Legislative Assembly of Alberta

The 30th Legislature
Second Session

Select Special Committee to Examine Safe Supply

Stakeholder Presentations

Tuesday, February 15, 2022
9 a.m.

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Select Special Committee to Examine Safe Supply

Nixon, Jeremy P., Calgary-Klein (UC), Chair
Allard, Tracy L., Grande Prairie (UC), Deputy Chair
Williams, Dan D.A., Peace River (UC),* Acting Deputy Chair

Amery, Mickey K., Calgary-Cross (UC)
Frey (formerly Glasgo), Michaela L., Brooks-Medicine Hat (UC)
Milliken, Nicholas, Calgary-Currie (UC)
Rosin, Miranda D., Banff-Kananaskis (UC)
Stephan, Jason, Red Deer-South (UC)
Yao, Tany, Fort McMurray-Wood Buffalo (UC)
Vacant
Vacant
Vacant
Vacant

* substitution for Tracy Allard

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Janet Schwegel	Director of Parliamentary Programs
Amanda LeBlanc	Deputy Editor of *Alberta Hansard*

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Select Special Committee to Examine Safe Supply

Participants

9 a.m. Tuesday, February 15, 2022

[Mr. Jeremy Nixon in the chair]

The Chair: All right. The meeting can be called to order. I believe we have quorum, so we will call the meeting to order. Hon. members, at the committee on January 18, 2022, the committee agreed that at the beginning of each meeting we would observe a moment of silence 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.

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. I am the MLA for Calgary-Klein and the chair of this committee. I'd now like to ask members and those joining the committee at the table to introduce themselves for the record, starting to my right.

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

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

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

Mr. Amery: Good morning. Mickey Amery, Calgary-Cross.

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

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

The Chair: All right. Now I'd like to welcome those joining us remotely, starting with Michaela Frey, to introduce themselves for the record.

Mrs. Frey: Good morning. Michaela Frey, MLA, Brooks-Medicine Hat.

The Chair: MLA Stephan. Oh, Mr. Stephan, you are muted.

Mr. Stephan: Let's try that again. MLA Jason Stephan, Red Deer-South.

The Chair: Excellent. Thank you, Mr. Stephan.

Oh, there we go. We have Mr. Williams online now. Mr. Williams, can you introduce yourself for the record?

Mr. Williams: Yeah. MLA Williams, MLA for Peace River and substituting for the deputy chair, Tracy Allard from Grande Prairie.

The Chair: Perfect. I'd like to note for the record the following substitution: Mr. Williams for the deputy chair, Mrs. Allard. Thank you for that.

A few housekeeping items before we get started. I would note for members that masks should be worn in the committee room except when you are speaking, and members are also encouraged to leave an appropriate amount of physical distancing around the table. Please note that microphones are operated by *Hansard*. Committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV. The audio- and videostream and the transcript of the meeting can be accessed via the Legislative Assembly website.

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We will go to item 2, approval of the agenda. Can I get a motion on the floor that the agenda for the February 15, 2022, meeting of the Select Special Committee to Examine Safe Supply be adopted as distributed? Motion moved by Ms Rosin. Any discussion about the agenda?

Hearing none, all in favour, please say aye. Everybody online in favour, please say aye. Perfect. Going forward, I'm just going to ask that as a collective answer, so if you're online, feel free to say aye or no when appropriate. That motion is carried.

Going on to item 3, approval of minutes, up next is the approval of minutes from the previous meeting. Are there any errors or omissions to note at this time?

Seeing none, would a member move the approval of the minutes, that the minutes for the February 3, 2022, meeting of the Select Special Committee to Examine Safe Supply be adopted as distributed? MLA Milliken. Any further discussion? Hearing none, all in favour, please say aye. Excellent. That is carried.

All right. That brings us to the main event, presentations. Hon. members, at its February 3, 2022, meeting the committee invited Dr. Julian Somers from the Centre for Applied Research in Mental Health and Addiction at Simon Fraser University, who is preparing an evidence review for the Ministry of Health, to make a presentation to the committee in relation to that review. I would now like to call upon Dr. Somers to make his presentation.

Dr. Somers, welcome, and we look forward to hearing from you. You have 30 minutes.

Julian Somers

Dr. Somers: Thank you, Mr. Chair and hon. members. It's an honour for our team to be invited to collaborate with public servants in the Ministry of Health on providing support to the committee, and it's a personal honour to be here today representing that work with you. My understanding housekeepingwise is that slides will be presented, and I'll signal when I'm moving forward. I'm still on my first slide if that's visible to you.

With no further ado, the next slide, rapid review, is a central part of what I'll be addressing today. I'm going to begin by providing just a quick orientation, hopefully, something that looks very familiar to members of the committee. I proceeded in overly great haste, and I'll try to avoid that in the future. Please allow me to pause now to note that I'm speaking with you today from my family's home in beautiful North Vancouver, British Columbia, which is also unceded territory of Coast Salish peoples.

Returning now, if I may, to the slides, the scope of the review that we are undertaking and that I'll be providing an interim report on as part of my remarks is outlined here. It has a few clauses, and as I've mentioned, I hope these are familiar to members of the committee. There are a couple of slight modifications to the mandate in order to provide us with what I hope is an appropriate refinement.

The first clause under the definition of safe supply is on the provision of pharmaceutical agents. The second clause is about the population of interest, and it is "to people who are addicted to or dependent on these substances and who are at high risk for poisoning" or other adverse outcomes. And, third, which is also related to the nature of the intervention, these agents would be provided "for unwitnessed consumption," if the individual wished, and "via their preferred route of administration."

The outcomes of particular interest are listed below, so safe supply in relation to fatal/nonfatal overdoses, more generally "the health or safety of individuals or communities" – and a couple of examples, crime or drug diversion, are listed there – and then any other potential benefits.

Next slide, please. With that definitional point addressed, the outline of my remarks is as follows. I'll make reference to some of the early framing of opioid prescribing and programs for the treatment of addiction, followed by the emergence of two separate systems of care. I'll move on to describe why British Columbia is an important and relevant exemplar for understanding safe supply and its emergence, an interim review of the results of our investigation of safe supply, and then a few related perspectives for your consideration drawn from addiction research.

9:10

Next, please. I'd like to introduce, as part of the context for my presentation, a couple of home truths from the field of addiction. This relatively simple looking figure was introduced as definitional of harm reduction or part of the definition of harm reduction. You can see that there are really two main components, one above the other. One is the volume of substance consumed, and below is the related but not entirely synonymous aspect of risk, where excessive use is associated with more risk, abstinence the lowest possible risk, and harm reduction is movement to the right. It does not require abstinence, and it does not require any particular form of intervention.

Seat belts in the 1970s were harm reduction for driving. In the future, with self-driving automobiles that have near perfect safety records, seat belts may no longer be necessary as means of reducing harm. Similarly, supervised consumption sites are essential in settings where there are numbers of people living homeless and using drugs, but if one is committed to providing housing and support for individuals, then the relative need for services like consumption sites decreases.

The other point I'd like to make here is that the subject of achievement of recovery from addiction emerged as an area of research after harm reduction, but it can be superimposed on this figure. Individuals experience recovery – that is, they are fundamentally no longer experiencing addiction; it's a qualitative state; it's defined best by the individuals themselves – and the likelihood that recovery is synonymous with abstinence is higher when an individual's addiction was very severe. However, it is abundantly clear from literature that individuals experience recovery from addiction without necessarily achieving abstinence. I'll mention that by way of background.

The next slide, please. This is an observation – the source here is more than 20 years old; the observation is far more than 20 years old – that individuals recover from alcohol and drug problems, including addictions, without necessarily encountering treatment. In fact, this is a common occurrence. You may be able to see from the title of the article that the context for this is a social context. The authors are pointing out the role of social capital. It's a multifaceted concept, social capital. Subsequent to this paper, some people working in the area have reframed social capital as recovery capital, intending to shine a spotlight on the facets of social capital that contribute most to recovery, but for our purposes I think social capital conveys the central idea effectively. When individuals have relatively more relevant social capital, recovery is more readily attainable, and when people don't, investing in shoring up their social capital is typically prerequisite to assisting them in overcoming their addictions.

Next slide, please. In this figure, drawn from a population-level analysis, all of the individuals in the lower left are dependent on or experiencing addiction with respect to these differing substances: nicotine, alcohol, cannabis, and cocaine. As the lines ascend, the proportion of each group that continues to experience addiction decreases. At the very top of the figure a score of 1 would mean no one in the original group any longer experiences addiction. From left to right is the march of time measured in decades – 10, 20, 30, et cetera – and it's clear from this figure that differing substances typically require differing periods of time before people are likely to experience recovery from addiction or no longer meet criteria for dependence.

Cannabis and cocaine tend to attenuate more quickly; those problems tend to resolve more quickly. You can see that the majority of people are no longer dependent after 10 years while alcohol and nicotine attenuate over longer periods of time. Paired with the previous observation about social capital and its contributions to recovery, we can superimpose on this thoughts about early in life – recognizing that almost all forms of dependence begin early in adulthood or in adolescence. So by the time 10 years have passed, we can imagine that we're looking commonly at people in their 20s assuming adult responsibilities, entering relationships, and moving forward in ways that are no longer consistent with use of drugs like cannabis and cocaine.

Over longer periods of time alcohol and nicotine dependence attenuate. They have less severe impacts on daily functioning and, nevertheless, attenuate as people experience things like health consequences, accidents or arrests involving impaired driving, the birth of children, grandchildren, and other types of catalysts which people typically reference as key motivators for their cessation of use or the end of their addiction.

Next slide, please. I mentioned in my outline the importance of B.C. This slide is developed from Senate materials sent from Canada's Senate in 1955 and, as you can see, a tallying of individuals referred to as addicted. They're presented in different categories reflecting the origins of addiction having first been prevalent among professionals, those being medical professionals: physicians, pharmacists, people with access to opioids and other drugs. The medical addicts are the individuals – and forgive me; I'm simply using the same terminology as the slide here. The medical category are individuals whose addiction is deemed to be a product of prescribing, so these would be patients, typically. The left column, so-called criminal addicts, is the one that exploded in numbers in the middle part of the last century, in particular following the Second World War.

You can see here that B.C. has by far the highest numbers of so-called criminal addicts, not necessarily the most medical or professional, but those numbers are dwarfed by those deemed to be criminal. This emergence, the phenomenon of the growth of this particular problem was a catalyst for immediate reforms, which then are the legacy that we've inherited today and, in some ways, are trying to remedy.

Next slide, please. I mentioned the catalytic role. This was in the late 1950s. Clinical researchers in both Canada and the U.S. were funded by their respective governments to attempt to intervene in the lives of people deemed to be criminal and addicted. The thinking behind the intervention is summarized here. This is the definition of rehabilitation. These are quotes taken entirely from the researcher's presentation of findings. The results of these programs were reported as extremely successful. You'll see from these few slides. Importantly, the role of medication, or methadone in this context, was as an inducement and as a transitional aid into treatment whereas rehabilitation is defined as activities in the social world, almost foreshadowing what we subsequently came to refer to as social capital or recovery capital.

9:20

Next slide, please. The aim being to free the individual from dependency but these changes in the social world often being essential to achieve first – my comments on social capital – and the cardinal principle being patience and the persistent provision of support to individuals.

Next slide, please. The Canadian research is eclipsed in the literature for its influence by the work of these researchers, in particular Marie Nyswander and her husband, Vincent Dole. You can see from this headline in *JAMA* that they are out of the gate reporting a blockbuster success. They're reporting – this is the abstract – 94 per cent success ending criminal activity. And what was that due to?

Next slide, please. They report the remarkable achievement of "social productivity . . . stable employment and responsible behaviour." They go on to say, "This, of course, cannot be attributed to the medication, which merely blocks drug hunger." They go on to explain that the achievement of this social productivity, something that the Portuguese described as social reintegration, was achieved through the interactions between their patients and humans that provided them with the supports and pathways forward in order to make a success of their lives in these various domains.

Next slide, please. The catalyst for these early methadone programs I referred to. There was a subsequent catalyst for the expansion of so-called narcotic addiction treatment coinciding with the reporting of these findings. One of the major catalysts, especially a U.S. catalyst, was the spectre of some 20,000 returning servicemen addicted to heroin. Very careful and fascinating research covering this phenomenon. But, cutting to the chase, very few and almost none of the returning servicemen required any form of treatment in order to overcome their addiction. They described that it was not because they didn't have access to heroin or something of that nature; it was that the lives that they were returning to were inherently of greater value to them than continuing to use heroin.

Next slide, please. Nevertheless, this era was the largest single expansion in spending on addiction treatment in North American history, certainly in U.S. history, a 10-fold increase.

Next slide, please. Those original authors, Dole and Nyswander, commented extremely critically on the rollout of narcotic addiction treatment bearing the name of their intervention, methadone maintenance treatment, and in particular they pointed out, first of all, that the programs are no longer attracting individuals who are in need of help. The reason they are not is that they overemphasize, as they describe it, a chemical agent and that the chemical agent can have very little effect on transforming people's lives. They go on to describe, in terms that I think we can understand quite easily, the kinds of things that are much more urgently needed yet were not provided and remain conspicuous in their absence from methadone treatment today.

Next slide, please. Confirmation of the harm that we all experience as a result of losing the plot and focusing on biochemical interventions as opposed to human ones is illustrated here. The likelihood of overdose mortality or, more correctly, poisoning mortality is powerfully related to unemployment. When people are employed and absent from work, their likelihood of poisoning is comparatively low, but unemployment is second only to disability, which is also coincident, typically, with underemployment or unemployment in this population.

Next slide, please. Going from the individual level, if we look at areas where people are living, there is a high correspondence between communities which are deemed to be socially deprived and the likelihood of both opioid prescribing and poisoning mortality.

Next slide, please. Our work in B.C. illustrates that rather than being an inducement into a program of social reintegration, people receiving methadone here are enrolled an average of eight years, during which they commit ongoing numbers of both nonviolent and violent offences, the opposite of Dole and Nyswander's findings.

Next slide, please. On the left we have, between 2008 and 2017, sharp increases in the numbers of people who are involuntarily admitted to hospital in B.C. where the primary reason is substance use disorder, that rising from 1,887 to 4,536.

Next slide. During the same period of time we have sharply increasing proportions of people in our correctional institutions. This is provincial custody. The lines are illustrating the increasing proportions of people who are held in custody and who have been diagnosed with a substance use disorder with or without a mental disorder prior to entering custody. In the most recent year available to us, 2017, it's 70 per cent of the custody population.

Next slide. Importantly, the overlap, which I alluded to briefly, with mental illness is substantial. And several studies – this is one of them – are now reporting the high degree of suicidality among people who survive poisonings and, referring to their state of mind at the time that they experienced the poisoning episode, the likelihood of experiencing suicidal intent increases with the number of prior poisonings.

Next slide. Social capital if I may. This one is illustrating one of those groups that I showed early on, the so-called professional addicts, being physicians. Physicians are assisted in overcoming addictions through programs that emphasize social and psychological supports framed around the social capital that they have retained during their addictions and without any opioid substitution therapy. It's almost a complement of what people in the public system receive, which is an opioid substitution therapy and very little, if any, support with things like work, improved housing, and social reintegration.

Next slide. I mentioned Portugal's national drug strategy. I draw your attention only to the lower of the two quotes, which is drawn from their guidance document, that, strictly speaking, there is no such thing as treatment, as they define it, without social reintegration.

Next slide. We do have high-quality studies that build the opportunities for social reintegration. This is actually a cost-effectiveness paper based on several randomized controlled trials, and this is an intervention known variously as recovery-oriented housing, also, synonymously, harm reduction housing. If you recall the line figure that I began with, those two terms are interchangeable in the sense that a focus on persistently reducing harms is likely to improve individuals' opportunities to experience recovery. This is an intervention that costs about $38,000 a year, by the way.

9:30

Next slide. This is how people describe their experiences in these interventions and gives some insight into the journey people who have been homeless – individuals in this trial have been homeless for an average of 10 years, struggling with serious mental illnesses and addictions, and here we see in their words how their experience of support contributes and lays a foundation to their opportunities to recover from both addiction and mental illness.

Next slide. This intervention has been shown to – it's highly robust. It works across Canada. It's been replicated in four cities in France, also using randomized control trials. It reduces reoffending by about 50 per cent in the first year compared to usual care. Next slide. It also reduces emergency department visits by about the same amount, 50 per cent. This is using administrative data, so I'm

not reporting things based on people's self-report but on our surveillance systems in B.C.

Next slide, please. Now I'm sort of tipping. Referring to study quality, I'd like to briefly introduce that there is an occasionally debated but nevertheless widely respected concept of levels of evidence. As background to our review of literature addressing safe supply, we are following this relatively traditional outline, which prioritizes reviews of randomized controlled trials, interventions where people are assigned a chance to receive one of two interventions – this gives us the highest degree of confidence that if there are differences between the two groups, it's due to the intervention and not other things – followed by individual randomized controlled trials, or it's possible to basically emulate a randomized trial but without true randomization. Lower would be case-control studies, or retrospective cohorts, where at least there is a comparison; case reports; and then, last, reasoning. The note added here by the Oxford Centre for Evidence-Based Medicine is that any individual study could be graded down in relation to a research question if it doesn't align with the purpose of the review – in our case, this review of safe supply – based on things like the population that's included, the intervention that's tried, or other things.

We framed our review around the population as described in my first slide, drawn from the committee's mandate, the intervention, safe supply, as it was defined. We entered these search terms into the MEDLINE search engine, and – next slide – our results were that we identified 839 articles. There were no systematic reviews or randomized controlled trials. There were a total of 18 articles that reported original research findings and discussed safe supply. Of the 18, 16 were conducted in Canada, 13 in B.C. I mentioned the importance of B.C. earlier. This is another reminder of that. The findings were based on either interviews or questionnaires. The interviews were typically with relatively small samples. Nine did not offer a definition of safe supply, and none were designed to examine the outcomes of interest, listed on that earlier slide, using any kind of objective measure such as administrative data, the kind of data that I referred to in relation to the reductions in crime and reductions in emergency department visits associated with housing, or any comparison group.

Next slide, please. The results of the papers did show that these are the most common themes reported in the results of the papers that we identified: a high prevalence of homelessness, often over 90 per cent in the study sample; a high prevalence of unemployment, near 100 per cent in some of the studies; a high prevalence of food insecurity. These are all factors strongly implicated in both the causes of addiction and, by addressing them, with reductions in harm and promotion of priority. Only one of the papers reviewed out of 18 focused on addressing these factors as an important implication of their results. All of the others overlooked them and instead – next slide – prioritized safe supply even though safe supply per se was typically undefined and not related to their study results.

These are a few – the top two are examples from B.C. and Canadian authors drawing a connection between their findings as implications for safe supply. Only one article, which happened to be from Indonesia, interpreted their results in an opposing way and said that instead it was important to focus on factors that influence the quality of life of the people rather than safe drug-use supplies.

Next slide, please. There is a difference of basic root causes between those that appear to be advocating for safe supply. That is that the cause of the . . .

The Chair: Sorry, Dr. Somers. That's the end of the 30 minutes, but if it's the will of the committee, I would like to put another five minutes on the clock so you can finish your last three slides.

Any concerns?

Some Hon. Members: Agreed.

The Chair: Agreed. Perfect.

Thank you, Dr. Somers.

Dr. Somers: Thank you, Mr. Chair.

A difference of root causes. From the perspective – and I'm offering this in an effort to make sense of this quite peculiar set of studies. It appears that the ability to overlook or the shared tendency to overlook social factors as causal is maybe motivated – maybe motivated – by the interpretation that addiction in the population of interest to us and of concern to us is caused by the supply of toxic molecules. This is an unusual, very much against-the-grain view in the area of addiction, where overwhelmingly addictions are understood to be influenced – and I've used this language of supply and demand, that the demand for addiction is created by isolation in these domains, by estrangement from society, by the absence of meaning in life. Among Indigenous colleagues I often am reminded that this is interpreted as experience of the loss of all relations or, more succinctly still, the loss of connection.

Next slide, please. The overlooking of social determinants of addiction or social causes is one aspect of this. There are other features that are also overlooked in advocating for safe supply that are important to emphasize. One is the known side effects of prescribing these. The top two studies – you won't be able to read this, perhaps – come from over 20 years ago. The lower one, from 2019, is a systematic review, a meta-analysis, high-quality evidence, emphasizing harms associated with long-term prescribing and, in this case, focusing on markedly heightened sensitivity to pain.

Next, please. Next slide. Other consequences or implications, I should say, of advocacy for safe supply include the demand placed on, in this case, Alberta's provincial formulary. Drug shortages are widely acknowledged across Canada, and one area that is particularly worrisome is our shortages involving anaesthetics. Fentanyl is one of the most important anaesthetics, is referenced specifically in this particular paper, where specialists in anaesthesia report that these shortages result in them providing inferior anaesthetics, using medications that they're not familiar with, and it must be considered what the diversion of a drug like fentanyl into other areas would have, the implications it would have, for surgical planning and alternatives. This is not an elastic commodity, as I'm sure members of the committee are aware.

