Legislative Assembly of Alberta

The 30th Legislature
Second Session

Select Special Committee to Examine Safe Supply

Stakeholder Presentations

Wednesday, February 16, 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
Milliken, Nicholas, Calgary-Currie (UC), Acting Deputy Chair

Amery, Mickey K., Calgary-Cross (UC)
Frey (formerly Glasgo), Michaela L., Brooks-Medicine Hat (UC)
Rosin, Miranda D., Banff-Kananaskis (UC)
Sigurdson, R.J., Highwood (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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Amanda LeBlanc	Deputy Editor of *Alberta Hansard*

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Standing Committee on Examine Safe Supply

Participants

9 a.m. Wednesday, February 16, 2022

[Mr. Jeremy Nixon in the chair]

The Chair: All right. Good morning, folks. I'd like to call the meeting to order.

Hon. members, we will now take a moment of silent reflection to commemorate the lives lost in Alberta due to drug poisoning, overdoses, and to the illness of addiction.

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

Mr. Milliken: Thank you, Chair. Nicholas Milliken, MLA, Calgary-Currie.

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

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

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

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

The Chair: Now I'd like to invite those joining us online, starting with MLA Frey.

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

Mr. Stephan: MLA Jason Stephan . . .

The Chair: Try that again, Mr. Stephan.

Mr. Stephan: Sorry about that. MLA Jason Stephan, Red Deer-South.

The Chair: There we go. Good to see you this morning.

I would like to note for the record the following substitutions: Mr. Sigurdson for Mrs. Allard, Mr. Milliken as deputy chair.

A few housekeeping items to address before we turn to the business at hand. 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 distance around the table. Please note that the microphones are operated by *Hansard* staff. Committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV. The audio- and videostream and transcripts of the meeting can be accessed via the Legislative Assembly website.

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I will move to the approval of the agenda. Can I get a member to move . . .

Mr. Yao: Aye.

The Chair: There we go. Tany Yao.

. . . that the agenda for the February 16, 2022, meeting of the Select Special Committee to Examine Safe Supply be adopted as distributed? Any conversation or thoughts on that?

Seeing none, all in favour, please say aye. Any opposed? That is carried.

All right. Now we're on to oral presentations. Hon. members, at the 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 for questions and answers with the committee members. Our first presenter today is Mr. Michael Shellenberger.

Welcome, Mr. Shellenberger. We appreciate having you. I'm going to pass it over to you right away. You have 10 minutes to present, and then we'll open it up for questions and answers.

Oh, you're on mute. It's the mantra of our time.

Mr. Shellenberger: Thank you. Can you hear me okay, Chair Nixon?

The Chair: Yes, I can.

Michael Shellenberger

Mr. Shellenberger: Thank you, sir. Thank you very much for inviting my testimony. It's an honour to be with you all today, and I look forward to our conversation.

I am an investigative journalist, the author of a new book called *San Fransicko*. It came out from HarperCollins last October. It's about the drug crisis in the United States, particularly in west coast cities, but I do think it has many similar lessons for Canada. The book is based on interviews with hundreds of addicts, including homeless addicts, dozens of experts from around the world, and field work, really, all over the United States but including the Netherlands and California. As background, in the late 1990s and early 2000s I worked for the George Soros foundation advocating decriminalization of drugs, harm reduction. I organized civil rights leaders to support needle exchange so heroin users would not get or transmit HIV/AIDS. It's a policy I still support.

I continue to support the treatment of addiction as a public health and medical problem, not as fundamentally a criminal justice one. Where I left off in the late 1990s, early 2000s was with an understanding that the goal was recovery from addiction, not addiction maintenance, and that there would always be a very small percentage of folks who may not be able to achieve recovery but that the goal of recovery was the right one, that addiction is paralyzing. It's dehumanizing for people. Sometimes it's not avoidable, but often it is, and that should be our goal.

I raise this because that is also the goal of European nations, including the Netherlands. The Netherlands, I think, is a great model for what we should be doing in the United States and perhaps as well in Canada. It's a very liberal country. It's not a country that has used significantly coercive measures such as the Philippines in addressing the drug crisis. They've decriminalized marijuana. They've tried to separate marijuana as a so-called soft drug from harder drugs like heroin. The Dutch system is not perfect. They still have problems with drug trafficking. They still have addicts, but they are mostly in pockets. They have broadly succeeded in moving folks out of addiction and towards recovery.

The mandate of your committee is quite limited to this concept of "safe supply," whether there is evidence that "safe supply" would reduce overdoses, the diversion of drugs, would have other impacts, what other risks it would create, what other advantages or

disadvantages there might be. I don't think I'm the first, and probably not the last, to really draw attention to the ways in which the framing of this issue around so-called safe supply – I think it's very problematic. I think that using the word "safe" itself associated with very dangerous and potentially deadly and addictive and intoxicating drugs risks being very misleading. I think it's been used in a very misleading way, and I've documented the ways in which words have been, I think, used to advance a political agenda without people knowing it, with people using language and it resulting in particular policy entailments that people did not sign up for.

Because one is in favour of giving clean needles to people using heroin, that does not necessarily imply that we should be doing similar things to maintain addiction. One might give people clean needles but also use more coercive measures to encourage or compel some amount of recovery. I think one of the most insidious myths I encountered in my research is this idea that nothing can be done to encourage recovery. I think there is a lot of truth to the fact that addicts need to choose recovery, but on the idea that people will hit bottom and then choose recovery, I don't think it's the case that that bottom is fixed. If you basically give people drugs to use and make their lives very comfortable to just use drugs all day, you're effectively lowering the bottom whereas if you have consequences for behavioural disorders, including public drug use, public camping, public defecation, you may raise the bottom and help people to get into recovery.

I think it's obvious, too, and worth being said that this is not simply a scientific issue in the sense that it would just be determined by science. It's mixed up with questions of values. So if your vision of a good society is where you have large numbers of people who have effectively stopped working, cut off relationships with their family, and are using very intoxicating, very addictive, very hard and dangerous drugs all day long, if that's your idea of a good society, there's no amount of science that's going to change your view.

9:10

I worry that there's been a strategy to frame the issue here as narrowly as possible around simply avoiding deaths. I think avoiding deaths is obviously an important goal, but it's not the only goal. There are many ways to get there. I would hope my role here and the role of other experts providing testimony is to play the role of honest broker rather than stealth policy advocate. An honest broker would describe for policy-makers a range of potential policy solutions in service of different goals and different values.

Again, if you think that maintaining someone's addiction is just as positive an outcome, just as good an outcome as helping them achieve recovery, well, you're making a values choice there. I think it's important to be explicit about: what's the values choice being made? You might reduce drug deaths, either from poisoning or overdoses, by simply administering drugs to them in a palliative way for the rest of their lives. You might also achieve that goal through recovery. The latter provides people, I think, with a full life, a life of human connection, of family, of romantic relationships, of children, of meaningful work. Again, a values judgment is being made there. Nonetheless, it's one that I think most people would agree is a better outcome than simply having your addiction maintained for the rest of your life.

Let me say something about the experience in the Netherlands. It's also a similar experience in other European cities. In fact, one of the most important papers on addiction in general, in my view, is a paper about the experience of five European cities – Amsterdam, Frankfurt, Lisbon, Vienna, Zurich – all of which in the late 1980s and early 1990s had a heroin epidemic. That heroin epidemic manifested as what researchers call open drug scenes. "Open drug scenes" is, I believe, more accurate than the words that we use in the United States and, I think, also in much of Canada, which are the words "homeless encampment." Homeless encampment makes it sound like what draws people there fundamentally is a kind of camp-out. In fact, these open drug scenes draw people because these are places where drugs are bought and sold and used. People, because of their addiction, are there. They've lost ties with family and friends. Disaffiliation is a key part of it. They've lost housing because of their addictions.

This paper on open drug scenes that was done by Helge Waal for the Norwegian government – I believe it came out about five or six years ago – finds that all of these cities did the same thing, which is that they disallowed public drug use, they disallowed public camping, they broke up the open air drug markets, and they did not allow congregations of drug buyers and sellers in their cities. The goal was recovery, not addiction maintenance.

Now, there's been a lot of publicity about the fact that in some European cities, including Amsterdam, heroin is provided for a small number of addicts. I investigated this question. Of course, it's of great interest to me. I went to the Netherlands twice to investigate, interviewed their top drug policy expert. I did the same for Portugal, by the way. There are, according to the Dutch government, 120 people who receive heroin maintenance, and I think it should be considered a kind of palliative care. These are people for whom methadone, the opioid substitute that helps many people to end their heroin addictions – a very small number of people, 120 people in total in all of the Netherlands. So I really think the Dutch have done a great job. I think Germany, France, Japan, other countries have also done, obviously, a much better job than the United States or Canada based on drug deaths alone, not to mention the open drug scenes.

Nonetheless, you can see that in the Netherlands the so-called, quote, unquote, safe supply of heroin by the government to a small number of addicts is a tiny part of a much broader effort, that included moving thousands of heroin addicts into recovery, with personalized plans overseen by social workers, involving families and friends. That's the basic pattern for how I believe all civilized nations and cities have dealt with drug epidemics similar to the one that we're experiencing in the United States and Canada.

There are differences between the Dutch system and the Portuguese system. Portugal: it's a different culture than the Netherlands. There are stronger family ties. They do use still a coercive apparatus that they call a commission for the dissuasion of addiction. The head of the Portuguese program, João Goulão, who I interviewed at length several months ago, said very clearly: we do not normalize hard drug use. I think it's also important to point out that even in the Netherlands, where you can smoke marijuana in specialized cafes, it's still not normalized, not to the extent to which things like alcohol have been.

I think that when you get to these questions of normalization, it's fair to say that in most developed nations like ours, we've tried to denormalize or stigmatize cigarette smoking, to great effect. I think there's been this idea that somehow stigma is simply a bad thing and should never be done, but I think that what we see from the Netherlands, what we see from Portugal is something quite different, which is that they are putting coercion on people to get out of addiction and into recovery. There's only a very small number of people for whom addiction maintenance is considered a priority. They have their policies and their strategies aimed at a values-based goal, which is recovery, not addiction maintenance.

Thank you very much.

The Chair: Thank you very much.

First up for question and answer we have MLA Frey.

Mrs. Frey: Hi, Mr. Shellenberger. Sorry. I'm coming to you through Zoom, so if my sound is poor, let me know. I just want to say thank you very much for coming today to be with us. As you know, this committee has been meeting for a few days. We're meeting about three days this week to talk to experts such as yourself about the issues regarding things like safe supply. We've been criticized pretty widely, especially by another party, for using quotations around the word "safe," and what I got from your presentation today was that you are of the same mindset in that we shouldn't be using normalizing language for something that is an illicit practice.

But I also liked your comparison to the Netherlands. In the Netherlands I know it's still illegal to carry illicit drugs, I believe, but you have safe places for soft drugs like marijuana and such in coffee shops. I'm just curious. In what you said, how we cannot normalize hard drugs, how do you think Canada is doing on that side of things? How do you think our verbiage, our discourse around drugs in Canada – do you see us going down the wrong path, or do you think that we need to change course?

Mr. Shellenberger: Well, first of all, thank you very much for the question. I think that Canada and the United States are both going down a terrible path in terms of the normalization, the destigmatization of hard drugs, including open drug use, open drug sales. These are things that are simply not allowed in the vast majority of other developed nations. As I mentioned, those five cities – Amsterdam, Frankfurt, Lisbon, Vienna, Zurich – did have open drug scenes. They shut them down.

By the way – and I didn't have a chance because we just didn't have a bunch of time – the impact of open drug scenes on communities is devastating. It's destructive to the fabric of a community. It's dangerous. Now, we spend a lot of time talking about opioids, but we are in two drug epidemics: one is on opioids; the other is on methamphetamine. We are seeing very extreme and bizarre and often dangerous and deadly behaviours by people suffering from meth-induced psychosis associated with these open drug scenes, so I think we're going down a terrible path.

I feel personally responsible for – I actually spent most of the last two decades working on energy and the environment. I came back to this issue because I worried that I had contributed to the normalization through my work in the late 1990s for the George Soros foundation. The normalization was not what I believed we had signed up for. My view was always that recovery was the goal, that addiction maintenance was not the goal, so I feel personally deceived.

9:20

I think that, really, what is being proposed is palliative care for all addicts. Palliative care I do think is appropriate in some cases. I mean, if you think of somebody who's 75 years old and has been using heroin for 35, 40 years, I think it may be very hard for those folks. But we're treating 25-year-olds suffering from opioid addiction, either heroin or fentanyl, as though they're 75-year-olds at the end of their lives or something. I think it's crazy.

I think that it was entirely appropriate to put safe supply in quotation marks. I would even call them scare quotes because what scares me are the ways in which we have seen efforts to really normalize not just addiction but, really, expanded use. If you're expanding supplies, you're going to be expanding use both among the people using but also the number of users.

The Chair: Supplemental, MLA?

Mrs. Frey: Yes. Thank you for your answer.

On that vein, I would just be curious what you think about opioid alternatives such as Suboxone and naltrexone in that lens given what you've said. I know you mentioned methadone once, which is different, but how do you feel about those other two?

Mr. Shellenberger: Very, very positive. I mean, I think that the thing we have to keep in mind is that many of the tools – I see the United States and Canada, different cities and states, differently – that we're using are great. Again, in the Netherlands – I just researched it, I just investigated it with my folks there – there are apparently something like 28 places where drugs can be used so-called safely, supervised, but those are in a system where the goal is recovery. I think it's important to keep our eyes on the prize here. Our goal should be recovery, not palliative care, not addiction maintenance. That means that there is a role, certainly, for methadone and Suboxone.

But my source in the Netherlands, who's now a senior drug policy expert, who was a nurse working in those areas, said to me, quote: in the '80s we just wanted to help people; we started with methadone programs and medical treatment; we did a lot of work without much of a carrot and a stick; it was a real disappointment; they just used the methadone to stay addicted; they dealt drugs and committed other crimes; they lied and cheated about it; we were just supporting a different kind of market; we had to learn the hard way. In other words, they tried an approach of just providing alternative supplies, including in that case methadone, and it didn't work. The addicts would use heroin in addition to the methadone. The same kinds of problems could be seen with Suboxone.

You have to have a goal, and the goal should be recovery for the vast majority of addicts. Again, there may be some cases where palliative care is necessary, but even for those individuals I think most psychiatrists and addiction specialists would tell you that it's not obvious who those people are, and it shouldn't be an easy decision to put somebody on palliative care. That's a very, very serious question, and there are reasons why governments and policy-makers have put into place safeguards everywhere palliative care is an option.

The Chair: MLA Yao.

Mr. Yao: Thank you so very much, Chair. Mr. Shellenberger, thank you so much for appearing before us. I find you to be one of the more interesting folks that we have presenting before us because of the fact that you're an investigative reporter. I'm just going to give a little backgrounder story that backs up my question. Several years ago the CBC wrote an article on this very issue, and they investigated Vancouver's scene. They had guests from Portugal's drug rehabilitation come visit, and in the article they said that the folks from Portugal were absolutely appalled at what was going on in Vancouver. Later on, when I went back to the article, they took out that portion of the article, and then a few days later, after that, they actually pulled the entire article, and I never saw it on the CBC's website again.

My question to you. Portugal, from my understanding, is considered one of the leaders in the world on addressing these addiction issues, and they've gone through all the experimentation on this issue. Can you summarize or clarify some of the other differences that Portugal does in regard to drug rehabilitation? I also want you to expand on the concept of destigmatizing these addictions because I feel that the stigma around these drugs helps to prevent people from actually trying them in the first place. Like, I think it's not an ideal thing to destigmatize these things.

Thank you.

Mr. Shellenberger: Thank you. Well, there's a lot packed in there, but let me say that I think that many of the journalists are very biased in favour of pretty radical drug decriminalization and harm

reduction measures. I don't think that that's because they're bad people; I think in many ways it's because they're very compassionate. I think there have been many instances where we simply used all sticks and no carrots for addressing addiction. Simply incarcerating people suffering from drug addiction, many of whom may have some underlying mental illness that's not being treated, is often a terrible thing to do, a real violation of their humanity. It's not getting them the proper treatment. So I think there's some amount of empathy and compassion and concern about just a law enforcement or incarceration response to addiction. That's totally understandable.

But as these things go, people go too far: they become dogmatic; they become ideological; they see what they want to see. They take away from Portugal that it's just about decriminalization. They overlook the fact that they have these commissions for the dissuasion of addiction, which couldn't be clearer about the purpose of those commissions.

Now, when you interview the head of the Portuguese drug program, João Goulão, or other European officials, those officials are attempting to speak both to people who err on the side of overincarceration and people that might err on the side of just overliberalization. You can pull from them different parts of it, but what they're saying, both in the Netherlands and Portugal, is that they're putting pressure on addicts for recovery. They're not making addiction illegal, or they're not criminalizing addiction, and I share this view. If someone is maintaining their addiction in the privacy of their home without disruption to the broader community, no breaking of laws, I don't think that should be a law enforcement priority. I don't think we need to be evangelical about this.

But the problem is that addiction means that people end up no longer working, no longer paying rent, being kicked out of their friends' and families' homes, end up on the street committing crimes. This is a very similar pattern around the world, so it makes sense to address the addiction in helping that person to achieve recovery and achieve a better life. There is a value statement here that we have to acknowledge.

Now, on this issue of stigmatization, even more than just stigma I think we should be frightened of these drugs. Methamphetamine and fentanyl are extremely – these are some of the most toxic, intoxicating, addictive, and deadly drugs ever invented. They make the heroin and cocaine epidemics of the past look like child's play in comparison. I mean, the poly drug use is rampant. When I interview homeless people – and I've been continuing to interview them in recent weeks, as I have for months before the book came out – people are using methamphetamine and fentanyl combined, and they're smoking them all day long. That's incredibly destructive, and we should be afraid of that.

You know, there's an old saying: love the sinner; hate the sin. I think that's still the right view, which is that we should have compassion and love for people who are fundamentally ill and whose behaviours are so self-destructive, but we should really understand that these are very dangerous drugs. There should be stigma on the use of them, particularly on the behaviours that result from them, so I think that's totally fine. I think there's no need to shame the person who's sick, because often they've lost control of their behaviours.

The Chair: Supplemental?

Mr. Yao: No. Thank you.

The Chair: MLA Stephan.

Mr. Stephan: Thank you. I bought your book, and I've read part of it. I appreciate you coming and speaking today. I know that in my community we are wrestling with some of these issues related to a desire to help those who are suffering under addictions. One of the arguments that I hear in favour of self-supply is that everyone agrees that recovery should be the focus, but if a person is dead, you can't help them towards recovery. I'm wondering: how would you answer that argument that is made in favour of safe supply?

Mr. Shellenberger: Well, I refer back to the – again, I think as experts here our role as honest brokers is to increase the policy options for policy-makers, not reduce them. So I find there's something really manipulative when somebody says something like that. It suggests that the only way to save lives is by giving people drugs. That's not the only way to save people's lives. There are many other ways.

9:30

One of them is to address the addiction. It's to do what they do in Portugal. When I asked João Goulão, the head of Portugal's drug program, what would happen to me if I shot heroin in public in Lisbon, he said: "You would be arrested. You would be arrested and brought to the police station, and if you had more than the amount allowed for under the law, you would be prosecuted for drug trafficking. If you had less, you would be brought before a commission for the dissuasion of addiction." He did not say: we would make sure that you had pure heroin or pure fentanyl to use. Nor did he say: we would give you a private room where you'd be supervised to use drugs. So there you go. In the signature country, the country that is the most cited by advocates of decriminalization, of so-called harm reduction, of so-called safe supply, safe supply is not what comes to mind when they first seek to address open drug use and drug addiction.

It's a similar story with people suffering overdose or at risk of overdose. It is not the case that just giving them pure drugs is the only solution. It's one possible solution, but it's also a potential response with many downsides. You know, again, I think that there is a role in the way that the Dutch have used it for some amount of so-called heroin maintenance, addiction maintenance for a small number of people as palliative care, but I think that what we're not seeing in those countries is some large-scale effort to provide thousands of addicts with heroin, with methamphetamine, with fentanyl. That has not been a response that's been tried around the world.

What is being proposed in Canada and has been pioneered in San Francisco is a radical experiment, and it's an experiment on people that I do not believe are providing their consent. Simply agreeing to accept drugs from government officials or to use those drugs in a government site is not the same as providing consent to participate in an experiment.

The Chair: Sorry, Member. You're muted, Mr. Stephan.

Mr. Stephan: Sorry. Thanks.

Just a supplemental question. You had mentioned the experiment that has been done in San Francisco in respect of safe supply. Based on your investigations, what have been the results of using this policy? What have you seen from it where it's been used?

Mr. Shellenberger: The San Francisco city government is currently operating an illegal supervised drug-use site in downtown San Francisco. It's resulted in an expansion of open-air drug dealing just across the street. It has basically devastated the farmers' market that existed in United Nations Plaza, which is the location of the supervised drug site. The government officials involved in it have misrepresented the site, citing their violation of state and federal laws. The people inside the site are smoking methamphetamine and fentanyl.

They're concentrating users. It's normalizing drug use. I think it's a very unethical experiment that does not have proper controls on it. I find it disturbing and scary, and I think that where the advocates of that experiment are headed is towards wanting to provide the people that go into that site with so-called safe supply. I find this very Orwellian. It feels like a horror movie that we've seen. It's simply not how the Dutch or the Portuguese or any European nation or Japan or South Korea or any other country in the world has dealt with addiction. I think it's rash. I think it's irrational. It's being pursued by people with a kind of religious zeal that seems completely unmoored from any scientific or ethical traditions.

The Chair: MLA Rosin.

Ms Rosin: Thank you. I've got a question based on your work as an investigative reporter. I think it's almost paradoxical. You've worked in some of the most major cities all over the world studying this issue. It does seem quite paradoxical to me that we've seen governments all over the world for decades really launching well-funded campaigns against the tobacco industry and trying to reduce the use of tobacco, accepting that using tobacco is not healthy for a human body, but on the flip side we are now seeing those very same governments go out and almost launch campaigns for the use of other illicit substances like opioids.

I think it's safe to say that the campaign against the tobacco industry by government has been waged and promoted and driven primarily by the medical industry, but I would think, and from what I've heard from other presenters as well, that if the medical industry is against promoting tobacco, the medical community would also be against promoting opioid use. On that vein, then, I'm curious who you think or who you've seen through your investigative research is behind the campaign for the decriminalization, almost, or the promotion of illicit substance use if it's not the medical community.

Mr. Shellenberger: Yeah. Thank you for your question. Yes. What you said: it's crazy that here we did this beautiful campaign to reduce cigarette smoking and have these positive results, and now here we are creating a special meth and fentanyl smoking section in one of our most important public plazas in San Francisco. Look, this campaign to expand the supply of drugs is coming from a particular ideological tradition. It's not coming from the medical profession. It's coming from what we would call the radical left or what we, I think, rebranded in the United States as progressive. It's based on a victim ideology that people suffering from addiction and mental illness are victims to whom everything should be given and nothing requested. It's based on very simple ideology that kind of classifies people, does not view people as going through a particular journey. I think it's very cynical. It's very dark. It's not based on, really, the last 150 years of experience dealing with opioid epidemics. It's not based on modern addiction science or psychiatry.

