say that "no amount of 'safe supply' can provide" the kind of support that he believes that individuals need.

Now, the department did not provide any particular background on why they selected Dr. Somers, of the many experts that are available at this particular organization, nor did they provide any context other than very general comments about why they chose this particular organization or whether they considered any other expertise that was available. Personally, I'm not of the view that we should simply be accepting this at this time without having had the opportunity for further consideration of other possible options. So I will be voting against this motion.

The Chair: I apologize. MLA Stephan, can you please state your motion one more time for us?

Mr. Stephan: Sure, and you're welcome to refine it. As I understand it, the department offered that when they have the literature review available on the 15th, they offered to have Julian Somers provide a presentation on that lit review. My motion is to permit that and accept that offer and to have that occur.

Am I allowed to speak on the concerns that were raised?

The Chair: Yes, you may.

Mr. Stephan: Sure. You know, I appreciate that we'll be hearing from a number of individuals as well, independent from the department, on the lit review, but all members will have the opportunity to ask questions, perhaps even cross-examine, frankly, if there are things that are said in respect of providing that summary review that they would like to challenge, so I don't really quite understand why, on the merits, as it relates to a summary of the lit review, there would be opposition to having that occur. I would invite the members opposite to challenge, frankly, anything that they disagree with in the course of providing that summary.

The Chair: Member Ganley.

Ms Ganley: Yes. Thank you, Mr. Chair. I'm just going to echo the comments of my colleague. I think it's pretty clear to me here that there is, as is often the case on sort of an evolving academic area, a debate, shall we say, of perspectives in the literature. It's pretty clear what perspective Mr. Stephan holds. It's pretty clear what perspective the minister in this instance holds, and I think, as outlined very articulately by my colleague Mr. Shepherd, it's pretty clear what perspective Dr. Somers holds. The purpose of a literature review is to sort of look into that debate and to present it.

Now, I mean, I think it's clear in any academic discipline that if you have a certain perspective, you can find in the instance of such a debate, you know, supporting experts on both sides. The concern here, again, is that when you have someone with a very clear perspective and a perspective that is not, shall we say, located in the middle of the debate, presenting the evidence, you're going to get a view of the evidence that, rather than covering the full spectrum, only covers a portion of the spectrum and therefore makes the debate appear different than it actually is.

I think, you know, the concerns that my colleague Mr. Shepherd has raised are valid. I think that process is troubling and problematic to me. I think research services: we have them to sort of provide a literature review to provide something that is from a comparatively nonpartisan and balanced perspective. I don't believe that adding a presentation on a literature review by someone with a specific perspective is helpful. I don't believe it's balanced, and I don't believe it's the best process forward.

The Chair: All right. Thank you, Member.

Yes. Ms Robert.

Ms Robert: Thank you, Mr. Chair. Mr. Stephan, I just want to make sure that we're really clear so that we get the correct motion that you want to move. I went back over the ministry's PowerPoint presentation, their slides. This is what they said. They said two different things. They said that the ministry has engaged experts to initiate a literature review to illuminate areas of the committee's mandate as requested and that they've committed to provide support to the committee in that regard. Then they also said that the ministry engaged researchers at Simon Fraser University to perform an evidence review using the committee's definition and that it's recommended that Dr. Julian Somers be invited to present on that evidence review.

In my reading of this, it appears that there's an evidence review and there's a lit review, so I just wanted to put that out there for you so you can decide what it is you're seeking.

Thank you.

11:30

Mr. Stephan: Well, I guess that I'm seeking to support the offer that was made by the ministry. If they referenced in their discussion that it, whatever it is in terms of definition, the evidence review – if that's what they said, then that is what I am asking for us to allow Julian Somers to provide a summary of.

How about this? I mean, I don't want to get confused in nomenclature. The review: as I understand it, they've engaged Simon Fraser to provide a review on this matter, and they have recommended that Julian Somers provide a summary of that or a presentation on that review that Simon Fraser was engaged to provide. Like, I don't know exactly, you know, the wording of what they said, but I just want to support them in achieving what they offered to do.

Why don't we just say, "the review"? I mean, I expect the evidence review will incorporate a literature review, so why don't you just say, "the review"?

The Chair: I just want to make sure we get this straight. That way we know what we're actually debating.

MLA Ganley is next.

Ms Ganley: Yes, Mr. Chair. I'm sorry. That just raised a bit of a question for me. We have discussion of an evidence review and a literature review. Honestly, I do not understand what the difference between those two terms is. Like, I mean, I know what a literature review is, having done them at some point in the past, but my understanding was generally that research services for the LAO provides a literature review. It sounds like there may also be a literature review coming from the department, and now we're also talking about an evidence review. It's not clear to me what we're talking about or how those things differ. So any assistance that anyone could provide me, in terms of what it is the committee is going to receive, would be helpful.

The Chair: Ms Robert, can you clarify?