9:40

Last slide, please. As we've been conducting our review, we became aware of the completion of some work by a group jointly led by Stanford University and *The Lancet* medical journal. This review emphasizes the importance of commercial and profit interests in the perpetuation of the opioid crisis, advocates strongly for changes but also touches on some of the issues of interest to our review and, I think, to the committee, emphasizing that policies that should attract skepticism include dispensing drugs from vending machines and prescribing potent opioids and other drugs to individuals with opiate use disorder in hopes of creating a safe addictive drug supply. The authors might have – I'm glad they didn't – simply reframed this as: policies that should attract skepticism are those espoused by people from British Columbia, which is very much the epicentre of this particular type of advice. As I've said, I'm glad they chose not to frame their review that way.

Let me adjourn there, and thank you again for the additional time.

The Chair: Thank you, Dr. Somers, for your presentation.

We're now going to open it up for question and answer with the members, and we will do that until 10:15 a.m. We're going to start with MLA Rosin.

Ms Rosin: Thank you, Doctor. I have a series of five quick questions for you. They shouldn't take too long. I'm just wondering if you can confirm. That last statement you had, that said policies that should attract skepticism include those that include the dispensing of what would be considered a safe supply drug system: can you just confirm what the source of that study was, please? You're on mute.

The Chair: Oh, sorry. Doctor, you're on mute.

Dr. Somers: Quite right. The source is *The Lancet* commission.

Ms Rosin: Thank you.

You had another definition of rehabilitation, and that definition was to detoxify addictions and addicts and teach them to function in society without the aid of drugs. Can you also just confirm one more time on the record what that source was?

Dr. Somers: The main source was Dole, Nyswander, and Warner from the *Journal of the American Medical Association* in I believe it's 1968.

Ms Rosin: Thank you.

You have some statistics about the likelihood to overdose of those who are employed versus unemployed. Can you just confirm one more time for us as well how significantly the likelihood to overdose increases in individuals who are unemployed compared to those who are employed?

Dr. Somers: Yeah. Among people who have been diagnosed with opiate use disorder, unemployment in this study increased the odds of poisoning by I believe it was about six times and is an insight into the larger – unemployment is also related to a higher likelihood of suicidality, and the onset of employment and support in employment leads in the opposite direction.

Ms Rosin: Thank you.

Do you have any data that would suggest how many people who are using safe supply drug provision are employed full-time or at least in a part-time consistent basis versus those who would use safe supply who would not be consistently employed?

Dr. Somers: Well, we found no papers reporting on the delivery of safe supply as we have defined it based on the committee's mandate. I can draw reference to other studies where drugs like heroin, for example, are prescribed to people – this is on an experimental basis – coming to clinic three times a day. In that Canadian research, if I'm not mistaken, over 90 per cent of the patients were unemployed at every time point where they were measured.

Ms Rosin: Thank you.

My last question, then, is: do you have any data to suggest how many of those who are reliant on safe supply or, if you don't have papers on safe supply for opioids, I suppose potentially prescription heroin – any data to show how many of those reliant on prescription heroin or opioids go on to get clean and who use that prescription basis as the springboard that gets them clean and rehabilitated, as the definition from before?

Dr. Somers: In North America, in particular, very few, if any. In the Ontario methadone program, for instance, for every additional year that a woman is receiving methadone, there is a 7 per cent increase in the likelihood of being convicted of a crime. For men it stays constant. It's referred to by many clients, patients as a form of chemical handcuffs, and I think that's an apt metaphor.

Ms Rosin: Perfect.

Thank you. Those are all my questions.

The Chair: Excellent. Thank you, Member.

We have MLA Yao up next.

Mr. Yao: Dr. Somers, thank you again for taking the time to speak with us as we study this very serious issue. As you went through the slides, I couldn't help notice that there's a certain parallel to Maslow's hierarchy. And for the general audience that's watching, all hundred people, Maslow's hierarchy is a study on how humans partake in behavioural motivation, the first step being physiological. If you have things like food and clothing, then you can focus on things like safety, which are job security and housing. And when you have that, then you can focus more on love and belonging and friendship, which are your social needs, eventually getting to the pinnacles of working on self-esteem and, ultimately, self-actualization. Is it safe to say that a lot of what you are explaining there really reflects Maslow's hierarchy? For example, you focused on housing first there, that if we can address the housing needs of a lot of the folks that have these addiction issues, they'll be in a better place to address their addiction issues. Is that fair to say?

Dr. Somers: Yes. Yeah, it is. I think a lot of what has come to pass in the field of addiction validates Abe's observations about motivation and, in particular, that if we are – in the case of those trials that I referred to, the part of housing first that has really been unsuccessfully translated into practice is an emphasis on individuals' own choices and supporting their, using more psychological terms, sense of agency. And when we are able to emphasize people's agency, like a choice of places to live, for instance, which is how we – as opposed to: here's your place. A choice of places and providing people with choices and the supports to stand by their choices and learn from them is the surest path that we know of to assist people overcoming their mental illness symptoms, their addiction struggles and is entirely consistent with the way that Maslow described the progression that you summarized.

Mr. Yao: A follow-up?

The Chair: Yes, sir.

Mr. Yao: Just to clarify, again, you studied systems like what happened in Portugal, who were considered leaders in addictions and whatnot, treatments, and you mentioned that they emphasize the fact that treatment requires social reintegration. So is it fair to say again, you know, that under Maslow's hierarchy that is like the social needs, the friendship under love and belonging? Again, if we're addressing the physiological issues, the safety issues, the love and belonging, they can start to focus on the self-esteem and, ultimately, the self-actualization. That is what other nations have identified, again, that is consistent with what you just said, that if we address all those issues beforehand – their safety, their shelter, as well as love and whatnot – they're in a better place to fight these addictions. Yes?

Dr. Somers: Yes. Absolutely that and reinforced by, as I point out, the high prevalence of suicidal intent and suicidal thoughts. The best response we have to help people transcend that kind of state of

despair involves the same elements that we're emphasizing or that are emphasized in helping people overcome addictions. It is summarized as establishing lives that are worth living.

9:50

Mr. Yao: Thank you, sir.

The Chair: Thank you, Member.
We next have MLA Milliken.

Mr. Milliken: Sure. Thank you, Dr. Somers, for being here today. I recognize that the purposes of your presentation today are to essentially go over a review of the literature as what is already out there. I guess one of my questions – I'm struggling a little bit in the sense that what I'm getting from this presentation, I believe, is that it would be fair to say that there isn't too much high-quality, evidence-based research out there currently dealing with safe supply. Is that a fair assessment?

Dr. Somers: Yep.

Mr. Milliken: Both for or against. I'm not even looking at it from the perspective of whether or not it's a good thing or a bad thing. What I'm looking for potentially is whether or not there's – essentially, what you're saying is that as of right now the literature out there is lacking.

Dr. Somers: It is lacking with respect to safe supply as the term is being used today; that is, leading to evidence supporting the increased prescribing of drugs, as your committee has provided by way of example, as a means of reducing harms in the population. There is a lot of evidence, that is not using the term "safe supply," that demonstrates the likely harmfulness of implementing activity as safe supply is defined here, and that's what led *The Lancet* commission to their conclusion that this is one of the recommendations to be skeptical of.

In our review we were searching for evidence where the authors are presenting findings and are then recommending an increase in prescribing. What we found in that tranche of 839 papers was that most of the authors that used the term "safe supply" were using it in relation to reduced prescribing. We did not include those papers because that's not the sense of the term as the committee is using it, but if we had searched for literature on evidence to support reduced prescribing, harms of prescribing, side effects of drugs, we would be overwhelmed. It's that source of literature, as I said, that is being referenced in *The Lancet* commission's overall interpretation that this is not a credible pathway to reducing suffering as against others where there's much stronger evidence.

Mr. Milliken: Thanks. Just as a quick follow-up, it would be my expectation that individuals either for or against safe supply, as defined with regard to this committee, would be rushing to create evidence-based resources to rely on. Do you know of any ongoing studies that may be happening?

Dr. Somers: Yes. There have been. We've come across, for example, descriptions of studies that have been published, so they're not presenting results yet; they're outlining the protocols that they are planning to follow in order to generate findings. You know, I hasten to add that when deployed among people who are homeless, unemployed, suicidal, living with serious mental illnesses, in states of despair, it is at least perplexing why investigators would choose to focus on leaving those aspects of peoples lives untouched, when they are directly implicated in the likelihood of recovery, and instead focusing on the marginal gains that may be achievable by prescribing drugs to them while they remain in those abject states of poverty and despair.

The Chair: Excellent.
Do you have a follow-up, Member?

Mr. Milliken: No.

The Chair: Okay. Thank you, Doctor.
We now have MLA Amery up.

Mr. Amery: Good morning, Dr. Somers, and thank you very much for this incredibly informative presentation that you've provided. I think all of us committee members are in debt to you for your time and your expertise in this area. Doctor, this committee is, as you know, tasked with examining several aspects of safe supply, including whether there's any evidence that a proposed safe supply would have an impact on fatal or nonfatal overdose, drug diversion, or associated health and community impacts.

You know, this is a broad and general question because I think that all of us committee members are here to learn as much as we can about this particular issue. With that in mind, is there any evidence that access to safe supply of opioids, heroin, crystal meth, cocaine, or other substances, for example, for people who are addicted to or dependent on these substances reduces the likelihood of suffering a fatal or a nonfatal overdose?

Dr. Somers: There's no direct evidence, because I am not aware of any government or oversight body making drugs like cocaine or crystal meth available to people whether they're addicted or not. The evidence of the relationship between more prescribing or more availability of drugs and harms is massive. There is an extremely strong correlation, witnessed most recently in the so-called oxycodone era and that crisis.

So there's no direct evidence, for the reasons that I've described. It would simply be illegal on an international scale, and I think that suppresses government's willingness to sort of buck international treaties and do things like prescribing crystal meth or making them available to people. It would go against all of the known evidence relating to harms of drugs and also, as I've mentioned, form a very kind of perplexing opportunity cost.

I don't know if any of your staff have done a back-of-napkin estimate of what it would cost to provide fentanyl to individuals on an annual basis. Our sketch is that it would very quickly, for fentanyl alone, go past six figures and while people remain homeless and nobody's helping them with their employment. We're ignoring reconciliation and the project of reconciliation as a contributor to reduce addiction. Why ignore all those things, given cost-effectiveness trials showing that interventions that cost a fraction of that amount are highly effective at supporting people in their ascent of Maslow's hierarchy, and instead prioritize something that is completely contraindicated by available evidence? It smacks of interests that go beyond those of the health of the individuals that we are attempting to support.

The Chair: A follow-up?

Mr. Amery: I'll take one more follow-up. Thank you, Dr. Somers, once again.

Now, my colleagues here earlier this morning have brought up some various examples of jurisdictions, if you will, that have applied or are attempting to apply a sort of safe supply model. My colleague Tany Yao brought up the example of Portugal earlier today in his question, and we have one model of proposed safe

supply here in Canada at least, in B.C., as one form of what they might purport to suggest is a safe supply model.

I understand that the evidence suggests, from your answer here and the answers prior to today, that there is sufficient evidence that exists, independent, credible evidence, for the harms of reduced prescribing, if you will. You also mentioned that there is credible evidence to suggest that prescribing or safe supply does not achieve its intended purpose.

I'm wondering if you can comment on whether or not you have any information to provide this committee with respect to how the jurisdictions that are implementing these policies or how the jurisdictions that are contemplating these approaches justify the introduction of safe supply and/or reduced prescribing practices and indicate that it is the correct path, given the evidence that you're bringing up here and given the evidence that you're suggesting is overwhelmingly in favour of not proceeding towards this type of practice.

10:00

Dr. Somers: Well, in B.C., where I call home, there is a long-standing disinterest in addressing social determinants of addiction. When I brought up at the beginning of the public health emergency – back when I was still invited to meetings here, I brought up the glaring, to me, involvement of the absence of reconciliation with Indigenous peoples as a contributor to their overrepresentation among decedents, our abysmal record of transitioning from institutional to community-based cure for mental illness as a means of explaining the overrepresentation of people with mental illness among those who are at risk, the increasing numbers of youth who are displaced from housing and means of supporting themselves economically, and there was an absolute disinterest in considering any further examination of risk factors in the social world as it contributes to the risk of poisoning.

The emphasis was on that it's an equal opportunity risk, and the only viable means of addressing it is by prescribing medications and getting people connected to the provincial formulary. It was entirely a supply-oriented focus. I think people, frankly, have their heads in the sand and perhaps are intimidated by the scale of addressing the social determinants. But other experiences such as that of Portugal emphasize, as do almost all of the successful treatment studies, including those that I've referred to today – all show that successfully overcoming addictions is achievable and is achieved best by promoting social reintegration using familiar structures to all of us participating today: work, home, family, meaningful elements of life.

Portugal's turnaround came without anything like safe supply. They used methadone, consistent with the studies that I've referred to earlier, and, on a far more important level, involved housing and support. In fact, they emphasized housing to such a degree that even though they were addressing homelessness and poisoning fatalities, they did not need to introduce a single consumption site, normally something that would be stock-in-trade when a large population of homeless individuals are using drugs. They were able to bypass the need for a consumption site because they prioritized rapid rehousing of individuals along with other forms of support that enabled them to be self-sufficient.

The Chair: Member? Excellent.

Next we have MLA Stephan.

Mr. Stephan: Great. Thank you so much for your presentation. One of the arguments, I think, at least that I've heard, in favour of safe supply, and I'd be interested in your response, is that some would assert that but for providing safe supply, individuals would die because they would be taking tainted drugs. I know that would be a common argument. I'm just wondering what you would say in response to that argument, that but for safe supply, individuals will access tainted drugs that will cause them to die.

Dr. Somers: Yeah. So keeping in mind this highly speculative environment in which this so-called safe supply is being described, I mean, the term itself is sort of – it obscures, I think, the meaning of what we're describing. But if we were to, you know, proceed with individuals, let's say, as I've alluded to, experiencing homelessness, social exclusion, joblessness, friendlessness, really often a lifelong lack of support, about a quarter of the people we've worked with meeting those criteria also experienced severe adverse childhood events, so this is a lifelong pattern.

Now we have a choice. We and you have a choice. We could approach that person at immediate risk, as you've described, and say that based on randomized controlled trial results and cost-effectiveness results at about $38,000 a year we could say today: I have some options of housing available that we could go and look at this afternoon, to be followed by support obtaining employment. Eighty per cent plus of the people that we meet and interview in this dynamic say on the day we meet them that they want to pursue paid employment, and about 60 per cent have worked for at least one year consecutively in the past. They have it in their repertoire. So we can approach people for that relatively small cost with these types of choices and, yes, support in using drugs more safely, reducing harms, proceeding in the direction toward recovery one small step at a time. We could do that today, invest in people, show them that we believe that they have more to achieve in life and that they have worth.

Or, for an as yet uncalculated but vastly greater sum of money, we could approach someone and say: "I can see quite clearly that you're suffering psychologically. I can see quite clearly that you're suffering due to exposure and a lack of a place to live. I'm going to not talk to you about those things. I'm going to ignore them as though they're somehow insoluble. Instead, how would you like a free supply of the drugs that you're taking addictively? I'll do that." Now, what kind of message is that to the person? Yes, it would be arguably better than nothing, but through that very act we're confirming their perceived worthlessness, that this is the best we can do, when, in fact, we can do much better. People in need of assistance consistently say that they want more. People, when they are seeking help, are not asking for a supply of drugs.

A large Scottish study of people seeking help with their opioid and polysubstance addictions reported that over 50 per cent were seeking help primarily to get off drugs and that less than 2 per cent were seeking help using drugs more safely. So this is not something that has a grassroots component to it. It is something that is being somehow introduced from outside.

The Chair: Thank you.

Member, did you have a follow-up? Mr. Stephan?

Mr. Stephan: Yes, please.

The Chair: Yes, sir.

Mr. Stephan: Yes, please. Thank you. I appreciate the distinction between recovery and harm reduction type of discussion there. Would you say, just to kind of clarify in terms of literature and the concept of safe supply, that there's a distinction between using prescriptions to wean people off drugs for the purposes of recovering from addictions versus prescribing to protect individuals in their addictions from tainted drugs? In terms of your search of literature and the discussion of safe supply, is there a distinction

there between, again, prescribing as a means to move people off being addicted and perhaps – my understanding is that methadone, I think, sometimes is used for that purpose; I stand to be corrected there – versus prescribing people with clean, I guess, drugs that aren't tainted but not really used for the purposes of moving people off addictions and towards recovery? Could you comment on that, those two differences in terms of safe supply?

10:10

Dr. Somers: Yeah. As yet there is no literature on prescribing drugs like crystal meth and cocaine to individuals. There is nothing on that side of the ledger, in response to your question, and there are many, many good reasons why proceeding in that direction would be potentially injurious to the recipients, to patients. Our physiology doesn't know where the molecules came from, and individuals who are using drugs in combinations are at high risk regardless of where they get their drugs from. Receiving prescription drugs is no assurance that individuals would no longer be purchasing additional drugs and using them. We have evidence, in our work with those experiencing homelessness and mental illness, that about 50 per cent of the people receiving methadone are using illicit drugs at the same time every day. There is very little reason to believe, first of all, that this project would be successful at displacing use of illicitly procured drugs. As I've said a couple of times now, it is simply bewildering that that form of intervention would be prioritized above others that have far more evidence of effectiveness and would simply also be cheaper.

The Chair: Thank you, Doctor.

Thank you, Member.

Next up we have MLA Milliken.

Mr. Milliken: Thank you for the opportunity to ask another question here. In jurisdictions where safe supply is being provided – by that, I mean in regard to ensuring or trying to ensure that people who are taking these drugs aren't getting tainted drugs, which, of course, I think the line of logic would then lead to an increase in overdoses – do you know or did you find in your research any studies or study that shows safe supply is associated with harm reduction both to users and/or the community or, I guess, on top of that, whether or not it's associated with a decrease in overdose deaths in those jurisdictions?

Dr. Somers: No.

The Chair: Excellent. That was quick. Thank you. Yeah.

Any other members? We have about two minutes left for questions. Any other questions? Okay. MLA Yao.

Mr. Yao: I guess I'm wondering, Dr. Somers, if you could sum up your presentation for us here as a general – are you able to do that?

Dr. Somers: Sure. Yeah. Thank you. Thank you. Yes. There is a large volume of evidence bearing on how best to assist people who are at greatest risk of poisoning. The pathway that has the highest evidence – a large volume of evidence focuses on, I'll put it this way, events in the social world, things in our social world, things outside of our skin, interactions with other people, opportunities. We've discussed a number of them here today: individuals struggling with inadequate housing or homelessness, with an absence of employment opportunities and thereby an absence of means to support themselves to be reintegrated in society. Those activities should be prioritized.

Alternatively, the focus on safe supply, as we've seen in the papers we've reviewed, despite measuring these types of obvious social deficiencies in people's lives, chooses not to prioritize them at all and instead focuses on an intervention that would only work, if it was to work, by having some effect within our skin by changing somehow the individual's experience of drugs, risk of drugs. There is simply no evidence that drugs on their own, as mentioned by Dole and Nyswander, that a mere chemical agent is capable of contributing to a meaningful change.

The upshot of this presentation and, I think, of experience in the field of addiction, especially over the last 50 years, emphasizes that individuals are highly capable of change, far more so than we usually give people credit for, and that their ability to pursue change is a function of the social opportunities that are made available to them and the support to take full advantage of those social opportunities. So I commend to the committee to consider examining those kinds of approaches that would emphasize social capital and to have a sense of hope in the capabilities that we're trying to assist.

The Chair: There you go. That sounded like a conclusion. Thank you, Dr. Somers. Sorry. I was going to interrupt you, but it sounded like we – that was good timing, so thank you for that.

Thank you for your presentation and to the Centre for Applied Research in Mental Health and Addiction at Simon Fraser University for preparing this evidence review for us. Really appreciate your time with that, so thank you.

We are actually going to take a short break, and we are going to reconvene back here at 10:20 for our next presenter. Thank you.

[The committee adjourned from 10:16 a.m. to 10:21 a.m.]

The Chair: Hon. members, at our February 3, 2022, meeting the committee directed that invitations be made to 27 individuals and organizations to make oral presentations in relation to matters that fall under the committee's mandate. Each of our presenters will have 10 minutes to make their presentations, followed by a 20-minute period of question and answer with committee members.

Our first presenter today is Dr. Nickie Mathew. Doctor, thank you for being here. You have 10 minutes to present, and then we'll open up for question and answer.

Nickie Mathew

Dr. Mathew: I'm sorry. If we can start with my presentation, if you're able to put it up. Thanks. I won't be looking at the camera because it's hard to see in gallery view.

I'm going to be presenting on safe supply. I want to have you guys understand the relationship between the opioid overdose epidemic and opioid prescribing, understand why opioid overdose has decreased in 2018 in the U.S. and 2019 in Canada, be able to critically examine the evidence for safe supply, and understand the facts and assumptions regarding safe supply.

If we can move to the next slide. Next slide. We're going to start with a little bit of history. Arthur Sackler was a Madison Avenue ad agent. He started the Terramycin campaign in 1951. This was a direct-to-physician advertising campaign. He made so much money off this that he and his brothers bought Purdue pharmaceuticals.