The Chair: Thank you, Mr. Shellenberger, for joining us this morning and for your presentation. We sincerely appreciate your time, and unfortunately we've run out of time.

Mr. Shellenberger: Thank you very much.

The Chair: Yeah. Feel free to stick around, too, if you're interested in the other presentations. Thank you.

Now we have Dr. Jeremy Devine joining us today. Doctor, are you on the line?

Dr. Devine: I'm on the line. Can you hear me?

The Chair: I can, yes. So we're going to pass it over to you right away. You've got 10 minutes to present, and then we'll open up for Q and A with the members. Thank you for being here today.

Jeremy Devine

Dr. Devine: Thank you so much. I just want to start by saying what an honour it is for me to be here sharing my thoughts on this issue of safe supply. My name is Jeremy, Dr. Devine, and I'm a resident physician currently completing my training in psychiatry over at McMaster University. It's such a privilege to add my voice to that of Dr. Humphreys, Mr. Shellenberger, Dr. Lembke, just incredible leaders on this issue of drug policy and addictions. It's a real honour for me to be here.

The issue of safe supply is much more than an academic debate. Safe supply has grown in momentum across Canada. The 2021 federal budget has allocated about $60 million specifically towards implementing 18 different safe supply projects across Canada. The B.C. ministry of health and addictions estimates that about 12,000 Canadians currently have access to a safe supply, and that number is likely larger if we consider other provinces. This is a really concerning development in Canadian drug policy.

The increasing practice of safe supply is dangerous and, I feel, oppressive to the individual who struggles with homelessness and addiction. Really, safe supply is far from an evidence-based and thoughtful public health intervention. It's really rooted in what I feel is a misguided ideology that denies that drug use in the setting of addiction is intrinsically dangerous. I really feel that safe supply is best understood as kind of a radical form of harm reduction which has pushed that philosophy far beyond its necessary limitations.

Let's look at some of the claims made by safe supply advocates and the evidence which either supports those claims or refutes them. Safe supply advocates will argue that the provisioning of high doses of medical grade opioids to an individual who struggles with regular fentanyl use will help reduce their reliance on the street supply of fentanyl. They argue that the individual provided safe supply will be at a lower risk of overdose death as their opioids are medically administered and thus considered safe.

9:40

But for those who are even remotely familiar with the nature of addiction, this idea on the surface should be met with strong skepticism. A central feature of addiction is the inability to control one's use, and when one is addicted, gradual tolerance and escalation of use is inevitable. That a regular fentanyl user will have their opioid cravings satisfied by being provided comparatively weaker hydromorphone or heroin is highly suspect and, I think, wrong. Preliminary evidence on the effectiveness of safe supply interventions is extraordinarily scarce, but what does exist confirms what we would reasonably expect. The vast majority of those who are prescribed a safe supply continue to use fentanyl on the street.

Dr. Mark Tyndall is a safe supply pioneer located out in British Columbia, in Vancouver. Dr. Tyndall has enrolled a number of severely addicted fentanyl users onto an opioid-dispensing machine. This machine distributes high doses of hydromorphone directly to the individual who struggles with a fentanyl addiction multiple times daily. Regrettably, in my opinion, these machines have proliferated across Canada. There are some in Nova Scotia, Ontario, and, of course, British Columbia.

In a 2020 podcast episode where Dr. Tyndall was interviewed, he shared the early results of his experiment enrolling severely addicted fentanyl users onto these vending machines. If I could just quote him directly as he discusses the preliminary results. Quote: I put 15 people on the machine; we did follow-up urines on

everybody, and 90 per cent still had fentanyl in their urine; I think they're using the drugs that I gave them; for many, it's not enough; for some, they still want to buy something. These early observations by Tyndall should really call into question that basic claim made by safe supply providers that providing high doses of opioids will allow them to abstain from being exposed to fentanyl and thus at risk of overdose.

Two Canadian studies, the North American opiate medication initiative, NAOMI, and the follow-up study, the study to assess long-term opioid medication effectiveness, SALOME, are frequently invoked by safe supply advocates as evidence for the alleged safety of prescribed heroin and hydromorphone in the setting of severe addiction. But this is incorrect. NAOMI and SALOME do not meaningfully inform the practice of safe supply. These two studies were conducted in British Columbia, and they simply examine the effects of giving high doses of heroin and hydromorphone directly to someone who struggles with a heroin addiction.

At the time they found that those who were provided heroin and hydromorphone seemed to use less street substances overall, although were still using quite a fair amount, and seemed to have decreased health care costs associated with that. The practice of giving heroin and hydromorphone did seem to increase what they somewhat disingenuously call treatment retention, this unsurprising finding that when an individual who has a heroin addiction is given high doses of heroin, they are more likely to return to the clinic. Treatment retention.

Furthermore, these studies gave heroin and hydromorphone under extremely restricted conditions. Individuals were given it multiple times daily, and they had to be monitored after being given heroin or hydromorphone. This is a stark contrast to safe supply in Canada as it's being practised, which features the relatively free distribution of opioids. Furthermore, both of these studies were conducted sort of in 2005-2008, during a time when fentanyl was relatively absent from the drug supply. It's not at all clear to me that the results still hold now that our environment is so contaminated with fentanyl. Really, to summarize, NAOMI and SALOME – I think you might hear more about those – can't be credibly invoked as evidence that supports this practice of safe supply.

Finally, some of these earlier studies, which on the surface appear to support the practice of safe supply, are clearly conducted in a biased manner towards their favoured ideology. With these more recent studies that I've looked at, it's clear to me that the benefit of a safe supply is a foregone conclusion for these individuals and that all that's left is to sort of rearrange the results in a way that maximizes the political success of the safe supply project.

As an example of this, I want to draw the committee's attention to a recent report that was published just in January of this year, January 2022. This report was published by the London InterCommunity Health Centre, and the report title was Safer Opioid Supply Program. It was conducted in London, Ontario. The chief lead is Dr. Andrea Sereda. She's another safe supply pioneer here in Canada. This report looked at about 250 patients, who they followed for about a year's time. These patients were all provided a safe supply. They were provided very high doses of hydromorphone to be used as they pleased.

As evidence of the success for the safe supply program the report authors boast a 94 per cent treatment retention rate. Again, it's unsurprising finding that when you're someone with a severe opioid addiction, you're much more likely to be retained in treatment if provided high doses of hydromorphone. But we should ask: what happened to those 6 per cent of individuals who weren't retained in treatment? When you comb through the report, it gives no real indication other than that these individuals are, quote, no longer enrolled. That's about as much information as you get from the report.

In fact, it was only during a web task that was launched to talk about the report that Dr. Sereda, when asked directly, acknowledged that some of those 16 clients, who were, quote, no longer enrolled, as said in the report, in fact died from a fentanyl overdose or died from infections related to injection drug use. Others were incarcerated or ended up in long-term care facilities. This is a problem because the report said nothing of that. They didn't mention it, and it presents a misleading sort of picture for the safety and efficacy of the safe supply program. I'm tempted to call it a kind of whitewashing of the data, which I think is deeply troubling.

But these tactics are frequently successful. For instance, uncritical journalists at the CBC: they kind of see that report, and they sort of accept the positive spin of it kind of on the face of it, and they write articles which are supportive of safe supply. I think, in this way, this is kind of how the program has gained so much political momentum over recent years. I see that as a big problem.

Fundamentally, I want to argue that those who are struggling with addiction and homelessness deserve so much more than a supply of opioids. I feel strongly that safe supply undermines what should be the central focus of our drug policy, which is to free the drug user from the mental prison that is addiction. Safe supply undermines that. I feel strongly that recovery is within reach for everybody, but we need a strategy that fosters agency, self-esteem, and a sense of purpose for the drug user.

As a physician I don't feel that I can prescribe that as I can hydromorphone. It's a deeper problem that requires a deeper solution. I feel that in that goal of achieving recovery, we can look to some of the European countries, which are very progressive and had a lot more success in managing this issue than we have in Canada. I'll mention briefly Portugal. It's the drug treatment system that I'm somewhat familiar with.

In Portugal the state will fund up to three years of in-patient rehabilitative care for those who really need it. And the state, once you're sort of released from rehab, will supply or will fund some of the salary for when you get back into the workforce. These sorts of creative ways of helping someone maintain recovery, for which work is a vital element sometimes, I think go a really long way and are so much more powerful than safe supply.

I want to end my discussion just by quoting Dr. Goulão, who is one of the architects of the Portuguese health care system. He summarizes his philosophy just in these few words. Let me pull them up. He says: our first goal is to help people resume their dignity; that's the most important thing, to give them the self-esteem that they've lost.

Thank you so much, committee, for listening to my thoughts on this issue. It's been a real privilege for me. I'm more than happy to answer any questions that the committee may have.

Thank you.

The Chair: Thank you, Doctor, for your presentation and your obvious heart on this issue. I appreciate that.

First up we have MLA Rosin.

9:50

Ms Rosin: Okay. I think we've got a bit of an echo. Okay; we're good. It's just the chair; not me.

Well, thank you for your presentation. I see that you are a psychiatry resident at the department of psychology, neuroscience and behaviour at McMaster University. I think that's interesting for this discussion because one of the most prominent arguments I hear in favour of safe supply is that groups or individuals who support

safe supply do still want addicts to get clean at some point, but many addicts aren't mentally ready yet, or they're not fit to take that step into recovery yet, so safe supply is a good way to just kind of keep them where they are, keep them safe, reduce harm because they're not mentally ready to take that step. I would be curious to hear, from your background in psychiatry, what you would say to those claims and, from a psychological standpoint, what your opinion would be on such an assertion.

Dr. Devine: Excellent question. Thank you so much. If I could just speak from sort of personal experience, from a recent patient encounter that I had on the ward just a couple of weeks ago. I'm going to keep it, of course, very vague, just respecting patient confidentiality. I was asked to see a man who was admitted to hospital after a stroke that was a consequence of injection drug use. This was a young man. He was in his 30s, and he had already somehow ended up being prescribed a safe supply. He was someone who struggled with homelessness, he was in and out of shelters, at a motel, and he had ended up being prescribed a safe supply.

When I saw him on the ward, I found him in a moment of tearfulness. He told me that he was thinking about his drug use and how it's impacted his family, how he's been unable to really care for his mother, who had some health conditions. He felt really mixed about his drug use. Of course, I'm interested in safe supply, and I asked him a little bit about how he felt being on a program which distributes him high doses of hydromorphone and, I feel, enables addiction. He said that he hated it. He wanted to be done with addiction. He wanted recovery. In fact, this young man – he had, as I recall, about a year of sober time in his past, which tells me off the bat that, of course, this is something that he can achieve. He's done it in the past.

Then I remember speaking with him; I was hoping to direct him again in that direction. I just think of the two options for him: on the one hand, we can ask him to re-enter rehab, to gain some self-esteem, to get some agency, to commit to sort of a better life, or we could discharge him on a safe supply and feel that we've done our due diligence and that he's protected with his opioids. There's really a crossroad kind of moment for him.

I feel that maybe I've lost track of your initial question, but it's this idea of readiness, that safe supply is an alternative to recovery, which is, I think, wrong and undersells the potential of a person. I hope that helps.

Ms Rosin: Yeah. I just have one follow-up. Of the patients that you've dealt with or of individuals you haven't dealt with but maybe have seen or spoken with who have been prescribed safe supply, do you have any estimation for how many of them are prescribed safe supply because they asserted that they were not ready to take the step to recovery versus how many were prescribed safe supply because the government decided for them that they weren't ready to take that step?

Dr. Devine: Excellent question. It gets to the thorny nature of sort of consent and what people truly want. What someone wants in the moment of desperation and withdrawal might very well be a safe supply. In that moment they might want that. But then, as they have time to settle and reflect, is that really what they want for the rest of their life? It's this idea that drug users are rational actors and can freely choose what they want at the moment. I don't agree with that.

That's why I really wish, as a psychiatrist working in Canada, that we had a bit more of an assertive treatment regimen like out in Portugal, which directs people even in tough moments towards recovery. Portugal, for instance – I know you guys heard testimony from Mr. Shellenberger on this issue – they have a drug dissuasion commission, which assertively directs patients towards treatment. I don't think that a lot of the time individuals are freely choosing safe supply. I think it's done out of desperation and just in the moment. I don't think it really reflects their true interests.

Thank you.

Mrs. Frey: Hello. I don't know if I'm working. There I am. Okay.

I really was struck by what you said about having a strategy that fosters agency. In your opinion as a physician, how do you find that agency and personal autonomy fit in when we're talking about safe supply? Advocates would say that, you know, somebody is coming to the doctor to get this prescription, blah, blah, blah, but if the goal is freedom from addiction, if the goal is recovery, how do you find that agency factors into the safe supply conversation?

Dr. Devine: I feel that it completely erases it. I think that's the crux of it. I don't think that safe supply respects the agency of the individual. You know, I think that some advocates will argue, "Well, we're empowering them; we're freeing them from reliance on the street supply, and they'll be more free to make decisions in their life," but I just can't see the logic there.

You know, we have to remember that opioids have been historically classified as narcotics, and to be pedantic just for a second, narcotic comes from the word "narkoun," which means to numb. Opioids numb the individual; they don't treat anything. They glaze over deeper issues and traumas and personal demons. I just can't see what's healthy and progressive about that.

So I feel strongly that safe supply undermines agency in the setting of addiction, which is the only true source of sort of self-determination and ultimately liberation from addiction, which, I think, people want deep down.

The Chair: Thank you.

A supplemental?

Mrs. Frey: Yeah. I guess it's kind of on a different vein. In your position as a physician, I know that part of the Hippocratic oath is to first do no harm. I certainly, personally, have an issue when I hear things like safe supply, and I wonder how that even fits into a physician's Hippocratic oath, and that's just from – and I'm not a physician at all; I'm a politician. I mean, maybe I don't know. Maybe there's something I'm missing. I was wondering if you could expand on that. Basically, how do you think that you are able to respect your oath and still practise safe supply?

Dr. Devine: Yeah. You know, it's such an interesting question. I think intellectually with psychiatry we've been criticized in the past, my field, as sort of offering medication solutions to deeper rooted human problems, and often I've been able to sort of push back against that for my work with thoughtful colleagues at McMaster, who I think really do try to understand those issues and try to get someone better. But when it comes to the issue of safe supply, I have a hard time dispelling that idea that we are sort of just distributing high doses of opioids not for the benefit of the patient but maybe for the benefit of law enforcement, because the patient isn't using as much drugs on the street, they're not getting into as much trouble, or maybe for the taxpayer because some of these studies claim that safe supply results in less money from the taxpayer.

As a physician our sole goal, my sole goal is empowering the individual towards health. I don't care about the taxpayer or if sort of the police have a harder job; I have to think what's in the best interest of the patient. Safe supply complicates that because it asks

us to consider prescribing something for vague societal benefits or health care costs.

That's sort of how I think of that issue. Thank you.

The Chair: MLA Amery.

Mr. Amery: Yeah. Thank you very much, Chair. Good morning, Dr. Devine, and thank you for your presentation here this morning. I can certainly see your passion in the area, and it's incredibly encouraging to hear from those on the front lines.

Now, I don't know if you watched any of these committee proceedings, but I have a particular interest in finding out as much about the possible successes and/or failures of safe or open drug supplies in jurisdictions that have already implemented or tried these policies, especially here in Canada and perhaps even in the U.S. Now, we've heard throughout our review terms like, quote, unquote, safe supply, addiction maintenance, and so on. Are these terms used synonymously and/or interchangeably? What proportion of patients, in your experience, who receive safe supply opioids then completely abstain from street-acquired opioids?

Dr. Devine: Right. I should clarify that I've seen a generous handful so far of patients who were prescribed a safe supply, and I'm always encountering them when they're in the emergency department or admitted to hospital for a complication of drug use, yet they're enrolled in a safe supply program, which is theoretically supposed to ameliorate that or address it. So I would say, off the bat, that a hundred per cent of patients prescribed a safe supply continue, in my experience, to use fentanyl to some degree on the street. And we heard that from that quote from Dr. Tyndall, who's enrolled patients on an opioid-dispensing machine: 90 per cent continued to use sort of fentanyl at a certain time point, and we don't even know down the road what percentage that number would be.

Again, other data I've seen sort of out of London: 80 per cent prescribed these doses continue to use fentanyl. Common sense suggests that for individuals with a severe addiction, you're always chasing higher doses. It's not something that you can control; it's in the nature of addiction to want more and more and to seek that escape. So the very principle of safe supply is flawed, in my opinion.

I think I missed the first part of your question. If you wanted to repeat that.

10:00

Mr. Amery: Yeah. Very quickly. Safe supply and addiction maintenance: are those terms used interchangeably and/or synonymously?

Dr. Devine: Addiction maintenance and safe supply. You know, I think that they – I think I would. I don't really see how safe supply is differentiated from addiction maintenance. I think that in many – the criticism I have of it is that it enables drug use and perpetuates addiction. So I would call it that, but I can't speak for others on that issue.

The Chair: Thank you.

Mr. Amery: Just a quick follow-up if I can, Chair.

The Chair: Go for it.

Mr. Amery: Thank you. Dr. Devine, we heard a lot of the presenters, including, I think, yourself, say that the primary objective and goal – I think all members of this committee would confirm that as well – is addiction recovery. I'm wondering if you can comment, based on your observations and anything else that you might be able to offer to this committee, whether safe supply and addiction recovery can ever be reconciled. And to expand on that, have any subscribing, quote, unquote, safe supply jurisdictions in Canada and/or the U.S. made any meaningful progress towards addiction recovery statistics?

Dr. Devine: Toward addiction recovery statistics. Excellent question. I'll say that I don't see how we can reconcile the practice of safe supply with addiction recovery. I see them fundamentally as sort of opposing forces.

With respect to sort of addiction recovery statistics in Canada, you know, I've tried to research into that. It's very challenging. I don't have great data on that. I'd love if we could have a national effort to figuring that out because I think that it's probably higher than we think it is. Safe supply is fundamentally pessimistic. It tells the individual that they can't sort of grow and overcome addiction and that they can't recover. So I think that we need to focus more on recovery.

The Chair: Thank you.

Next up we have MLA Milliken.

Mr. Milliken: Thank you, Chair. Thank you, Dr. Devine, for being here today. As was stated by my colleague, your passion definitely comes through in the presentation. I guess one of the reasons why our committee has been struck is because it is fair to say – I think it can be stated that there are definitely proponents of safe supply. I've talked to proponents, obviously, and one of the arguments or lines of logic that they use would be that when an individual is enrolled in safe supply, what it does is it offers an opportunity almost for an off-ramp. Every time there's a touchpoint between, say, a doctor who's prescribing and the receiver of the opioids, that could be an opportunity for the doctor to perhaps push the individual towards some of the proven treatments that people agree are proven and evidence based. I guess my question would be: do you think that that's sort of bearing through on the data? Is that actually occurring, or is it a situation perhaps where maybe there are negative externalities associated with safe supply that may end up being sort of more significant? Your thoughts?

Dr. Devine: Yeah. Thank you for the question. That is a frequent line of argument. I remember that when I was a medical student, Toronto was getting its first supervised injection site, and my initial response was sort of: okay; this makes sense to me. Let's provide individuals a safe space to use so that we can make connections with them, as you said, and sort of point them in the right direction. But as I looked a bit deeper into it and I saw some of the rhetoric and what I thought was the ideology out of British Columbia, where these ideas first gained currency, I saw that that was very much not the case. Many caring Canadians will support safe supply and harm reduction as a stepping stone towards recovery. But I have to be clear. That is not what's happening. That is not the direction that we're going in, and that's why I'm so concerned by safe supply.

If I could just give a quick quote by Dr. Mark Tyndall – this is one of the safe supply pioneers who enrols individuals on vending machines – just to give you a thought of how he views recovery and what his thoughts are on that issue. He once said, quote: "One of our messages is to have reasonable expectations for people, so we've really pushed back on this, quote, everybody can recover type thing. People have these unrealistic expectations. Like, if you allow drug users to go to supervised injection sites, we need to get them hooked up with the care, and then we need to get them abstinent and recovered. That so rarely happens to people that I don't have those expectations anymore."

You see here this really alarming shift in how we're thinking of addiction, that it's something that can be maintained and perpetuated and that the whole idea of recovery is somehow antiquated. We have to push back on that so far, and that's really what kind of drove me, I think, to put pen to paper and get my voice out there on the issue.

The Chair: Supplemental?

Mr. Milliken: Yeah. Thank you, Chair. Sometimes I'll just ask what I think is perhaps where the rubber hits the road with regard to the questions. I would say: in your estimation is there a type of safe supply or addiction maintenance program that is, in fact, safe?

Dr. Devine: Yeah. A good question again. You know, I suppose I can see some of the rationale behind sort of maybe those strict heroin injection programs or the strict hydromorphone injection programs, but again this isn't safe supply. These are injectable opioid treatments, which places like the Dutch do, where patients are highly monitored, highly controlled, and it's really best understood as a palliative care approach to the drug user. There's a recognition that that individual is dying from their addiction and there's not much that we can do about it.

With respect to safe supply? No, I don't think that there's anything that can be safely done in that way. That's my personal feeling on it, and I think the data bears it out so far.

The Chair: MLA Stephan.

Mr. Stephan: Thank you. I appreciate your presentation. I appreciate your comment. We have an overdose prevention site in our community, and it is under what is termed a harm reduction pillar. I assume that safe supply would also fall under a harm reduction type of pillar. I'm wondering what your knowledge is about the permanence of these pillars. Why is harm reduction elevated to a pillar that is similar in status as recovery in some of the political messaging that we're hearing?

Dr. Devine: Thank you. Having followed this issue closely, I think that there's something kind of chic about harm reduction. It has a certain radical element to it, a kind of progressiveness. I think there's something really exciting. Many safe supply providers and harm reduction advocates will talk about dismantling kind of what they view as prohibition or the war on drugs. It has a kind of revolutionary kind of extremist excitement about it, and I understand it to some extent. I think that's why they've latched on to harm reduction and taken it to the extreme.

I should say that Canada, regrettably, is where harm reduction has gained the most momentum. Our drug policy has been completely dominated by harm reduction in the past probably five years, maybe even a decade. We've put all of our resources into this novel philosophy, I think partly because of the excitement of it, and we've lost sight of the bigger picture. We've lost sight of the individual who's suffering with addiction and the imperative to move towards recovery, so I think that's where I place kind of the excitement around harm reduction.

Thank you.

The Chair: Supplemental, Member? Oh, you're muted.

Mr. Stephan: I don't have any other questions. Thanks.

The Chair: Thank you.

Excellent. I don't see any other questions at this time.

With that, I would very much like to thank you for your time, Dr. Devine, and your presentation for us today.

Dr. Devine: My pleasure. Thank you so much.

The Chair: Thank you.

We will now take a very quick break. We're a little bit behind, so if members can try and be back in the room by 10:14, that would be excellent.

[The committee adjourned from 10:09 a.m. to 10:14 a.m.]