Ms Robert: Certainly. Thank you, Mr. Chair. Okay. Ms Ganley, and for the benefit of the whole committee, I'll offer a few things that, hopefully, will clarify. Research services has been tasked, through a motion of the committee, to provide a crossjurisdictional comparison on the government programs and policies in place in Canada with respect to safe supply. That's the research that they've been directed to provide. The ministry indicated to us today in its presentation that it has engaged experts to initiate a literature review to illuminate areas of the committee's mandate, and that will be provided to the committee in written form.

Now, the third thing that we're dealing with right now with respect to Mr. Stephan's motion is in relation to a comment that the ministry made today, that the ministry has engaged researchers at Simon Fraser to perform an evidence review. According to their PowerPoint it's to provide a "broad and comprehensive review of available evidence" and "will address each of the outcomes detailed in the Committee's mandate." So my understanding is that that is separate from the ministry's literature review. It's certainly separate from research services' crossjurisdictional comparison, and this motion is a request for Dr. Julian Somers from Simon Fraser to make a presentation with respect to that one element, the evidence review.

I hope that helps. Thanks.

Ms Ganley: Thank you.

The Chair: Perfect. MLA Stephan, can we confirm, before we debate further, that this is the heart of your motion, that you're good with this?

Mr. Stephan: Yeah, it's fine. I mean, you know, whether or not someone wants to call it a literature review or an evidence review, it's a subset of the review. Simon Fraser is doing a review, and Julian Somers is providing a presentation on that review. So it would capture whatever you want to call it, whether it's an evidence review or a lit review. You know, maybe those terms are interchangeable. I don't really know. As I understood it when I was listening, Simon Fraser is doing a review, and they offered to have Julian Somers make a presentation on that review. So whatever the adjective is, it's kind of incorporated in this term, the review.

The Chair: So if you support it, then can you please read your motion into the record.

Mr. Stephan: Sure. Moved by Mr. Stephan that

> the SSC to Examine Safe Supply invite Dr. Julian Somers to make a presentation to the committee in relation to the review being completed for the Ministry of Health by Simon Fraser University.

The Chair: Thank you.

MLA Shepherd.

Mr. Shepherd: Thank you, Mr. Chair. My thoughts on the motion itself I think I've made clear, but I just wanted to note that in order to be as accurate as possible, the review isn't being done by Simon Fraser University. It is being done by the Centre for Applied Research in Mental Health & Addiction, which is located at Simon Fraser University. To my view, it would be – I don't want to be nitpicking, but I think it would be more accurate for the motion to reference CARMHA as opposed to the larger body of Simon Fraser.

The Chair: Is that a proposed amendment, Mr. Shepherd?

Mr. Shepherd: If that's the best way to approach it, yeah, I would propose an amendment.

The Chair: Okay. We'll have to get approval first to move the amendment. I will ask the committee if we want to approve that amendment, so I will ask that question at this time. All in favour of allowing the amendment, please say aye. Any opposed? All right. That is carried.

We'll draft that up for us and get it on the screen.

MLA Shepherd, does that capture your intent?

Mr. Shepherd: Yes, it does, Mr. Chair, with the exception of – it should be "addiction."

The Chair: Yes.

Mr. Shepherd: We'll delve into questions of math at a later date.

The Chair: Oh, there we go. Perfect.

Mr. Shepherd: Yes.

Mr. Stephan: Can I just ask for clarification? It's at Simon Fraser University – oh, okay. Sorry. The amendment: the way they've structured it, there's no Simon Fraser University.

Mr. Shepherd: You know, if it would help Mr. Stephan to indicate that that is where the centre is located, I'd be fine with simply adding "Centre for Applied Research in Mental Health & Addiction at" in front of "Simon Fraser University."

Mr. Stephan: That's great.

The Chair: Okay. We're going to make that change, and then I'll have you move that, Mr. Shepherd.

Mr. Shepherd: Certainly.

11:40

The Chair: Perfect. Mr. Shepherd, if you could read your amendment into the record.

Mr. Shepherd: Certainly. I would move, then, that

> the motion be amended by striking out "Simon Fraser University" and substituting "Centre for Applied Research in Mental Health & Addiction at Simon Fraser University."

The Chair: Perfect. Any discussion on the amendment?

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

> That amendment is carried.

We're back onto the main motion. Any further discussion on the main motion as amended?

All right. Hearing and seeing none, I will call the question. All in favour of the main motion as amended, please say aye. Any opposed to the motion as amended, please say no. All right.

> That is carried.

We are now moving on to – sorry. Are there any matters under section (b) to be discussed at this time?

Hearing none, we're going to move on to other business. Is there any other business that members wish to discuss at this time?

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

And with that, I will ask a member to move to adjourn.

Mr. Yao: Right here.

The Chair: Perfect. Member Yao. All those in favour, please say aye. Any opposed? That is carried.

Thank you.

[The committee adjourned at 11:42 a.m.]

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