If we can move to the next slide. In 1980 Jane Porter and Hershel Jick wrote a five-line letter to the editor in the *New England Journal of Medicine*, saying that addiction is rare and less than 1 per cent of people prescribed narcotics. However, this was only with people who were in hospital. They didn't follow them up after hospital. This became lionized as an extensive study in *Scientific American* and a landmark study in *Time* magazine. This was quoted over 1,300 times by other scientific papers.

If we can move to the next slide. In 1996 the American Pain Society president, Dr. James Campbell, said in his presentations to the American Pain Society that if pain were assessed with the same zeal as other vital signs, it would have a much better chance of being treated properly; we need to train doctors and nurses to treat pain as a vital sign.

Also in 1996, OxyContin was released by Purdue pharmaceuticals with the same techniques that Arthur Sackler used in the Terramycin campaign, quoting the five-line letter to the editor by Porter and Jick.

So what happened after this?

If we can move to the next slide. This is a graph of overdose deaths in Ontario between 1991 and 2015. I'd like everybody to follow the red line. The red line is the number of overdose deaths with OxyContin. The next line that I want you guys to look at is the dark blue line. After a while OxyContin became replaced by fentanyl, and the number of fentanyl overdoses increased.

If we can move to the next slide. This slide shows the relationship between the number of opioid prescriptions and the number of prescription opioid overdose deaths. As opioid prescriptions increased, the number of opioid overdose deaths increased.

If we can move to the next slide. Roughly 21 to 29 per cent of patients prescribed opioids for chronic pain misused them. Between 8 to 12 per cent developed an opioid use disorder. An estimated 4 to 6 per cent who misused prescription opioids transitioned to heroin. About 80 per cent of the people who used heroin first misused prescription opioids. The take-home point from this is that most people who use opioids do not start with heroin or fentanyl. They start with prescription opioids. This is illustrated in the next slide.

One of the fundamental issues is that you have two groups of people. One group of people uses prescription opioids, one group of people uses illicit opioids, and there's an overlap in between. However, every year 4 per cent to 6 per cent of the people who use prescription opioids transition over to illicit opioids, and when we increase the amount of opioids in the population, we have an increase of opioid use disorder.

We can move to the next slide. This is opioid overdose death rates in British Columbia. What you'll notice is that there was a dramatic decrease in 2019. Why did this happen?

We can move to the next slide. We're going to focus on this part in 2019 in B.C., but moving to the next slide, we're going to focus on 2018 in the United States. This is from the *New York Times*. It talked about how the total drug overdose deaths in America declined by around 5 per cent last year, meaning 2018, the first drop since 1990. The decline was almost entirely due to a dip in deaths from prescription opioid painkillers. Fatal overdoses on other drugs, particularly fentanyl and methamphetamine, continued to rise. So there was a decrease in opioid overdose deaths by decreasing the number of prescription opioids.

Now, what happened in 2019 in British Columbia? If we can move to the next slide. There was a decrease in medications such as opioids and benzodiazepines that can cause overdose. The next slide. There was an increase in the amount of take-home naloxone that was handed out. Next slide. There were safe injection sites. These were very localized. They weren't providing the drugs, but this was a safe place for people to use. The next slide. There was an increase in opioid agonist therapy prescribing. If we can move to the next slide. All of these four factors contributed to the decrease in overdoses in British Columbia in 2019.

We're going to go over the evidence for safe supply. If we can move to the next slide. These are the statistics that are mostly touted by the people who are talking about the evidence for safe supply. Between March 27 and August 31, 2020, 2,780 people received the risk-mitigation, a.k.a. safe supply, medications. Of the 2,780 people, 10 people died, leaving a mortality rate of less than .4 per cent. One big factor here is that half the people were prescribed opioids; about a quarter, stimulants; about a fifth were prescribed alcohol withdrawal management medications – it's unclear why this was included in safe supply – and 12 per cent were prescribed benzodiazepine.

If we can move to the next slide. A .4 per cent mortality rate sounds like a good number, but if we break it down to the population level, how many people have an opioid use disorder? How many people have an alcohol use disorder? How many people have a stimulant use disorder? How many people have a sedative use disorder? If you add all of that up and take the number of overdoses in 2017, the base rate of overdose death is .2 per cent. But the rate of .4 per cent that's touted in their study occurred over five months, so it wasn't even one year. You could expect that mortality rate to increase over a period of a year.

The other thing that they don't reveal is what percentage of people in their .4 per cent were on opioid agonist therapy. There were no comparison groups, and there were no objective measures to see if people were using less fentanyl. So this .4 per cent that they're touting is actually higher than the base rate of overdose death in the population of British Columbia.

Why do we need objective measures? If we can move to the next slide. There was a study in the *Journal of the American Medical Association* in 2012. This followed I think it was about 8,000 people over six years, and what they found was that high patient satisfaction was related to lower emergency department visits but greater in-patient use, higher overall health care and prescription drug expenditures, and increased mortality. So the higher the patient satisfaction, the more people died. This is why we can't rely on patients' self-report to evaluate this program. We need to look at objective measures.

I'm going to go over some of the facts and assumptions regarding safe supply. If we can move to the next slide. Increasing the amount of prescription opioids available has known harms. It increases the number of opioid overdose deaths, and it increases the number of people with opioid use disorder. The benefits of safe supply are unknown.

If we can move to the next slide. Proponents will say that patients are looking for safer alternatives and consistent dosing for the substance of choice. We do not know if safer supply reduces overdose. The assumption is that patients will use hydromorphone instead of fentanyl. One possible outcome is that the assumption is true, and patients want hydromorphone instead of fentanyl. Another outcome is that it does not decrease fentanyl use, and hydromorphone is used in addition to fentanyl. Another outcome is that patients may sell safe supply to get more fentanyl. Another outcome is that safe supply can be diverted, creating more addiction in the population. And another outcome is that patients may use safe supply in harmful ways, causing more harm, like crushing and injecting tablets, leading to infections, vasculitis, and lung diseases. Any evaluation of the program will need to consider all of these outcomes.

10:30

If we can move to the next slide. Proponents will say that we are forcing patients into restricted treatment modalities when they are not ready for addiction treatment. So the assumption is that this approach will be beneficial for patients. One possible outcome is that the assumption is true and safe supply will keep patients alive. Another possible outcome is that safe supply may increase risk of death per patients prescribed it, increasing exposure to opioids, increasing access to fentanyl through diversion. Another possible outcome is that, overall, death rates may increase as more people

become addicted to diverted opioids and stimulants. Any evaluation of the program would need to consider all these possible outcomes.

And we'll go to my last slide. This was from a CBC article, and this was someone who uses drugs and was prescribed safe supply. He was saying that some days he doesn't take the pills, which is why a stockpile is building up in the supportive housing unit he lives in. Quote: "Maybe more than half of the people that I know . . ."

The Chair: Sorry, Doctor. That was . . .

Dr. Mathew: ". . . that are on these are looking to sell them."

The Chair: Sorry, Doctor. That was 10 minutes. But I see you've got one slide, so maybe if you can wrap up. Thank you.

Dr. Mathew: Yeah. I was just finishing that quote.

There is a large amount of diversion taking place, but no one is evaluating the amount of diversion.

The Chair: Thank you, Doctor. That was a lot of information to cram into 10 minutes, so we appreciate . . .

Dr. Mathew: Sure.

The Chair: . . . your efforts. No. Thank you for that.

I will now open up for 20 minutes of question and answer with the members. Is there a member that would like to start? MLA Rosin.

Ms Rosin: Okay. Thank you for the presentation. You mentioned the number of people who are prescribed opioids. I'm wondering if we can break that number down a bit.

Dr. Mathew: Sure.

Ms Rosin: So for the people who are prescribed opioids, what percentage of those people develop an opioid use disorder?

Dr. Mathew: This is for chronic pain. Between 8 to 12 per cent of the people who are prescribed opioids will develop an opioid use disorder. Opioids are one of the top medications that are prescribed, so a large number of people are developing an opioid use disorder.

Ms Rosin: Okay. Thank you.

And then: what percentage of people who misuse their prescription opioids transition to heroin after being prescribed?

Dr. Mathew: Four to 6 per cent of the people who are prescribed opioids will transition to heroin. This is the worry with safe supply, that we're going to increase the number of people addicted to prescription opioids, and then every year 4 to 6 per cent of them will go and transition to illicit opioids. That's the danger. We hear from patient groups that they don't like hydromorphone, that they don't like the safer alternatives to opioids.

Recently in Vancouver – I'm not sure if you guys are following the news there – they were handing out crystal meth, cocaine, and heroin, and they had people who use drugs rate them on a five-point scale. They were mentioning – you know, people were rating the cocaine and the methamphetamine 4 out of 5, but they have much lower scores for the heroin. The reason is that people are used to taking fentanyl. They are used to taking illicit fentanyl. This is what is demanded in the drug market at this point in time. So it's unlikely, if we prescribe them these other opioids, that they're going to use them instead of fentanyl for recreational use.

Ms Rosin: Okay. So you brought me to my next question, which is: if 4 to 6 per cent of people transition every year to heroin from the prescription opioids, at this moment in history do you know how many people who are currently using heroin or what percentage of people currently using illicit heroin started with prescription opioids?

Dr. Mathew: Eighty per cent.

Ms Rosin: Thank you.

Just two more questions. You mentioned that in the past – I'm not sure what year it was – there was a decrease in the number of prescription opioids prescribed, and that resulted in a decrease in deaths from opioid overdose. I'm wondering if you can just give us the numbers one more time on how much the prescriptions decreased by and, as a result, how much the deaths decreased by.

Dr. Mathew: I have a graph showing how much it's decreasing by. For opioids, it went from around 800 prescriptions in mid-2015, and then this dropped to about 550 prescriptions by July 2017. There's been a reduction in time with opioid prescribing. What I'm worried about is that we have made some gains by decreasing the amount of opioids that are prescribed in society, and we might reverse these gains by prescribing more opioids than we've ever prescribed.

Ms Rosin: Okay. My final question. You mentioned that the mortality rates amongst those who begin with prescription opioids or those who are using a safe supply system are actually higher than those who are not using such a system. I'm just wondering if you can tell us quite how much higher or how large that difference is between the mortality rates of the two systems.

Dr. Mathew: What they are using for evidence for safe supply – so this was the 2,780 patients – the mortality rate was .4 per cent in five months. The base rate mortality is .2 per cent in a full year. The thing that they're using to tout as "safe supply is working" I don't think shows the data that they think it's showing.

Ms Rosin: Just to be clear, the mortality rate was twice as high in a short period of five months as the baseline mortality rate?

Dr. Mathew: It is. However, I mean, there have to be some caveats to that in that the people who are prescribed safe supply tend to be sicker. But they're not measuring any of this, and there are not objective outcomes to see if people are using less fentanyl. I don't really understand why they aren't using things like urine drug screens to see if people are using less fentanyl once they go on to safe supply. What they are essentially doing is that they are asking patients: "Is this program working for you? What are the benefits?" Then they take that at face value, which really isn't how a lot of medical interventions are studied.

Ms Rosin: Thank you.

The Chair: Excellent. MLA Yao.

Mr. Yao: Thank you, Chair. Dr. Mathew, thank you so much for taking the time to speak with us at our committee as we study this very serious issue. I have a few points I just would like you to reflect on and provide your answers to. Based on your presentation, there are a high number of people that become addicted to opioids and whatnot due to prescriptions. That said, these prescriptions are reflective of an inherent safe supply, I guess, that we have already out in the system. Is that fair to say?

And then: how are our physicians in Canada educated in addictions? To what level, and are they at a level where they are recognizing these issues around addictions to the prescriptions that they distribute? Do they work on weaning the patients off these

opioid potential addictions? If you will on that. Those are my first questions.

Dr. Mathew: Sure. There is a lot to unpack there. I was wondering if you can say the first question over again, that this comes from an inherent safe supply. I didn't understand the question.

Mr. Yao: A lot of addictions seem to come from people who start off with prescribed medications from physicians; say, they have a hip surgery. They're waiting, like, two years to get that hip surgery because our system is pretty slow here in Canada, and they get addicted to those prescriptions. Is it safe to say that, technically speaking, there already is a safe supply out there? It's what we prescribe to our patients for their pain relief.

Dr. Mathew: I think that's absolutely correct. Most of the people who use illicit opioids – 80 per cent – started with prescription opioids. There are two groups. There are people that these are directly prescribed to who become addicted, and then some of those people divert the medications, and they are sold in the population. When you increase the amount of prescription opioids in a population, you increase the amount of addiction to opioids, and you increase the amount of addiction overdose deaths.

Mr. Yao: My second part to that question was: are our physicians here in Canada – you work out of British Columbia. Is that correct?

Dr. Mathew: Yes.

Mr. Yao: Are our physicians in Canada educated to the point where they understand the opioid issues and that part of their treatment programs for their patients is weaning them off these very same opioids that they prescribe? Or is that somewhat questionable?

Dr. Mathew: To be honest, I can't speak to the rest of Canada. I know, for myself, I've given a lot of lectures to physicians and residents, and it is part of the psychiatry training program at the University of British Columbia. I don't know what's happening with the rest of the training. However, the College of Physicians and Surgeons of British Columbia also has a standard of practice that physicians must follow. So there has been a lot of education about this, but I couldn't speak to the rest of Canada regarding this topic.

10:40

Mr. Yao: Thank you.

My second question, a follow-up, Chair. You had some slides there that talk about patient satisfaction but that that does equal a higher mortality rate. Are we basically saying that if we're just simply to rely on the patients who are addicted to these medications, we can't necessarily rely on their satisfaction in saying that they need to maintain these opioids because, ultimately, it does lead to an increase in a higher mortality rate? The reason why I ask this question is that for some of the groups that withdrew from our discussions here, our consultation process, those are their arguments, that these people would have, that their loved ones would have survived had they just simply had access to clean drugs.

Dr. Mathew: I think it's even broader than the question that you're asking. In general in medicine, when you look at medical interventions, you cannot rely on just patient self-report; you have to look at objective measures of benefit. This is why we have allopathic medicine and we don't have homeopathic medicine in Canada, and the reason is that we have randomized controlled trials. If you look at the experience of human disease, most people that have diseases in general, like the broad experience of disease, will get better by themselves. For most people, their experience of disease would be the flu or things like that. So when you have an intervention, you have to compare a group that doesn't get the intervention to a group that does, because a lot of people who don't get the intervention will get better. So you have to see whether your intervention is better than the placebo group. Does that make sense?

Mr. Yao: Yes, sir.

The Chair: Excellent. We now have MLA Amery.

Mr. Amery: Good morning, and thank you, Dr. Mathew, for your time and your presentations here today. I want to go back a little bit to some of the information that you provided in your slide deck. I know that 10 minutes is barely enough time to scratch the surface in this incredibly important area, and I wanted to kind of go back and have you highlight some of the things that you wanted to bring up in your presentation.

You've already illustrated that the relationship between opioid prescribing and overdose deaths is directly related. That is, when we saw the chart that you had presented earlier, we saw that where opioid prescribing increases, we see an almost corresponding increase in the total overdose deaths. I understand that overdose deaths are one factor for consideration. It's a metric that a lot of people place an incredible emphasis on and, I think, for good reason, but I also think that there are other issues that we need to talk about as well. You know, to be clear, I don't want to for a moment suggest that overdose deaths are not an incredibly important factor and the ultimate tragedy, if you will, but there are other impacts that I think we need to talk about, some of which you alluded to in your presentation.

Now, the idea, perhaps, Doctor, is that safe supply reduces deaths, and I'm not sure in particular where the evidence lies in relation to that metric, but I want to know what other impacts we are seeing and in particular in B.C., where this safe supply model is being implemented. I think it's the best example that we have in Canada of, you know, a safe supply or a quasi safe supply model and, really, the best jurisdiction that we can compare to other Canadian provinces for more information. Now, what we're seeing, I think, in your slide show and in the key assumptions that you highlighted is that overdose deaths are not the only impact that we're seeing as a result of safe supply. Can you describe for the committee whether the evidence is settled, that, in fact, overdose deaths are decreasing in safe supply jurisdictions like B.C.?

And, similarly, I want to give you an opportunity to comment on what trends and impacts B.C. is currently experiencing that you may not have had a full opportunity to comment on during your slide presentation.

Dr. Mathew: That's a very large question, and I'll try to unpack it the best I can. There is the issue with overdose deaths, but there's also the issue with addictions. We had a case where there was a girl who was going to UBC who had gastric surgery. She was prescribed hydromorphone, became addicted to the hydromorphone, started buying the readily available hydromorphone and overdosed several times. She showed up at Vancouver general hospital, and when she got to hospital, instead of starting her on treatment, they discharged her with a prescription of safe supply hydromorphone. They kept doing this, and she kept overdosing. Eventually she met up with a colleague of mine, and he started her on Suboxone, and she said that she would have started on Suboxone earlier if safe supply wasn't available.

So one of the issues is that you can increase the amount of addiction in the population, and this has negative effects on health care costs, and this has negative effects on the people of British

Columbia. We need to somehow try to look to see what the impact of it is, because with safe supply, we have to look at things like overdose stats. We need to look at the impact of addiction overall and the health care costs available to that. We need to see what the net result of all of these issues is, but there doesn't seem to be any sort of search to see what the net effect is and what the net effect of diverted safe supply medications is in the population with a possible increase in addiction.

Mr. Amery: Thank you, Dr. Mathew. I'm going to yield my follow-up to another colleague who has a question for you.

The Chair: Thank you, MLA Amery.

We now have MLA Stephan.

Mr. Stephan: Sure. Thank you for that presentation. I thought it was excellent. Near the end of your presentation it seemed that you had talked about how safe supply is sometimes used perhaps in inappropriate ways. In that, I know that sometimes I've heard and my understanding is that individuals suffering under drug addictions are really looking for the next high – they're trying to get that high – and that the potency of safe supply is sometimes not good enough for what they are seeking and that sometimes they'll use the safe supply that they're provided for purposes of a type of currency to get drugs that they think will get them that high, or they'll use the safe supply in a more intense way to try to, again, seek the potency that will give them that desired high that they're looking for. Can you comment, in terms of studies, on the use of safe supply as currency, for example, to get perhaps nonprescribed drugs or when safe supply is used beyond the way in which it is prescribed or intended by the user of it?

Dr. Mathew: There aren't great studies on this. I did write a case study of a person who was convicted of fentanyl and methamphetamine distribution in the Downtown Eastside, and he was talking about what happened before safe supply came in and COVID and what happened before. One of the metrics that I found interesting was that he said that the street price of hydromorphone tablets was $10. So an eight-milligram hydromorphone tablet was $10 before safe supply went in. At the time of the interview with him, which was in August 2020, the price of hydromorphone tablets had decreased to $2 a tablet. More recently, so within the last six months, it's dropped down to 25 cents a tablet, so now you can get four tablets for a dollar. If people were consuming the safe supply that they were being prescribed, there would not be a drop in the street price of hydromorphone. With hydromorphone being more available and cheaper, it gives more opportunity for people to use this for nonmedical use and become addicted to hydromorphone over time.

Some of the benefits of safe supply are that sometimes when people are in withdrawal, they might take some of the safe supply to stave off the effects of withdrawal, but oftentimes what happens is that people who are using safe supply don't feel that it's strong enough, and then they will sell their tablets for currency to get more fentanyl. The other thing is that when they are using safe supply, they might not use it in tablet form. They might crush it and inject it, and that can cause a lot of issues with infections and other injection site issues.

The Chair: Excellent. Thank you.

We now have MLA Milliken, with about two minutes left. [interjection] Oh, sorry. Member Stephan, did you have a follow-up?

Mr. Stephan: Yeah, a very quick one. I'm just wondering: what's the B.C. government's response to the fact that there is this dramatic fall in the street price of safe supply medications? That sounds very serious to me.

10:50

Dr. Mathew: To be honest, I don't really follow politics a lot, so I don't know what the response is.

The Chair: Excellent. MLA Milliken, with two minutes left.

Mr. Milliken: Sure. I'll just ask very, very quickly, then: do you know of any studies that show that safe supply is associated with better outcomes such as recovery for opioid users?

Dr. Mathew: Not in the model that we have in British Columbia. Some of the things that they might cite are injectable opioid agonist therapy treatments that are found in places like Switzerland, but the problem is that with the Swiss model you do have injectable opioid agonist therapy, but you also have a lot of societal intervention such as their four-pillars model, that includes treatment, harm reduction, law enforcement. What they've done is that they've taken that medication and they've taken it outside of the Swiss model, and they're just looking at the medication alone, so we don't have evidence for that.

The other example is John Marks. He was a physician in Merseyside in the United Kingdom, in Manchester, and he prescribed heroin and cocaine in the '80s. What he was doing was not studied. There aren't published studies on this. However, it's very different from the safe supply model that they have in British Columbia because in that model they had the psychiatrist, they had a social worker, and they had the probation officer for the patient, and the patient would have to convince these three people every week that these medications were benefiting them. We actually don't have . . .

The Chair: Thank you, Dr. Mathew. That does conclude our time for question and answer. On behalf of the committee I sincerely thank you for taking the time and preparing the presentation and delivering it. We really appreciate your time and hope you have a good day. You're welcome to join us to listen in on the rest of the presentations.