The Chair: Hello, Doctor – I'm going to mispronounce your last name.

Dr. Lembke: Lembke. Dr. Lembke.

The Chair: Lembke. Thank you very much for that. Hello, Dr. Lembke. Thank you for being here today. I apologize; we're a little behind schedule. Sorry to make you wait there, but we'll dive right in.

Dr. Lembke: No problem.

The Chair: So we'll open up for 10 minutes of presentation and then question and answer with our members. Again, very much appreciate you being here. I'll pass it over to you.

Dr. Lembke: Should I go ahead and get started?

The Chair: Yes.

Anna Lembke

Dr. Lembke: Okay. First of all, thank you for having me. I'm honoured to be here. I'd like to cover three major points in the 10 minutes that I have. First of all, I'd like to talk about how the arguments around safe supply and the climate in which these discussions are occurring is very similar to the climate in the United States in the late 1990s right before the paradigm shift in the use of opioids for the treatment of pain, that led to the quadrupling of opioid prescribing in the United States and ultimately caused the opioid epidemic.

Secondly, I think it bears on this discussion to compare and contrast the safe supply that is being proposed with chemicals like heroin and hydromorphone with the use of methadone maintenance and buprenorphine, often referred to as Suboxone, that we currently have as established types of care for the treatment of opioid addiction. I'd like to compare and contrast those.

Thirdly, I'd like to talk about the ways in which I view safe supply as a form of chemical abandonment of vulnerable individuals with addiction, echoing on some of the things that Dr. Devine already touched on.

And then, if there's time, I'd also like to address one of the questions, that was asked of Dr. Devine, regarding whether or not patients are mentally ready to enter into addiction treatment and recovery and how safe supply fits into that.

First, just very briefly, in the late 1990s in the United States there was widespread recognition that we were not doing a good job treating patients with pain, and there was a mantra about the undertreatment of pain and a strong sense of urgency around wanting to do better. This was a real and true thing in medicine and in the state of pain care, but what wasn't real and what wasn't true was that opioids prescribed more liberally by doctors in the treatment of pain would solve this problem. So there was an enormous mismatch between the evidence and this sense of urgency and wanting to really help people with a very serious problem. In fact, the evidence that was used to support more liberal prescribing

of opioids for the treatment of minor and chronic pain conditions consisted of very poor evidence.

Of course, you've heard already from Dr. Devine the ways in which the evidence in favour of safe supply are really not adequate data sources. They're biased. They don't really look more broadly at what's happening in the communities where safe supply is being offered, what happens to the people who drop out of those studies. I just really urge this committee to be very careful and very thoughtful when thinking about safe supply, to acknowledge the fact that we are in the midst of an opioid epidemic, that people are dying, and of course we all care about that problem, but that sense of urgency that we feel to solve it shouldn't cover our eyes to the fact that safe supply is not well supported by the evidence, that one of the biggest risk factors for addiction to anything is simple access to that drug, and that we, in fact, already tried this experiment of more liberally prescribing opioids for pain. That, in fact, is what caused our opioid epidemic.

Second, I'd like to talk about buprenorphine and methadone maintenance and how they are different from things like heroin and hydromorphone. One of the main factors in addiction is that people are caught in this endless cycle of intoxication, withdrawal, craving, drug seeking, intoxication, withdrawal, craving, drug seeking. That consumes all of their energy and creativity and is the essence of what we talk about when we talk about the hijacked brain, that, really, those limbic and reward centres have taken over the grey matter cortex and people are living in their lizard brain, which is sometimes the way we refer to the triune brain or this very primitive pleasure-pain reward system. They're no longer able to access their frontal lobe function, their delayed gratification and future planning function.

What we need to do is get them out of that state, right? One of the ways that we can do that is with sustained abstinence. Of course, that's very painful in the beginning – there's intense craving – but when people get over that state and start to get their frontal lobes back online, then they have real agency, and they can again make informed choices. What methadone maintenance and buprenorphine have as very important, unique properties as opioids is that they have a very long half-life, so they remain in the system for longer than 24 hours once they get to steady state. That means that people are no longer in this cycle of intoxication, withdrawal, drug seeking, intoxication, withdrawal, drug seeking that rules their whole day. They're able to achieve a steady-state blood level, which then allows them to enter into other recovery activities. This is really a fundamental and important difference, and you can see this on any kind of metabolic graph of how methadone and buprenorphine work in the system. They have this long half-life.

10:20

In addition to that, buprenorphine has two other properties that make it a very unique and very safe opioid and hence appropriate in the treatment of opioid use disorder. Buprenorphine has what we call a very strong binding affinity. So if this is the opioid receptor, then this is buprenorphine. Buprenorphine is an opioid. It binds that opioid receptor very, very tightly such that it acts as an antagonist on that receptor so that other opioids can't get in. What you have is buprenorphine binding the opioid receptor, stimulating the opioid receptor, causing that relief from craving. But at the same time if an individual on buprenorphine uses heroin or uses hydromorphone, the heroin and the hydromorphone can't get in because buprenorphine is effectively acting to block that receptor.

Third, buprenorphine has a ceiling effect on respiratory depression. How is it that people die from opioids? Opioids have three main impacts on the brain. Number one, they in the short term relieve physical pain. Number two, they cause euphoria by releasing a whole lot of dopamine in our brain's reward pathway. Number three, they work on the lower brain stem functions to slow down the heart rate and slow down respiration. When people take more opioids than their brain can tolerate, then they slow down their breathing, they slow down their heart rate, they fall asleep, and they don't wake up again.

Over time, as Dr. Devine talked about, people need more and more of their drug to get the same effect in terms of the euphoria and the pain relief. They build up tolerance, but they don't build up the same kind of tolerance at the same rate to the respiratory suppression effect. As they're escalating the dose over time to get that good feeling or to get pain relief, they're slowing down their heart rate, they're slowing down their respiratory rate, and eventually it's too much and they accidentally overdose and die.

Buprenorphine has a ceiling effect on respiratory suppression. It's very difficult, in fact, to overdose on buprenorphine, especially when taken alone, because it doesn't slow down the heart rate and respiratory effect in the same way. When I'm teaching medical students about the unique properties of methadone maintenance and buprenorphine, I talk about doing the buprenorphine dance. I say there is a long half-life, there is a tight binding affinity, and there is a ceiling effect on respiratory suppression.

Finally, I want to just speak to this issue of chemical abandonment. I really do agree with Dr. Devine that prescribing a pill or giving these vulnerable people drugs is really the easy way out. Where we need to put our resources is into recovery treatments, recovery housing, recovery communities. This is really where there's hope and where there's optimism and what these people deserve. I really do believe that to just throw hydromorphone and heroin at people without the evidence to support these interventions is a kind of easy way out and a kind of chemical abandonment.

Finally, I want to just talk very briefly to the question that was asked about patients being mentally ready. You know, one of the things that I teach my residents and my medical students – I'll say, "Go evaluate that person in the emergency room who is there because they're intoxicated from alcohol, in an alcohol withdrawal, and see what you find out." They'll come back to me and they'll say: "Dr. Lembke, that person is not at all interested in treatment. They just want to be discharged from the emergency room." I say, "Okay; now I want you to wait and then, if we have the opportunity, I want you to go back and interview that person a day later or two days later, once they're through the worst of their alcohol withdrawal." What my students will come back and report to me is: "You wouldn't believe it, Dr. Lembke. Now they're interested in treatment."

What's the difference? They got through the worst of their withdrawal. They got through the chemical hijacking of their brain, which is the nature of the disease of addiction. What happens as soon as we get that huge surge of dopamine in response to any intoxicant is that it's followed by a dopamine deficit state, which is what constitutes craving. In that state the overpowering physiologic urge to need to get more drug pushes out every other consideration. The key there, in that vulnerable moment, is not to offer that individual heroin or hydromorphone without an evidence base to support it but, rather, to offer that person addiction treatment recovery, evidence-based recovery.

I want to emphasize that that can sometimes be an opioid in the form of buprenorphine or methadone maintenance, but remember that buprenorphine and methadone maintenance have multiple placebo-controlled trials across generations and continents showing their efficacy in the treatment of opioid use disorder. We did not enter into those treatments lightly.

Thank you so much for giving me the time to speak today.

The Chair: Thank you, Dr. Lembke.

We're going to open it up for Q and A, but before we do that, if Member Sigurdson could introduce himself for the record.

Mr. Sigurdson: Thank you, Chair. R.J. Sigurdson, MLA for Highwood. Just very glad to be here today and to hear the presentations. Thank you very much, Chair, for the opportunity to introduce myself.

The Chair: Perfect. Thank you, Member.

We will now open up for questions and answers.

Mr. Yao: Dr. Lembke, thank you so much for taking the time to speak with us here today. What I got out of your presentation was that there might actually be different definitions of what safe supply is and that you might support the concept that provides more clinically safe drugs like buprenorphine, which, again, has things like less ability for respiratory depression than, say, your fentanyls and that. Please clarify that we need to really truly define what is safe supply and then identify what we would support in that case, and that might not necessarily be the street drugs that are being provided in jurisdictions like British Columbia.

Dr. Lembke: Thank you so much for the opportunity to clarify myself. I realize that my statements probably require clarification. Methadone maintenance and buprenorphine are evidence-based treatments for opioid addiction. They are not safe supply. How is that different beyond the pharmacokinetics and the pharmacodynamics of how they work? Because they're studied and because their administration occurs within the context of a treatment setting. You go and see an addiction treatment doctor or at least somebody who has been trained in how to administer these drugs for opioid use disorder. It is understood that you are working to get into recovery.

That administration of buprenorphine and methadone maintenance occurs in the context of regular urine drug screens, regular looking at the prescription drug monitoring database and making sure that you're not getting your supply, getting drugs, from somewhere else. Recovery is defined as: you are not using your addictive drugs. You're getting buprenorphine from me, but that's medication to treat your opioid use disorder. That's not just one more stop in your chain of drugs that you're acquiring.

Furthermore, when we have patients who we get on buprenorphine and their urine tox screen continues to demonstrate that they are using other opioids, we will eventually not continue buprenorphine. We will say: this is not working; this is not helping you to get into recovery.

One of the questions that was asked of Dr. Devine was: is there evidence that safe supply gets people into recovery? I don't know what that evidence is, but I haven't seen such robust evidence yet. When we prescribe methadone and buprenorphine, we are doing it in a recovery setting. We are providing treatment. We are treatment.

The Chair: Supplemental?

Mr. Yao: Yeah. Thank you so much for that. Just to clarify that rehabilitation is a complex issue. Even a portion of it in providing these medications to appease a physiological reaction to withdrawal and whatnot: it's not just about providing the drugs. There's a more holistic approach to this.

Dr. Lembke: Yes. Thank you. Again, what it does is that it allows the person to get into – this is, by the way, a person who has severe opioid use disorder who has not been able to abstain. It gets them into a physiologic state where then they are able to actively engage in recovery treatment, go to groups, go to peer recovery, get individual treatment, re-engage with their families, re-engage with their work, re-engage with their lives – right? – re-engage with their community. It's not a form of chemical abandonment. It's a way to allow people to get into recovery and re-engage with their lives and be important, contributing members of society.

10:30

The Chair: Thank you, Doctor.

MLA Milliken.

Mr. Milliken: Sure. Thank you, Dr. Lembke, so much for appearing here today. You are, I believe, currently a professor and medical director of addiction medicine at Stanford University. This is to say that it could be considered that you are a teacher of addiction medicine at one of North America's leading universities. And I think, based on some of the presentation and even in your recent answer to my colleague, it could be viewed that you would probably take more of a holistic harm reduction type of viewpoint with regard to how to treat opioid-addicted individuals. I don't want to put you on the spot, but would you be willing to just go a little bit deeper into your bio as to the reason perhaps, with your expertise, why you're here today?

Dr. Lembke: Are you referring to the book I wrote or something else in particular?

Mr. Milliken: Some of your experiences that would lend it to be the reason behind why you would be here today.

Dr. Lembke: Well, I published a book called *Drug Dealer, MD: How Doctors Were Duped, Patients Got Hooked, and Why It's So Hard to Stop.* This is a book that's looked at the origins of the opioid epidemic in the United States. It was cited by the *New York Times* as one of the top five books to read to understand the opioid epidemic in the United States. What I argue in that book is that supply or access to drugs is one of the biggest risk factors for becoming addicted and dying from drugs. Of course, there are other risk factors. There are genetic risk factors. There are developmental and trauma-related risk factors. But one of the simplest and most important risk factors to this discussion is simple access to drugs, which increases addiction at the individual and the population levels.

I'm also the founder of our addiction medicine dual diagnosis clinic, which is a holistic harm reduction clinic. We prescribe buprenorphine. We believe in harm reduction, but we believe in harm reduction as a pathway to recovery.

Mr. Milliken: Okay. And just to build also on what my colleague had mentioned, in your presentation you talked about buprenorphine or Suboxone being what seems to be, at least, promising or valuable as part of a kit or as part of a puzzle with regard to helping individuals who have issues with regard to OUD. My question was going to be: potentially what other investments or policy kind of directions should perhaps our jurisdiction, which is going through some of the issues that obviously your jurisdiction in America is going through as well – but I think you kind of listed that. I guess what I would do is just take it a little bit further, then. Is there evidence or data to show that for somebody who is perhaps being treated along the lines of Suboxone use with other surrounding, enveloping strategies, whether it's group therapy, things of that nature, there is a pathway to recovery on that relative to perhaps any data that there might be with regard to that same recovery focus or recovery result through individuals who would be on safe supply and then also still possibly have the opportunity for some of those other enveloping strategies as well?

Dr. Lembke: Yes. Thank you. The data for the efficacy of buprenorphine and methadone maintenance in the treatment of opioid use disorder is probably one of the most robust data sources we have for the treatment of any addictive disorder in all of addiction medicine. Not only has the treatment with methadone maintenance and buprenorphine been shown to reduce the use of other opioids and illicit opioids; it's also been shown to reduce involvement in crime, reduce transmission of HIV and other infectious diseases, and to improve overall quality of life. I think these are really, really important sources of evidence that we really have to, you know, sort of hang our hat on, and we need to expect the same of the evidence for safe supply if we're really going to implement safe supply.

So far safe supply has not demonstrated that to be the case. I am not aware of any evidence showing that safe supply helps people get into treatment and into recovery. That's, of course, you know, always been the dream and the idea, but I'm not sure that there's evidence to support that. That's why I really want this committee to be very, very careful and not get ahead of the evidence.

The Chair: Thank you, Doctor.

Any other questions?

Mr. Milliken: I think you may have been on for the previous presenter as well, so I'll ask the same question – it won't be verbatim, but it will be along a similar vein – and you kind of touched on it with your response just now. A lot of proponents of safe supply would genuinely come to a discussion surrounding safe supply with this line of logic that every single time an individual who has OUD ends up in front of some sort of caretaker, where perhaps they are being prescribed opioids, it's an opportunity for that caregiver, or doctor as one example, to try to intervene with regard to their opioid use by perhaps sending them towards more evidence-based treatments. What would you say to somebody who would talk to you with that line of logic and say that? Like, how could it be possible to dissuade from that kind of logic? I've heard it from a lot of proponents of safe supply. I'm not trying to answer it on your behalf or whatever, but I think you kind of mentioned something with regard to whether or not the data bears that out.

Dr. Lembke: Yeah. I think this is what the proponents of safe supply are getting at. There's a piece of this that is true and real, which is that there is a golden moment when we need to intervene to get a person with severe addiction on the right path and not on the path toward worsening addiction and death. So the question then becomes: how do we do that? The way we need to do that is to lower the barrier to access evidence-based treatment for opioid addiction and other addictions. The way that we go against that is, in fact, to in that moment of crisis offer things like heroin and hydromorphone, which are not evidence based and which, as far as we can tell, just perpetuate the cycle of addiction.

The evidence is really key, if you can show me evidence that, you know, giving hydromorphone or heroin allows people to become more functional in their lives, allows people to get jobs, decreases involvement in crime, decreases transmission of HIV, decreases the overdose risk not just in that setting but broadly in the community. We can't just look at that one data point; there's so much confirmation bias around that. We have to look at the ripple effect from those sites in the community. Are overdoses in the community going down? I haven't seen data to show that.

Further, I will just liken it again to the opioid epidemic and emphasize that pain doctors in the early 2000s would prescribe opioids for minor and chronic pain conditions, and patients would come back and say, "You're the best doctor; you're the only one who understands me," because, of course, in the short term opioids are an amazing treatment for pain. In the long term they don't work, and they get people on this terrible path toward physiological dependence and, in some cases, addiction and overdose death.

But the confirmation bias there was overwhelming, such that you had this whole cohort of doctors who were desperate to help people with pain – pain is awful; chronic pain is so debilitating – and then in that moment of their sliced interaction they became wild proponents of this liberal opioid prescribing. It was only when we looked broadly at the data on diversion and misuse and overdose, when we looked at it from a population level, because addiction is a public health problem as well as being the problem of an individual, that we could see: oh, my goodness, this has been an unmitigated disaster.

The Chair: Thank you, Doctor.

Any other questions from the committee?

All right. Hearing and seeing none, thank you, Dr. Lembke, for joining us and for your presentation today. I very much appreciate that.

10:40

All right. We will continue to move along. We have now with us Dr. Keith Humphreys. Thank you, Doctor, for being here with us today. We're going to open it up to you for 10 minutes of presentation and then 20 minutes of question and answer with our members. I will pass it over to you.

Keith Humphreys

Dr. Humphreys: Thank you very much for the honour of getting to speak to you today. I did send in some slides. Could the clerk put those up?

The Chair: Yes. We'll do that right away.

Dr. Humphreys: Terrific. Thank you so much.

My name is Keith Humphreys. I'm a professor at Stanford University. I'm a former White House drug policy adviser to President Barack Obama and President George W. Bush, and I'm speaking today as the chair of the Stanford-*Lancet* Commission on the North American Opioid Crisis. This is a group that was founded by *The Lancet*, which is, I believe, the world's most influential medical journal, in partnership with Stanford University looking at the situation of the United States and Canada, and we came to some conclusions about the topic that you're wrestling with today.

Could we go to the next slide, please. Thank you. There were 17 of us who worked for 18 months, beginning in February 2020. It was a very diverse group, so experts in addiction medicine, biochemistry, emergency medicine, epidemiology, also experts in law, in pain medicine, in policy analysis. We were also diverse in terms of backgrounds: clinicians, researchers, educators, policy-makers, also people with lived experience of chronic pain and of addiction.

To the next slide, please. These are who our commission members were. They are all leaders in the field, in fact also including Dr. Lembke, who was a member of the commission, who you just met. It includes former advisers to Presidents, people who led various significant issues in health. We set a standard that for us to recommend anything, 90 per cent of the group had to agree on it. We were able to attain that in many different areas, and that's not always easy to maintain, just sort of a cat-herding exercise. But the things I'm going to say today were supported by everybody on the commission.

Please go to the next slide. Here's the simple question: why do we have an opioid crisis? How did this all start in the United States and in Canada?

Next slide, please. It came about very simply, from an oversupply of drugs in the community, specifically opioids. This is data from the peak of prescribing in our two nations, which was around 2011, and compares the U.S. and Canada to every other developed nation, and what you can see is that the U.S. is extremely off the chart, Canada not quite as high but also way off the chart, you know, four, five, six times what you see in other developed countries. This is how it started, a massive spread of opioids in the community.

If you go to the next slide, please. Why did this happen? This was the commission's analysis. What opioid manufacturers claimed, prior to all of this, and regulators conceded were the following four things: first, that legally produced, clearly labelled opioids are low-risk medications; second, that being concerned about the risk of opioids is opiophobia, old fashioned, that you need to let that go; third, they said that public health would benefit by increased distribution of opioids; and then, fourth, that controlled drugs will be consistently taken as directed and only by the person to whom they are prescribed. We will return to these assumptions in a minute.

Please go to the next slide. What turned out to actually be true? Well, first off, being legally produced and prescribed did not make these medications safe. Millions of people became addicted to them; millions of people still are. Hundreds of thousands of people died of overdose.

Second, understating the risk of opioids is dangerous. In some cases it was criminal; in the case of Purdue Pharma, for example. So being worried about these drugs is not opiophobia; it is, in fact, rational.

Third, contrary to the idea that public health and safety would inherently benefit, the 400 per cent increase in distribution of opioids in the U.S. and Canada caused, you know, trillions of dollars of damage to our countries.

Last, the faith that controlled drugs will be taken as directed was wrong. When large numbers of controlled drugs go out to the community, they are frequently diverted to other people – they may be shared; they may be stolen; they may be sold – and that spreads harm far beyond the person to whom they were prescribed.

That's what happened. All those assumptions were wrong.

Now please go to the next slide. We're now in the present moment. What are safe supply advocates claiming, and what are regulators such as yourselves being asked to concede? These should all look familiar: legally produced, clearly labelled opioids are low-risk medications; being concerned about the risk of opioids is opiophobia; public health would benefit by increased distribution of opioids; and the controlled drugs will be consistently taken as directed, only by the person to whom they are prescribed. You can insert here whichever quote you like to use in these situations: those who forget history are condemned to repeat it; insanity is doing the same thing over and over again and expecting a different result. Maybe we should just say: fool me once, shame on you; fool me twice, shame on me. The fact that these same messages are being said by people who are advocates not connected to the industry does not make them any more true.

Please go to the next slide. Here is the actual text from our commission report, which I'm happy to provide to you, what we said about safe supply.

> Evidence clearly shows the folly of assuming that population health inherently improves when health-care systems provide as many opioids as possible with as few regulatory constraints as possible. Policies that should attract scepticism include the dispensing of hydromorphone from vending machines and prescribing a range of potent opioids and other drugs ([for example], benzodiazepines, stimulants) to individuals with [opioid use disorder] in hopes of creating a safe addictive-drug supply.
>
> Although expressed from a public health viewpoint, these messages echo the opioid manufacturers in presuming that unrestricted opioid provision can only improve public health. The faith of some advocates that opioids are safe as long as they are not derived from illicit markets is impossible to reconcile with the hundreds of thousands of overdose deaths from legal, pharmaceutical grade opioids that preceded the introduction of fentanyl into US and Canadian heroin markets.

Next slide, please. We clearly do not have faith in this approach as a commission, but we don't despair. There are many policies that can work and can save lives, which is something everybody wants to do. There are many recommendations in the report; I will just highlight four alternatives.

One is to permanently mainstream recovery-oriented addiction care within health and social care systems. Care is often underfunded. It's often fragmented. It's often not connected to the rest of the health care system. If it were, that would save lives.

Second, we absolutely support offering medications for opioid use disorder to all patients with the disorder; in other words, methadone maintenance, buprenorphine maintenance. The commission noted that the evidence for these is very, very strong. They are not the same thing as just handing out opioids or methamphetamine or drugs in the community. They are clinical interventions, and they absolutely save lives.