I'd now like to invite Dr. Madras to join us today. Dr. Madras, thank you for being here. We're going to open it up for 10 minutes of presentation, followed by 20 minutes of Q and A with the members. Thank you, Doctor. I hand it over to you.

Bertha Madras

Dr. Madras: Thank you very much. Can you hear and see me?

The Chair: Yes, we can.

Dr. Madras: Wonderful. I can't see myself.

I thank the distinguished members of this special committee for the opportunity to appear before you today to discuss safe supply. I'd like to preface my remarks by saying that your responsibility is grave, the stakes are very high, and the decisions you make in this session may echo for generations to come as they reach nearly every domain of life in the province. It's a decision that should not be hurried because it is, in fact, a social experiment of vast, multigenerational implications. It is also a human experiment without, really, informed consent because the evidence in terms of randomized controlled trials, meta-analysis reviews is zero, as pointed out so aptly by Dr. Somers. The end points may be

ambiguous, they may be grievous, or they may terminate with remorse.

The Canadian government has decided that a tainted drug supply is the core of part of a response to the opioid overdose crisis, and I'd like to emphasize the fact that if it were not for opioid overdose deaths, that have catalyzed so much government intervention, we would not have these hearings anywhere in the country, because addiction has been festering in both the United States and Canada for decades without too much government concern as to its consequences. It is only because of the deaths, and justifiably so to some extent, that this has happened.

The really important issue is to discuss opioids. I understand completely the inclusion of psychostimulants as well as other classes of drugs, but opioids are a unique class, which may not have been highlighted by Dr. Somers, inasmuch as if treated with behavioural therapies or what have you, the dropout rate is well over 80 per cent. Opioids are really quite a unique class of drugs because it is one of the toughest addictions to deal with. Aging out is relatively common for alcoholism, for smoking, and for some of the other drugs, but aging out is far rarer with opioid addiction.

We also have to highlight the fact that opioids have different types of biological effects, one of which, if it's a full agonist such as methadone, such as fentanyl, such as heroin, will promote a full-blown effect in the brain, except that certain drugs like methadone do not promote the highs and lows that other types of opioids do such as heroin and fentanyl.

Buprenorphine is another medication which has been approved for treatment, and it, too, does not promote the highs and lows that one gets with full agonists, which can be achieved by misusing prescription opioids such as hydrocodone or oxycodone derivatives.

I've been asked to proffer my opinion. It is based on four roles which I've been engaged in: as a research scientist in public policy and as a member of the President's opioid commission and as an educator. My fourth role is that of a protagonistic Cassandra, a person who tries to predict the future.

I'm going to focus today on a broad view of public health policy. The science that backs this up would consume many hours and probably about 120 slides. What is the underlying reason? The underlying reason for safe supply is that it assumes that the government's responsibility is to provide pharmaceutical-grade substances with high abuse liability, with addictive potential, with adverse consequences, to people with a substance use disorder. The alleged purpose is to prevent overdose deaths due to fentanyl contamination, to prevent overdose deaths due to unregulated quantities, and to prevent health effects due to contamination of the supply with fillers and toxic substances.

I make four points, and I would like to pose four questions to you, and of course I'm open to questions from everyone. Will increased access to pristine drugs increase use? Our current and historical examples support that they will increase use. We can look at the history of tobacco, alcohol, marijuana, prescription opioids, fentanyl, cocaine, methamphetamine. Price and purity govern supply. Providing free drugs will reduce the perception of harm. As you reduce the perception of harm, you increase use. This has been throughout many of our national surveys, starting from the 1970s. We will also see increased diversion, as we've witnessed with prescription opioids.

The question is: does this committee have any evidence that supplying safe drugs will stabilize or decrease use and substance use disorders? The prescription opioid disaster catalyzed in the U.S. is a paradigm of how increased supply of pristine opioids resulted in increased misuse, diversion. At some point more than 70 per cent of the people misusing opioids received them from friends, family, either bought or just taken or stolen. Use will rise amongst youth and young adults, which are the most vulnerable population.

The second question is: will increased use of pharmaceutical-grade drugs ultimately have a negative impact on overdose deaths, diversion, and so on? The focus on drug purity sidesteps a critical factor. Alcohol, tobacco, opioids are manufactured to pristine quality, yet they kill more people annually than other illicit drugs combined. If access is easy, use is normalized, the patterns of use, and that's the key issue, the uncontrollable use by the user. Does this committee have evidence that safe supply has increased entry into treatment more effectively than improving access to treatment, drug courts, or other means of treatment entry? Regulating the purity of a drug and its dose omits a critical element of this problem. You cannot regulate whether or not people use a safe supply safely, how much, how often, what drug combinations people use.

11:00

Substance use, the very definition, is defined as uncontrollable drug use despite adverse consequences. Unless recovery and abstinence are the goals, regardless of drug purity addiction will continue to take its toll on people from in utero to old age. The impact will continue to be negative regardless of the quality of the drug. Prescription opioids: again, I've done a very, very in-depth survey of how we got into this problem, when I wrote a majority report of the President's commission on the opioid crisis, a perfect example of how increased access and normalization for any pain indication increase misuse, addiction, overdose, and deaths.

The third issue is increased access. Will it increase risks to individuals? The term "safe" is asymmetric, as I've said, and refers not only to supply, but it has to refer to safe use, and the emphasis on recovery has to be critical. Does this committee have evidence that safe supply will be used as an incentive to motivate people into treatment and recovery, and are there any other benefits or consequences of safe supply? Does this committee have evidence that safe supply will be limited to pristine heroin, cocaine, crystal meth, which is not even a prescription formulation currently, and fentanyl, or will subpopulations demand new psychoactive substances that appeal to them, new stimulants based on cathinone analogs, pyrovalerone analogs, and new opioids? Are physicians willing to prescribe these drugs, including fentanyl, as they're currently doing in British Columbia? Will you regulate the use? There are thousands of potential new substances that are coming on the market that may rise to fashionable use, as fentanyl has, and what will happen then? I can give you reams and reams of data and experiences over this.

In summary, my testimony does not address optimistic preventions. My narrative addresses the very important disconnect between safe supply and safe use. Based on the preponderance of historical and current evidence, I do not believe that Alberta should take this step.

The Chair: Thank you, Dr. Madras, for that presentation.

We're now going to open it up for question and answer with the – even though we've already done the question stuff. Hopefully, we'll get some answers, too. We'll start with MLA Frey.

Mrs. Frey: Hi, Dr. Madras. Thank you so much for your presentation. I was really intrigued when you were talking about – I think your quote was: as you reduce the perception of harm, you will increase usage. I'm wondering if you could relate that to – I know there's a conversation around a lot of political circles about decriminalization of things like opioids and harmful drugs that we know are also very addictive. So would you think the same phenomenon could happen through a decriminalization lens? If

governments start to normalize the use of illicit substances, do you think that could also lead to more usage and pressure on health care systems?

Dr. Madras: Well, we already have seen it. We have certainly seen it, certainly in Canada and in the United States, with regard to marijuana, which is legal now in Canada, and it's been decriminalized in most states in the United States. What we've seen is a vast increase in use, a rapid increase not only in use but in cannabis use disorder. From 2016 to 2019 we had 900,000 more people with cannabis use disorder in the United States, and we're seeing all the consequences associated with it. Perception of harm of marijuana has declined dramatically in the U.S. amongst youth, and that's a very good example of normalizing use, increasing access, decriminalizing, and seeing that perception of harm has declined quite dramatically.

Now, that is not true for certain other substances such as tobacco, where the use rates are declining even though it's easily accessible and the tobacco products are relatively pristine. But there has been a very massive campaign to demoralize smoking in the country because of its health consequences, not because of its psychoactive effect. As a consequence of that, use has declined amongst youth, and more youth are not using alcohol and tobacco now than ever before.

So it is possible to legalize drugs and to decrease use, but the bar is extremely high, and we're going to lose a generation while we figure out how to promote prevention for specific types of drugs. Tobacco prevention has been around for almost 40-plus years. Alcohol ads and prevention have been around for as long if not longer.

Mrs. Frey: I certainly appreciate that.

Mr. Chair, do you mind if I add a follow-up?

The Chair: Yes. I mean, I don't mind. Go ahead.

Mrs. Frey: Thank you. I guess my follow-up question would be to Dr. Madras again. How would you describe your qualifications for being able to speak to this committee? When looking at the list, I know you have many letters behind your name. We know that you're qualified. But for the people of Alberta who are listening in on this, can you please give us a little bit of background or, you know, how you arrived at some of the high-quality medical evidence that you give to this committee and what perspective you're speaking from?

Dr. Madras: Well, I speak from a basic science perspective. I certainly can describe to the public as well as to my colleagues how drugs affect the brain in terms of the molecular, cellular biology, anatomical effects, behavioural effects, and so on because that's been core to my entire career.

Secondly, with regard to public policy I was confirmed unanimously by the United States Senate to be the deputy drug czar of the United States between 2006 and 2008. During that period and prior to I had been studying the social, the psychological, the treatment modalities for substance use disorders quite extensively. I organized the first and only course at Harvard Medical School at the time on addiction biology and addiction consequences and treatment. The course ran for 15 years. During that time it was a very extensive learning experience for me because I always partnered with addiction treatment specialists and visited many treatment centres, saw treatment withdrawal centres. During the time that I was the deputy drug czar, I visited multiple treatment facilities around the country. Above all, I listened to people who were suffering with addiction and listened to their families and listened to their stories and listened to how systems are failing them. I did an extensive program to try to catalyze screening and brief interventions for people who are along the full spectrum of substance use and managed to accomplish a number of goals during the tenure I was in Washington.

Fast-forward a decade. The President appointed me to the opioid commission along with five other people: three governors, an Attorney General, and a former Congressman, Patrick Kennedy. The chairman of the committee, Governor Chris Christie, asked me, essentially, to shepherd the entire commission report, and in doing so, I summoned the expertise of all my friends and colleagues as well as my own experiences and likely composed between 65 and 68 per cent of the commission report using a number of resources, including my home base, which has addiction treatment specialists as well.

I've been in this field since the 1960s, when I was a graduate student. I was the heir of the CIA LSD experiments. The LSD was given to me without my knowledge of what the source was, the origin, or its human use. I was asked to study how it works at the Allan Memorial Institute in Montreal. Since that time my commitment to understanding how drugs affect the brain at the molecular, cellular, and so on levels has gone unwavering for the past 60 years. I was a graduate student at the age of 20 there.

11:10

The Chair: Thank you, Doctor.

MLA Yao.

Mr. Yao: Thank you so much, Chair. Again, Dr. Madras, thank you so much for taking the time to speak with us. We greatly appreciate that you're probably very busy at Harvard Medical School right now. I have three points I'd just like you to expand on if possible.

The first point is that you mentioned something along the lines of: this is a social experiment, and there is zero evidence, ultimately, on this issue.

The second point I'm asking you about is that you mentioned aging out. If you could provide a definition of what that means. You talked about how the aging out is different for opioids compared to things like alcohol and caffeine and whatnot. If you could expand on that.

The third is that you make a good point that we cannot regulate whether people will use a safe supply safely. Is it fair to say that despite access to safe supply of a pharmaceutical, we will still have deaths? I guess we could compare that to acetaminophen, which is a very safe supply that's available in any drugstore, yet one could argue that's one of the most lethal medications out there readily available for people because of its destructive abilities on our livers.

If you could expand on those three comments, I'd greatly appreciate it.

Dr. Madras: Sure. I wonder if you could just repeat the first question, because with prepulse inhibition I was listening to questions 2 and 3 too carefully.

Mr. Yao: No problem. The first one was that I thought I heard you mention that this was a social experiment and that there is ultimately zero evidence on this.

Dr. Madras: Yes. Basically, as your first speaker mentioned so eloquently, there is no real good, solid data on whether or not you can administer cocaine or a methamphetamine or amphetamine or any of the other substances and what the long-term outcomes are going to be in that population.

There may be short-term gains, but take, for example, the prescription opioid crisis that was catalyzed in the United States. At the time that it began to be ramped up – and there are at least 33

causes of the opioid crisis that catalyzed this problem. At the time that they ramped up, we had zero – zero – information on whether or not it is safe to prescribe opioids for longer than three months. Yet the pharmaceutical industry, the patient population, the joint commission, the Federation of State Medical Boards, the veterans administration, a number of other organizations began to promote pain as the fifth vital sign and the absolute need to use opioids for these chronic conditions such as lower back pain, such as knee pain, without evidence on what would happen over the long term, without evidence on whether or not they were even necessary.

What we have found recently, because the field was compelled to do the studies, is that NSAIDs, nonsteroidal anti-inflammatory medications, are just as effective as opioids for the most common causes of pain. Chronic administration of opioids after even seven days puts the individual at risk for very prolonged use because the opioids promote neural adaptation in the brain that appears to be durable and, in fact, drives continued ongoing use. I think that's really important.

We don't have good, solid, high-quality evidence on whether or not safe supply is going to work. We have had studies in the country on trying to treat people with fixed doses of methamphetamine or amphetamine in clinical trials. They've all failed. I can tell you that there's – or methylphenidate. None of them have – because I was very much involved in medications development for quite a while.

The second issue, the same question, was aging out. Aging out is a well-known phenomenon. People quit smoking, a very high proportion of people who, when they're given warnings about smoking, quit, and most of them quit cold turkey without going to rehab or going to a treatment centre. With alcoholism, if it's not severe, if they do not have a number of other confounding factors – psychiatric problems, social problems, and so on – and genetic disposition, many people can quit heavy alcohol use, problematic use, or even alcoholism without an intervention. But opioids: the quit rate is very, very low compared to these other drugs.

I think that pretty much answers the question. Safe supply: if anybody can point me to high-quality research, I would be very willing to listen to it. From the best of my research on looking at the literature, it just does not exist.

The Chair: Member, did you have a follow-up?

Mr. Yao: No. That's fine.

The Chair: Perfect.

Ms Rosin: Thank you so much for being here. I have a couple of questions. Most of them will focus on statistics, so it should be quite quick. As MLA Frey mentioned, you quoted that clean drugs reduce the perception of harm, which increases the use of the drugs, which I found to be such a profoundly simple but logical and straightforward statement. I'm wondering if there's any data from the United States that suggests just how much the use of drugs increases in jurisdictions that provide, quote, unquote, clean drugs.

Dr. Madras: Well, I think the easiest data is just looking at Len Paulozzi's work from the CDC showing that as prescriptions of opioids increased, the number of overdose deaths increased almost in a perfect parallel line. I think that by far the most profound example of what happens when you supply clean, pristine drugs to people is to look at the opioid crisis, because the data are overwhelming. They're abundant. Problematically, as of the last study that I have seen, about 65 per cent of people who entered treatment for opioid addiction now did not begin with prescription opioids. That number was much, much higher in the early part of the opioid crisis. Now people are really initiating with fentanyl and heroin. Fentanyl is becoming the drug of choice, and in some places heroin is not even available. It is only fentanyl, fentanyl adulterated with cocaine or methamphetamine or prescription drugs or benzodiazepine. All that data, every one of the questions that you ask I can provide citations for as a follow-up. I'd be delighted to do it.

Ms Rosin: I would love that, if you could do that.

I have another question, then. On average, if you look at the death rate from opioids in the United States, what percentage of individuals who die from use of opioids die from tainted or drug poisoning versus just overuse in a normal overdose?

Dr. Madras: That's a very important question. I don't think we have solid evidence that people, if only we could ask them post hoc – there have been studies done by one of my colleagues, Dr. Hilary Connery, at McLean Hospital in which she has interviewed people who went through an overdose but actually survived. They were asked: what were their intentions in taking the drug? Lamentably, above 30 per cent roughly – and I have to get the actual figures, because I don't have them memorized, but approximately a third – were actually intending to commit suicide.

The others: you know, what percentage of the rest were unaware that they had tainted supplies versus non? There have actually been a couple of studies in the U.S. on doing that, and I'm trying to remember the breakdown. But it's not inconsequential that people are aware that they want to use the fentanyl and are pushing the boundaries to get a greater high. The problem with fentanyl, as with certain other potent opioids, is that it produces rapid tolerance, which means you need to increase the dose in order to get the same effect. People, you know, self-report that they're always chasing that first high. They want to get back to the point at which they were introduced to the drug intravenously and it gave them such a euphoric feeling. They've developed tolerance to it. They're still trying to increase the dose to achieve that same effect.

11:20

The answer is that I do believe there are some studies. I can excavate them for you. I don't have the proportions on hand, but I would say that there is a significant but minority number of people who are actually using the drug with the view that they may die and are not in despair over it.

Ms Rosin: Okay. Thank you. If you could find those studies after the committee today, that would be wonderful.

My last question is that you also made an interesting note that there has been a campaign against the use of tobacco by governments for decades, but interestingly it seems as though governments in some jurisdictions are now almost campaigning for the use of illicit drugs and opioids. I'm just wondering why you think there is a discrepancy there between the approach of governments towards tobacco versus illicit substances and what or who is driving that.

Dr. Madras: Well, this is truly a political question which I have many, many opinions on because I have been very privy to a number of situations where I know what the pressures are with respect to pushing illicit opioids or, I mean, pushing illicit drugs. I can say that, for example, with marijuana there was no grassroots movement among the general population to legalize marijuana in various states. It was a heavily financed campaign involving hundreds of millions of dollars, going state by state to try to understand how to carve ads and legal documents to shape it according to those states' desires, primarily starting by medicalizing and, after medicalizing, legalizing.

We're seeing the same movement now for hallucinogens, we've seen it for marijuana, and I suspect we're going to see it for opioids in the future. Kevin Sabet, who follows me, is going to be probably a bit more forthcoming with regard to all these pressures, but needless to say, there are big industries now involved and vast investments. There are over 300 companies now that have invested in promoting hallucinogens, and we're going to see this movement. The only people standing in the way of this movement are legislators, you. You.

The Chair: Thank you, Dr. Madras. Sorry to cut you off there. That concludes our time for question and answer today and actually is a nice transition to Dr. Sabet. Thank you again, Dr. Madras, for your presentation and joining us today.

Thank you, Dr. Sabet, for being here. We're going to open up for 10 minutes of presentation for yourself, and then we're going to have a Q and A with our members. I hand it over to you. Oh, Doctor, you're muted.

Kevin Sabet

Dr. Sabet: Great. Well, thank you, Chair and committee members. Thank you for inviting me. It's my pleasure to offer oral testimony today at the select special committee to address safe supply in Alberta. I have studied, researched, written about drug policy and criminal justice policy for more than 25 years, having been the only drug policy political appointee in both Republican, the George W. Bush, and Democratic, the William Jefferson Clinton and Barack Obama, administrations. Most recently from 2009 to 2011 I served in the Obama administration as a senior drug policy adviser to the director of that office. I am currently a fellow at the Institute for Social and Policy Studies at Yale University and a cofounder and president, with former congressman Patrick J. Kennedy, of SAM, Smart Approaches to Marijuana, a nonprofit public health organization dedicated to working with scientists and policy-makers to advance evidence-based marijuana policy. My doctorate is in social policy from Oxford University, and my undergraduate degree in political science and public policy is from the University of California, Berkley.

Now, while safe supply is not an accepted medical term – I think it's really important to say that at the outset, that it is a marketing term designed to sell a policy – we in the United States do have lots of examples of physician-prescribed opioids and a long history of opioid proliferation and wide open supply. We have implemented a nearly analogous policy by allowing a supply of opioids to be prescribed via doctors and supplied by pharmaceutical companies.

Today I will share with you the experience of the United States and our version of safe supply of pharmaceutical drugs. Now, to start, it's important for some background. As we talked about today, grimly, the Centers for Disease Control and Prevention had announced recently that there were over 100,000 overdose deaths in the 12-month period ending in April 2021 – and we just have new data coming out saying the same thing from other sources – marking an increase of about 30 per cent from the 78,000 deaths during the same period the year before. Of these deaths, these 100,000 or so deaths, the CDC estimated that about 75 per cent of them resulted from the overdoses of opioids, an increase of 35 per cent from the previous year.

Opioids, ranging from prescription painkillers to heroin and synthetic drugs like the fentanyl class of drugs, are now responsible for over 75 per cent of overdose deaths. The CDC also found that overdose deaths involving opioids have increased over six times since 1999. The Department of Health and Human Services estimated that 1.6 million Americans today have an opioid use disorder, and this is generally regarded as an undercount both of those with an opioid use disorder and also our death count rate because the data that we have to collect these are not as complete and comprehensive as we would like. In response to these alarming increases in deaths caused by opioids, the Trump administration, the previous administration, declared a public health emergency in October 2017. Similarly, the Biden-Harris administration's White House and drug policy have called for an extension of the opioid public health emergency declarations. Policy-makers are now taking steps to address the overprescription of licit, legal opioids such as OxyContin as well as confront the inflow of illicit opioids such as those in the fentanyl class of drugs.