Third, we should promote opioid stewardship in medicine. It's not just the amount of opioids; it's where they are prescribed and how monitored they are. Some of the other testimony has gotten into this, but just to give you an example, Germany is the one nation that prescribes opioids at the same level as Canada, and they do not have an opioid crisis. And you think: why is that so if they have the same volume of opioids? It's because almost all their opioid prescribing is in hospitals and other supervised settings. The difference between Canada and Germany is that there are about four times as many people in Canada walking around with ambulatory opioid prescriptions; in other words, leaving with a bunch of pills and being unsupervised. Once you do that, you know you're going to have spillovers into the community, into people to whom they were not prescribed. It's not that you can't provide opioids. Like, for example, you have hydromorphone clinics under supervision in Canada. That is a really different beast than just handing the drug out and hoping for the best.

Last, we can think about prevention. I mean, the committee talked about and recommended investing in the healthy development of young people, sometimes through traditional prevention programs, sometimes just through programs that advance the health particularly of kids in low-income environments, whether that's school readiness programs or nurse visiting programs for moms and moms-to-be.

Last slide. Thank you very much. That was the conclusion to the commission, and I'm very happy to answer any questions that you may have.

The Chair: Thank you, Dr. Humphreys.

First we have MLA Amery.

Mr. Amery: Morning, Dr. Humphreys, and thank you very much for your presentation here this morning. I'm looking at the executive summary on this commission report: "The Stanford-*Lancet* Commission was formed in response to the soaring opioid-related morbidity and mortality [rates] that the [U.S.] and Canada have experienced." In February of this year, as you had just mentioned, the commission on the North American opioid crisis

published Responding to the Opioid Crisis in North America and Beyond: Recommendations of the Stanford-*Lancet* Commission. I understand that you were the author of this report.

10:50

With respect to safe supply the report indicated that policies that should attract skepticism include the dispensing of hydromorphone from vending machines and providing a range of potent opioids and other drugs to individuals with opioid use disorder in the hopes of creating a safe addictive-drug supply. In addition to that, Doctor, it's further indicated that the faith of some of the advocates that opioids are safe as long as they are not derived from illicit markets is impossible to reconcile with the hundreds of thousands of overdose deaths from legal pharmaceutical-grade opioids that preceded the introduction of fentanyl into U.S. and Canadian markets.

Now, I'm wondering if you can comment to this committee, whether it be in your personal experience or whatever you may have encountered throughout your studies and in creating this report, whether those who did receive safe supply opioids were still acquiring drugs from illicit markets and whether there was a corresponding increase in the rate of addictions and overdose in these safe supply jurisdictions that you analyzed.

Dr. Humphreys: Thank you for that question. I do want to clarify that although I was the leader of the commission, all 17 of us wrote the report together, so it reflects the opinion of a broad group of people.

It is definitely true that even people in, you know, high-quality treatment programs, like the buprenorphine clinics, still use other drugs. It varies on the rate, but it's not unusual at all to see people also, for example, using some opioids on top of, as they say, or using cocaine and so on.

The critical difference with safe supply is the use by people who are not patients in the clinic. You know, someone mentioned a study earlier following 17 people who were given drugs in the community and evaluating how many of them are still using fentanyl. We have to remember that anyone they shared those drugs with, anyone who may have started an addiction from those drugs, anyone who may have died from those drugs would not be in those kinds of studies, so that literature is silent about the expanding risk. We know for a fact – it is not hypothetical – that when we flood communities with drugs, they spread beyond the person who gets the actual prescription. There's no way to assess, and that is a weakness in safe supply studies. Because they don't admit the possibility that someone else could be harmed, they don't measure the possibility, but the fact they chose not to do that doesn't mean that it isn't there.

The Chair: Supplemental? No?

MLA Rosin.

Ms Rosin: Okay. Thank you for your presentation today on the report, which was actually referenced by someone earlier in our week of deliberations. It's great to actually have you here as chair and as the author of that report.

I think it's interesting, something you said, because one of the most common arguments in favour of safe supply from proponents of such a program is that it is a harm reduction tool, and individuals who are not ready to take that step into a better future and receive treatment can at least have harm reduced through provision of safe opioids. But you said something profound, which I thought was in stark contrast to that, which was that safe supply spreads harm, which is essentially the entire opposite of what proponents of safe supply would normally argue. I'm just curious what you would say to individuals about that claim that safe supply is a harm reduction tool.

Dr. Humphreys: Well, harm reduction is an empirical claim. I mean, you know, if I just call something harm reducing, I have to show you evidence that harm is, in fact, lower. If it is true that distributing, say, OxyContin widely reduced harm or would reduce harm, why did all these people die? All the evidence shows that we had a surge in overdose rates, so it's just claiming that label but providing no evidence that harm is in fact reduced.

We also know that even people – if you were in a household where someone prescribed OxyContin, a different person in the household, your risk of developing an addiction went up, whether that was a kid going through the medicine cabinet or somebody visiting the home, relatives taking those drugs as well. You cause more harm, so the person who is the patient becomes the vector for more people to become addicted.

In science we have to actually show evidence to declare that something is harm reducing, just like, you know, we don't say: I provide effective treatment. I don't call it effective until I see that, in fact, it is. I think the bar has been set too low here, that just labelling something as harm reduction implies that there's strong evidence that it reduces harm. We don't have that proof at all.

Ms Rosin: Would you argue that safe supply potentially does the opposite of reducing harm?

Dr. Humphreys: It entirely could. As I mentioned – you know, when people are very enthusiastic about something, they usually design studies in such a way that it's hard for negative effects to show up. I cannot prove one way or the other, because it hasn't been studied, whether there's any diversion.

But if we just think about it fairly rationally, if we get to the point where – if I go to a clinic and I say, "I need 30 days of hydromorphone and 30 days of crystal methamphetamine and 30 days' worth of benzodiazepine," the odds that I will take all that myself are pretty low. I will probably share some of it. I may sell some of it, and that can include to people who are not addicted, so the rate of addiction goes up because of these safe supply programs. I could also share drugs or sell drugs to people who don't have my level of tolerance. While I could take that combination of drugs, they can't, and they die. Those are real risks, and they're not hypothetical.

This happened all the time during the opioid crisis. Prescriptions went to people other than to whom they were prescribed, and the fact that that hasn't even been considered says to me that people are too much trapped in enthusiasm and not willing to do the careful testing to make sure that what they're doing is not going to do more harm than good.

Ms Rosin: Thank you.

I have one further question. One other claim made by proponents of safe supply often is that we have more of a drug poisoning crisis than we have an addictions crisis. I am wondering if through *The Lancet* reports, studies, and research they found any statistics related to the ratio of those who overdose from a drug poisoning versus just from an ordinary overdose, whether intentional or not intentional or they survive or they don't. Yeah. Is there any data either way?

Dr. Humphreys: Yes. We have seen a transition of overdoses since this all started. Now they are primarily from synthetic opioids like fentanyl although if we call them all poisoning, we are sort of assuming that no one is using fentanyl intentionally, which is probably not the case.

There's still, though, an addiction crisis. I mean, saying that addiction isn't a big deal makes sense unless you've ever been addicted or known somebody who is. You know, it's a very

unpleasant state to be in. It has high morbidity apart from the risk of mortality. It's very hard on families; it's very hard on communities. So I wouldn't dismiss it.

And, last, there are plenty of smart things we can do about overdose. Just to take one thing, *The Lancet*'s model shows that widespread provision of naloxone, the opioid rescue medication, is the number one policy that would greatly reduce opioid overdoses. It's not as if we are powerless to respond to this apart from just handing out more opioids, as we did during the first wave of this crisis.

The Chair: MLA Milliken.

Mr. Milliken: Sure. Thank you very much, Chair. Thank you, Dr. Humphreys, for being here and for your presentation. I'm going to make my questions, I think, pretty direct, I guess, is the best way to put it. I've asked several individuals who've presented to us something of a similar vein, so I'll ask it to you as well. Is there any evidence that safe supply policies that have been implemented in jurisdictions decrease the rate of addiction and/or lethal or nonlethal overdose?

Dr. Humphreys: No. The evidence is nowhere near at that level, in part because of this challenge of not looking beyond the person enrolled in the program. We cannot make that claim.

Mr. Milliken: Thank you.

Second, a very similar question: is there any evidence that safe supply policies implemented in jurisdictions, as we've seen, increase the rate of addiction and/or lethal or nonlethal overdoses?

Dr. Humphreys: I don't think we know the answer to that question.

Mr. Milliken: Okay. Can I ask one more?

The Chair: Yep.

Mr. Milliken: Your presentation had an interesting part to it in your recommendations. I'm going to pull it up on this. Your fourth actually talked about something that we haven't – it's the first time that I think I've heard this as one of the potential ideas with regard to policy recommendations. The fourth one was to invest in a healthy development of young people. I'm curious. I'm not in any way, shape, or form trying to dispute that. It seems pretty logical on its face, but again we've talked a lot about evidence and data. Have we got any jurisdictions, perhaps in America, where they've implemented policies like this? And has that led to any sort of statistical advantage with regard to opioid use in those general areas?

11:00

Dr. Humphreys: Yeah. We're talking about long-term investments, first off. These are not things that will show up in 12 months. But you can look at both well-evidenced prevention programs like communities that care – that is a good example – that strengthen basic capacities in kids like the ability to recognize and manage emotion, to exercise behavioural self-control, and to form positive connections with other people. Those have long-term benefits in terms of reduced smoking, drinking, use of drugs, and also lots of other things that we worry about with kids like lower rates of depression, lower rates of getting involved with crime, lower rates of flunking out of school.

We also know that if you go further back in development to things like, for low-income mothers, the Nurse-Family Partnership, which is a program that sends a nurse out to take care of mom through prenatal care and then stay with her through the early time of becoming a parent, in randomized studies kids in those programs have lower rates of drug use decades later. So, you know, we need to think long term.

I mean, overdose is terrible. We all want to reduce it. But, you know, we have to think long term, just like we can't deal with heart disease by just putting up the paddles available to give a shock to someone who is having a heart attack. Of course you want to save that person, but we will never end the epidemic if we just let the cases accrue and deal with the very severe problems only. We have to think preventatively. That's how we get rid of all epidemics. That's why we say that it's so important to make those investments up front so that we are all not sitting here older and sadder 20 years from now, still grappling with a problem like this.

The Chair: MLA Yao.

Mr. Yao: Thank you so much, Chair, and thank you, Dr. Humphreys, for taking the time to speak with us. I was just hoping you could clarify some comments that you made earlier. You referred to the opioid epidemic of the late 1990s. It is well studied, well documented, and acknowledged by every agency that that was truly an epidemic and, again, well studied. With the push for the concept or the various definitions of what safe supply is, you indicated – and if you could just clarify – that by pushing that agenda, we are demonstrating that we truly haven't taken the lessons that we had from the opioid epidemic of the 1990s.

Thank you.

Dr. Humphreys: Yes. That is absolutely correct. I could take lines out of some things that have been written advocating for safe supply and shift them, replace them with lines from marketing for OxyContin by Purdue Pharma 25 years ago. It is the same message of: the more opioids the better; these are safe; stop being such a fuddy-duddy; stop worrying; let's give these out; good things will result. We should learn the lesson of very recent history, that that is not a good way to promote population health.

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

Mr. Stephan: Hi. Thank you very much for your time in speaking to the committee today. A question I had is: I'm wondering if you had looked at how expensive it is to pursue safe supply as policy. I know for every dollar that we spend as a government on one policy, we may take away a dollar to be spent on another policy. In the area of addiction, for example, safe supply dollars may otherwise be used for addiction recovery services. I'm just wondering if you looked at how expensive a safe supply type of policy would be.

Dr. Humphreys: Thanks for that question. We didn't do economic modelling of that policy, but I will say that your fundamental logic is correct. A previous speaker mentioned, you know, that there is a significant budgetary commitment in the Canadian budget towards this. That money could have been spent on treatment and recovery. Sometimes, when I hear people say that we need to do this because it will get people into treatment and recovery, I wonder, though: wouldn't you get even more people in if you actually spent that money on treatment and recovery? It's just a perspective.

The Chair: A supplemental?

MLA Sigurdson.

Mr. Sigurdson: Thank you, Chair. Thank you, Dr. Humphreys, for your presentation. Just when you were speaking – you were answering MLA Milliken's question – you kind of talked about something as far as long-term strategies and investing in the future.

You kind of commented on the fact that – you know, we've got to look at this in a broad view, and I don't think any of us deny that something needs to be done. But what that should look like is very important to all of us.

I guess my question will revolve around: basically, in your experience, what do you think the chief criteria should be surrounding any drug programs in the future in determining the effectiveness and the success of that program? Do you have any advice that you can provide to us on what that really should look like so that we can measure the success of what we're doing moving forward?

Dr. Humphreys: One of the key points of the commission is that opioids are not good or bad. You know, there is a role for them. We would not want to have medicine without them. They have many uses and benefits. So, you know, our policy towards them should, first off, secure adequate supplies of opioids for those who need them. Second, it should not be initiating people on opioids who do not need them, which happened quite a bit. And then, third, it should improve population health. So that would be both functionality, well-being as well as risk of other types of illnesses, and premature mortality. Those things altogether we have to keep in mind.

We do also have to consider public safety because addiction, unlike, say, high blood pressure, does often have externalities. People do things they would not otherwise do. Some of those things threaten public safety, so we want a policy that also protects people who do not use drugs from behaviour that people might engage in while they are using drugs.

The Chair: A supplemental?

Mr. Sigurdson: Yes. Thank you, Chair. I guess that when you're explaining that – I mean, it hearkens back to what you had mentioned before about when we go down this road of safe supply, that there is an expanding risk component there that definitely needs to be looked at and considered. Maybe this is putting you on the spot a little bit, but when it comes to that and you look at it overall, would you be willing to comment on what you think the ethical concerns are when it comes to moving forward with something like safe supply?

Dr. Humphreys: Sure. And I will just be speaking for myself, because we didn't go into this deeply as a commission. My worries are several. One, we are underestimating the capacity of people to recover. We can give them a bunch of pills and send them away rather than engage them in a meaningful way and see if they would like a different kind of life and whether we would be willing to help them find that kind of life, which may take more effort and may take more money but is doing right by them ethically.

Second, I worry about the expanding scope of where drugs will go. I mean, I have seen people argue in this area that, you know, basically, on the basis of attestation, I should be able to get fentanyl and crystal meth and benzodiazepines. And we just know from the prior experience that that's going to go to other places.

What are we going to do when someone comes in and says, "My friend, my husband, my wife, my son is dead because he got drugs from someone else that came from a doctor who said that they were giving it out in forms of safe supply"? What is that physician going to say? What is the government going to say about why they spent the money that way to introduce more people to drugs that are potentially lethal. Those are really tough questions to grapple with, that I have not seen addressed to this point.

The Chair: MLA Milliken.

Mr. Milliken: Sure. Thank you very much, sir, for being here, again, today. I'm mindful of the time. I'm struck by the report in the sense that it seems to have gone down what a lot of us have been dealing with throughout this committee on an evidence-based, almost like a qualitative side of things. It seems like, of the four points that come out of the report, two are sort of quantitative and two are qualitative.

The qualitative side of things hasn't been discussed quite as much, but I think you kind of answered a bit of it with regard to MLA Sigurdson's question. I'll just give you a quick opportunity. Through your research and experience on this, have you seen a jurisdiction that has inputted safe supply and done so in a way that has led to a safe result?

Dr. Humphreys: No. I don't think we have evidence at all that this has a net benefit for communities, and, you know, I suspect we will not get it, because the people who are wishing it haven't designed evaluations in such a way that they would even detect those kinds of problems.

11:10

The Chair: Excellent. Well, that concludes our time for questions and answers today.

We really appreciate you taking the time, Dr. Humphreys, to share with us today, for your presentation and your work in this field. Thank you so much for being here today.

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

The Chair: All right, members. Do you guys want to just skip the break? Excellent. All right.

Thank you, Dr. Durnin. Thank you for being here today. I know you've been here all morning, so you kind of already know what we're doing. We're going to do 10 minutes of presentation, followed by Q and A. I will pass it over to you right away.

Máire Durnin

Dr. Durnin: Thank you. Can you hear me okay?

The Chair: Yes, I can. Thank you.

Dr. Durnin: Okay. Fine. I go by Durnin just to make matters simple. I know my name is a mouthful, just to clarify that.

I'm coming to you as a physician who works in the trenches in addiction in B.C., and I've done so for almost 20 years. So my perspective is going to be more qualitative. You've heard a lot of science. I am going to say that I endorse a lot of what I've heard from previous speakers – I've been sort of in and out all day, so I haven't heard everything – for example, what Dr. Humphreys said, what Dr. Rieb alluded to, what Dr. Somers alluded to, and so forth.

My experience is different. I work right across the spectrum of addiction. I work with individuals in harm reduction, and by that, I do not mean safe supply. I work right with them through the whole spectrum of recovery, right up to individuals who are in full recovery leading productive, quality lives and are so happy to be doing so. There is a huge spectrum of in-between, where people are on repeated cycles of recovery and relapse, and their stories are just as important here.

But if I get nothing else through to you in this, you know, few minutes, what I would really like you to understand out of this is that recovery is possible. It is not an elitist phenomenon. There is a perception, I think, more so in this province, that recovery is restricted to those who have, you know, unlimited resources and so on. That is not necessarily the case.

To give you a perspective on my background, I have worked in the Downtown Eastside of Vancouver for many years. I have worked in correctional settings. Today I'm working in a private recovery centre, the Orchard on Bowen Island. I also work in occupational health settings, where we have an extra tool to help people get better when they want to keep their jobs; it's an incentive. Also, on top of that, I serve on the board of VisionQuest, which is a recovery society nonprofit which takes individuals mostly out of correctional settings, in fact, and helps them in long-term recovery and does so on a shoestring budget.

The message that I would like you to hear is that if you can direct the resources towards more recovery as opposed to what has been traditionally done in this province, which is harm reduction, I think you have the opportunity to make great changes here.

We're talking mainly about safe supply, you know, and the perspective on that, so I want to get back to that. I want to tell you a story about one of my own patients because even though I've been working in addictions for a while, I didn't really understand this until I was working in the Downtown Eastside of Vancouver. I had patients that had been addicted to oxycodone before in family practice, and I had seen lots of stuff when I was working in an HIV setting, but when I was working in Downtown Eastside in about 2008 – and this was just when the oxycodone crisis was brewing, but we didn't really understand until a couple of years later.

Back then there was a terrible event, where there were eight overdoses in one weekend. At that time that was a tragedy, right? Now that would be great, but back then that was a tragedy. What we did: we had notices up in all of our rooms. We said, "There is some potent stuff out there; please be careful; please don't use alone; come and talk to us," all the usual stuff.

My patients would come in and they would talk to me, and they would, you know, do the usual stuff, and I'd find them looking at this notice. I'd say something to them, and they'd go, "Uh-huh," and they'd get out.

Finally, I had one girl come in to me, and she stared at that thing, and she said, "Could you take that notice down?" And I went: "Well, hang on. We're trying to save people's lives here. We're trying to make people feel better." And she said, "I see that notice, and all I want to do is go out there and get some of that stuff." For the first time I actually understood how someone in addiction thinks. They do not think like normies, which is what they would call nonaddicted people. They think: the more potent, the more better, the more I want it. That concept has been borne out to me time and time and time again by my patients when they come in to see me.

It is no accident that right now out there on the streets of Downtown Eastside and in Surrey, where I work now, people will overdose, and rescuers will come up and Narcan them – and these are people who are on the streets themselves. They will Narcan these patients two, three, four, six times because that's what it takes with the potency of this stuff. And the first thing those people ask when that person comes around out of their overdose is: where did you get your stuff? This is something that we need to understand. This is how people think. There will never be a more potent opiate that we can make that is greater than what the dealers can supply. It's like a game of better than, better than, better than. They will always top it.

That was just borne out to me last week. One of my patients came up from the Downtown Eastside, and I said, "Is it still as bad down there?" He said, "It's worse." Right now they are giving out what are called hot flaps. Hot flaps are really potent opioids that the dealers are giving out free to certain patients because they know those patients will use them, they know those patients will overdose, and they know that everybody is going to want to know where they got their stuff. That is the reality of what you're dealing with, and that's why safe supply can never be enough for these people.

I will read you out a statement that is from the Opioid Use Disorder Practice Update, which was recently put out in British Columbia. It contains two statements which I find to be a complete, you know, contradiction in terms. The statement reads that it is recognized that every dose of a safe supply "reduces risk of overdose." But in the same paragraph it says, "Many individuals may continue to use a combination of prescribed hydromorphone and illicit opioids." And that is what you heard from other presenters; 90 per cent or more will continue to use potent opioids. We know that it only takes one grain of carfentanil or the also potent U-47700, that are contaminated in these things deliberately by the dealers to knock somebody out, to overdose. What is the point?

Conversely, as you have also heard from other presenters in this field, these opioids are being sold and redistributed. You heard this from Dr. Rieb yesterday and others. I have patients who have told me that they are selling their safe supply. It is literally being put in Canada Post by drug dealers and shipped out east to Newfoundland. A colleague told me yesterday that the same thing is happening with pills being shipped to Yukon through Canada Post. Again, they're being sold for much – somebody is making a lot of money out of that, and our government is paying for it.

The irony is that the people who could really speak to you – and I wish they could speak to you on this – are the people who are actually in recovery. Those people will tell you more authentically than I can that they would never, never sanction safe supply if they were in their addiction. They know exactly what they would do with it, which is what I've told you. But the irony is that those people who are in recovery have to keep quiet. You're not hearing from them. I have asked some of my patients to speak out to you and to put their comments in, you know, the comment section for your committee. But, again, if they put their own names to those comments, they are in fear of being censured by either other people who don't understand or by people in harm reduction who believe that they are against harm reduction in general, which is not the case. I want you to understand that.

11:20

I also want you to understand that on the other spectrum – and there's everything in between, which we can talk about – recovery is possible. It is done every day. It does not have to be super expensive. To give you one example, I serve on the board of VisionQuest, and I just learned yesterday from their executive director that they operate on a shoestring budget of I think it's $35.90 per client per day. That is compared to $60 per day for a shelter bed. So they are struggling, but it doesn't have to be that way. If more of those resources were diverted towards recovery, I believe we could do much better.

I realize I'm out of time, but I would just like to say that with respect to those people who are in recovery through the fact that they have hooks through their work that they have to remain so, it's another tool that we have to help people get better. I would really like to stress that this is not just for people in high-powered professions like health professions or pilots or that kind of work but also for people across the street – construction workers, labourers – anybody that we can bring into the fold and bring into what we call contingency management, which is where people have incentivized to do better. This has better results in my population.

The last thing, if there's time, to say. The clinic that I work in, that I started with Dr. Melamed, who you're also going to hear from: we started that as a therapeutic setting with harm reduction, where people could feel safe to walk in. We did not prescribe and

never have done safe supply. We do consider buprenorphine and methadone harm reduction that brings people into a safe environment where we do wraparound care and provide them with a safe place, a trusting place, that when they feel ready, they can talk to us about recovery without judgment.

Okay. I think I'm going to stop there. I don't know whether my time is up, but there is a lot of stuff to go through. I'll let you ask if you want more.

The Chair: Thank you, Dr. Durnin, for your passion and work with those struggling with addictions. Thank you for that.

We will open it up now for Q and A with the members, and we'll start with MLA Milliken.