But it's important to ask how we got here. *Nature* magazine, the renowned scientific magazine, has argued that it wasn't until the mid-1990s, when pharmaceutical companies introduced opioid-based products and in particular OxyContin, a sustained release formulation of a decades-old medication called oxycodone, manufactured by Purdue Pharma, that such prescriptions surged and the use of opioids to treat chronic pain became widespread. In other words, these had been around for a very long time, but it wasn't until they were marketed as such, marketed as safe, and supplied in large amounts that this became a much bigger problem.

The *North Carolina Medical Journal* published a study that found that several factors have contributed to the overreliance on opioids for the treatment of chronic pain. Starting in the late 1980s, the medical establishment came under fierce criticism from patient advocacy and other groups for undertreating both malignant and nonmalignant pain. This became known as the movement to make pain a fifth vital sign. In 2017 Medicare structured reimbursement to hospitals – up until then, I should say, we structured reimbursement to hospitals in part on how thoroughly pain was eliminated, so there was an incentive to treat pain and treat pain aggressively.

As a result, opioid medications were heavily prescribed. Physicians were incentivized to utilize them, and they were incentivized by multiple sources: they were incentivized by government, they were incentivized by business, they were incentivized by shadow groups. It's very important to understand the influence that a lot of these groups have on the political system. Being in Canada right now, where I am currently, just in your neighbour province, I wish I could say that the influence of these groups was only confined to the United States, but I have witnessed the influence of these groups also here in our country of Canada.

The most recently released national drug control strategy, the one in the Biden-Harris administration, has stated that the overprescribing of drugs, the diversion of prescription drugs for nonmedical use, and the lack of accountability or oversight in prescribing practices increase the availability of these drugs in America's homes and workplaces, making them far too easy to fall into the wrong hands. That is the word of President Biden's drug policy office, and I agree with it wholeheartedly.

As such, governmental agencies have been working to advance safe prescribing practices which will try to ensure that fewer pills are given to patients and that patients are fully aware of the risks of their medications. A study found, for example, that 61 per cent of opioids prescribed following surgery were left over, which amounted to something like, you know, 27 five-milligram hydrocodone extra tablets per person. Assuming a maximum dose of six tablets per day, the average individual was left with enough medication to treat pain for an additional five days.

11:30

Now, let's be clear. The majority of opioid addictions in America started with legal prescription pills found in medicine cabinets at

home. In 2017 health care providers across the United States wrote almost 200 million prescriptions for opioid pain medications, which is about 60 prescriptions per 100 people, far outpacing the need for pain relief. NPR reported that oversupply of opioids floods communities with vast quantities of opioid medications that go unused, building up a deadly reservoir of drugs in home medicine cabinets that often wind up being abused.

Now, there are many second- and third-order effects of the opioid epidemic that we often forget. For example, the recent U.S. Commission on Combating Synthetic Opioid Trafficking, that RAND was a part of, announced in their report that the current overdose crisis has cost the U.S. approximately $1 trillion annually in just the past few years. The costs include, you know, greater health care costs and lost productivity. In 2021 a study found that the opioid epidemic is the primary reason for the reduction in the recent decline of U.S. life expectancy. And *JAMA* found that drug poisoning deaths contributed to a loss of about a quarter of a year in life expectancy. Most of this loss was unintentional.

We've seen even an effect on the labour force, which obviously is a huge issue right now. Alan Kreuger, a professor at Princeton University, found that labour force participation has fallen more in areas where more opioid pain medication is prescribed, causing the problem of depressed labour force participation and the opioid crisis to be intertwined.

This is causing a huge strain on the foster care system. We rarely talk about the effects on families and children, but it's very important. In the past few years the number of foster children nationally in the U.S. has risen by 10 per cent, and the Department of Health and Human Services has reported that many in the child welfare field think that parental substance abuse, including prescription drugs, illicit drugs, alcohol, marijuana, but especially opioids, has been the primary cause of the increase in foster care placements. There are studies finding that higher rates of overdose deaths and hospitalizations correspond with higher rates of child welfare caseloads.

In a report about the connections between the opioid epidemic and education outcomes the Brookings Institute concluded that exposure to the opioid epidemic is likely to impact important education outcomes other than test scores such as attendance, probability of school disciplinary action, graduation, or college enrolment. They also say that the opioid epidemic is a widespread societal problem and we are only starting to understand the far-reaching consequences that will be borne by individuals and communities.

Listen, the bottom line is that we have had experience with a flowing, regulated, medical, legal supply of opioids. In the United States it is not going well, and it has not ended well, and we don't think that it will end well. I sincerely worry that by flooding willing users with more substances, our problem will be made much, much worse. Again, this goes back to what Dr. Madras and so many others have eloquently stated about availability and use. There are not many truisms in drug policy because this issue is one that is complex, context dependent, and really intertwined with so many issues, but one truism that most scholars agree on, most experts agree on is that greater availability leads to greater problems because of greater use.

Now, that isn't to say that there isn't a role for opioid medications in society. Of course, there is, and we have to understand, you know, that we don't want to go back to the other extreme of totally undertreating pain and that pain is an issue that is important to deal with, but we have seen – it seems often in these policy debates that we want to go from one extreme to the other, and I find that regrettable.

Thank you for allowing me to submit testimony.

The Chair: Thank you, Doctor, for your comments.

We're now going to open up for Q and A with our members. Is there a member that would like to ask a question? MLA Yao.

Mr. Yao: Thank you so much, Chair. Dr. Sabet, thank you so much for taking the time to speak with us. A very thorough presentation. Thank you for speaking in layman's terms for our general public. I guess, to summarize your presentation, you've demonstrated that there are a lot of studies and evidence that contradict the concept of safe supply. Is that fair to say?

Dr. Sabet: Yeah. Absolutely. Really, it should not be seen as a partisan issue, by any means. Now, this is something that everybody should be coming together on. We all want to see the reduced incidence of substance use disorder. We all want to see the reduced instances of problems in the foster care system and other systems. Nobody wants to leave anybody suffering that has a legitimate purpose to use certain medications. Now, as we've heard earlier, there are sometimes better medications that are less addictive that should be our first order. Remember, a lot of these opioids were meant to be used in hospital settings under the strict supervision of physicians in really regulated environments as opposed to sort of a wide open environment. My concern with a wide open environment is that we are really opening ourselves up to more problems. This is not a partisan concern. This is a public health and public safety concern.

Mr. Yao: Thank you so much for that.

The Chair: No follow-up?

Mr. Yao: No, sir.

The Chair: All right.

MLA Rosin.

Ms Rosin: Okay. Thank you. I just have one question. I will ask you the same question that I asked Dr. Madras, because she said that you may have more of an answer for it coming from that political and research-based lens. It's been noted, and I think it is interesting to compare the campaign that we've seen from governments against the tobacco industry and tobacco usage over the past couple of decades, we will say, compared to the campaign almost for illicit drug use substance by the same governments. I'm just wondering if you could touch on why you think there is a difference in those two vastly different campaign tactics for substances that are both probably equally addictive and who or what you think is driving those different campaign narratives.

Dr. Sabet: Well, it's one of the great paradoxes of our time, to be honest, MLA. It is one of the great paradoxes of drug policy, that we would say that we have learned and understand the harms of tobacco and nicotine that can be so severe, and they are. The legality and normalization of nicotine in North America have cost more than 650,000 lives annually even now, when we know what the harms are and when there's general agreement that we should not expand the use of that drug, of nicotine. We have general agreement that we shouldn't expand the use because it's harmful. We've said, you know, that a way not to expand the use is to make sure that we have heavy regulations, that we have a campaign of discouraging the use of that drug.

Why would we turn around and say that that rule does not apply to other classes of harmful drugs? Now, there is an important difference and caveat because we know that there really is no accepted medical use for nicotine whereas for some of these other

drugs there is accepted medical use. But that is a very fine line between accepted medical use of opioids and misuse and abuse and wide open supply of those drugs.

That latter scenario is what we embraced in the United States for some of the reasons I just superficially touched on, and it has put us in the position we are at now because it's introducing a whole class of people as well to drugs that they may not normally have come into contact with. Again, availability and normalization really do dictate and drive behaviour. It doesn't mean that if drugs were legalized tomorrow, everyone in this room is going to go and try them because they're legal. No. But it does mean that certainly young people grow up in an environment of acceptance, and it means that if we have an inclination to try them, if we have an inclination to want to use them, it's much easier to get whereas with tobacco we've said that we want to make it harder to get. So we've placed all of these different controls on nicotine, and they've worked. Those controls have worked in terms of reducing public health impact and in terms of reducing initiation of use and reducing substance use disorders.

I do think it is a paradox that on the one hand we want to approve of some drugs and not approve of others. Again, understanding with the small caveat that there is some accepted use, no one is saying that we want to outright prohibit the use. I don't think anybody on this committee – correct me if I'm wrong – is saying that we want to outright prohibit the use of medically appropriate opioids used under the care of a competent physician versus sort of one of these pain clinics like we had in Florida or these other places that did not have legitimate medical supervision. I think it is a great paradox. It's a great question.

Ms Rosin: Just to confirm, with that paradox I think it's safe to say that the campaign against tobacco and to reduce tobacco consumption has been primarily driven by the medical community. Would you say that the other side of that paradox, the drive to increase opioid reuse, has also been driven by the medical community? Or would you say that it has been driven by outside sources that go beyond the medical community?

11:40

Dr. Sabet: Well, I think that a lot of it is the latter, unfortunately. You know, look, the medical community is certainly, at least in the United States 20 years ago, partially responsible for the problem we have now because they were incentivized to prescribe, as I mentioned. But they weren't always like that; they were pushed by companies and a government that went along with it and other private organizations funded by these industries that had an incentive to increase use. So they were sort of the messenger in that. They were kind of a third order in that chain.

Currently what I see when I look at the global movement – you know, it is a global movement to legitimize and legalize all drugs. I mean, let's be very clear. It doesn't stop at cannabis. It's moving to opioids; it's now going to be moving to – we've heard a lot about stimulants and the issue of legalizing crack cocaine, methamphetamine, sort of, really, all drugs. That is really not driven by the medical community at all, just like the push to legalize cannabis both in Canada and the United States was not pushed by the medical community. In fact, even today the medical community in the United States generally opposes the full-scale federal legalization and commercialization of marijuana.

You know, I wish that the medical community would be driving more of these decisions, but unfortunately I think they're driven by private parties with their own agendas, either agendas to sell these substances, which unfortunately we have seen – I mean, I couldn't believe it when I saw that there were actually companies in Canada that were ready to supply, quote, unquote, safely these drugs to governments. Again, I think it's really borne out of a feeling of helplessness and hopelessness as well by governments, saying: "You know what? Nothing is working; we don't know what to do, so we're just going to double down on whatever the most influential interest group is saying, and very loudly, in our ears."

And I have seen that, unfortunately, a little bit in B.C. Again, here in B.C. – that's where I am right now; I'm here temporarily – we see one of the worst opioid rates in the western hemisphere, and we hear more and more calls, I think, to double down on this idea that we should have drugs more available, not less available, not to get people treatment, and that is really what does worry me.

Ms Rosin: Thank you.

The Chair: MLA Stephan.

Mr. Stephan: Thank you. I didn't get an opportunity to ask this question to our last speaker, but I'd like to ask it to you, and that is I'm wondering if the term "safe supply" would be an oxymoron in that the last speaker asserted that clean drugs are still not safe drugs. So where did the term "safe supply" even originate? Do you know?

Dr. Sabet: My understanding is that it was really a marketing term by advocates. Terms are very important, and when you want to make political change, they're very important. I've got to hand it to them. It's a great term, but it's not a medical term. It's great politically, and when I put that add-on as I advise different political administrations, I think it's a great term. They did a great job on it. It gives the impression that you can use drugs safely, that we should encourage the use of drugs because we can do so safely.

To me, that's like saying that if we, you know, teach people where to hold the steering wheel and where they should be looking, then we should be okay with them going 150 kilometres or 200 kilometres per hour on the highway, because most people who speed are not going to get into a car crash, so we could say that's generally safe, so what do we need speed limits for? We don't need them. We can actually teach people how to do something that is inherently dangerous more safely. I think that that's certainly the wrong way, really not helpful at all.

Before the fentanyl crisis which we have, we know that there were still an unacceptable number of overdose deaths, number one – the idea of a drug overdose didn't just happen when the fentanyls were introduced – and, number two, we know that when you encourage the use of certain drugs, let's say a, quote, unquote, clean heroin, you're also backhandedly encouraging the use of all other drugs as well.

I mean, addiction is not something that's so neat and tidy and clean that can be easily segmented: okay; I'm only going to use when I'm given this certain amount by the government, and that's what I'm told that's what I'm going to use. Maybe some people can do that, and hats off to them. For the majority of those having a substance use disorder, that's not how it works. For multiple reasons this has nothing to do with a, quote, unquote, safe supply, but it is a very good marketing term.

Mr. Stephan: May I ask a supplemental question?

The Chair: Yes, sir.

Mr. Stephan: Is the promoting of this concept of safe supply, then, in some cases deceiving and even increasing harm?

Dr. Sabet: Yes, it is, because it's giving the impression that we can safely use drugs. It's giving society the impression that it's okay to

safely use. Again, I don't doubt that some people use these drugs and their lives aren't ruined, again, I mean, just like some people go 160 kilometres on the highway once or maybe every day for a month and they don't get into a car crash. That's not a reason to say that those things are safe; they're not safe. When you go over the speed limit, you increase your risk of death, injury, bodily harm, et cetera. When you use any of these drugs, you greatly increase your risk of a negative consequence not just to you but to your family and society. We don't talk about that enough. We don't talk about the victims enough.

It is a total misnomer, from a scientific point of view, to call it safe, because there can't be a supply that's safe. Inherently these are dangerous substances.

Mr. Stephan: I really appreciate you speaking to that. Thanks.

Dr. Sabet: Thanks.

The Chair: Thank you.

MLA Amery we have next.

Mr. Amery: Thank you very much, Chair. Good morning to you, Dr. Sabet, and thank you for your time and your willingness to share your expertise with this committee. I can't tell you how much we all, I think, appreciate the common-sense approach, the simplified answers that you're providing to us, straightforward and to the point. I think that's very important for all those who are watching.

I wanted to stray away from some of the political discussions with respect to guests before this committee, but I think that inevitably questions of politics, of government policy are intertwined with topics like this. I ask this of you because from the outset, in addition to the incredibly capable resumé and the breadth of experience that you've demonstrated before this committee this morning, we know full well that you've worked for various U.S. administrations, on both sides of the political spectrum, so I would venture to say that you've got a wide array of exposure to the different political ideologies in both Canada and the U.S.

With that said, we've heard a very thorough analysis from you with respect to the role of the medical community in opioid prescribing. I think you mentioned a little bit, when you were talking to my colleague MLA Rosin, about the role of various actors within this entire topic that we're discussing.

You know, we could talk about multiple angles, I think, but I want to know if you can impart any information to this committee with respect to what you believe the role and responsibilities of drug manufacturers are in this particular debate. Have they recognized that they play a key role in how their drugs are used? Are they involved in the debate on safe supply at all? What can you tell us about what approaches governments are taking, both south of the border and here in Canada, with respect to what they are asking of drug manufacturers, especially when you mention things like – I think it's maybe not a direct quote, but you said this earlier – B.C. having one of the worst rates of opioid abuse in the western hemisphere? I think I'd like to hear from you if you can comment on what responsibility the drug manufacturers are taking and what governments are doing to hold all actors accountable in this particular debate.

Dr. Sabet: Well, thanks for the question. I think that, like so many things, sometimes government can be late to the switch and react when things have happened. You know, we were seeing in the United States the undue influence of companies like Purdue Pharma. Right now, I mean, Purdue Pharma is a dirty word to everybody in the United States. You can't utter that word, and there isn't an ounce of sympathy by anybody, which is pretty astounding.

I mean, the only people to hold that kind of place in drug history would be the tobacco companies. But I would say that Purdue Pharma is even lower on the rung today than tobacco companies, which also, by the way, wilfully lied to the American people and, really, to the global population for over a century about the harmfulness of their product because they needed people to use a lot of their product to make money. That's really the worry here, that we have private companies that have an incentive for people to use heavily. That was the issue with Purdue Pharma and other companies in the United States.

There were people in government that tried to raise alarm during this crisis in the mid-2000s, in the early 2000s, at the time when we were reconsidering what pain was, but they weren't really listened to because those lobbying forces were very strong.

11:50

Although I'm here right now, I do not know the Canadian landscape with regard to that as well as I do the American landscape. But I will say that I have been astonished in my, you know, even very light research for the work before this committee for today to see the connection between some people that even publish papers on how great this idea, for example, on safe supply is, their connection to distributing and manufacturing and being part of the supply chain of what would be a, quote, unquote, safe supply. I was actually astonished at that because I did not expect to find that.

You know, I don't have the exact names or anything in front of me right now, but I was astonished to see that there were some of those interests, those, quote, unquote, research and corporate interests or at least supplying interests – I don't know how they've set up their company; it could be a nonprofit; I don't know – that were intertwined. That was astounding to me.

In the U.S. we are really paying a dear price for not looking at manufacturers as being responsible. We just kind of didn't – the people didn't want to look at them, and I think we have to. I think we have to understand that they do play a role in this, and I think we have to tread very, very lightly. If we are flirting with the idea of increasing the availability and use of pharmaceutical drugs and wanting to encourage that, which is what safe supply by definition does, I think we have to tread very lightly. We are dealing with multinational corporations that have intense lobbying capability. Even if you try and write them out of the law, they find ways into it.

Again, that's why I really need to stress to this committee that this has to be a bipartisan issue. There's nothing partisan about – we all want to have an open debate. I don't think anybody wants a closed debate. We want an open debate and discussion. It was regrettable to me to see the nature of kind of some of the responses even to this committee's inquiry. It's important to inquire about something that's happening. Frankly, you know, in a lot of countries, including my own, if you didn't like a topic, you never would bring it to a committee and have a hearing. You didn't even want to discuss it, so I think this committee should be lauded for even wanting to have the discussion.

But it's regrettable to me that we're not even – I would love to hear from the advocates, and I think you would, too. It's regrettable to me that we don't see that. You know, I don't know if it's out of line to say that or out of order here and not appropriate, but it's how I feel, especially as sort of somebody that has a heart in both countries. When I look to Canada, I think about a country that really should value and does value a civic discourse and debate, frankly a lot more than my own country often does, especially with today's very intense partisanism. So that's regrettable to me.

The Chair: Thank you, Doctor.

We have time, about one minute.

Mr. Milliken: I had another question, that would probably take me more than a minute to talk about, so what I'll do is that I'll just go to a question that I've asked of a couple of other presenters, and that is: in your experience on both sides of the aisle, all that kind of stuff, do you know of any evidence that showcases that increasing supply or even safe supply, whether or not it can – do you know of any evidence to show that it leads to better outcomes for users and, I think you mentioned, families and communities as well?

Dr. Sabet: No. I mean, the evidence is the opposite. The evidence is that when you increase the availability of harmful substances, you get worse outcomes. You get worse outcomes when it comes to children, child welfare, family unity. You get worse outcomes when it comes to hospitalizations and emergency room rates, and you get worse outcomes when it comes to life expectancy and even short-term things like education, workplace issues, and safety. Again, that is why we have to understand that there is a role for these drugs in a very regulated way, but in the way that is often presented as a so-called safe supply, I worry that that will get out of hand very quickly and produce negative consequences overall.

The Chair: Thank you, Dr. Sabet, for joining us here today and for your presentation. I hope you enjoy your stay in Canada. You're going to have to come to the other side of the Rockies next time you're up here and check out Alberta – you'll love it – if you haven't already. We just appreciate your time and hope you have a great day.

Dr. Sabet: I would love to. Thank you, committee.

The Chair: Perfect. We are now going to take a break for lunch and reconvene here at 1 p.m. Thank you, committee.

[The committee adjourned from 11:55 a.m. to 1 p.m.]

The Chair: Excellent. Thank you, members. I hope you enjoyed your lunch hour.

We're going to get right back into it because we have lots of good presentations this afternoon. I wanted to be able to invite Dr. Best to our committee work, and thank you for being here today. We are doing 10-minute presentations followed by 20-minute Q and A with the members of the committee. Without further ado, I'll pass it over to you if you'll dive right in to your presentation. Thank you again for being here, and I look forward to hearing what you have to say.

David Best

Dr. Best: Many thanks for inviting me. I thought I would just start with a little bit of background on who I am and what my background is as a foreigner and a foreigner with a funny accent. I thought that might be a useful way to start for me. I am a champion and advocate for addiction recovery, and I have worked in the addictions field since the early '90s. I've worked in a range of settings. Starting in clinical settings, I worked in a methadone maintenance clinic, a heroin detox ward. I've worked in an alcohol detox ward, and in the last 10 or 15 years I've primarily researched around recovery. I've worked in clinical research and policy settings, so I'm an experienced academic.

The first thing I wanted to say is that people will have seen my name and potentially said: here is somebody on the recovery side of this debate. I hope other people will say to you and have said to you that this is an unhelpful false dichotomy between recovery and harm reduction. Essentially, one of the key things, I guess, and not the most sophisticated lesson to learn is that you don't recover if you're dead. We need to have a system which allows people to stay alive long enough to enable and facilitate recovery.

I also come at this from a slightly unusual angle inasmuch as I am a criminologist. I want to talk on some of the debate about crime and crime evidence as part of the discussion, but I will come on to this later.

Much of my early work, when I worked in south London at the institute of psychiatry, was about peer use of naloxone. I think it's really important that we have a recovery-oriented system that is predicated on a model of hope that ultimately aims to support people's individual journeys to recovery but that that system starts with community-focused harm reduction activities.

I want to make it clear; I reject the false dichotomy of recovery and harm reduction, but nonetheless I will come at this primarily from a recovery perspective. There are two models that I would like to champion as part of that approach.

The first is CHIME, that the fundamental aims we should have for all interventions are connections, hope, identity, meaning, and empowerment. The process for right across whatever system of care you use is fundamentally about that process of creating positive social connections that generate hope, that allow the building of positive identity, that give people meaningful activities – and that is something I will come back to – and that, in turn, allows effective empowerment of individuals. The two fundamental premises for me for any part of a system – harm reduction, front-end community focus right through to treatment pathways – are the importance of generating hope and aspirations for meaningful change.

In outcome studies and particularly the drug outcome research study in Scotland, DORIS, led by Neil McKeganey, people were asked: what do you want from interventions, interventions right across the board? Fundamentally, people will say that they want to lead a meaningful life, a meaningful life that's free from problem drug use. In their survey, when asked about their aspirations, very, very few people answered that what they wanted was endless maintenance supply of drugs. We get too bogged down in debates about segmentations of populations and utterly patronizing and unhelpful notions of: some people are too complicated or too difficult and complex to hope for lasting change.

In my world of long-term recovery we know that many of the people who effectively achieve lasting and stable recovery are people who would have been regarded as incredibly complex cases, and the treatment system cannot be paternalizing. It cannot segment off a hopeless group of people for whom the best we can hope is to keep people alive and keep people out of jail. For everybody the aspiration should be about long-term change and the viability of long-term recovery.

Anything that offers indefinite provision of substitution therapies of any kind is, in my view, massively risky, and the evidence in favour of those kind of interventions is fundamentally premised on a public health and a public safety model, not an individual well-being model, and it's crucially important that we have a model in place that inspires and promotes recovery. Now, as you all hear, the debates around safe consumption and the provision of medications of various kinds to people: the key is not the principle but the practice and the practice of systems.

I want to go right back to the very start of my career, when I was doing my PhD in Edinburgh. At that time an attempt to control the spread of HIV in Edinburgh, a major risk to the population, the substance using population at that time, encouraged secondary distribution of methadone. Now, I then started interviewing people whose primary drug use was diverted methadone, and if you start providing a poorly regulated process in a poorly regulated market, you will create a secondary distribution network.

It's also important to say, I think, that if we create centres, physical locations and centres – is around the challenge of the location and the management of the location. There has been some debate in the lead-up to this select committee about crime, crime nexuses. Well, one of the things that I think is important – and there have been challenges of the viability of your crime evidence around the way data is collected, but the history of criminology is predicated on the assumption that we are very poor at collecting crime data, whichever measure you use. Self-report: well, people will tend to report the crimes they've been caught for and not much else. Arrest data is basically a function of both policing priorities, policing resources, and the competence of the criminal, conviction data and prison data even more so. All crime data is flawed when we talk about reporting.

The two measures that you have used, public perceptions and police calls, are no more or less flawed than any other indicator, and what they represent and from what I – I totally accept that you can't make causal claims, but you can very rarely make causal claims in social public policy debates in any case. What the data you have suggests is the problem of the social nexus of criminality. So where people congregate and there are identifiable, visible congregation points, you have high risk of normalizing substance use and behaviour.

The other problem you have, as in my own previous experiences of being involved in injectable methadone clinics, is: people then start to reject earlier options, lower tier options. Why should someone go through the drudgery of daily prescribed oral methadone when there are things potentially much more appealing? I guess given the costs typically of running safe consumption rooms and the cost-effectiveness debates around safe consumption rooms, there are challenges to the number of places available, and we wouldn't want there to be a high number of places available for people to potentially access what should be a treatment effectively towards the last resort. For me, the challenge fundamentally is around location. How do you avoid this becoming a location?

To give you an example of this, many years ago I worked in south London at St Thomas' in a ward called MOPD4, and MOPD4 was a ward specifically for HIV-positive heroin injectors who were typically on very high doses of methadone and other prescribed medications. It became a nexus for bullying, and it became a nexus for diversion. The challenge there was that people with HIV were typically given very high doses of methadone and benzos and other people took them off them, bought them from them, diverted them, and they were used to fund other forms of drug use. The question is not whether it's appropriate to prescribe somebody but how you can avoid some of those high-risk scenarios.

To link that to the Edinburgh study I mentioned earlier, the big problem is that once you have diversion, you have a different set of risk factors, of initiation and overdose of naive populations to whom the substances weren't prescribed or made available, and linked to the complexities that drug use is typically not a rational process. It's driven up this at the high end of problematic use by compulsion, tolerance, withdrawals, and cravings that mean the planning of behaviours to get into specific sites to use in particular ways is challenging and problematic.

For me, the key kind of conclusions about this are that you need to focus very much on questions of pathways, pathways in, pathways out, how you create recovery-oriented, hope-based models even for people who engage in safe injection facilities or safe consumption facilities. You need to create expectations and beliefs throughout the system that this is not simply an alternative to standard treatment processes, and you need to think very, very carefully about how you create meaningful pathways to and through those systems that are associated with logistics that avoid crime nexus, that avoid diversion and leakage of drugs into the community, and that avoid creating normalization and normalized expectations of serious and problematic substance use. That cannot be on an indefinite or maintenance basis because effectively what you then create is a public health, public safety crisis at the cost of individual well-being and choice.

1:10

I think, just to conclude, what for me is a challenge here is that you provide a very small level of provision at a very high cost for a small number of individuals that, while it may evaluate positively from a satisfaction and experiential point of view, doesn't provide the level of long-term change and hope to individuals but not only to individuals, because we learn from recovery models that the goal is a ripple effect from the individual to the family and the community. Any evaluation has to be relative to recovery-oriented models that attempt to provide provision that is effective across all of these three populations. The beneficiaries of any intervention within a recovery-oriented model, which you should have, have to take into account all three of those populations moving forward.

I see my clock is down to nine seconds, so I will stop at that point.

The Chair: Thank you, Dr. Best.

We'll now open it up for questions and answers with the members here, and we'll start with MLA Milliken.

Mr. Milliken: Thank you, Chair. Thank you very much for your passionate presentation. It came across, and I can see based on the fact that I think, through your background, you have experiences not just sort of philosophically about these kinds of issues but also on the ground and, actually, hands on. You mentioned at one point that you were in there actually doing the interviews, and that comes across with your level of knowledge. So I do want to thank you for that. I also like the logic of just listening with regard to this hope-based model for meaningful change, a meaningful life being one of the main points of what addicts often are looking for, fleshed out from your interviews.

I guess one of the things, though, that I have a question on is that you mentioned that diversion is something that you can pretty much expect. I was wondering if you could maybe expand on that, because jurisdictions with safe supply experience diversion. I was wondering if you could explain a little bit as to why it happens and perhaps if there are any kind of mitigating factors to try to stop it as well.

Dr. Best: Yeah. Sure. I think let's start with the principles and experience of diversion. People generally don't want to take their drugs in stigmatized, stigmatizing clinics in sterile clinical conditions. We generally operate on a contingency model, where if people are using in a controlled way, they are allowed take-homes. I'll give you my own experience of a methadone maintenance clinic in south London, in Camberwell, where I worked for two or three years. We had our own on-site pharmacy, and people would generally, Monday to Friday, be dispensed to in the clinic. They would have to be breathalyzed to make sure they weren't alcohol intoxicated to avoid central nervous system depression overdoses. They'd be provided with their medication. They'd have to take some orange juice or water afterwards to ensure there would be no spit-backs, and they would leave. But it was open from 9 to 5, Monday to Friday.

On Friday nights people would get take-aways simply on cost-effectiveness and staffing grounds. For roughly a quarter of our clients, Friday night would be party night. They would take their weekend take-homes, and they would go down to Camberwell Green, just a few hundred yards away, and they would swap, they

would sell, they would use, and they would use a combination of things. This is certainly not everyone but a significant proportion. We had around 400 clients in that clinic. The problem we had was that they were not using according to the guidelines and recommendations. They would sell, and by Monday morning, when I would arrive at work at half past 8, there would be a large number of people in severe withdrawal because they'd either sold their methadone or swapped their methadone and they were then withdrawing over the weekend.

One of the challenges of prescription-based systems is the problem of noncompliance and the management of noncompliance. So we had problems of a combination of alcohol, of benzodiazepine use, prescribed and nonprescribed, and the challenge of systems. As a criminologist you have multiple sources of potential leakage: you have staff sources of leakage, and you have client sources of leakage. Unless you're going to operate a system that's 24 hours a day, seven days a week, 52 weeks a year, you will face significant challenges of diversion of substances.

Diversion of substances is problematic in a couple of ways. One, it means noncompliance with whatever regime they were prescribed under and, two, potential leakage to vulnerable non-using groups and populations. I think one of the big challenges you have – and it's a valuable commodity. The purer the substances you provide and the further away you move from things like methadone linctus, the higher the risk of both diversion and the creation of an illicit market around those clinics and communities, and this is where the danger of the drug-crime nexus potentially grows.

The Chair: Is there a follow-up, Member?

Mr. Milliken: I guess what I'd do, just switching course a little bit, is: what are the objective measures to determine whether safe supply is effective?

Dr. Best: I mean, I guess that they would be potentially predicated at three levels. You'll have the individual level, where traditionally there would be health measures and the traditional measures of drug treatment outcomes, which would be in six different domains: impact of substance use – so illicit substance use, external illicit substance use – on physical health, psychological health, social networks, meaningful activities, families, and criminology. So that would be at the individual level. From my point of view as a recovery advocate, I would also add to that citizenship and global well-being and quality of life. I think one of the challenges about potentially offering something that may reduce the likelihood of moving towards recovery-oriented or abstinence-oriented models is: are you potentially reducing the likelihood of the person achieving employment, achieving reunification of families?

Now, one of the things that I've always thought was a myth and a shibboleth was the idea that there is a substantial proportion of medicated populations who is high functioning and achieves these things regardless. I think one of the challenges of this question is really around what measures you have. There would be the individual measure of well-being. You then would add to that, potentially, family measures and community measures, so you'd have measures of community satisfaction.

The notion of outcome is not a simple measure, and one of the things we've learned from a recovery model is that we switch from thinking of the individual as the unit of analysis to the individual being part of a broader system of: how does it impact on the individual, how does it impact on their family, how does it impact on their neighbourhood, and how does it impact on their community? So public health and public safety are kind of community factors, but there are broader factors we'd want to look at as well.

Sorry if that was too messy and academic an answer.

The Chair: Thank you, Doctor.

Next up we have MLA Yao.

Mr. Yao: Thank you so much, Chair. Dr. Best, thank you so much for taking the time to speak to us and our committee. It's greatly appreciated.

Dr. Best: My pleasure.

Mr. Yao: I just want to reflect on some of the comments you made and just clarify the context, if you will, and I'll finalize with just a final question to you. You talked about keeping people alive until they can be treated, and you talked about recovery systems that respect the individuals and that, you know, the models must promote things like positive social connections, meaningful activities, et cetera. Then you kind of mentioned that some people will reject lower tier options like oral methadone for other alternatives. I guess my question to you, based on all of these comments, is: in the field of addictions, are there truly substantive options available for the addicted individuals, or is providing them the actual pharmaceuticals or drugs a very clear and patent, reasonable treatment for people?

Thank you.

1:20

Dr. Best: Okay. Thank you very much for the question. The first thing I'd want to say is that from the best evidence we have available, of all people who have a lifetime substance use disorder, 58 per cent will eventually achieve stable recovery, meaning five years of continuous sobriety at some point in their journey. So we know that for the majority of people, long-term recovery-oriented change is a viable option, which also, obviously, leaves you with the corollary or the flip side, which is that 42 per cent of people don't. I think one of the dangers has been that we potentially are too inclined far too quick, in systems terms, to write people off and consign them to that world, saying: well, the best we can hope for you is to keep you alive and keep you out of prison.

One of the great successes of recovery models and one of the things that's astonished me throughout my career in different countries, including Canada, has been the astonishing capacity and resilience particularly of peer-based models to support people into recovery. Now, I think, for me, this is a question of mechanics, not a question of philosophy or principle. I have no problem with the idea of substitute prescribing. I have no problem with the idea of overdose prevention, naloxone programs, needle exchanges, or, indeed, safe consumption sites on the grounds that they are predicated on and embedded within a peer-based, recovery-oriented model of care. So the idea would be that nobody gets stuck in methadone or any other form of parking lot, that we don't just abandon people.

Look, there's a huge danger. One of the most contentious studies I've ever done – and I apologize for going back to methadone prescribing, but it's relevant to this point. The idea of substitute prescriptions is that there are three component parts: there's the substitution, pharmacotherapy; there's the psychosocial intervention; and there's care and case management. Well, when I did a study in Birmingham, we looked at every person who was engaged in substitute prescribing in Birmingham, and on average they were seen once a month for an average of nine minutes. The danger is that the pharmaceutical intervention, the pharmacotherapy, dominates and that nothing else happens. The mechanics of treatment have to

include this much broader psychosocial path and psychosocial support system.

You know, for me, it's not about whether you provide any particular interventions. It's how it's part of a broader model of care that offers a genuine chance for family, meaningful activity, employment, decent housing, and education. If you offer something like safe consumption as a stand-alone intervention for a small group of people, it doesn't help your system, and it doesn't do any of those challenge stigma and reintegration things.

The Chair: Excellent. Thank you.

You have a follow-up?

Mr. Yao: Just to very quickly follow up, actually a question provided by my good friend from Banff-Kananaskis, you mentioned that 58 per cent of addicts will recover on their own initiative. Does that number decrease where safe supply exists, or does it increase? Is it a factor in areas that do provide safe supply?

Thank you.

Dr. Best: Yeah. Let me be clear: I didn't say that people recover on their own; I said that 58 per cent of people will eventually achieve stable recovery. We don't have good enough evidence to say what the community factors are that predict that and how much that's related to safe supply. I don't think safe supply is sufficiently either uniform or evidenced as a mechanism of change to allow us to assess the attribution of that figure. My apologies. I don't think the science is good enough to tell us that at this stage.

The Chair: Thank you, Member.

Next we have MLA Frey.

Mrs. Frey: Thank you very much. My question is based along your comments about recovery-oriented care. Our government has been very bullish on this. We've said very publicly – our minister has stated it; we've stated it, you know – that we are looking at a recovery-oriented continuum of care. So, to me, the idea of safe supply kind of flies in the face of that recovery-oriented system of care or continuum of care. But I also see that there are harm reduction techniques that can be used to achieve that end. I was just wondering if you could expand on your experience and the experience that you've seen. What harm reduction techniques are the most effective at achieving a recovery-oriented system of care, and which are the most detrimental to that?

Dr. Best: Yeah. Let me just say that the whole idea of a recovery-oriented approach or a recovery-oriented system is predicated on the notion of continuum of care. So it's entirely consistent with the notion that you will attempt to engage people in recovery interventions from their first contact, whether that's with a needle exchange, whether it's with a prescribing clinic, or indeed with a safe consumption room. The idea would be to say that we meet people where they are, and we work with them towards that model.

Now, some of the most wonderful and effective recovery-oriented systems pick people up in emergency rooms, pick people up at the gates of prison and take them to mutual aid or 12-step meetings, get them involved in recovery housing, get them involved in peer-based recovery support services. The starting point is not so important.

The focus on medication, the focus on providing safe supply, to me, is secondary to the how it's done and the why it's done. If you ask me about what a recovery-oriented system in practice means, it's a recalibration of the allocation of resources much, much more to community-focused, strength-based reintegration efforts, but it doesn't mean that those things couldn't be done within an entire gamut of harm reduction services.

Now, it seems perfectly legitimate to me – you asked me about the most effective. I think something like take-home naloxone works beautifully. Potentially somebody coming out of prison who is going to meet somebody, a peer, to take them to a recovery residence, take them to a 12-step meeting, but they have naloxone in their backpack when they come out: that seems, to me, a beautiful alignment of the two things. There's a safety net, but there's a pathway to long-term change.

The challenge, once you go down the road of prescribing services, is that they create networks, they create expectations, beliefs, and identities, frequently stigmatized identities, that are hard to reconcile, so the mechanisms through which they are set up, through which diversion is prevented to prevent significant community harms and through which hope and aspiration – meaningful aspiration for change is crucial.

I think that in some ways I'd want to avoid kind of leaf tabling or ranking harm reduction intervention because, for me, the crucial point is how they can be utilized to initiate the process of what will technically be community-based and peer-delivered approaches to recovery-oriented models, which are increasingly strongly evidenced that what we want to do, even for somebody in a safe consumption room, is to start identifying what recovery capital they have and how we can use peers, social networks, and community resources to build that recovery capital way beyond the point they'd want to use a safe consumption room or a methadone prescription.

The Chair: Is there a follow-up, Member?

Mrs. Frey: No. And I'm sorry, Mr. Chair. I have to turn off the video from time to time or else I start to lose the Internet connection.

The Chair: MLA Stephan.

Mr. Stephan: Sure. Thank you for that presentation. I just have a question about the argument that you sometimes hear in respect of safe supply, that there are some who are suffering under these addictions that are not interested in recovery and that the opportunity to keep them alive is an end that justifies the means of safe supply. I'm just wondering if you could speak to that argument, that someone who is alive has a chance in the future of recovery and that somehow safe supply keeps him alive.

Thanks.

Dr. Best: I have absolutely no problem with that argument. As you're probably aware – I'm sure you're aware – the question of motivation is a really complex, fragile, and changeable thing, so the notion that somebody is interested or isn't interested in recovery seems, to me, almost a misleading concept. It's exposure to successful recovery – peers in recovery, groups in recovery, organizations – that inspires and promotes change. I don't see any of these things as kind of blocks of things that happen inside people's heads, and I'm not particularly wedded to or convinced by any of those clinical arguments that would say that somebody is too addicted or too complex or too messy to be thinking about recovery models. I think that's paternalizing and dismissive and problematic.

The other part of your comment and question of: do we need to provide supports and medications to allow individuals to stabilize to enable them to benefit from recovery models? Absolutely. Now, I think there's a significant challenge around the duration and the intensity of that offer. I think we have to offer recovery-oriented models at every point and safe consumption rooms and prescribing clinics and needle exchanges because the ultimate point of a recovery model is not to write people off. Everybody should have

that hope of change and be exposed to role models and successes that allow them to aspire to and believe in and be part of that change model.

1:30

That's a very different kind of social network and social identity, the kind that may well be at risk of happening in maintenance clinics, in safe consumption sites, where an entirely different sociocultural and value set of identities and expectations link to stigmatization that accompanies that approach and that model.

So, for me, I think, yes, of course, you have to keep people alive, and you have to offer – any recovery-oriented system has to offer a full range of options, but the weight and the emphasis and the strain is on creating hope and support and change.

The Chair: Excellent. MLA Amery, with about a minute left.

Mr. Amery: Certainly. Thank you, Dr. Best, for providing us with your presentation and your perspective as it relates to your observations and findings. I know from your bio that your research interests include things like recovery pathways, recovery capital and its measurements, social identity theory and implications for recovery, addictions treatment effectiveness, and family experiences of addiction and recovery among other areas, of course, that you have undoubtedly evaluated. Your area of expertise and your focus of study appear to be recovery based, yet this committee here is contemplating the viability of, quote, unquote, safe supply. It's become clear from our work here, even just today, from the people that we spoke to, including yourself, that safe supply is not really a uniform theory. That means the jurisdictions that have embraced this concept have different methodologies and applications, and I think that's fine. I mean, different jurisdictions have different challenges and therefore, I think, have to apply models that work for them.

Dr. Best, my preamble was long, but my question is going to be quick and simple. I want to know whether there is any evidence that you can describe to this committee or that you are aware of which reconciles the concept of safe supply and addiction recovery. In simpler terms, just to kind of narrow it down a little bit for the uninitiated like me, it appears, for me, that the two cannot be reconciled. I'm not sure that supplying those with the very substances that lead them into addiction is the answer. Am I wrong?

Dr. Best: Okay. No, you're not wrong. I mean, I would just want to quickly say that although I'm a recovery advocate, champion, and researcher, my background and my history as an academic is in clinical research and treatment services, including a diverse range of harm reduction experiences. I have no direct experience of safe supply. I would not prioritize safe supply within a recovery-oriented model. I cannot provide you with evidence that says that they are inconsistent or contradictory. Safe supply, if it's going to be embedded, has to be within a recovery-oriented approach and has to fulfill the criteria of moving people forward as much as possible into recovery-oriented models.

I'm sorry. That's a far too short answer to what's a very big question.

The Chair: That's quite okay because we actually ran out of time there. I'm sure we could have spent a lot more time asking questions, and we are very much appreciative of the time that you did take with us and your presentation. Feel free to join us for the rest of the afternoon as well if you're interested. Thank you, Dr. Best.