Mr. Milliken: Thank you, Chair. Thank you, Dr. Durnin, for your presentation here today. Again, the passion comes through. I've got one question that's almost a bit of – I would almost call it housekeeping for myself and then another question that I think is going to get fleshed out or I might be able to ask if given the opportunity. One thing that I just wanted to – you've got, obviously, a lot of on-the-ground experience with regard to this, everything that we're doing with this committee. Those that are on safe supply: it's my understanding that they would be over time developing a tolerance, something that I don't think we've heard on the record yet but that I think you may have kind of almost alluded to. Those who are providing safe supply: would they be increasing the potency given to the individual with an OUD over time?

Dr. Durnin: Do you mean what's out there now or what is being proposed?

Mr. Milliken: What's being prescribed right now on the ground, say, in East Van. If somebody is receiving it, whether it's from a vending machine or anything along those lines, is it being increased over time as they stay on the program?

Dr. Durnin: Well, that is the natural course of opioid addiction, tolerance for increasing amounts of opioids over time. To give you an example, I was talking with a physician who works in Vancouver general, and it took something like 600 micrograms of fentanyl or something equivalent to that just to stabilize one of their patients who came in in aggression and psychosis. By the way, one of the things that I did not touch on in terms of the downside of safe supply is the provider burnout and fatigue from dealing with these individuals on top of everything else. But 600 micrograms of fentanyl is a phenomenal amount. I mean, to give you a comparison, if you started someone who was naive to opioids on 12 micrograms, they could overdose. So yes.

Mr. Milliken: Thank you for that. On the ground how are providers such as doctors determining how to ramp that up? At what rate? What I'm looking for is that a lot of what we've heard from people who have OUD is that they are out there going for some illicit substances in order to self-medicate for their own needs, what they have. I'm just trying to get at: like, what are the parameters for the doctors prescribing to increase over time? Is there any kind of data fleshed out there that if that does continue to be increased, there is some sort of stability, or do we see a situation where it's tough to get that right, that individuals go out on their own and potentially would experience some sort of lethal or nonlethal overdose?

Dr. Durnin: Well, the fact is that, in the first place, as you know and have heard, people are not using safe supply without also using illicit opiates, by and large, so which is doing what is somewhat hard to tell. That being said, I – don't quote me on exact numbers, because I haven't looked at it recently. My impression was something like people were being allowed to prescribe – and that was within the judgment of the physician – up to about 14 eight-milligram pills of hydromorphone a day. That is roughly 500 milligrams of morphine. But I have seen people getting up to 30 pills a day. They've come in to me being prescribed that.

My understanding was that there was an earlier document put out by the B.C. Centre on Substance Use which referenced ramping up the potency of opioids to fentanyl, et cetera. That, I think, was subsequently retracted, so that is, I believe, on the table potentially in the future right now, with no clear benefit.

Mr. Milliken: Thank you very much.

If I could?

The Chair: Go for it.

Mr. Milliken: Given your experiences on the ground – and you kind of alluded to the issue of drug diversion in that last response – do you know of any processes or policies that could decrease drug diversion?

Dr. Durnin: Well, no. There is a complete atmosphere of, you know, standing back and doing nothing right now in this province. I do not know of anything, and I think the answer to your question is what Dr. Humphreys said. He's just explained that to you, that limiting the supply of opiates is the only thing that's going to reduce this demand and the diversion.

Mr. Stephan: Good morning. Thanks for your presentation this morning. One of the things that you raised – and I really appreciate your perspective – is that safe supply can't compete with unsafe supply because those who are suffering under addictions are not seeking more safe drugs. They're seeking more potent drugs, and market forces by drug dealers are seeking to provide that demand.

The question that I have is that we see the government in your jurisdiction, B.C. – notwithstanding this, they seem to be pursuing safe supply type policies. I'm wondering: why are they doing this in the face of the fact that safe supply is not what those who are suffering under addictions want?

Dr. Durnin: You must remember that people who are getting safe supply have, you know, a vested interest in continuing to get it – that's the patients themselves – because they will sell it and divert it for more potent opiates. They may use – and I've seen a couple of my patients doing this: I'll keep a pill in the morning so I stay out of withdrawal when I wake up until I can go get more potent stuff. But the answer to your question, "Why is the government doing this?" I don't know. I can only assume that there is pressure from sources or a belief that without the evidence this is a better way to go.

You heard Dr. Mathew, I believe, yesterday speaking about the four pillars of addiction treatment, which are prevention, harm reduction, treatment, and law enforcement, and we seem to be sitting on one pillar, which is harm reduction. For example, in the Downtown Eastside you can look. There is an open market for stolen goods, and the police literally just stand back and don't even go in there. We're past that point. There is very little law enforcement, you know, unless they have to go in there and intervene, and we have very little treatment, as I've told you. It doesn't make sense to me that a recovery community could be getting less than 36 bucks a day from the government when a shelter bed is getting 60 bucks.

11:30

The Chair: MLA Yao.
Oh, sorry. A supplemental?

Mr. Stephan: Yeah. Just a quick one. You had mentioned the four pillars and that the B.C. government seems to be putting emphasis on the harm reduction pillar. Do you feel that there is a hierarchy of pillars in terms of public good for both those who are suffering under addictions and their families and the communities they live in?

Dr. Durnin: I think that nobody wants to see people go to jail because they are addicted to drugs, from the law enforcement point of view. We want to see something along the lines of the Portuguese model, okay? From that point of view, I would say that law enforcement is not the priority in that sense, but I see all the other treatment modalities as being equally protective. For example, one of the criticisms that is levelled, which is in favour of safe supply, is because a lot of the overdoses happening were of individuals who were using alone at home. That's, you know, a fair comment, but I would say that the answer to that in the long term – and it's not a short-term solution – is prevention and education, none of which is happening, to my experience, here at the present time. We have advocated to the government; myself and others have tried to advocate for change. We haven't seen it yet.

The Chair: MLA Yao.

Mr. Yao: Thank you so much, Chair, and thank you, Dr. Durnin, for appearing before us. I was just wondering if you could expand or clarify your comments regarding shelter beds and the economics around that. The backgrounder is that some previous guests and speakers have maintained that providing things like the safety of a shelter, food, clothing, things like family and peer support are proven things that facilitate recovery and should be emphasized. Is that what you were getting at, or am I way off course?

Dr. Durnin: No. I absolutely agree with those comments. You, I think, referenced Maslow's hierarchy of needs and so on, and that's absolutely true. You can't really talk to a homeless person who is using drugs about recovery when they're out in the street that night, right? It's just impractical. But what is happening, in my experience, is that people are being siloed. If there is any housing, they are thrown there without any visible supports. I've talked to support workers who have left in frustration from shelters like these. I have no problem with shelter beds, et cetera, et cetera, if it's part of a well-organized community.

You've heard the term "recovery-oriented systems of care." This is the work of William White and John Kelly. It's in the literature. It's a very viable concept in terms of how to organize the recovery landscape from harm reduction up to engaging people. Shelter beds are part of that. What I'm saying is that it's kind of ironic that we can give that to a shelter bed when we can only give about half of that to an organization trying to promote recovery.

The Chair: A supplemental?

Mr. Yao: Yeah. Thank you, Chair. Based on your experiences working with, well, government agencies and whatnot, addiction is a complex issue, and governments seem to take a very one-dimensional approach to rehabilitation and support for this when there should probably be more of a co-ordinated effort with, like, a housing agency like BC Housing, as an example, with their social services with the addictions and mental health agencies. Is that fair?

Dr. Durnin: Yeah, for sure, it's a complex issue, but it's been done in other jurisdictions. It's being done in other areas, and I think that it can be done here. You know, I think that if we keep digging ourselves into the hole, the first thing one should do is stop digging and start to turn around this ship a little bit. It can be done. Yes, we will not see the results this year or next year, but down the road you will start to see the numbers drop.

To one of your other colleague's earlier comments, the overdose rate in B.C. has gone up in the last two years with safe supply. It was over 1,700 deaths last year, in 2020, and I believe over 2,200 in 2021 so far.

The Chair: MLA Milliken.

Mr. Milliken: Thank you, Chair. You had mentioned in your presentation earlier that you had been encouraging individuals who have experienced recovery to come before the committee or to share their experiences, and then you had stated that they had felt like they were being silenced or pressured to be silenced. This is kind of getting into a little bit of, I guess, perhaps hearsay, so as a member of the committee I would give it the requisite weight and value based on that as, like, a premise. But if they were invited – you've obviously had interactions with some of these individuals – if they were brought before this committee, what do you think they would say?

Dr. Durnin: I can tell you that those individuals have a perspective on what it is to be living in addiction as opposed to living in recovery, and they can tell you, hands down, where their lives may have gone had they not gotten into recovery. They can also tell you how someone in addiction thinks and why it would be perfectly normal for someone in addiction to want to continue in safe supply, which is what you have heard from, you know, other people as well.

You must remember to think of this as a brain disease. We know that we can put this disease into remission, but it can take two or three years for that individual. Therapeutic communities such as San Patrignano in Italy take people on with the commitment of three years. We know it takes that long to change their brains, so how can you expect someone who is in active addiction or in early recovery to resist the idea of, you know, using pills if they're available and handed to them?

The other corollary, I would say, that those people would ask – and I'm talking about people who've had the support of getting back into the workplace – is that in early recovery people really need to know that they are supported by their community, by their government, by their workplace in getting back because it's a crucial part of recovery. To give you an example, my patients in Alliance Clinic, where I've been working, often will go to recovery for, you know, two or three months. They come back out, and they're suddenly having to go back to 12-hour-a-day jobs because they've got to feed their family. They're in construction. They're in labour. They're in nontechnical jobs. They need to go back out and feed their families. They're under stress. They can't carry on with the support work they need to do.

I would reference you to my earlier comments to the Standing Committee on Health in 2014, to the House of Commons, in which it incorporates some of the aspects of recovery for people coming out of the early stages, where, as Dr. Rieb mentioned yesterday, there is support for people, say, to work half-time initially so they can continue their recovery work, so they can take additional training, so that they can be accountable in their recovery. That is what I think those people would tell you.

The Chair: A supplemental?

Mr. Milliken: No follow-up, but I just do want to take the opportunity to thank you for your response. I know how difficult it can be to sort of speak on behalf of others. I think that when it's brought to my attention that certain individuals are feeling silenced, that worries me. We've gone above and beyond with the opportunities to bring everybody possible to this committee, so I just want to take the opportunity to thank you for that response.

Thanks.

The Chair: Thank you, MLA.

MLA Amery.

Mr. Amery: Thank you very much, Chair. Good morning, Doctor, and thank you very much for being here as well. I echo, I think on behalf of all my colleagues, how important this discussion is, so I thank you for your time. I'm going to go over some of your earlier presentation if I may. Forgive me if some of it overlaps with some of what my colleagues have already asked, but I do think it's important to get it on the record.

11:40

You began by saying that recovery is possible for all and not restricted to the elite, and I think that was an excellent segue into what I have to ask you about here today. In your presentation you then continued by saying unequivocally that safe supply can never be enough for those suffering from addictions.

You then moved on in your presentation to suggest – and I think it was a quote. Forgive me. I don't remember who you were quoting, but it was suggested in that quote that safe supply reduces overdoses. I think we've heard multiple times from you and in our own considerations – some of this might be a little bit dated now that you've covered it, but one of the strongest arguments in favour of safe supply is that it does, according to the proponents, reduce overdoses. I don't know how accurate that statement is – I think you've clarified that with respect to your comparison of the B.C. situation over the years that you've provided us with – but even if it were and as tragic as overdoses are, I know that's not the only metric that we need to consider here. We need to think of things like societal and interpersonal and family damage that is caused, health and economic consequences, for example, and the countless other impacts of drug abuse.

My question is this. It's a two-part question. I'll ask them both at the same time in the interest of the limited time that we have. Are you aware of any credible evidence that supports the notion that the safe supply of opioids does, in fact, with all other things being equal, reduce overdoses? I know that there are complications with the pandemic right now that may have impacted the B.C. numbers that you've quoted, but all things being equal, I wonder if you can comment on whether or not there is evidence to suggest that safe supply jurisdictions do have reduced situations of overdoses. Then, finally, regardless of what your answer to that is, what other consequences, whether positive or negative, are safe supply jurisdictions dealing with, and how do they compare with other non safe supply jurisdictions when it comes to the other metrics of drug abuse in a society?

Dr. Durnin: To your last part, I'm not quite sure what you mean by other safe supply jurisdictions.

Mr. Amery: I'm asking if you – sorry.

Dr. Durnin: Do you mean like in Ontario or whatever?

Mr. Amery: Yeah. Ontario, B.C., and non safe supply jurisdictions as they compare to one another.

Dr. Durnin: Okay. I cannot speak to the other jurisdictions really. What I can explain to you is how, first, I have no evidence, as other speakers have said, that harm reduction, safe supply has had a positive impact on anything respecting, you know, overdoses, et cetera, in this province.

Secondly, to give you an idea of the impact, as I said, I work in Alliance Clinic with Dr. Melamed, and we work within that clinic with the full spectrum of people, from harm reduction patients right up to recovery patients who are coming off methadone or Suboxone in many cases. Within that population we have seen a decimation of those who are in sort of active addiction at the time of safe supply coming out.

To be clear, we will prescribe methadone and Suboxone for people because we will engage with them that way. They will come to us, and before this so-called safe supply that was our hook to have them come back to us. They would take methadone or Suboxone to stay out of withdrawal, and we would then engage with them, and that's what I call harm reduction. They might continue to use other substances, including fentanyl, but they would come back to us to get back on methadone or Suboxone. Eventually, we would wait and hope, and in some cases they do want to engage for the next steps.

With safe supply that kind of went out the window. Many of our patients scattered. Many did not come back. A few did. They are basically either lost to follow-up, you know, and we're not getting the new patients to replace them because now on the street you can get anything, any time, anywhere.

The Chair: Excellent. Thank you, Dr. Durnin, for your time. That does conclude our time for question and answer. I sincerely appreciate you taking the time to be able to present to us today, so thank you for that.

Dr. Durnin: You're welcome.

The Chair: All right. Members, that brings us to our lunch break. We will reconvene back here at 1 o'clock.

[The committee adjourned from 11:45 a.m. to 1 p.m.]

The Chair: Okay. Thank you, committee members. I hope you had a good lunch break. We will get back to it.

I want to welcome Dr. Melamed to our committee. I appreciate you taking the time to be able to present to members on this very important issue. We will open it up for you to be able to present for 10 minutes and then turn it over to the members for some Q and A time. Without further ado, I'll pass it over to you, Doctor.

Jennifer Melamed

Dr. Melamed: Thank you for allowing me to attend and provide my opinion on this. I would like to start by telling you what my experience has been in addiction medicine and how long I have been practising addiction medicine. I started and worked primarily as a family physician in British Columbia from 1992 to 2000. At that point addiction treatment became a small component of the work that I was doing, and then in 2004 I devoted my practice completely to addictions and pain management. At that time I was working as a consultant in two different detox facilities, one being the Cordova detox and the other one being the Vancouver detox. At that time methadone was not permitted in the detoxes; we only worked with clonidine and other substances to control the symptoms. We were losing many individuals because of the severity of the withdrawal, that they couldn't tolerate.

We were then permitted to use methadone but only on a tapering basis. But even then I would discuss this with patients and say, "If

you're finding the methadone is helping you, let's stop the taper, keep you on this dose, and refer you to a methadone physician outside of detox so we can stabilize you on this dose," because methadone does have benefit in assisting treatment.

I was one of the initial prescribers in this province of a drug you've heard of, Suboxone, which is buprenorphine and naloxone. I organized, with the company at that time, talks explaining to doctors how to use the product, so I am well versed in Suboxone. I was on the Methadone Maintenance Committee, which was under the auspices of the College of Physicians and Surgeons, from 2009 to 2014, and during that time I taught other physicians, who were trying to learn, on how to prescribe methadone safely, because it is a drug that, if not used properly, can have fatal consequences. I also taught a course on pain, and in fact one of the people I taught with was Dr. Rieb at that time.

Starting in 2015, I branched out and started working in occupational medicine. Now, occupational medicine I think is really important in our discussion today because this is for individuals who are considered to be in a position called safety sensitive. Safety sensitive is defined as: if you make a mistake at work, either yourself, other individuals, or the organization can be harmed. When people think of safety sensitive individuals, the immediate response is doctors, lawyers, police officers, paramedics. That is correct, but there are people called safety sensitive who work on the docks. The people who work in the hospital as the cleaner is also considered safety sensitive because if they go to work impaired and leave the floor wet, somebody could get hurt. It is not only highly qualified individuals with degrees, et cetera, behind their name who are safety sensitive. Safety sensitive covers an entire spectrum of people, and in my opinion – and I will explain this – people who have either insurance or are considered safety sensitive are being offered a superior level of care.

I want to talk today primarily about what I see in my practice. I am sitting today in Alliance Clinic prescribing methadone and Suboxone. Some of my patients have been with me since 2006, since I started, okay? They have followed me from clinic to clinic, and I think what's really important, which we're lacking now as part of our treatment paradigm, is having a therapeutic alliance with a patient. Patients trust us, and that is really important. They trust our opinion. They listen to us. They come back.

What we have seen with the use of these alternate medications, which are being referred to as safe supply – I will refer to them as safer although, according to the B.C. Center on Substance Use document, they are actually calling it risk mitigation; they understand there is a risk with these medications – is that we are losing our therapeutic alliance with our patients. We're losing the ability to educate them, to work with them. Prescribing medication is but one arm of treating addiction, okay? We need to encourage them to do their counselling.

Many of these patients, as you've heard from other presenters, have severe underlying trauma, have severe underlying mental issues, and have physical issues. As a physician who does full-service care, I have counsellors in the clinic. We help them with housing. We help them with everything that is needed so that they can get onto the path of recovery. Recovery involves methadone and Suboxone. It involves recovery-oriented systems of care, which you've heard about from other individuals. But the important part for us is engaging individuals in recovery and not just giving them a medication.

As part of my occupational health experience, I run two groups a week for health care professionals in recovery. These are nurses, doctors, pharmacists, physicians, dentists. All of these individuals, after completing intense treatment, not short-term treatment but intense treatment, are then enrolled in a contingency-based program where, in order to remain at work, they need to demonstrate abstinence. Every one of the individuals in my group – and I have 40 to 50 people attending these groups – remains abstinent, remains at work, and remains committed to their recovery. So recovery and engagement in recovery do work.

We have, as I've said before, schoolteachers or teaching assistants who are also involved in recovery, and for them it works, too. In my opinion, we are creating a class of people who have been offered a second-class form of treatment by just saying, "Here is palliative care; let's give you these medications," with no proof that they work. I've heard the term, as I've been listening to the talks, calling this "harm reduction." In my opinion, this is not harm reduction; this is harm facilitation.

We know for a fact that the medications are being diverted. We see it here. My husband, who is also an addiction physician, went into the store two doors down from our clinic, and a patient, who is not a patient of our clinic, said to him, "Are you taking patients?" And he said yes. The patient said to him, "Well, can I get Dillies?" Now, Dillies is a street word for Dilaudid. Dilaudid is hydromorphone. A person in active recovery or who is looking for recovery is not going to talk to me about Dillies.

I am worried by what I see. I sit on a committee where prescription opioids are prescribed, where there are members with lived and living experience who have said to us straight up in this committee: "Give me what I want. If I want fentanyl, don't give me hydromorphone." My voice is shouted down in this committee, and, honestly, I feel intimidated because as soon as I stand up for recovery, I am in the minority. We are made to feel very uncomfortable. We are being told, even by the coroner in British Columbia, that there are not enough of us who are prepared to prescribe these risk-mitigation medications. We are not comfortable. We were trained from day one that doctors do no harm, and we see this as doing harm, and this is why we're staying away from it, okay? We've had an opioid epidemic, and we're not prepared to go there again.

Thank you.

The Chair: Thank you very much for that presentation.

We'll now open it up for question and answer with the members. Are there any members with a question? MLA Milliken.

1:10

Mr. Milliken: Thank you, Chair. Thank you for the opportunity. Thank you, Dr. Melamed, for being here today and for presenting for us. I think it's fair to say that you've got quite an impressive amount of on-the-ground experience with regard to individuals with OUD.

In your presentation you had mentioned that you have some patients who have been with you since, I believe, essentially the start, when, I think, you kind of devoted your practice, kind of moved it over to more addictions and pain management. I'm not sure if it was 2004 or 2006. You mentioned that you had some of the individuals who were with you and, I believe, on perhaps Suboxone since that time.

I understand that recovery is an ongoing journey and that there are lots of factors to it. Would you say, though, then, just for the benefit of those listening, that there are scenarios that you have experienced where individuals who have OUD, opioid use disorder, can be stable for extensive periods of time? I get that it's not necessarily just the Suboxone; it could be also a family of other aids that might envelop that individual through their recovery journey. But would you say that there are individuals who have been on the road to recovery through the effective use of Suboxone for that

significant period of time? I think that what we're looking at is somewhere in the neighbourhood of 16 or 18 years.

Dr. Melamed: Absolutely. The important thing to remember is that in the beginning there was no Suboxone. Suboxone is a drug that was only introduced later, so the only arm we had in the beginning was methadone. We had people who were on high doses of methadone who we've transitioned over to Suboxone, because sometimes as they're tapering off their methadone, they have found the taper very difficult.

We now have two more drugs in our armamentarium. We have injectable Suboxone, which also helps people wean off or with maintenance. The injectable form: they come in once a month for an injection in their abdomen. It maintains them for the entire month. So there is the injectable. For people who choose to wean off, they still remain connected with me in many cases. I am still their family doctor. I am still talking to them about their children. I am working with them on their physical health.

I saw a young woman this morning who has weaned off her methadone but presented with awful anxiety two or three weeks ago, knowing this could be a risk for her to relapse. So we treat the anxiety. I have known her since she was in active addiction, had no contact with her children because they said to her: Mom, we cannot handle you coming and going. She now has her two sons, who are around. They're old enough not to live with her, but they're well connected with her. She goes to their sports games. They are doing fantastically. She was listening to what I was going to present today, and the people who are in recovery understand this.

I'm not sure who it was – I think it was Dr. Lembke – who used the word "hijacking" of the brain. Addiction is defined very easily by four Cs – okay? – craving, loss of control, use despite consequences, and a compulsion to use. We're then asking people whose brain has been hijacked to make healthy decisions for their ongoing care. So we work with these individuals. We help them through it. We taper them off.

I received a call two weeks ago from a psychiatrist who said to me that he had a complaint from a public health worker because one of my patients, while in treatment, had made the personal decision to wean himself off methadone. This individual is living on the island now. He is doing fantastically. I am in contact with him regularly. He has maintained sobriety since the summer. This public health worker wanted to put a complaint in against the treatment centre because nobody should ever be taken off methadone or Suboxone, in her opinion. This is incorrect.

If an individual chooses something and their recovery is stable and they have worked on all their arms, if they're attending extended – if they're going to meetings, whichever meeting they choose to do, if they're connected with a recovery community and the choice is theirs, I will help them wean off the drug. I will also offer them, as you've heard, naltrexone in an oral form in case they relapse, which can block them. Some of them take it; some choose not to take it. But the recovery does not have to always entail these drugs, and I am never not available to my patients, even when they have weaned off.

The Chair: A supplemental?

Mr. Milliken: Yeah. Thank you for that. You've obviously got experience working with individuals who would probably be – and I'm not sure exactly what the definition would be – in some sort of long-term recovery state. However, have you experienced, in your practice with your patients, situations or pressures whereby you've seen individuals, who you are treating relatively effectively, leaving potentially to pursue perhaps safe supply programs?

Dr. Melamed: Absolutely. When this was done to a young 18-year-old man even before methadone and Suboxone were offered and were used – the drug Kadian just came in. I really got upset about this because eventually he left. He was getting it downtown. He wasn't getting it from a reliable physician who he could meet with regularly and have all the supports around him. We see patients here who leave us. We watch them on their PharmaNet, their prescription review, maybe four or five doses or four or five days or slightly longer, getting the harm facilitation medication, and then they're gone. No more prescribing is happening. They will often come back here, and you say to them, "What happened?" "I don't know, Doc."

I had a situation many years ago where one of my patients left and was included in the injectable IOAT program, and I actually put in a complaint because at that point the patient had to have failed to be included in the IOAT program, the injectable program. This patient had not failed. This patient had years of sobriety, was working in construction. This case was taken to the ethics committee, and it was deemed inappropriate for this person to have been included at that time. I still remember somebody in the committee saying: well, obviously, what you were doing was not meeting this patient's needs. But the person had to stop working because now he's using heroin three times a day. He became unstable. Some of these patients will come back to us. Some of them won't. We lose some of them permanently.

The Chair: Thank you, Doctor.

Next up we have MLA Yao.

Mr. Yao: Thank you so much, Chair, and thank you, Dr. Melamed, for taking the time to speak to us today. I was just looking at your resumé here, and you're a former co-owner and the current medical director of the Alliance Clinic in Surrey, B.C., where they do prescribe opioid-assisted treatments.

Dr. Melamed: That's where I am today as I'm talking to you.

Mr. Yao: Okay. Again, the argument for safe supply is that it is a reasonable option that will save lives. I mean, from your perspective, are there other options for recovery based on the individual severity of their addiction? Are opioids the be-all and end-all to helping people overcome these challenges?

Dr. Melamed: It's important to remember that for many people who are in active opioid use disorder, so they're in active addiction – you to say them: why did you carry on using? They no longer enjoy what they're doing, but the biggest feeling that they experience is withdrawal. Withdrawal is described as one of the worst experiences. I remember saying to somebody – I was teaching somebody in the clinic here and said that withdrawal can be explained as one of the worst severe flus you've ever experienced. And the patient stopped me and said: "Doctor, no. You are underestimating the severity of what we go through."

The reason they keep going back is because of the withdrawal. It's important for us to manage the withdrawal, which is what methadone and Suboxone does. Once you've addressed that, then you have to treat the addiction. Methadone and Suboxone are just one arm of treating. For certain individuals, they don't want to be on methadone or Suboxone. They say: I want to be drug free.

1:20

That is very difficult, but we will support them, and we will encourage them to use naltrexone, which is an opioid antagonist, which, if they relapse, will stop them from dying or suffering severe harm. But it is that withdrawal that takes them back, and the

withdrawal feeds in to the craving. So we understand that, and we work with them on that.

Besides methadone and Suboxone, which have long half-lives – even if you miss a dose, you do not go into withdrawal. They will carry you for longer than 24 hours. It stops you from thinking about preventing that withdrawal, which is the major reason that many people in addiction keep using.

The Chair: Excellent.

MLA Stephan.

Mr. Stephan: Great. Thank you for your presentation. I just want to ask two questions. The first one is: why is B.C. pursuing safe supply policies despite what you're seeing?

Dr. Melamed: Honestly, I don't know, okay? Surely we would have seen by this point an improvement in the overdose deaths if safe supply was working. I struggle to say that word, "safe supply," but I will use it. The coroner keeps saying: well, there are not enough physicians providing this medication so therefore safe supply is not allowed to a large enough number of the population. I think it was Dr. Humphreys or Mr. Michael Shellenberger this morning who spoke about the percentage of the population who are being on these medications as palliative care. I agree, okay? This is palliative care, but it is not working.

I think what has happened is that, honestly, the government has gotten desperate. There is also a lot of outside pressure – okay? – from organizations and from parents who have lost their children who have said: if this drug was available, our children wouldn't have died. That's supposition. We don't know that. So I don't know why they're going on with this program regardless, and I think we'd have to try and weed that out of them.

Mr. Stephan: Okay. Well, thank you for sharing that perspective. Whenever we act out of desperation, often we don't make the best decisions.

One of the earlier speakers talked about the importance of social capital in helping individuals become free of addictions. I'm just wondering. Individuals who are using safe supply: can you maybe describe what their socialization is with others when they are using safe supply?

Dr. Melamed: I think anyone who is involved in addiction is involved in the same socialization. All of these short-term drugs, be they fentanyl, which is so overwhelming and so powerful that, as you've heard before, hydromorphone is not going to cut it for people who are using fentanyl. You're on the street always looking for the next high. I don't know if anybody here has seen the streets of Vancouver recently. We have open drug use. It is continuing. It is on the sidewalks. It's all over. I myself am scared to go to the Downtown Eastside on my own, alone, which is something I never used to be.

Socialization. Yes. You're sitting with other individuals who are also actively using, but you're not able to pursue housing. We're putting people into housing, but nearly all the housing facilities have supervised consumption sites in the facility. So even if you're trying to stay sober, it is very difficult. The dealers, according to my patients, live in the house as well. So you cannot even find a safe place in your own housing where you can get away from ongoing drug use. Socialization for these individuals 90 per cent of the time involves socializing with other people in addiction who are either on their way back from the consumption site, accessing drugs – there is no outside involvement with anything else that's going on. We try and encourage that. We try and encourage individuals to reach out to sober people in the community.

Twelve-step recovery is great. It is not all Godly based. Agnostic AA has become very important. I don't know if it's been mentioned yet, but the conference studies that John Kelly did showed that involvement in therapeutic communities has greater efficacy. You cannot get better on your own, okay? Addiction is a disease where you need a community. A therapeutic community plus your doctor who helps you, although we play a very small role in this, plus your counsellor plus your recovery team is absolutely imperative for recovery.

The Chair: Thank you, Doctor.

Are there any other members with questions? MLA Milliken.

Mr. Milliken: Yeah. Thank you. And thank you for the opportunity to ask another question. This is a quick one. I notice that you've done some practice audits, et cetera, as a member of the Methadone Maintenance Committee for the College of Physicians and Surgeons of B.C. I'm just wondering if, through your experiences, whether you know – often what we find throughout this committee process is that the individuals or groups that are for safe supply: so far it's been very tough to find individuals or groups from the medical community who are for this. In that, then, do you know or are you aware of any college of physicians and surgeons that has approved this type of safe supply prescribing, specifically, if the answer can only be for B.C., whether or not B.C. has?

Dr. Melamed: The College of Physicians and Surgeons of B.C. has taken a step back, okay? When we were asked to renew our licence this year, there was a little box that said: will you be prescribing safe supply? That was just because when our prescriptions come up, if we're not within the norm, we would be flagged, and that would mean that we'd be looked at. But this way you won't be flagged. You'll be doing something about – they will just leave you alone.

The college is not saying: don't do it. The college is not saying: we will come down hard on you. But the college is not involved in this. They look after the public. They are stepping back from this. This is being run by the government and by the B.C. Center on Substance Use.

The Chair: Excellent.

Any supplemental? No.

Any other members? We've got about a minute and 46 seconds left.

Mr. Yao: Dr. Melamed, if you could just clarify. You made some comments about the coroner's office having a stance on this issue. Could you just clarify those comments? Because I'm not . . .

Dr. Melamed: Yes.

Mr. Yao: I thought I heard you say that they were supportive of safe supply.

Thank you.

Dr. Melamed: Yeah. The coroner is supportive of it. She's not a physician – okay? – and she is encouraging safe supply. She's saying that in the deaths she's seeing, she's not seeing high levels of hydromorphone in the deaths; she's seeing fentanyl. But you cannot look at it that way. What you would have to do is look at the prescriptions that are being provided to those individuals and see if they're receiving the prescriptions and they're selling them or whether they actually are not getting them.

The other thing that's said all the time – I don't want to go over my time – is that these drugs are going to be safer for individuals who are using alone in their home, like a construction worker. That

person is not going to go to their physician and say: I have an addiction; please give me hydromorphone. The shame and the stigma is going to keep them locked up in their private place and not change the situation for them.

The other thing to remember is that every time somebody overdoses, there is brain damage. So for individuals who are having seven, eight, nine requirements for naloxone, some of them three or four times a day, there is brain damage that's happening in these individuals.

The Chair: Thank you, Doctor. That does bring us to the conclusion of our time with you today. We're all very thankful for your presentation and for the work that you do. Thank you for that.

1:30

We will now move on to our next presenter, Mr. Earl Thiessen with the Oxford House. Thank you, Mr. Thiessen, for being with us today. I have to comment that I love the art behind you. Thank you for sharing that with us. It looks beautiful. We're going to open up for you to be able to present with us for 10 minutes and then open it up for Q and A afterwards. Without further ado, Mr. Thiessen.

Earl Thiessen

Mr. Thiessen: Excellent. Thank you. First, I'd like to thank you all for this opportunity to share my lived and professional experience on this matter. I was homeless for seven years in Calgary, addicted to alcohol, cocaine, and pharmaceuticals for 20 years. Only after two overdoses on an alcohol-and-pharmaceutical combination and the murder of my partner, who is one of the missing and murdered Indigenous women in our country, in 2007, did I reach out for help for me, right? That was the huge thing for me. Many of the homeless people that I hung out with are now deceased from alcohol, drug abuse, and accidents related to both drugs and alcohol.

I understand we're here to speak about safe supply, but I feel it's my obligation as an Indigenous leader in the recovery sector and as a recovery service provider in the mental health and addiction sector as well as a person in long-term recovery in the mental health and addiction sector to remind everybody that methamphetamine abuse is still on the rise and that alcohol is still the leading contributor to death and health issues in Alberta.

With the committee's permission, I'd like to share a short video with you.

[A video was shown from 1:32 p.m. to 1:33 p.m.]

The young lady in that video was my sister Amy, a 31-year-old paralegal, mother, daughter, and sister that died alone at home in Hawkwood in northwest suburban Calgary from an overdose. I and my wife are now raising her three-year-old daughter and 16-year-old son. The other beautiful Cree woman in that video is my mom. She died four years ago. I found her body. She died as a direct result of alcohol abuse and not healing from her childhood trauma of being placed in foster care and the shame society placed on her for her Indigenous heritage. I want to thank you for allowing me to share that video with you all.

Most of my experience is lived experience. I am in this sector. I do oversee an organization that is recovery and abstinence based, but I pulled a couple of quotes here. One is: if you're someone who is smoking meth every day, you can't smoke extended-release Dexedrine. Dilaudid is not the same as heroin and certainly not the same as fentanyl, says Nyx. The reason it's ineffective isn't because safe supply as a concept doesn't work; it's because you're not giving people what they want, so of course they're going to divert their drug use. In other words, if people aren't providing addicts with their drug of choice, they will continue to seek it out regardless of being provided with other drugs. In my opinion, nothing is stopping an addict from getting their free drugs and trading them to their dealer for their drug of choice. I can't be the first person saying this.

Opioids were perfectly legal when our family members became addicted to them, promoted by pharmaceutical giants and doled out by unsuspecting physicians, who enabled the crisis by accepting drug companies' claims that they were safe. An example of that is OxyContin. When the reality became clear and prescriptions became hard to come by, it was too late.

Opioids are commonly prescribed in Canada and are the medication class most frequently identified in harmful medication incidents voluntarily reported to the Institute for Safe Medication Practices Canada. One report states that over 12,800 people died from overdose involving any opioid, including prescribed and illicit opioids, from 2016 to 2019. That's a government of Canada stat. Another report states that between January 16 and June 21 there were almost 25,000 apparent opioid deaths. Another report states that the number for the same period was almost 23,000. One report says that 4,395 people overdosed on opioids in 2020. On the same page it states that that number was 6,214 deaths in Canada. Pretty dramatic differences. My point is that we can find any data we want to support our cause, whether it be for or against.

Another point is that although fentanyl remains the leading cause of opioid death, updated data shows that the prescribed painkiller hydromorphone sits as the second-deadliest drug when it comes to fatal overdoses. That's a stat from the province of Ontario. Hydromorphone is similar to heroin and goes by the trade name Dilaudid. It's extremely addictive and is used to treat pain. This is one of the most talked-about drugs when speaking about safe supply. If we do more on prevention and treatment, we can save lives.

According to a study done by the government on opioid-related deaths in Alberta from 2017, it's clear that we may also want to address the issue of opioid dependency recovery for those suffering from substance use disorder that are incarcerated in our corrections system. An approach to help offer recovery services while in custody could dramatically increase the number of deaths of those being released. Roughly 41 per cent of opioid addicts coming out of incarceration overdose within the first two years after their release. This includes federal, provincial, and remand centres. There is a program, TKO program, treatment, knowledge, opportunity, that is a wonderful complement to this idea. They provide supportive classes on addiction, literacy, and career and education planning. This is an effective way to build self-esteem and self-worth, better stabilizing those being released.

Several factors have contributed to a worsening of alcohol- and drug-related issues and overdoses over the course of the pandemic, including increased feelings of isolation, stress and anxiety, and limited availability or accessibility of services for those who use drugs. We need more treatment services to be created and supported, not safe supply.

We're all hearing about the long wait-list for residential treatment. I believe one area that needs to be focused on is pretreatment housing. The purpose of this housing model is to keep people safe while waiting for treatment in a peer-supportive environment.

I'd like to state that over the past two-plus years the whole recovery-oriented system of care in Alberta has done a three-sixty. An actual investment in improving people and recovering lives by the Alberta government has had a massive impact on the sector. I've been in the sector for 12-plus years, and over the past year, while speaking with our residents, one of the biggest sighs of relief is the fact that the cost of residential treatment is being taken care of. I

can only hope that other provinces in our country can follow Alberta's lead.

This is lived experience speaking again. When I've spoken to alcoholics and addicts in our housing – and I mean thousands of in-person discussions – the one thing we all relate to is trauma. Discussions from childhood trauma that carries into adulthood: I don't have sympathetic conversations; I have empathetic heart-to-hearts.

1:40

Not one of us wants to keep using. We all want to talk about our trauma. We need a release, we need healing, and we need people with lived experience to provide this opportunity. To an addict and an alcoholic, trust is the beginning of taking that first step. The opportunity to speak about trauma with someone they trust is the beginning of the healing process, and that's vital. We want to reconnect with our self-worth, self-esteem, and purpose. I'm not a doctor, but I've heard that by people speaking here. We were disconnected due to our traumatic experiences. We want to live a life free of substances. A safe supply is the farthest thing from our minds. You can't put a Band-Aid on trauma.

Now, to an addict who has no intention of healing, no intention of learning to trust anyone, or facing themselves or their trauma, this idea would be appealing, and I'm speaking as an addict. We can play out that it's helping just to get our fix, and, trust me, I've done it a hundred times in active addiction. I would walk out of a doctor's office with enough pills to fill a Ziploc bag. To meet someone where they're at is commendable, but to leave them there is a miscarriage of my morals.

There is a way out of addiction, and it's recovery. I understand that not everyone is ready to take that step, and nothing that society in general does will make that decision for them; they need to make that choice themselves. My sister and mother chose not to heal and recover. I love and miss them dearly. They're not suffering anymore. If I had begun my recovery journey, I wouldn't be here either. Survival mode keeps you alive, but it's not living. I've heard people say, "Dead people don't recover," and to that I say, "People in recovery don't overdose and die."

My final point: if we seek harsher penalties for drug dealers that sell fentanyl causing overdose deaths, will we hold the prescriber of so-called safe supply accountable to the same standards?

Thanks again for this opportunity. I'll take any questions you have.

The Chair: Thank you, Mr. Thiessen, for sharing your story, your mother's story, and your sister's story and putting a human face to all of this. This isn't just statistics but people. Thank you for that.

We'll now open up for Q and A. MLA Amery.

Mr. Amery: Thank you, Chair, and thank you, Mr. Thiessen, for coming here today, for sharing your experiences and your background with us, and, I think most importantly, for sharing some of the details of the personal tragedies that you've shared with us. On behalf of, I think, my colleagues I want to send our sincerest condolences to you and your family for your untimely losses. Certainly, this is one of the tragic aspects of this entire consideration.

Mr. Thiessen, it's clear that you bring a wealth of experience and information to us, but this is the first time that we've had an Indigenous leader address the committee. Addiction plagues all groups in society equally, and I know that there are many ways to approach treatment and recovery. Obviously, we're here to consider the concept of safe supply. You've spent some time in your presentation discussing treatment and recovery, and you've emphasized that those are the important components that we should focus on, and I appreciate that. As an Indigenous community leader with experience in the field of addiction services you said that we need to focus on things like pretreatment housing, which is one thing that you emphasized, addiction recovery, but you specifically said: not safe supply. What is working, in your view, both within Indigenous communities and within the greater public to the extent that they differ?

Mr. Thiessen: Thank you for the question. What's working – and I've heard many of the doctors say this – is pure support in both aspects. As a First Nations person, what happened years and years, hundreds of years ago was disconnection – right? – disconnection from our culture, from our practice, from our ceremonies, and that comes into play with addiction as well. There's a disconnection from self, from your family, from your community. They coincide. For the healing process – this is what I say – to take place, we need to speak about our traumas. For me, in my opinion – and I've seen thousands of successful cases – it's the peer support environment. It's the opposite of disconnection. You're reconnecting, right? You're reconnecting with your culture. You're getting put in a group setting where you can actually have discussions with like-minded people about your traumas, and it's an empathetic discussion. It's the gateway for people to heal and take that step towards their recovery journey. In keeping somebody in their place of discomfort – right? – like I said, you can't put a Band-Aid on trauma. You have to have a healing process.

The Chair: A supplemental, Member?

Mr. Amery: Yes, please. Mr. Thiessen, you mentioned disconnection with communities, disconnection with families, and so on. Is the disconnection you describe a consequence of opioid abuse? If so, does this guide your advice to this committee about why safe supply is not one of the treatment procedures you would recommend, and why?

Mr. Thiessen: One hundred per cent. People like to use in isolation, right? To keep them in isolation isn't going to be productive. Like, even when I used, you might use with people, but you're alone, right? For someone in recovery or in addiction, that's going to make perfect sense, right? We need to heal around others. Community: it just means everything. Being alone, isolating – I call it running laps, basically, in your own head – by yourself is not healthy, right? I mean, you're going to use, commit suicide. The recovery-oriented system of care needs to be the focus. I'm speaking this for myself. I'm 14 years clean and sober. I went from homelessness to overseeing Canada's largest peer-supported recovery housing organization, with my recovery. That may not be the be-all, end-all for everybody, but it was for me and for hundreds of people: my best man, my wife, half of my staff, and the list goes on and on. I mean, the evidence is on the camera speaking with you.

Mr. Milliken: Thank you, Mr. Thiessen, for being here. I will be directing people to watch that video. It is powerful. There are times where I recognize that I am at a loss when it comes to available information relative to people that I speak to, and that happens – surprise, surprise – quite a bit. In this circumstance, though, it's especially true. So I want to really thank you for being here and sharing your lived experience as well as your expertise.

You did touch very briefly on criminalization. I have some experience through part of a previous legal practice that I was working with, which touched on individuals entering into the judicial field, et cetera, through use of opioids and other substances. I am keenly aware that it affects all communities, the whole community of Alberta, any jurisdiction you can think of. But I also

do think, through my experience, that there has been a disproportionately large burden that the Indigenous community has felt throughout criminalization. I was just wondering, kind of putting you on the spot, if you have a view with regard to decriminalization and then, depending on your view, whether or not that could actually be of benefit for Alberta.

Mr. Thiessen: I've been asked this question before. There are many different views people have on decriminalization. My view on decriminalization would be to have the people getting charged with small, personal-possession offences or with large – well, I don't want to say "large" because I don't want to get out of hand. Charges like that or related to minor offences: there should be an ultimatum, right?

1:50

This is a part where I get a lot of push-back. You can either give the person the opportunity to be charged, go to jail and get a criminal record, or to enter into a recovery-focused treatment, right? In my opinion, anything less than a year would be insufficient. We spend decades and years using. It's going to take a little bit longer to start that. But when it comes to decriminalization, that would be something I support, and we actually work with the drug court and have a collaborative home with them in Calgary as well. It would prevent people from going to jail. It would give them the option. Maybe that's the push they need.

I got arrested with 11 warrants. The JP saw it in his heart to release me, and I told him, "I need help with my addiction and the murder of my partner," and he gave me that small window of opportunity. This could be the opportunity people are waiting for, where they have no other option if they don't want that, to go into a medical detox and to a residential recovery program and then enter long-term, peer-supported housing. I think it would change the whole demographics of everything that's happening in the province.

Mr. Milliken: If I could, just based completely on your response there, I was just wondering, then, if you would agree that perhaps there's some sort of opportunity within government policy. It's my kind of understanding that, for the most part, if I was a police officer and encountering somebody who had an OUD, was deep in use, my only real tool would be to put that individual in handcuffs. I'm just wondering. Are you, then, implying through your answer that if there was some other direction, whether it was some sort of opportunity where they could just be moved straight into some sort of treatment focused – I know you talked about TKO: treatment, knowledge, opportunity. I'm assuming that's kind of, also based on some of your responses, based on evidence-based treatment, education, traditional knowledge. We've heard through many stakeholders that have come and talked to us that there has to be an element of hope associated in order for someone to have effective treatment. I was just wondering: is that kind of something that you think might be lacking in Alberta?

Mr. Thiessen: I think that, well, it's lacking everywhere. I think it would definitely be a benefit, right? When you're put in that position – and it's a choice. Every person that is struggling with addiction needs recovery. It's the want that makes the difference, and giving somebody that opportunity to avoid doing time, to go into a program, I think is going to do nothing but benefit people. I always say that want and need are light years apart. For the people that need to, you know, hopefully they have hope. The people that want to recover most of the time do recover.

Mr. Milliken: Thank you very much.

With that, I'll cede the floor.

The Chair: Thank you, Member.

MLA Sigurdson.

Mr. Sigurdson: Thank you, Chair. I as well would like to express deep gratitude to you, Mr. Thiessen, for sharing your story. I think when we go through this and we start talking about concepts like safe supply or decriminalization, you know, a lot of these theories are kicked around, and I think it's incredibly important, considering the fact that – to be clear, my understanding is that for over a decade you've served with Oxford House, developer of numerous recovery housing models, pretreatment housing, collective peer-supported Indigenous recovery housing model. I'm really interested to know. I mean, you're on the ground. You're the person that's living this. You've experienced it personally with your family. You're out there every day working with these people. I just really have one question. When we're talking about this safe supply – and maybe I'm putting you on the spot a bit, but I think your voice really matters here because you are on the front line dealing with this every day. If safe supply is expanded, what do you think the reality is of that for you and the work that you're doing moving forward?