Dr. Best: Many thanks.

The Chair: We sincerely appreciate you. Thank you.

Dr. Best: Thank you.

The Chair: Next up we have Dr. Launette Rieb, who has actually been with us all day. Thank you, Doctor, for being with us here today and being a part of our conversation. We look forward to hearing from you. You have 10 minutes for a presentation, and then we'll open it up for a Q and A. I'll pass it to you.

Launette Rieb

Dr. Rieb: Great. Thanks for having me. I don't see my slides on the screen.

The Chair: Oh, it's coming. There you go. Ten minutes, starting now.

Dr. Rieb: Okay. Great. Thank you for asking me to come and share some thoughts on safe supply.

Next slide. I have no relationship with the pharmaceutical industry – I am going to be getting a small honorarium from the government of Alberta to sit on one of their committees – and no perceived conflicts of interest.

Next slide. For this session, I'd like to be able to place the current crisis in context, to list some pros and cons of safe supply, and to identify other evidence-based options to address the opioid epidemic.

Next slide. Substance use represents the top preventable cause of death world-wide according to the World Health Organization.

Next slide. It's not just an opiate crisis. In Canada alcohol is the number one cause of hospitalization, with more admissions than opiates, stimulants, and cannabis combined. Even hospital admission rates for cannabis are similar to opiate-related causes, but we're not hearing about any of this in the media compared to the opiate crisis. Really, we have an addiction crisis in Canada.

Next slide. Some of the previous speakers that you heard today went into detail around the opiate crisis, so I won't go into great detail on this slide, but just understand that there is a significant role of big pharma that created this, including lobbying, paying for textbooks promoting pain as the fifth vital sign, and incentivizing physicians to prescribe opioids. They also recruited patient advocates to be the face of pain and did not bring forward the people who were becoming addicted or having trouble with their medication.

Palliative care docs and anesthesiologists opened chronic pain management centres using medications typically confined for hospital use, and other doctors followed suit. So doctors played a role in one of the waves of the crisis with no upper limits to prescribing, guided by the patient's pain experience and sympathy of the doctor for the patient. We now know that 75 to 80 per cent of injection heroin users started with the prescription opioids to which they got tolerant. Opioids not only relieve pain but cause pain. I do research in that area, and opiate withdrawal pain particularly is a driver of reinitiation. Again, we can talk more about that in the question period if you like. Then the tainted drug supply, with contamination of all sorts of things, you can see listed on the slide.

Next slide. Just to understand that all of the things you see listed on the screen can affect someone's addiction liability or that risk to a population, but the key thing that cannot be done without is exposure. If you don't have exposure, you don't have a substance use disorder. Reduction of exposure or elimination of exposure is one way to intervene. We have not talked at all about primary and secondary prevention, which is part of what's important.

Next slide. When the COVID-19 pandemic hit, there was a need to self-isolate and quarantine and an increase in contamination of the drug supply as supply chains got cut off and rising deaths. The BCCDC and the BCCSU created new guidance on prescribing pharmaceuticals, opioids, stimulants, and benzodiazepines that were outside of evidence-based treatment. These were not medications that had been studied or that usually were provided for opiate agonist therapy, OAT. This was to take home unsupervised that people could use orally, but many people were snorting and injecting.

The term "pandemic prescribing," also known as risk mitigation, also known as pharmaceutical alternatives, also known as safe supply: these are all euphemistic names, but I will use the term "safe supply" in this talk because that is what the committee is choosing. This is a form of medicalization versus decriminalization and legalization, which, again, we can talk about in the question period.

Next slide. The hoped-for outcomes. Again, there's no published data, but the hoped-for outcomes when this was rolled out in British Columbia are that it may be desired by a certain segment of the drug-using population; it may reduce stigma to those; it may be more convenient than if they had to go in and get something supervised; it may help if someone had to quarantine. The hope is that it would mitigate overdose and that it might be less expensive than having someone have to witness, in a supervised setting, an injectable medication, which is expensive to have all the set-up and the nursing staff, and that it may link users with care providers and encourage treatment. That is the hope.

Next slide. There was a presentation last week by a colleague I respect, Dr. Paxton Bach, from the BCCSU. It is not my data. I am not going to present it in detail. This is my understanding of what they said from that hour and a half presentation, just some of the key features.

There have been six and a half thousand people who have received these medications. There is no intervention on this scale that would be rolled out without prior evidence that could be peer reviewed, so it's quite marked. Certainly, no evidence was presented that it decreased overdose risks. It was anecdotal information around acknowledgement of diversion and around some patients wanting to unlink from physicians and nurses and health care providers altogether to get this information. There was some anecdotal evidence that people could self-isolate a bit better and that some people did report some increased use, but many reported that they continued to use illicit substances.

1:40

Next slide. The concerns I have over this are that on a population level this is an experiment with no published data, the consequences of which may take years to see. Just like with prescribing opioids for pain, it took years to see all the impact. The potential benefits may be confounded. For example, in the data, they showed that about 83 per cent of people of the six and a half thousand were either on an opioid agonist treatment – methadone, Suboxone, injectable, hydromorphone, or slow-release oral morphine – they were already on that when they went and accessed the safe supply, or within a week of accessing safe supply they got this. It was mainly being given out by addiction doctors when people were already in or as a way to help hook them in to care. So when you look at potential benefits that may be rolled out by this research, it may be confounded because the benefit that they're seeing may actually be from the opioid agonist therapy itself and not as much from the safe supply. So this needs to be teased out.

Some harms may not be captured right away, like infections from injecting tablet formations that are meant to be taken orally; youth who may uptake a diverted supply; a diversion which includes increased availability, decreased cost of pharmaceuticals at street level, which can drive up use and addiction in the long run. If we think of China and the opium that was pushed into the country and Ohio and the OxyContin as well as spread across Canada and the U.S. These are the effects on society.

Increased wealth and power of drug dealers purchasing low-cost diverted medications and selling them elsewhere. One of my colleagues at Vancouver general hospital told me a number of months ago that one of the well-known drug dealers from the Downtown Eastside was in for a medical condition. She sat down on the edge of his bed and asked him how he was doing financially, and he said that it was the best thing that had ever happened to him. He made a million dollars this year from buying up safe supply off the street from people who had it dispensed to them, and he sold it across Canada and to the United States, making a huge profit because the street price of these drugs, as Dr. Mathew has mentioned, has tumbled down to just three or four pills for a dollar instead of $8 to $10 a tablet, so you can sell it elsewhere for an enormous profit. The other issue: coercion of vulnerable individuals being asked to sell their supply in order to have dealers make supply.

Next slide, please. Some of my other concerns are that even the term "safe supply" can give this false impression that they're safe to use and inject, which may encourage needle use and lead to increased use. People can still overdose on medical-grade opioids. We have years of experience with pharmaceuticals. If diverted, an opioid-naive person, someone who had not been using, can still overdose, but they thought it was safe because it was a medicine. Also, some sell their safe supply to buy fentanyl. There are people seeking fentanyl, as we know, and they can still overdose because of the fentanyl. All stimulant trials have failed, so giving safe supply in terms of fentanyl does not seem wise. You could give an opioid blocker instead to prevent contamination of overdose due to opioids if someone took a stimulant, but no one is talking in such terms.

Next slide. Other concerns. It may pull people from stable treatment. We'll need to see. We need studies that look at this. It may delay treatment readiness if it's done outside of a treatment context, just handing out a public health form, instead of by addiction doctors who are using it just as an engagement tool. It may palliate a treatable disorder. This is one of my big worries, that just like with cancer treatment, if we did not offer all of the evidence-based treatments and pulled people into care and instead just gave them opioids and palliated their disease, there would be an uproar, so we have to make sure we don't do that with this particular condition. There will be people who decline treatment. Just like with cancer, there are people who want homeopathic remedies instead of taking surgery, radiation, and chemotherapy, and that is their right, but that is not where we put the public health care dollar.

Special groups. Youth, older adults, pregnant women: we're not sure how it affects them.

There's been no exit strategy articulated. Once you're on, what's the indication to get off? They were presenting the other day that even people who have negative urine drug screens for the medicine that they're prescribed are still given more of it, so what's the exit strategy?

Next slide. There are evidence-based options, and I'm sure your committee will go through these: primary and secondary prevention, medication-assisted therapies like buprenorphine, methadone, slow-release oral morphine, and something that we don't have in Canada but is available in the U.S. and Europe is extended-release injectable naltrexone. It's like naloxone, only it lasts a month. You can inject it, and it's onboard for a month. You

can ask me in the question period about that substance if you like. We don't even have it available in Canada though I worked with some people to bring it in on special authority, but no one, any government, paid for it. Now, the latest study out on this shows that it's even better than buprenorphine in terms of sobriety rates; 70 per cent at one year and craving rate 1 out of 10. Behavioural treatments abound, and I've listed them there.

Next slide. To save lives, we need to fund primary and secondary prevention; offer treatment to all those who are wanting it; make treatment accessible and affordable; bring extended-release injectable naltrexone to Canada, which is good, especially for people who have safety-sensitive work because it's an opioid blocker, so people are sober when they go back to work; cover new formulations of buprenorphine; supervised consumption sites and injection sites need to be embedded in care if they are used; expanding naltrexone; prioritizing pregnant women, youth; and helping employers get workers back into treatment and back to work. If you are going to decriminalize, do it in the Portuguese model: house, treat, medical care, et cetera.

The Chair: Excellent. Thank you, Doctor. I'm pretty sure the first question from the member was to ask you to just work through the last couple of slides that you have there. I heard that question, so feel free to take a couple more minutes to finish your presentation.

Dr. Rieb: Okay. Great. Thank you.

What I tried to do here is to put in a small decision balance. Now, obviously, people on all sides of this – and I do respect people who are coming at this question from all different angles. I don't envy your position, having to make decisions here, but we're all trying to get the same thing, which is a reduction in death and increased quality of life. What I tried to do is look at a decision balance of providing safe supply, the pros and cons, or no safe supply, the pros and cons.

With safe supply, the pros: there are many but just in a nutshell, you may save some lives, particularly if it's used to engage patients onto proven treatment, especially in a contained environment like a supervised injection site, where they can't take that medication home and divert it. The cons are that it may cost lives in future; diversion can increase street availability the way it's rolled out right now, creating the next wave of opioid crisis; palliating a treatable disorder; and the legal risk of supplying unproven treatment. We all know the class action suits that are coming against organizations that promoted high-dose opiates for the pain crisis.

Some of the pros of not having safe supply are that resources can go to proven treatments and save lives and do not add to the next wave of the opioid crisis. There are many other things that I've already articulated in the talk. The cons are that some people who use drugs may decline or fail treatment, and they may die. Just like with cancer treatment, there are some people who can't access or who decline treatment. The legal risk of not providing safe supply when the federal government and B.C. are rolling out safe supply: you'll have to think of that on your decision tree.

Next slide. In summary, safe supply is an intervention that may reduce risk to some individuals, particularly when combined with opioid agonist therapies, but to others it may bring harm. Other evidence-based interventions exist, some of which I have talked about and some of the other speakers have talked about. Prevention, treatment, health care, housing, and jobs all reduce harm.

Next slide. The next two slides are some of my opioid-related research, including on pain. I did some of the first research with my residents around a link between seized drugs and the contaminated drug supply when comparing coroner data.

Next slide. It's also part of the research. I've listed some key naltrexone studies for you just because it's not a very well-known intervention. There's tons of evidence on buprenorphine and methadone, but I thought I would provide the naltrexone information because it's not well known here.

Next slide. I'm just recommending a book called *Empire of Pain* if you want to understand the origins of the opioid crisis and the role of the pharmaceutical industry.

Thank you very much for your attention, and I'll take questions.

The Chair: Thank you, Doctor. That was a lot of information. We're very appreciative of you taking the time to prepare that.

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

Mr. Milliken: Perfect. Thank you, Chair. I really do actually appreciate the fact that we offered the opportunity to go over those last few slides because you actually answered one of my questions with this decision balance. One of the things, though: at the outset of your presentation you had mentioned that you'd be listing potential pros and cons, and until that decision matrix that you put together, I was actually having trouble finding pros that you were listing. With your comment, then, in summary, where you say: "'Safe supply' is an intervention that may reduce risk to some individuals particularly when combined with OAT, but to others it may bring harm." That, of course, is opioid . . .

1:50

Dr. Rieb: Agonist.

Mr. Milliken: . . . agonist therapy. My apologies on that one. Do you know of any studies or data-based backing to show that that is or is not the case?

Dr. Rieb: What I presented was what are the hopeful, hoped-for outcomes. That's why some of the public health interventions have promoted trying safe supply. But there is no data. There is no published data that would support this intervention thus far. There's research being done now, but there's no supported data thus far. There's anecdotal report that some individuals are saying that they benefit.

Mr. Milliken: A follow-up?

The Chair: Yes, sir.

Mr. Milliken: Something else that you had mentioned early on in your presentation. You had stated: opioid-induced pain sensitivity and then also pain in withdrawal. I could see a possibility where safe supply may be effective with regard to dealing with potential pain from withdrawal. However, I just wanted to see if you could expand on that, especially on the opioid-induced pain sensitivity.

Dr. Rieb: Yeah. First, I'm getting some feedback; someone has their mic on.

Ironically, opiates are very good to relieve pain in the acute setting, but very soon there are many changes within the nervous system that will make the person more pain sensitive. Also, once they're tolerant, when they have withdrawal, they can have generalized aches and pains as well as pain return to old injury sites, even healed injury sites that were pain free prior. This tremendous pain that you can have can drive use. One of the key risk factors with opioid use that's different than all other substance use is the tremendous pain people can have. So safe supply: certainly, anything that can relieve withdrawal may have some benefit, but it's not a safe way to deliver that. Truly, to use evidence-based

medicines: methadone; Suboxone has been shown to decrease pain by about 50 per cent when people are converted over to it. If you can detoxify someone and they can go on a non-opioid, this can also be an effective intervention if they don't have an underlying chronic pain disorder that needs an opiate for treatment.

The Chair: Do you have a follow-up?

Mr. Milliken: Thank you. I will take the opportunity actually to shift us in a bit of a different direction. Just when the beeper went off, you had started what I thought was a potential part of a discussion with regard to – you've mentioned Portugal. Portugal has some notoriety with regard to decriminalization of drugs. It's my understanding that there may have been some successes with regard to bringing down overdose rates in that country.

Dr. Rieb: Yes. Very much so.

Mr. Milliken: It's my understanding that they may have been able to do it – and I'm not trying to answer the question for you or anything like that – without using safe supply or supervised injection sites. Yeah.

Dr. Rieb: Your understanding is correct. They took a treatment-focused lens, and how they decriminalized is not the way it's being proposed in Canada and elsewhere. How they actually decriminalized is that if you were found with a substance, possession of small amounts – and, you know, they had documentation and agreed upon what level that would be – you would be brought in and interviewed by a social worker and sometimes others to determine if you have a substance use disorder.

If so, you would be offered treatment paid for by the government up to a year, including residential treatment if needed; access to medical care, psychiatric care; all medications paid for that would treat your substance use disorder; and then vocational rehabilitation. Then they pay, for the first six months to a year, 50 per cent of your salary to your employer wherever you can get integrated in to the job force. So you go from being the least likely to be employed to the most likely to be employed. They offered housing, they offered all of this integrated care within the community, and it had extremely high quality of life improvement ratings from the people who participated. They dropped their overdose rates, their incarceration rates, their HIV rates. They diverted some of that money to health care that had been to the criminal justice system, and then they used some of the money from the criminal justice system at a low level to help secure their borders from importation from that tainted supply. So they were able to in this way really help their society.

The Chair: MLA Milliken.

Mr. Milliken: Yeah. Essentially, it sounds like you've told us that it's actually quite a complicated – any potential solution is complicated and has many different factors.

Dr. Rieb: It is.

Mr. Milliken: Yeah. Taking from you on that, then what evidence-based medications and social interventions are we lacking in our sort of armament to fight the opioid crisis?

Dr. Rieb: Right. Some of the good things you guys have been doing in Alberta are that you created a 24-hour, seven-day-a-week access so someone could get on to buprenorphine, so that's excellent. You're increasing both residential treatment and also second-stage recovery as well as sober living communities, because some people need years to fully stabilize given the years of use and damage to their brain and to their bodies and their emotions, et cetera.

Other things we need are both the evidence-based social interventions as well as evidence-based medication, and I had listed those during the talk. One medication that we don't have at all, like I mentioned, is naltrexone. I helped to spearhead a letter of 34 addiction doctors in 2018, and we helped Jane Philpott, then the Minister of Health, understand that naltrexone was an important thing in the armamentarium. She got Health Canada to allow this medication to come in, but no health authority or province paid for it on their formularies, so people could not access this. So injectable forms of that and injectable forms of buprenorphine as well as all the other medications that I listed in my talk.

The Chair: Excellent. Thank you.

Did you have a follow-up to that, Member?

Mr. Milliken: I would have a question that would be unrelated, so if somebody else . . .

The Chair: Okay. MLA Yao, and then we'll come back to you.

Mr. Yao: Thank you very much, Chair, and Dr. Rieb, thank you so much for taking the time to speak with us. You have a very lengthy resumé here. I'm going to clue in on just one or two points of your resumé, which is that you're a member of the Canadian Society of Addiction Medicine Education Committee as well as a key committee member with the College of Family Physicians of Canada's competency creation working group for the certificate of added competence in addiction medicine.

In your presentation you mentioned that 75 to 80 per cent of heroin users started out as prescription users, or they were given prescription opioids for their pain relief and whatnot. I think that's reflective of, certainly, our physicians contributing to this crisis. In your position do you see more education, more competency being targeted at physicians to try to alleviate this issue?

Dr. Rieb: Thank you very much for that question. Yes. I've done addiction medicine for close to 30 years now and been working in pain medicine, or pain rehabilitation, as a family physician for about 18 years. I have taught through the College of Physicians and Surgeons of British Columbia, through the College of Family Physicians. Also, I'm part of the pain and addiction common threads committee in the United States for the American side of addiction medicine. So I've taught nationally, internationally, and locally and to med students and fellows, all trying to help with understanding rational prescribing, and I teach physicians on how to help bring down some of the outrageous opiate doses that we were doing.

People are doing a much better job in the medical profession now with this. There are guidelines now. There used to be no guidelines on upper limits that you could go to, so I used to see patients come in very frequently on hundreds or thousands of milligram equivalent of morphine, and now that's very rare in the pain setting. In the addiction setting it's still quite high, but we have done all this work to help mitigate.

Over two decades I've taught doctors on how to help mitigate and have more rational prescribing, and then to have it unleashed on the other end by saying that you can just provide, you know, safe supply – it's very confusing to doctors because all someone has to do is say that they have an addiction or take fentanyl once so it's in their urine drug screen, and then they have access to this very high-potency opioid whereas they've been curtailed on the chronic noncancer pain side. So it's creating quite a bizarre environment right now.

2:00

Mr. Yao: Thank you.
No follow-up.

The Chair: No follow-up. Okay.
Any further questions?

Mr. Milliken: The question that I was going to ask was actually well done just previously. However, I do have another one that I could just – if you would allow? Yeah.

In your presentation you mentioned that overdoses still occur with safe supply and that most were due to the individual being alone. Given your experience, would a more effective prevention of overdoses be focusing on reducing the use of opioids by yourself versus toxicity of the drug being used?

Dr. Rieb: Sorry. I don't think I mentioned anything about being alone although that is a risk factor, using alone. Also, just to clarify . . .

Mr. Milliken: It could have been another presenter.

Dr. Rieb: Yeah.
. . . I don't think I said the first part of your question exactly either.

But I'll address the issue of being alone. I didn't say that people overdose more with safe supply. We don't know the answer yet; that's being researched. The issue of using alone: obviously, that's one of the public health interventions, trying to use with a buddy and trying not to use at the same time your buddy is using, to have naloxone present, to go to, if available, a supervised injection site, that kind of thing. That's, you know, kind of a base level of harm reduction.

The Chair: Excellent. Do you have a follow-up, Member?

Mr. Milliken: No. Thank you.

The Chair: No. Perfect.
MLA Rosin.

Ms Rosin: Thank you. I just have one follow-up, actually, to my colleague MLA Yao's question. You raise an interesting point, I think, that the medical community and doctors undergo years of training and schooling to learn how to properly prescribe and diagnose medications, but in a safe supply model individuals could just walk out and essentially get the drugs almost without a proper prescription or allowance. So would it be fair to say that the concept of safe supply almost undermines the medical community and undermines the work and the teachings that doctors do and go through?

Dr. Rieb: On the one hand I can say: very much so. At a bare minimum it certainly confuses people a lot. There are certainly advocates in the medical community and there are a lot of public health doctors who think that this would be the way to go.

Again, I liken it to when the palliative care doctors, you know, became involved in the treatment of chronic noncancer pain. Anesthesiologists who'd only worked in the hospital ended up prescribing these high doses, and they didn't see the impact. As an addiction medicine doc I got the fallout from their prescribing practices. So these public health interventions, though they look good on the surface – oh, this is compassionate and may help – in the broad societal view may actually cause harm, and it may also be very difficult for doctors to gauge how much to give. I may be proven wrong in the long run. That's the thing about evidence and medicine, to keep an open mind and try not to demonize people who have alternate views. But I think, trying to make the best evidence approach, there are other ways to tackle this problem.