Mr. Thiessen: I think that's a very good question, and I really, really worry about people that are on the cusp of grabbing ahold of their lives and recovering, that when they're having a safe supply, they're just going to scratch that whole idea, right? To me, safe supply, like people say, is going to keep you alive, but that's not what people want to do. People want to recover. People want their lives back. They want to hug their children. They want to hug their parents, right? They want to live a productive lifestyle, and I don't know – I haven't seen, in my 12 years, someone successfully do that while on drugs. I mean, it's basic. I don't want to say that it hasn't happened ever, but I've never seen it. So my worry is that the want for that recovery and that reconnection will decrease, and that's horrible, because, as you've seen, I mean, I lost my mom, and I lost my sister and many others along the line.

If there was safe supply, I wouldn't be here talking with you, because if I'm going to get 20 hydromorphone and I'm told to take one every eight hours as an addict – I was speaking with one of my staff, and we both started laughing, because that isn't happening. I'm doing three, and if that doesn't work, I'm doing two more. So safe supply isn't going to be productive for recovery, period.

The Chair: A supplemental?

Mr. Sigurdson: Maybe I will just follow up on that. Based on what you've said – and we've got to focus around harm reduction strategies – maybe you can comment on how these should coexist with recovery-oriented approaches, which is, I think, really what you're talking about, that recovery-oriented, putting the lens on that, shining the light on that as the key approach. Is that correct? Just a bit of a clarification, and once again thank you, Mr. Thiessen.

Mr. Thiessen: Yeah. I mean, harm reduction, again, has many different views, right? You could look at – pretreatment housing is harm reduction. That's positive harm reduction. Given somebody who's taken that step to go through medical detox and that wants to change their life, pretreatment could be viewed as a type of harm reduction, but that's a positive harm reduction, right? There have to be positive outcomes. There are going to be roadblocks with everything, but that was the whole purpose of me developing for Oxford House pretreatment housing and entry-level housing for the chronically homeless and institutionalized, that there is a safe place for people to go when they make that decision to recover.

I mean, I've said it. It's a form of harm reduction, and to me that's true, but then there's safe supply, which people say is a form of

harm reduction. But that's not a safe form of harm reduction, right? Moving people through the steps to recover is a safety measure with harm reduction aspects, I guess you could say, in place.

Mr. Stephan: Thank you for your presentation. I was very moved by your video, and something that struck me is that often individuals who die of overdoses do it in isolation. They often die alone, and I wanted to ask whether or not – you talked about the importance of connection to help healing. Other individuals have referred to this as social capital in terms of helping move towards recovery. I'm just wondering: does safe supply just by its very nature connect people, or does it tend to move them towards isolation in their addictions?

Mr. Thiessen: In my opinion, as a person in recovery, I would say that it would contribute to isolation, right? If I was using, I would grab my little goodie bag or prescription, whatever people deem it, and I would be gone.

2:00

If I was homeless, I would be under the bridge using. I would find somewhere to use alone because, number one, I wouldn't want to share it, right? Because it's mine. That's another thing that promotes isolation, right? That's why in our homes it's peer supported. You can't be alone. We all know, unless, you know, you're extremely busy and you're alone and you like to collect your thoughts and spend some time by yourself, to be alone and struggling with trauma and addiction is not healthy for anybody. It's counterproductive.

The Chair: Thank you.

Mr. Stephan: Can I ask a supplemental?

The Chair: Yes, you may.

Mr. Stephan: Again, just talking about the isolation, I find that so sad, actually. I'm just wondering if it's a sense of shame that drives people to be in isolation while suffering under these addictions.

Mr. Thiessen: One hundred per cent. One hundred per cent it is. There's a lot of shame. I as a male that was sexually abused at a young age, as a young teenager – I was a pretty recognized freestyle wrestler. You don't talk about stuff like that to your friends, right? It all comes back to shame, Jason. It all does. And it's okay to cry, because that means we're feeling. I had to hold mine back when I spoke about my mom.

It is shame based. You're ashamed of being neglected. You're ashamed of being beaten. You're ashamed of having your culture disrespected. Emotional, mental, physical: all the aspects of the medicine wheel, right? Sexual abuse is a huge, huge thing when it comes to people feeling shame and isolating when they use. That's why I'm a huge supporter of the DORS app as well.

The Chair: Thank you, Member.

Next up we have MLA Milliken, with about 30 seconds.

Mr. Milliken: Yeah. Thank you again for being here. If we don't have time, we can connect. I represent an area of Calgary. If you could just briefly tell me about pretreatment housing and then also whether or not it's a function of there not being enough beds.

Mr. Thiessen: It is a direct function of there not being enough beds, and I think we need pretreatment homes across the province. That would fill a huge void for people waiting to get into treatment, and it's still the peer-supported environment – right? – so it's a win-win.

The Chair: Mr. Thiessen, feel free to finish answering that question. Thank you.

Mr. Thiessen: Like, I developed this from my lived experience. I was sitting in detox waiting for my treatment date two months from then thinking: if I go back to the streets, I might not make it back. That prompted me to develop the model for Oxford House. We need more; I can't say that enough. We need more pretreatment housing, peer-supported recovery housing, period, and that is a big plug for Oxford House.

The Chair: We appreciate the plug.

Thank you again, Mr. Thiessen, for joining us here today and bringing a face to this conversation. We certainly appreciate that, helping us see the harm in addiction but also the victory in recovery. We appreciate you sharing your story.

Mr. Thiessen: Thank you.

The Chair: Thank you.

We're now going to move on. We're going to skip our break and jump into our next presentation as we have our next presenter here with us. Mr. Posner, thank you for joining us here today. We're going to open it up for you for 10 minutes of presentation and then 20 minutes of Q and A with our members.

Mr. Thiessen, feel free to remain with us for the rest of the afternoon.

I'll pass it over to you, Mr. Posner.

Gerald Posner

Mr. Posner: Thank you very much. I want to thank the members of the committee for having me today on this very, very important issue and with such a distinguished panel. I'm not a doctor. I'm not a psychiatrist. I'm not somebody who works in addiction care, nor do I have the amazing and actually very, very moving life story that Mr. Thiessen just gave.

I come to you instead, as Mr. Shellenberger did, the first witness today, as an investigative reporter, somebody who has looked into this and written about this as a reporter. I'm an attorney by trade, a nonpractising attorney now. For nearly the past 40 years I've published 13 books of investigative nonfiction, and the last one was a 200-year history of the American pharmaceutical industry and drug industry world-wide called *Pharma*. That book, about a third of it, is about the opioid crisis and how it developed and how it came to be and how it flourished.

When I started that project five years ago, now six, I originally had a layperson's view of safe supply and harm reduction. I thought it was a good idea. I thought that in simplistic terms but what I now know were naive terms. In theory I liked that there was sort of this solution that might be able to reduce the spread of disease and reduce deaths as well in a high-risk population that it was very difficult to get access to. That was something that I thought was worth pursuing.

What I found out over time is that safe supply is anything but safe and that harm reduction often, as it's pushed nowadays in some cities, does not actually reduce harm in any quantifiable way. There's overwhelming support – you as politicians have a difficult task ahead of you because you're balancing this issue against widespread public opinion support for what's viewed as safe supply even though many people, when they say that they're in favour of it, would not know what it is if asked in detail. If you do a Google search, as I'm sure you have, for safe supply and harm reduction, the first couple of pages will only be articles or sources that sort of promote the idea of safe supply as being very, very good.

We've heard the benefits, and I'm not to say that there aren't benefits to it if you're looking just at the addict. Certainly, there's a reduction in overdose deaths. You'll hear about the number of people who have been saved in safe injection sites when naloxone has been applied. You'll hear about emergency room medical costs coming down and government health care costs coming down. The problem is that in the studies that I came across – I have analyzed it; I've looked at literally dozens of them – it's very hard to find what I call statistics or credible evidence that you can rely on and take home to the bank and say: this is the definitive study. The problem is that many of the authors already come in with a bias toward safe supply, and as a result they put their thumbs ever so lightly on the scale, and they deliver the information in a way that makes it look, especially to the broad public, as though this is an easy solution to have.

Of course, reducing the number of overdose deaths sounds interesting until you look at something like the supervised consumption committee final report, that came out not long ago in Alberta, that showed that outside of the safe supply zones in Vancouver the death rate was lower, of course, in the actual clinics but 100 per cent to 400 per cent higher in the immediate adjacent area. The number of overdoses in San Francisco, outside of the current experiment that's being run there, has actually increased as opposed to decreased. The same thing happens with reductions in costs to emergency care. That's because the emergency care being given to ODs in safe injection sites, of course, is naloxone. That's being delivered at the SIS, not at the emergency care, not at the hospital.

What about the generic claim that you often hear about the long-term health care costs, what you have to deal with because you're taking a dollar from one part of the system and putting it into another, that you'll save money in the long run? I've seen a report from Wharton that said that in San Francisco for every dollar spent on safe supply, taxpayers would save about $2.30. That's very persuasive. But when you get into the numbers, what you find out, what they're actually looking at, is the number of people who end up, then, going into the hospital with an overdose as opposed to those treated with an overdose at the site. In addition, they're not considering what I call the long-term health effects of chronic drug use, from heart disease to kidney failure to pulmonary symptoms to possible psychosis. That's not taken into account.

They're also not taking into account what I call the nonmedical costs. For instance, in San Francisco, which has a needle supply program, in 2018, the last year for which I was able to get statistics, they distributed over 5 million needles. That sounds good. It's going to reduce hepatitis and HIV infections. But, of course, what does it also do? Two million of the needles don't come back. So San Francisco had to spend another $13 million on sanitation services to be able to go around the city and pick them up. They also had to spend additional money, nearly $20 million, on what came out as additional police resources around the area for drug dealing in the open encampments. So there's no way to necessarily match apples and apples when you look at the long list when you consider this.

2:10

I actually think that in some ways I've come to believe – I call it, for myself, PSAM, possibly safer addictive maintenance. If you think of safe supply as addiction maintenance, which it is, is it safer? Possibly so, but that's the best you can say about it at this time. If you're really looking at the figures and you're not somebody who's absolutely against it, I'm willing to be persuaded by the evidence that it's good. I'm also willing to be persuaded by the evidence that there are problems with it.

One of the things that I want to very briefly touch on, just for a couple of minutes before opening up for Q and A, is that from my work on the opioid crisis and how it played out in the United States and then in Canada and in Europe subsequently, one of the things that happened is that prescription opioids have been destigmatized. That's key, I think, because we're talking about that with safe supply and very many of the harm reduction policies. Do we destigmatize the dangers of some of the most dangerous of the narcotics by supplying them? That clearly happened with prescription opioids.

Talk to doctors who went to medical school in the '60s and '70s. They were convinced that opioids were used for end-of-life, terminal cancer pain. When Cicely Saunders, the nurse turned practitioner, invented hospice in England in the 1960s, she was looking for an end-of-life pain medication that would be long-term acting so she could send people home to die instead of giving it to them every four hours in an IV. When that was finally invented in 1980 by a subsidiary in Britain owned by the Sackler family, who owned Purdue Pharma, called Napp, it was a 12-hour-acting morphine capsule.

When it finally in the '80s picked up a little bit of force, there was a reanalysis by pain doctors in an emerging field, most of them from cancer care, saying: "We think that we have overstigmatized opioids. They are less addictive than we had thought before, and in addition we should be treating pain as a stand-alone condition." That's why, when you go into the doctor today, among the five different diagnoses they want to hear from you right off the bat, one of them is, "What's your level of pain on a scale of 1 to 10, and how are you feeling today?" and, if somebody has pain, to treat it.

In the '80s you had a growing acceptance and a belief by a small group of doctors that maybe opioids are not just for end-of-life, palliative care, and then, of course, in 1996 the Sacklers and Purdue Pharma get OxyContin approved. They don't use morphine because they think that has too much of a bad sort of reputation with the public. Instead, they're using oxycodone wrapped in their 12-hour invisible polymer coating. And what does it take? I've seen the documents on the court cases. The sales force went out, and they told doctors that you could use it for osteoarthritis, that you can use it for back pain and a whole host of things for which it had never been used before.

The doctors: it's not like a light switch. American physicians did not immediately turn overnight and start to prescribe it in record numbers so that Purdue was making big money. It wasn't until 2001 that we get the first reports in the press about problems with diversion, and this means that it took five years for Purdue, with repeated visits to physicians, pain physicians, to be able to turn those physicians to destigmatize prescription opioids, to think that they could prescribe them for things that had not been that serious.

The process of the opioid epidemic that we talk about, that Dr. Humphreys talked about earlier as being a problem of oversupply, is also a problem of the way that prescription opioids came to be viewed not only by physicians who were prescribing them as less dangerous than they were but certainly by the patients who were taking them. One of the considerations that I think you have – and I don't envy the task that you have as public officials – is in determining, whether and if you do a safe supply system or program, to what extent you make sure that it does not destigmatize the drugs like methamphetamine and the drugs like fentanyl and others or hydrocodone and those drugs that on the street have a bad reputation and should continue to in many ways because they are so deadly.

I want to thank you very much for giving me an opportunity to give my presentation, my view on safe supply and what I've learned from the opioid crisis, and I hope it's of some assistance to you.

The Chair: Well, thank you very much for your presentation.

I will pass it over to MLA Rosin to get us started with question and answer.

Ms Rosin: Thank you so much for your presentation. You touched on this closer to the end already, but you have done quite an extensive amount of research on the history of the pharmaceutical industry, which, again, you did touch on. I think there's no denying that opioids only came to the forefront of society and medical practice through significant amounts of money and lobbying from manufacturers of the drugs when they were first introduced. However, I am curious what your take is on the role of opioids in modern-day society, in the year 2022, and who is pushing this movement to now essentially decriminalize and have the government provide these opioids and entirely normalize them in society. Is it the medical community? Is it the manufacturers? Who is behind this movement in the modern day?

Mr. Posner: Yeah. Very interesting. It's a good question. It's not the medical community. It's not the manufacturers. As a matter of fact, on the opioid crisis itself, the manufacturers are clearly to blame because they overmarketed – no question about it – but there's plenty of blame to go around. You not only had the manufacturers; you had doctors who, in some cases, were overprescribing. You had some who were running illegal pill mills and later lost their licences as a result of that. You had pharmacies. Some of the biggest chain pharmacies in the United States – CVS, Walgreens, Duane Reade – ended up paying multihundred-million-dollar settlements with the Department of Justice for their acceptance of fraudulent prescriptions for opioids in some communities.

You had distributors, billion-dollar distributors, multibillion-dollar ones like McKesson, Cardinal Health, AmerisourceBergen, who knew where every pill was going. They knew when 5 million pills were going to a town in West Virginia with only 3,000 people. They never reported it to the FDA. And the last one, the FDA, which I just mentioned: also behind the scenes not responding aggressively even when they were pushed by the drug enforcement administration.

So the opioid crisis became, in many ways, the perfect storm. But it's not the manufacturers or any of those other parties today who are encouraging the use of safe supply and the distribution of opioids widely at that level. It's more from a group of, in many cases, drug addiction specialists, or from what I call sort of social benefit groups that really think this is the best way to go.

I mean, I must tell you that I don't think it's all about money and profit. I've dealt with many parents who lost a child. Some of them, like Marianne Skolek, who I write about in my book, are so adamantly against safe supply, but many of the others who lost their children to opioids are sort of adamantly, you know, passionately for safe supply because they think their child would be alive. So it becomes an emotional issue. You have parents' groups. You have opioid-survivor groups that are pushing it. The difficulty, I think, for you as politicians is that there is this sort of widespread public support that says that it must be a good thing. Only when you get into the details do you find that the devil is in the details and how many problems there are in almost every city that's rolled out a safe supply or safe injection site program.

Ms Rosin: Thank you.

I think there's no denying, from your presentation and from others we've heard, that there are many other unintended consequences in jurisdictions that roll out safe supply. But one of the main arguments we hear for safe supply is that many addicts are not quite ready to take that step to recovery and treatment yet, and safe supply gives them a way of maintaining and staying alive until the point when they are ready, until they are ready to take that step into treatment. I would be curious if you know of any data from any jurisdictions that have implemented safe supply to suggest that where there is safe supply, there is an increase of individuals who eventually access treatment. Or is there a decrease in those who access treatment where there is safe supply? Or does the rate of those accessing treatment stay relatively the same regardless of a safe supply system?

Mr. Posner: It's very interesting. I cannot find a situation yet – it may exist – in which somebody has done the analysis to show an increase or decrease in the number of people seeking treatment in a given municipality and then show how many of those people seeking treatment had been part of the safe supply program versus those who are coming in from outside, either through a 12-step program, through a church, through a family initiative to get them into supply. They're not breaking it out like that.

What I do find is that I understand and hear the argument often that people aren't ready for recovery. There's also the discouraging fact that a lot of people who enter recovery programs don't succeed. That's why we have such a high rate of people relapse. Individuals look at that and say: "Well, recovery is not working now, so why don't we try safe supply? At least they can bide their time on a safe supply of narcotics until they're ready to go to treatment." What I find in most of the situations that I have analyzed so far is that the safe supply takes away the impetus to go to recovery because what it does is that it keeps the addiction going. It lets the addiction flourish.

2:20

What you're doing is that you're doing no harm in the sense that you are essentially building up a maintenance program to make sure that the addict doesn't have to go for recovery. I'm not sure what the incentive is unless you build it into safe supply and encourage them to do so. Otherwise, you're going to end up with safe supply literally just being a maintenance program for addicts, with very few ending up in real rehab.

Ms Rosin: Okay. Just to confirm – and then I'll pass it off to one of my colleagues – I think that from what you've said, there is no data to break down the reasons that individuals access treatment, whether that's through a church or through their communities or through safe supply. But you would say that there is also no data to suggest that in jurisdictions where safe supply exists, there are more individuals accessing treatment than in jurisdictions that do not have safe supply. If anything, you would say that it's the opposite and that there are fewer.

Mr. Posner: That's right. I mean, you can't determine that from the existing way the statistics are broken out, and that's part of the problem.

The Chair: Excellent.

Mr. Milliken: Thank you, Mr. Posner, for being here. Also, I just want to say thank you to my colleague MLA Rosin for that. That was a really good line of questioning. Because of that, I'm going to take it in a bit of a different direction, noting that I know you gave us a little bit of a bio of yourself at the outset. I think that it's pretty fair to say that we have a bona fide historian in our midst right now, having been a finalist for the Pulitzer in history and then also having extensive knowledge of the American pharmaceutical industry, specifically in prescription opioid business models.

I was wondering if I could put you on the spot, for the benefit of all those watching and for the committee, to perhaps provide a little bit of an overview on the science of harm reduction and how perhaps it's changed since its introduction however many decades ago, when it was introduced.

Mr. Posner: Yeah. You raise a good point because "harm reduction" is, you know, two words we throw around all the time. Two things. First of all, the names are very, very positive. Harm reduction: how can you be against harm reduction as a concept? Of course you want to reduce harm. Safe supply sounds great because the word "safe" is there, so you think that we're combining both. When harm reduction starts – and you look at it literally in the 1970s, 1980s, when there were harm reduction movements in New York – they're talking about harm reduction. It's really built around having somebody stop their use of drugs by slowly giving them a support system that can get them off their addiction.

Then we see that the first place it really takes place is Switzerland, the 1980s. They start to lead the way in changing harm reduction to mean safe supply or some version of it or a safe injection site, even. They don't do it until the early 1990s, but it's revolutionary at the time. But once that happens in Switzerland and then later happens in Amsterdam, then you have it happen in Luxembourg, and you start to see it happen in the European countries. It's being discussed inside of sort of clinical papers.

Harm reduction moves from being a system where you could slowly wean somebody off a physical addiction to a narcotic with a support system in terms of housing and financial support for in-between jobs – maybe the government would be there, and so would individual sort of networks that are helping them – to becoming one just strictly about: can we keep the addicted population with less harm if we save their lives, reduce the amount of transmitted HIV and hepatitis infections from dirty needles, and give them drugs ourselves? That transition really happens in the late '90s to early 2000s, when it takes hold.

Today, if you talk about harm reduction or if you talk about safe supply, most people are thinking in terms of an establishment where the government either gives the drug of choice to the individual who is registered for the use, or in some cases they allow the addict to come in with their own drug, which creates, then, an additional problem because that drug is tested at the site to see what it is. If it has an extraordinarily high amount of fentanyl that could be lethal or it has rat poison or something else mixed in it, that centre is then faced with the uncomfortable decision of what to do. Do they confiscate the sample and let the addict have nothing, or do they replace it with a government substitute that happens to be pure and better? You know, there are all the problems with diversion and everything else, but essentially harm reduction, which started out as more of a weaning off addiction, has today become a full substitute for what I call addiction maintenance.

The Chair: Excellent.

Mr. Stephan: I thank you for your presentation. You had talked about how safe supply contributed to the removal of a stigma against partaking in drugs. I'm wondering: in your research how important is it for there to be a stigma on a behaviour before someone will seek recovery from a drug addiction?

Mr. Posner: Well, you know, I may be a dinosaur when it comes to this because I actually happen to think that there needs to be a stigma attached to many of the drugs before many people with an addiction will seek treatment. Now, I'm sure that right away there will be somebody who could prove the opposite and that they'll give some case examples where somebody didn't think that the drug they were taking was terrible and that they still ended up going through full recovery and getting clean of the drug.

But I think that to the extent that we destigmatize these drugs, as had happened with prescription opioids for doctors who were prescribing them – you know, doctors weren't prescribing prescription opioids in the United States or in Canada or in the U.K. for back pain or osteoarthritis because they were evil or because they thought that they were doing something that was terrible. They actually thought at that point that that opioid was all right and that their patients would not come back with addiction problems and that it was an effective treatment. So you take away the stigma, and I think you make it easier, especially for young people.

By the way, you know, one of the things that's very interesting here: you have addicts who have been for 20, 25 years. They have not overdosed; they haven't died. They may have had overdoses, but they're still alive. They've been, let's say, heroin users. Those are the 120 people that Michael Shellenberger talked about earlier that are in Amsterdam, 120 people literally out of a population of 17 and a half million. You know, in Switzerland they have very, very firm rules before you can get a replacement for heroin. They had originally only allowed 1,000 people to have that. Now they have 3,000 in a country of 8 and a half million. So you're talking about palliative care there.

It is so interesting to me, as an aside, if you look at this as a history, that prescription opioids started as palliative care for terminal, end-of-life cancer care. Here we are now talking about rolling out safe supply that would in essence be for many long-term users the equivalent of palliative care for them. It's not a good place, necessarily, to end up at. For 20-year-olds who have been using the drug for a year, two years, three years, to let them know that they don't necessarily have to find a way to recovery but that they might be able to stay on a government-supplied form of heroin for the future I think is the wrong message to send out.

Mr. Stephan: Can I just ask a supplemental?

The Chair: Of course.