The Chair: Excellent. MLA, any follow-up?

Ms Rosin: No. Thank you. My question was a follow-up to somebody else's.

The Chair: There you go.
MLA Milliken.

Mr. Milliken: Sure. Just a general question, that I've put in some way, shape, and form to several of the presenters. This committee is tasked with examining several aspects of safe supply, including whether there is evidence that a proposed safe supply would have an impact on fatal or nonfatal overdose, drug diversion, or associated health and community impacts. With that in mind, is there any evidence, that you know of, that access to a safe supply of opioids or other substances for people who are addicted to or dependent on these substances reduces their likelihood of suffering a fatal or nonfatal overdose?

Dr. Rieb: We don't have any data on this yet, and in terms of – there are lots of anecdotal reports of drug diversion, however, right now.

The Chair: Excellent.

Dr Rieb: But with any intervention there will be individuals who benefit just like when we prescribed very high doses of opiates for pain; there were some people who came forward who said, "I can get back to work; I'm doing better," but there were other people who got addicted and harmed and their families were destroyed. So you have to look at the overall picture. This is an intervention that has been rolled out in a population before we have the data for it and also before we can look at all of the different harms that may be associated. Some of the data is kind of being targeted toward potential benefit, I feel.

The Chair: MLA Milliken.

Mr. Milliken: Thank you. Somewhat aside, on one of your slides you had mentioned that palliating a treatable disorder is not good medicine. It's been discussed with a couple of the other presenters, but who would you say are the advocates, then, for safe supply?

Dr. Rieb: I think it's a combination of a certain section of user groups that have been given voice and have their voice being heard now that may not have been heard, people who may not want treatment but see it as – it's more of a civil libertarian argument, that they have the right to do anything and they want to be able to use this like any other person uses any other substance. Personally, I don't even think the public can handle open access to antibiotics. I don't think open access to highly addictive substances is the way to go.

The second are public health doctors who see the harm of people dying and wanting to make an intervention and saying that this may be it. Also, the health care systems and all those social supports needed are not built in yet. They've been not funded by governments in the way that they needed to in order to avoid this crisis, so what do you do in the meantime?

Also, I think there are advocates, parents and others who have lost people, who have died to this, who have gotten onboard to think this may be the solution. I personally don't think it is the solution, but because that's become – even government is funding some of

those groups to be able to say just like, you know, pharma did fund advocacy groups to say that they needed the opiates as well.

I think this is a bit of a tough topic and very emotional, but certainly I think people are going to die on either side of this issue. It's difficult, but what you want to do is try to mitigate harm in the best way you can and bring forward the most evidence-based treatments possible and bring people into care as well as possible.

The Chair: Thank you, Dr. Rieb. I believe that that is it for questions on our side of things, so I just want to thank you very much for joining us, for your presentation, for your passion and the work that you do. I also want to thank you for sharing your art with us today. I particularly enjoyed the piece. The joy of living in a Zoom world is that we get to enjoy so much of everybody's art, so thank you for that.

Dr. Rieb: Yeah. My husband did that.

The Chair: Oh, really?

Dr. Rieb: Yeah.

The Chair: It's a beautiful piece. Pass that on to him for me. Thank you for being here with us today.

Dr. Rieb: Thanks for asking me.

The Chair: All right. Now we have Dr. Sharon Koivu here with us today. Thank you so much for being here with us today to be able to present. First, we're going to open it up for you to be able to present to us for 10 minutes, and then we'll go from there into a Q and A with the members. Without further ado, I will pass it over to you.

Thank you.

Sharon Koivu

Dr. Koivu: Great. Thank you. Members of the Select Special Committee to Examine Safe Supply, good afternoon. I know you've had a long afternoon, so thank you very much for the opportunity to speak with you today and share my experience.

I've been a physician in Ontario for over 35 years. I've worked in primary care and as an acting medical officer of health. I have a certificate of added competence and focused practice in addiction medicine and palliative care. My role in addiction medicine has principally been to offer an in-patient consultation service in an urban hospital. Most of my addiction work involves seeing patients who are admitted with infectious complications of injection drug use. From 2012 until 2021 I was the only physician in my city working in this capacity. I provide a nonjudgmental, client-focused approach using harm reduction strategies meeting people where they are. I initiate or continue opioid agonist therapy as patients are ready and connect them with appropriate community resources.

2:10

We now have what is referred to as a safe supply program in my area. It is delivered at the InterCommunity Health Centre. Because it is run through a community health centre, it is associated with wraparound services such as primary care and housing first initiatives. These additional services have been shown to improve health outcomes. The initial inclusion group for safe supply was women who were street-level workers at risk and who were experiencing homelessness or were vulnerably housed. This program has since expanded.

In my experience this safe supply program involves prescribing opioids, often in large amounts. While the program promotes daily dispensing, many patients that I saw received scripts for several days, even one to two weeks, at a time. The most commonly prescribed drug is immediate-release hydromorphone tablets, also called Dilaudid or D8s on the street as they usually are eight-milligram tablets. Kadian, a long-acting morphine capsule, is occasionally prescribed. Also, I am aware that some clients have received injectable hydromorphone.

Now, it is important to recognize that clients receive a prescription that they fill at a pharmacy. Taking the pills or medication is neither verified nor witnessed. This should not be confused with a witnessed injectable opioid agonist therapy program. This safe supply program is not part of and does not provide a supervised injection site.

Initially I was supportive of safe supply. Locally we had had a huge problem with heart valve infections called tricuspid valve endocarditis as well as an increase in HIV in people injecting drugs. In listening to their stories, I discovered that patients with these infections were injecting Hydromorph Contin, long-acting hydromorphone. Working with infectious disease and research experts, we were able to prove and publish this causality.

After the safe supply program started, I noticed an increase in horrendous infections. These included spinal osteomyelitis, an infection of the bones of the spine; epidural or spinal abscesses, at times causing paraplegia; and brain abscesses. Previously I had rarely seen these infections, and I wanted to understand why they were increasing. In speaking with these patients, I discovered that approximately 90 per cent were injecting Dilaudid. While some of the patients I saw were in the safe supply program, over 80 per cent were not. They were buying drugs diverted from the safe supply program. Their experience, suffering, and death are not captured by data provided by the program. The number of people suffering and dying from infectious complications of injection drug use in our region is high. We found that at least as many people die from infections from injection drug use as from overdose.

Since safe supply began, I had a significant decrease in patients who would consider initiating or continuing evidence-based opioid agonist therapies such as methadone or Suboxone. Increasingly, patients requested safe supply, even those who have been stable on an opioid agonist therapy. Many acknowledge that they were motivated by the income associated with diversion.

When I first began my addiction work, in 2012, most of the patients that I saw had developed an opioid addiction after being prescribed opioids for chronic pain. This has changed since safe supply. I am seeing much younger patients, who have started by taking diverted opioids. The flood of diverted opioids on the streets has led them to be relatively inexpensive. It can be cheaper to buy a D8 than a beer. This has led to an increase in the number of people using opioids. People can afford to use higher doses. This in turn has resulted in an increased demand for more potent opioids, ultimately increasing the demand for fentanyl.

I have also had patients who were in the safe supply program that diverted their Dilaudid to buy fentanyl. This does not exclude them from the program even if they are not using any of their prescribed Dilaudid as the program generally does not perform urine drug tests.

In our community there is more fentanyl now than before the safe supply started. We have had an increase in deaths from overdose. I personally have witnessed much suffering and death as a consequence of infections caused by injecting Dilaudid, which patients informed me they got from the safe supply program. I have also had patients that died of overdose who were in the program. For me, these are not statistics. They are people that I knew, valued, and cared for. I am here today to honour them.

My commitment has been very personal. From 2015 until 2021 I lived within one kilometre of the InterCommunity Health Centre. I

chose to live in this amazing, diverse neighbourhood to actively promote harm reduction and be part of a community in which a supervised injection site was being considered. Going for a walk often meant chatting with people who had been my patients and truly meeting people where they are. This was my home.

I moved into the neighbourhood before the safe supply program was a concept. I watched the community change first-hand. These changes included public health outcomes and concerns. A large amount of diversion has been from one specific pharmacy located near the InterCommunity Health Centre. This has led to an increase in people staying in tents in surrounding parking lots and in neighbouring storefronts in order to get quick access to diverted drugs. I knew many of the people staying in these tents, some who were experiencing homelessness and others who were actually housed. These conditions are very unsanitary and may explain some of the increase in infection. Local businesses are also affected as accessing them can entail stepping over drug paraphernalia as well as human feces. Storefront windows have often been broken or vandalized, resulting in some businesses closing altogether.

In my personal experience crime in a residential neighbourhood has also increased. This includes things such as bicycle theft, car break-ins, and stealing copper pipes and wiring from homes. I understand that this is generally not from people in the safe supply program but largely from those requiring money to buy diverted drugs. I have family in other parts of the city that are socioeconomically similar who have not experienced this increase in crime.

Finally, sadly, because the program is not witnessed, vulnerable clients at times must surrender their prescribed drugs to other more dominant members of the society or community or are at risk of physical violence. These victims can be the same people that the safe supply program was initially intended to help.

Members of this committee, we are in a crisis. We need to be open-minded and innovative in our approach to solving this crisis. We need to reduce harm, not just pass suffering from one person to another. Unfortunately, a program that involves prescribing large amounts of unwitnessed opioids has unintended side effects. Diversion causes great harm. In my experience it has led to an increase in the number of people using opioids and the use of higher doses. As people seek a greater high that cannot be met by prescription opioids, they may turn to toxic fentanyl. Community safety may be compromised as people seek ways to pay for diverted drugs. And, as I can attest to, injection of pills designed to be swallowed can cause tragic suffering and death. The flooding of prescription opioids onto the streets started this crisis. We need to be more creative and passionate to end it.

Thank you.

The Chair: Thank you, Doctor, for the presentation.

We're now going to open it up for members to be able to ask questions, and we're going to start with MLA Milliken.

2:20

Mr. Milliken: Thank you very much, Chair. Thank you, Dr. Koivu. I want to express my thanks. Obviously, you're on the front lines with regard to health care, so I'm sure, not even just with regard to the issue that we're talking about today but obviously with the experiences that we've all had for the last couple of years here – again, I do want to thank you for all that you've done.

Given that you have what seems to be a pretty solid wealth of experience with regard to on the ground of safe supply, I just want to take – I can't help myself. I have to take the opportunity to say: okay; if I was to champion safe supply and if I was to get it to a point where we were potentially doing safe supply in Alberta, what would you do, if given the opportunity to kind of help out with creating it, given your experience, to make it as safe as possible if it was instituted? What I mean by that is that you mentioned a few things like: historically, it sounds like urine tests aren't often used to ensure that individuals are taking what they're supposed to be taking; perhaps ways to decrease some of the different infections that you had mentioned; perhaps another one, just off the top, would be witnessing. Things like that.

Dr. Koivu: Okay. I guess I'd start by saying that I think it's hard to make safe supply safe, and there are safer medications, such as Suboxone and methadone, that we need to have a lot better access to and wraparound services attached to those, and we can talk about that more. But there are things that can make safe supply, even the concept of it, less destructive than it is now. I understand the moral injury of watching people suffering and dying and wanting to do something to help that, but the problem with safe supply as it is now is that for every person you are helping that you can see, that's in front of you, you could be harming one or two other people that you don't see. You can feel good about what you've done because the harm you're doing might not be visible to you.

One of the most important things if people decided to have a model of prescribing opioids would be witnessing. Any of the things that even the people who promote safe supply say are helpful would still be there in witnessed drugs, and witnessing means that you know what they're taking, you know how much they're taking, and you know that you're not adding to someone else who might develop an addiction from the pills that you're prescribing. I think witnessing, to me, is the most important.

When people come into the hospital and they haven't had witnessed doses, it becomes very confusing to know what a safe dose is for them because we have no idea how much they're diverting. Normally you can look at what people are prescribed and know what they need. It's completely different and very challenging in hospital to work with people who are in a safe supply program because we don't know what they're taking. I've had patients who had severe problems such as COPD that were diverting most of their drugs but, if they happened to take them and are witnessed, are at risk of dying.

I'd say that witnessing is the most important, and the next one would be tying it to a supervised injection site. I mean, giving pills is not a good thing. If people are injecting, it would be better to be a type of medication that was supposed to be injectable, but also having the injections in front of you in a supervised injection site would be paramount.

Mr. Milliken: Just as a very brief follow-up, you had mentioned, perhaps alternatively, some wraparound services. What would you have been indicating with that?

Dr. Koivu: Well, if you look at a community health centre, they have primary care, whether it's through nurse practitioners or family physicians providing primary care. They often have social work, counselling, housing first models to help people get housing, the other social determinants of health that we know help people who are experiencing homelessness, vulnerably housed, or at-risk populations. Those services are at a community health centre. Where I live, for example, if you go to a methadone clinic or a clinic like a rapid access addiction medicine clinic to get Suboxone, buprenorphine, they're not available as part of the service, which makes it very, very unfortunate because those are things that are needed to help with anyone's health outcomes.

I think that, ideally, wraparound services – so primary care, helping to treat people, helping with vocational training, getting

them back into the workforce, all of those things that can be available through a community health centre – need to be available for people who are using methadone and Suboxone. They shouldn't be essentially discriminated against for choosing an opioid agonist therapy that is evidence based.

The Chair: MLA Amery.

Mr. Amery: Thank you very much, Chair, and thank you, Dr. Koivu, for your obvious passion for this area. It's incredibly important to hear what you had to say.

I'm going to start off by reading a little bit of history about what I have in front of me, and then I'm going to ask you a couple of questions about that if that's okay. In March 2020 you published a study titled New Hepatitis C Diagnoses in Ontario, Canada are Associated with the Local Prescription Patterns of a Controlled-release Opioid in the *Journal of Viral Hepatitis*. The prescribed opioid is safe-supply hydromorphone. The study concluded, in part, that their findings add support to evidence that hydromorphone controlled-release use is contributing to hepatitis C virus spread in Ontario.

You have provided us in your presentation today with a lot of extra details in relation to some of the impacts that you have observed over the years. Notably, you have said that you have noticed an increase in health-related issues, transmissible diseases, and other related concerns which you articulated in the initial part of your presentation. You also talked about the impact on younger patients and the exposure that you are finding with respect to opioids because of their abundance in the market. These are, in my view, some of the foreseeable consequences of increasing the opioid supply in any community, but I was also a little bit surprised to hear when you mentioned that opioid-related overdoses increased, in your observations, as well.

That was my preamble. My question is relatively straightforward. You had mentioned in your presentation earlier that you had approached the concept of safe supply with an open mind, maybe even a favourable position at the very outset. I like what you said earlier to my colleague MLA Milliken, when you said that we all have an inherent desire to do something to help those in need when we think that we can contribute. I think you're absolutely correct about that. But I'm also wondering if you can comment, for our committee's benefit, on what information or beliefs or positions you had at the very beginning, when you were contemplating a favourable approach to safe supply, how that evolved, how long it took to shift towards this current position, which I believe has changed significantly since that time, and what sorts of impacts you've observed in your community with respect to the damage that it's caused in that period of time.

I don't think we can afford to have a trial period given that you've already experienced some of these things. I'd like to hear from you what has transpired since then. I think it's preferable to hear from somebody who has gone through it than to try and have it exposed to this province here and find out first-hand.

Thank you.

Dr. Koivu: Thank you. I hope I can explain this in a way that will kind of explain my experience. I was a palliative care physician. I started seeing a lot of patients who were dying of infectious complications of injection drug use. That is what brought me in to working in addiction. Particularly, the problem we had in London was a heart valve infection. The first heart valve that enters your heart from the bloodstream is called the tricuspid valve. We also were having an increase in our HIV and hep C, but it's rare to see an increase in HIV in injection drug users. We found that it was a long-acting type of hydromorphone that has beads that was creating this problem.

2:30

When safe supply came out and they were going to be using a different formula of hydromorphone – they were using long-acting before; they were going to be using short-acting, which looks like it dissolves better – I actually thought that that might be an answer, that we would have a safer type of drug that you could be giving to patients and decrease the amount of infections. But what I saw – in a way, it doesn't surprise me retrospectively – was that we were getting different infections, and in some ways they were more horrific. I started seeing people particularly with spine infections that were making them potentially paraplegic, so they couldn't walk. There might be less death, but the suffering that I was seeing from these infections was absolutely horrific. Even the suffering I see in palliative care couldn't prepare me for this suffering.

As I said, I didn't know what drug people were taking. I had really good relationships with my patients and have had for a long time. Being the only one who sees these patients, I had the ability to talk to essentially everybody admitted to hospital about what they took. The thing that was most striking was that the vast majority of people were taking Dilaudid, the immediate-release Dilaudid that now was flooding our community because it was coming from safe supply. I realized that we had traded one bad thing, tricuspid valve infections, for another bad thing, spinal infections and other infections. We've actually shown that even though we had a campaign to educate about the tricuspid valve infections, overall infections in our community have increased since safe supply. These are, overall, horrific injection drug use infections.

I actually thought, naively, that if I just tell people what I'm seeing, it would have an effect, and I was kind of surprised that when I was saying, "I'm seeing some really bad things," it didn't seem to have the impact on the people prescribing safe supply that I was hoping it would. It's been really hard to watch that suffering – I can't describe how hard it has been – people that I have known for years who had developed much more severe infections. I had patients in the program who have died of overdose that I had known for years. I've been touched watching how – what I get to see are the ones that are suffering and not doing well.

As I pointed out, I lived in that community. I moved into that community, knowing it was kind of an edgy, urban, diverse community, wanting to promote harm reduction. Normally I'm the radical in a room. I'm the one really trying to support kind of meeting patients where they're at. I wasn't prepared for how the community was going to change. As I said, you know, people are now living in tents in parking lots behind the pharmacy so they can get the diverted drugs quickly. They're cheaper in the morning than they are in the afternoon. The impact that all of that has had on our community is really hard to explain to someone not living there. There's a hypervigilance that you have to have that you don't experience when you live in a rural community or even outside of this community to know what it's like to really live where this is all happening.

The Chair: MLA Amery, do you have a straightforward supplemental?

Mr. Amery: Straightforward, direct. Dr. Koivu, thank you for your impactful response. Increased drug overdose deaths, increased social impacts, increased drug use, increased diseases, increased infections, increased exposure to younger communities: can you describe whether you've observed any perceived benefits touted by safe supply advocates in your community?

Dr. Koivu: I will say that I have not seen the benefits, but I will also say that the people that might benefit are, then, not necessarily going to be in hospital. I can't say that there can't be benefits to individuals and anecdotally, but I can honestly say that I have seen no benefits, and I have seen horrible experiences both for the patients, with the increase in drug use, as you say, the increase in deaths overall, and then the changes in the community. I have not seen the positives.

The Chair: MLA Yao.

Mr. Yao: Thank you so much, Chair, and thank you, Dr. Koivu, for taking the time to speak with us. I'd like to just expand on Mr. Amery's last question to you. Early in your presentation you mentioned first-stage housing and that aspects like that have demonstrated to provide effectiveness for people that are trying to rehabilitate. That segues into a conversation we had with a previous presenter on Maslow's hierarchy and that if we can address certain needs like their physiological needs, like food and clothing; their safety needs, like their housing; and their social needs, like having peer and family support, those are proven supports in helping people kick the habits, if you will. Is it a fair estimation, on your part, that those are proven supports that we can try to address with people over these issues of safe supply?

Dr. Koivu: Absolutely. I mean, if we look at addiction, we used to talk about pillars, which would be prevention, treatment, harm reduction, and enforcement. We've sort of now put all of our weight into harm reduction, but part of treatment isn't just the treatment with the medications like methadone and Suboxone, which are proven evidence-based treatments, but they also include looking at social determinants of health. We know that they have an impact on outcomes. Unfortunately, they're attached to the community health centre, and instead of that being a place where people go to get their evidence-based medicine, they've been connected to the safe supply programs. So, yes, absolutely, connecting those same wraparound services to evidence-based opioid agonist therapy that already exists such as methadone and Suboxone would absolutely likely improve outcomes.

Mr. Yao: Thank you.

No follow-up.

The Chair: Excellent. Any other questions from members?

All right. Seeing none, I want to thank you, Dr. Koivu, for joining us here today and for your presentation and your obvious passion and heart for the work that you do. Thank you, and we really appreciate your time.

Dr. Koivu: Thank you very much for having me.

The Chair: All right. That concludes our presentations for the day and brings us to item 6, other business. Is there any other business that the committee members wish to bring forward at this time?

All right. Hearing and seeing none, we will move on to item 7, the date of the next meeting. The next meeting begins at 9 a.m., Wednesday, February 16, 2022.

With that, we head to adjournment. If there is nothing else for the committee's consideration, I'll call for a motion to adjourn. Member Yao moves that the February 15, 2022, meeting of the Select Special Committee to Examine Safe Supply be adjourned. All in favour, say aye. Any opposed? That is carried.

[The committee adjourned at 2:39 p.m.]

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