Mr. Stephan: Thank you, Mr. Chair. As you were talking, I thought about safe supply, and it also seems to result – and I've heard this from other speakers as well – in increased supply. I'm wondering if you're aware of any studies, by proponents of safe supply or otherwise, that look at, because there's an increased supply, what the impacts of safe supply are from, for example, a diversion context in seeing new men and women become introduced to a supply of drugs, whether clean or unclean, that are inherently unsafe both in terms of new addicted individuals from the incremental growth in supply or even additional deaths.

Mr. Posner: There is little question, I believe, that you certainly have a growth in the number of new users. There is no question that safe supply adds to the amount of narcotics that are available in the community, which a safe supply institute is. There are people who are getting the safe supply amount of the narcotic, they're going out, and as you heard from those doctors and those involved in addiction work earlier, many of those who are addicted are looking for a stronger hit. They will find it on the street through an illegal drug dealer, and they'll sell what they already got as their government supply to somebody else, so it filters out into the community.

Those proponents of safe supply should go to Amsterdam and ask the police there why they are having problems with Albanian and Nigerian gangs running drugs in a community in which otherwise you can get many of the drugs at a government institution. Because those drug dealers know that they are offering

more bang for the dollar. They're giving you a combination sometimes of fentanyl mixed with methamphetamine, what used to be called in the old days of heroin and cocaine a speedball, that killed the actor John Belushi. You can buy things on the street that you can't get from a government source.

2:30

The same thing in Platzpitz, which is the plaza in Zurich, which many people know as Needle Park. It hasn't been called that in years, because the Swiss cleaned it up in the '90s. They went in and did a sweep and took out all the outside drug dealers, but there's still drug dealing that goes in and around Platzpitz and around Zurich and in Geneva. The Swiss will tell you the same thing: just because you have a safe supply, you don't necessarily eliminate the illegal market. San Francisco is seeing that in multiple ways outside of their operating safe supply institute right now, and you don't eliminate the need, you know, for police for local crime, because, still, people are looking for something different. What you are doing is adding the supply, the government supply of narcotics distributed to a safe supply institute or centre, out onto the street, in many cases, because of diversion.

The Chair: Thank you, Member.

MLA Yao.

Mr. Yao: Thank you so much, Chair, and thank you, Mr. Posner, for taking the time to speak with us. Your resumé is vastly different than a lot of the other folks that have spoken to us, and I find it very interesting, specifically your high-level approach to a lot of these aspects. I mean, a lot of your research on things surrounding World War II and the Holocaust are very interesting as well as your review about the history of the American pharmaceutical industry.

This high-level perspective: I'm wondering if you can talk more about the lobbying efforts and general influences that these pharmaceutical companies have had over the years to support some of the controversial policies, including the opioid crisis of the 1990s, but more importantly do you see any of that with this current issue around safe supply? Do we see any influence coming from that area?

Thank you.

Mr. Posner: I don't see that influence yet, but that doesn't mean it's not there. You know, I'm sort of with my wife, Trisha, who's also an author. We're a two-person operation, so I wish I had a team of researchers that could go out and look at it, and we haven't been able to investigate that fully.

What I do know is this. There is absolutely no doubt that pharmaceutical companies – and when I say that, I'm not just talking about American pharmaceutical companies because, as you know so well, they are multinational companies. If you look at the top 10 biggest, they're all public companies. They operate, you know, in Germany, France, U.K., Canada. Here in the U.S. they have regional headquarters. They always claim that they need high prices for their drugs because of the fact that they do so much research and development, and my point on that is that if you take the top 10 companies, the biggest in the world, they spend more on average for promotion, advertising as it is, even in medical journals, and on lobbying than they do on research and development. They also spend more on share buybacks.

We know they spend a fortune in terms of making sure that their influence is felt. I don't yet have the evidence – I don't know if it's there to show that there's a hand of the pharmaceutical industry behind the safe supply movement – but I do know this. They certainly are not standing against it, because when they are against something, as they were against sharing the intellectual property rights, for instance, for COVID-19 vaccines when they were developing them – there was a suggestion we should do the same thing as we did in World War II and no company would own the rights to penicillin; everybody would share the research. That they fought. They wanted to keep their patents on individual vaccines. That's fine, but my point is that you know when they're against something. They stand up, and they're very noisy about it.

We haven't seen the Pfizers, the Lillys, the Johnson & Johnsons, the Mercks of the world yet standing up in any public forum or campaign and saying: by the way, safe supply is unsafe for the following reasons, X, Y, and Z. I find their silence rather unusual, but I don't yet have the evidence to present to you and this committee, the credible evidence to show you that they have a hand in tipping the scale towards safe supply.

Mr. Yao: Thank you.

The Chair: Do you have a supplemental, Member?

Mr. Yao: No, sir.

The Chair: No? Okay. Thank you.

Any other questions for Mr. Posner?

All right. Hearing and seeing none and knowing that we've only got 30 seconds left, I very much appreciate your time today, Mr. Posner, and your presentation and your work, so thank you for joining us today.

We will move on to our next presenter, but before we do that, there's just a small error in our schedule for the day that we need to fix. We do have Dr. Tanguay up next, and it says from 2:35 to 2:55, but of course we're going to need at least 30 minutes with him, so I just need to get unanimous consent to extend our meeting time beyond 3 o'clock. I'll just ask one question: is there anyone opposed to extending our meeting beyond 3 o'clock? All right. Hearing none, that means we can do that. Perfect.

Now we will move on. Welcome, Dr. Tanguay, to our committee. We appreciate you taking the time to be able to present to us today. We'll open it up to you for 10 minutes of presentation and then 20 minutes of Q and A with the members here. Without further ado, I will pass it over to you.

Robert Tanguay

Dr. Tanguay: Thank you very much. I'm just going to pull up a PowerPoint if that's all right. Hopefully, you guys can see that okay.

The Chair: Yeah. We can see that. Actually, the clerk has it up as well. The clerk is just asking that you not share the screen. He'll share the PowerPoint.

Dr. Tanguay: All right. Okay. I guess the presentation is there, and I'm not sharing anymore. Is that working?

The Chair: Yeah. We're looking at it. Safe supply: where are we coming from?

Dr. Tanguay: Thank you. First of all, thank you for inviting me to speak. It's an honour, obviously, to be here. As mentioned, my name is Dr. Rob Tanguay. I'm a psychiatrist. I have subspeciality training in addiction medicine that I did a fellowship and one-year training in, followed by cross-appointed with anaesthesia in pain medicine. It puts me as one of the few in North America as a psychiatrist with training in both pain and addiction, so that's always given me a unique perspective on opioids and, to another extent, cannabis. We're going to be kind of discussing a bit of what you just finished hearing a bit more about coming from more of the medical aspects.

You can jump to the next slide. We're going to move into the story of opioids. The next slide. Sorry. I should have sent you a PowerPoint. This is basically a review of the number of opioid-related deaths in Ontario. It wouldn't matter if you're in Ontario, Alberta, you know, Texas; it's going to look fairly similar in a lot of aspects. The reason I use it is that it's quite a colourful graph, and it really can help tell a bit of a story of what we've seen and what was going on.

If we go to the next slide. You'll see that 1996 was the year that a long-acting OxyContin was formulated. Now, before that, we had some MS Contin and some of the other long acting, but really we were using opioids in the pain world for short usages only, and there were only short-acting medications. Now, when they shifted it to long-acting medications, they didn't need further FDA approval for the treatment of pain for indications because they already had those indications. But now all of a sudden we could take what were normally five-milligram tablets and jam a whole whack of them into 80-milligram and 100-milligram and 120-milligram tablets, something that was completely unheard of. You can see that the only real opioid-related deaths at that time came from two things, codeine and morphine, because they were the only medications really prescribed by primary care and were accessible in most of the communities.

Now, you can see in the next slide that between 1996 and 2000 not a lot really changed. You see a little bit of a blip there. That represents methadone. The theory is that some methadone clinics might have opened in Ontario at that time, but not much had really changed. But in the year 2000 a couple of things occurred. One, a massive shift in how we were looking at pain. The fifth vital sign came out, which was perpetuated by the American Pain Society at that time, which no longer exists, and was funded a lot by the pharmaceutical industry, which you guys have heard a lot about today. You know, the second thing was that there was a movement in education that it was okay to prescribe opioids for all chronic pain, and in fact this switch occurred that now you were not a good doctor if you weren't prescribing enough, and you could actually get college complaints for not palliating pain and taking care of people.

If we go to the next slide. The pharmaceutical industry was very strong. This is a bit of a shot at Purdue – and this isn't just Purdue; this could have been Janssen and other pharmaceutical industry companies that were selling opioids – but we saw lots of gimmicks and toys. That's actually an MS Contin or a morphine sulphate long-acting tablet stuffie. That is a toy for your kids. Now, if you can find one, there's actually a green one, an OxyContin stuffie, that's out there. I would purchase it from you because I have been looking for it for a long time.

2:40

And that's not always the shocking part. At that time swing is alive. OxyContin is the cure for all pain. How do you spell relief? It's Percocet. You know, there was a big movement, and these are just some of the gimmicks that were given to doctors and families and everyone else as part of the salesmanship that was going on.

Scrolling down, you know, a lot of education started happening by the pharmaceutical industry towards physicians. Now, that continues to occur today – that has occurred for many, many generations – and this is where a lot of that education comes from. But, you know, Purdue knew, as did the other companies, the more that they got in front of physicians, the more likely the physician is to prescribe that medication. All of the pharmaceutical industry knows that. The problem is that if we don't have the pharmaceutical industry being involved in medical education, there's basically a paucity of medical education because nobody is funding it.

You know, despite the fact that marketing of OxyContin increased the amount of prescribing of OxyContin just by going to see the physicians, they also knew that there were harms involved in this. They were selling processes like: it's not addictive; pain is the fifth vital sign; there is no top dose; you give as much as that patient needs in order to be stable and to palliate that pain. Unfortunately, these are the same kind of stories that we are now hearing again 20 years later from a lot of the safe supply physicians, saying: I allow my patient to decide; I give my patient as much as they need.

One of my mentors quickly told me, when learning about pain medicine, that we are not liquor stores and that patients don't get to come in and choose whatever they want to choose, that we are the physicians, and it is our job to manage and create functionality, not palliative care. It was these kinds of teachings of the fifth vital sign, that there is no maximum dose, we palliate pain, we keep going as much as needed – even though the origins of the epidemic, the pharmaceutical industry, was well aware that morphine sulfate, back in the mid-90s, was being peddled in Vancouver and elsewhere. They knew that these long-acting opioids had significant street value. They did nothing about it.

We like to blame the medical industry and doctors, but if we pull back and think about one thing for a second, the doctors had nothing else to treat pain. Physio is not covered. Mental health is not covered. All the other aspects of pain medicine that actually benefit people are not covered. The only thing they had was their prescription pad and a slick-selling salesman telling them why they should do it.

Next slide. Now, of course, between the year 2000 – and if we go to the next slide after that – and the year 2012 we see the red line, which represents oxycodone: a significant number of opioid-related deaths. It was the most popular opioid on the street. It was everywhere. In 2012 OxyContin was removed, and OxyNeo comes into play. Now, this is a fascinating development. The pharmaceutical industry comes out saying: now we have a tablet you can't chew, you can't inject, you can't snort. It turns out it has no street value, and we see a sudden droppage in oxycodone-related overdoses, and we see a shoot up at this point of hydromorphone and other substances. Next slide. This also opened the door, unfortunately, for fentanyl, and we'll come to that.

So what about consumption of opioids in the North American market? If we go to the next slide. I'm sure you've heard about this already, but the United States consumes – next slide; sorry – over 50 per cent of the world's entire opioid production. Half goes to the United States. If we go to the next slide. When we look at opioid prescribing and consumption, the United States: number one. And right behind the United States is our own country, in Canada. If we go to the next slide. If you go the bottom, actually, you see Israel, France – you know, not Third World countries but countries that were well developed with good medical systems – not prescribing and consuming. And, of course, OxyContin started in North America, but it's become an international phenomenon.

Next slide. You heard from the previous lecturer about these international companies. Mundipharma is owned by the Sackler family. And outside of the United States and Canada is where OxyContin and oxycodone are being produced, not OxyNeo, I might remind you. To give you an idea, China is worth $1 billion in Mundipharma as they prepare to sell it. The entire network may be worth well over $5 billion as the Sackler family looks to sell Mundipharma.

Next slide. What's interesting – we talked about China. A few years ago China was barely prescribing any opioids. Since Mundipharma has been in China, we've seen an exponential growth in the amount of sales and distribution of oxycodone. It might

almost say that North America was the test market and the rest of the world is where we're going.

Next slide. When we actually look at who we prescribe to in the United States, it's fascinating that 16 per cent of Americans who have a mental health disorder received over half of all the opioids prescribed in the United States, meaning that 25 per cent of the world's opioids go to the 1 in 6 Americans who struggle with mental health. Unbelievable when we look at our own prescribing habits.

Next slide. We're just going to go past that slide, and you guys can take a look at that later.

You know, we know that when we look at the prescription of opioids and deaths, the correlation coefficient is .99; 1 is absolutely if we do A, we get B. If we prescribe more, we see more deaths.

Next slide. This is no different than lung cancer and cigarettes smoked per day. It's the same correlation coefficient.

Next slide. I know I only have 10 minutes, so I'm running into it. So what do we do?

Next slide. We know safe supply is a big piece. We know that in 2012 was when we saw the next wave into the synthetic market and now the fentanyl-related overdose. Really, it was a perfect storm. OxyContin was removed, heroin started shooting up, and in came fentanyl and synthetic analogues of it.

Next slide. These are obviously much more potent and dangerous, but what we had – and you've probably seen this graph, I'm sure, several times already. If you haven't, you can take a look at it. This is that concept of the drug policy spectrum and an unregulated legal market, which is basically what we were doing with the prescription of opioids everywhere. Unregulated became highly harmful.

Next slide. So what can we do? Safer supply is the belief that we can regulate it.

I'm out of time, but I can take questions there, or I can just finish one piece. Go ahead.

The Chair: That's what I was just about to say, Dr. Tanguay. I think there's consensus at the table here that we would love for you to finish your presentation. This is some great information. If you felt like you had to race over something, feel free to expand upon that. We appreciate that.

Thank you.

Dr. Tanguay: Perfect. Let's talk about safe supply or safer supply. Now, it was safe supply. Now it's safer supply because they've realized: opioids aren't safe; we should just kind of end it at that level. Are prescribed hydromorphone opioids safer than fentanyl? Probably true, but you know that doesn't talk about society as a whole or looking at the spectrum of the culture of drug use versus the access point and danger to an entire society and community.

The four-pillar drug system, which really is a Portuguese model that has been used elsewhere, includes prevention, treatment, harm reduction, and enforcement. You heard a great description of what harm reduction was and what it's morphed into. The concept of the Portuguese piece was: ramp up treatment; ramp up prevention techniques, which we don't see a lot of right now; ramp up enforcement – i.e., you cannot use drugs – even though in harm reduction they decriminalized the personal use of drugs, which is an important process because that removes the concept that addiction is an illegal process. Rather, it is truly a health disorder. We don't make it illegal to have a broken leg. We don't make it illegal to have cancer. I don't know why it's illegal to suffer from a disorder like addiction, but that doesn't mean that it's okay to use drugs in open areas. That's where enforcement ramped up.

So how can we use this model and incorporate it with the concept of safe supply and other treatments into, well, quite simply, a devastating opioid crisis where more young people have died from an opioid overdose than COVID in the last couple of years? Imagine if we spent the money on opioids that we have on COVID.

Scrolling down, what we can look at is that the concept of responsible legal regulation and decriminalization is that we keep the societal and health harms low. The problem is that safe supply – i.e., handing over as much hydromorphone or other opioids or whatever substance that somebody wants, again back to that liquor store concept or the old concept of how a pain doc would just give as much opioids as needed – really leads to that unregulated legal market, which has high societal and health harms.

2:50

So how do we keep those harms down? Now, the way safe supply works now in opioids is that you get up to 30 eight-milligram hydromorphones and you take those home with you and do whatever. We know a lot of it is diverted, and we know there's a pushback. Diversion is a form of income for those who have inequity in income. That's kind of garbagey stuff and spin on an illegal aspect to pay for your fentanyl because the hydromorphone isn't enough to keep you stable. That increases the access and the harms, creating an unregulated legal market, extremely dangerous in all of the experts' viewpoints regardless of where you're coming from. How do we bring it back down, where we've got it safe and we don't have that unregulated criminal market and unregulated legal market, your basically illicit market that we see today and a lot of your activism that we see on the other side?

Next slide. One of the thoughts that has been shared a lot – we have these supervised consumption sites, these services that allow people to go in and use their illicit product in-house and reduce their risk of death. We know that that's true – and we published on it – if you're only using it. The reality is that in B.C., where it's been published, with the highest SCSs per capita in the country, maybe the world, 95 per cent of people do not use in those programs. We need to incentivize the program to prevent death and use those four pillars and increase enforcement to make sure that people are using it in there.

What could that look like? Well, we need to medicalize the SCSs and put in physicians who are trained in motivational interviewing in addiction to meet people where they are, the harm reduction mantra, which is truly a motivational interviewing concept, that was around many decades before it was stolen, towards the harm reduction. It's about meeting them where they are and not leaving them but actually working with them towards a pathway to recovery and health.

So that means – right now we've tried this with the SCSs in Alberta, and they've pushed back, saying: we don't want you there. Imagine physicians prescribing so-called safer supply. That may include things like buprenorphine, naloxone, or Suboxone and methadone. It may be Kadian or slow-release oral morphine, or maybe it's hydromorphone. Whatever the case may be, it's prescribed by a physician and must be used under supervised aspects to prevent any chance of diversion.

Now, what do you do for the communities that have these programs in them? Well, you remove the criminal element. If you scroll down to the last page, no longer do you have a bunch of people excited to sell drugs outside of the SCS because they're inside the SCS being prescribed. You remove the stigma.

We've talked about stigma a bit, and it gets a little crazy sometimes. The true concept of removing stigma is making it okay to get help. The SCSs have created a safe environment for people. The problem is that nobody is really getting a lot of help there. They call them referrals, but we have no breakdown or pathways of where the referrals went. If I were having chest pains and I went to my

family doctor and they said, "Look, it's not an emergent thing, but you should go see a cardiologist," my family doctor would refer me to a cardiologist, not, "Oh, the cardiologist might be available down the street and around the corner; why don't you go knock on their door?" and then marking that off as a referral. It would improve the community and the acceptance of stigma in the community.

If we change these things – we have ATCO trailers everywhere – and turn them away from the consumption site and into a true medical clinic, a primary care, street-level clinic where you can get, you know, treatment for infections, treatment for mental health, OAT, and other evidence-based treatments but also an opportunity that if you don't want any of that, "Fine; here is one treatment that we can do in this so-called safer supply, but you cannot leave with it, you cannot go anywhere, and we can start building a relationship to move it up," this may reduce overdoses by encouraging the SCS along with enforcement, where you can't use outside of these medical clinics, and may overall improve all aspects and not create an area where with safe supply we increase access and we create this legal unregulated market that is extremely dangerous.

This is just a concept but a concept that has been reviewed with many think tanks, both Conservative think tanks and local think tanks here in Calgary, and has been acceptable as a way to actually support street-level drug use and possibly prevent the harms of safe supply and harm reduction in some of the SCSs that are out there.

I will stop there and open it up to whatever questions may come, and I apologize for going over time.

The Chair: No. We appreciate your time and your presentation.

Mr. Milliken: Thank you, Doctor. If I could ask the clerk to put up 8 of 27. It's the main graph that we kind of started with. It happens to have the line for 2000. I'm not looking at the vertical line. It's not the first time that I have seen this graph. I'm going to wait, just for the benefit for those who might be watching. Awesome. Thank you so much.

Okay. With that graph, taking a look at it, I am seeing, like, generally speaking, opioid-related deaths increasing.

Dr. Tanguay: Correct.

Mr. Milliken: I'm seeing hydrocodone and tramadol relatively stable on the low end. The next one that I'd say is relatively stable might be morphine, probably due to its use, and then I'm seeing some pretty disturbing trend lines going up, including methadone and hydromorphone. I'm just wondering if you're seeing anything in that data. I'm seeing the acceleration on some of them, including methadone and hydromorphone. I'm seeing hydrocodone and tramadol obviously low and stable, and then morphine relatively stable but still at some pretty high numbers, and then I'm seeing all of the rest, especially fentanyl. Oxy has a dip, but it goes up, and the general trend line can't be disputed as going up. I'm just wondering why that is the case.

Dr. Tanguay: Sure. Let's start with the hydrocodone. Hydrocodone is not available in Canada. Hence, it's always stable and low, and anything that we do have here is imported from the U.S. Tramadol is a synthetic opioid that is intermixed with an SNRI, and only a certain number of people can even get the opioid effect from it, so we don't expect it to be high. You know, certainly, in certain populations it may be a drug of abuse such as in prisons and other areas where there's no other access, but we don't see it a lot.

The methadone is interesting. Methadone, we know, is a very dangerous medication if not used correctly, and under poorly trained hands it can increase death, and that methadone is probably directly related with the increase in methadone prescribing for a combination of both – we see it used in pain and in addiction treatment. You know, even though the data clearly states that methadone is much, much safer than heroin or fentanyl or any of the other opioids, under the guise of addiction medicine – and that's the thing. Addiction medicine is a practice, unlike the prescription of safe supply, where there's no practice of addiction medicine; it's just person centred, where whatever they want, they get. You're absolutely right. This is what unregulated legal supply looks like. When we're just prescribing relentlessly, we see increases in death.

Now, of course, if you were to go to slide 20, you know, when OxyContin came down and we started pushing down our prescribing, we also saw the massive increase in fentanyl and illicit substances causing more overdose deaths. But, again, we've just got to step back and remember. Opioids are not safe to anyone, and that is what we have to remember. They may be beneficial to some people in pain, but they should be focused on functionality, not on palliating the pain. They may be beneficial in treatment as an opioid agonist therapy to be safer than injecting fentanyl, but we don't have any data to show that people stop using fentanyl or reduce their risks. The best data we have is in OAT with methadone and Suboxone. You can actually look at the Alberta surveillance reports and actually see that about 55 per cent of people who are using methadone and Suboxone have no other substances in urine screens. That is much better than what we see in a lot of other treatments.

I hope that answered your question.

3:00

Mr. Milliken: It does very well.

What I would also just ask, though: do we have any data – I'm kind of taking this 2-D, going back to eight, and trying to kind of make it 3-D. What I mean by that is, like, methadone obviously increasing. It's kind of a velocity versus acceleration question. If we're giving methadone out at an increasing rate, are the deaths per user not increasing relative to other ones like fentanyl, which might be the inverse of that relationship? Thoughts?

Dr. Tanguay: I would say that you're absolutely correct on that. That's a really good view of looking at it at a systemic level. We've increased and ramped up the amount of methadone. Again, this is available on the Alberta surveillance website. But you see an increase over the last two decades of methadone. It started as kind of a treatment for heroin, and that was about it. And then the pain opioid prescribing, legal, unregulated supply also meant an increase in addiction and an increase in methadone use and treatment. I would say that the risk hasn't changed; it's just the number of prescriptions being doled out because of using it in a treatment facility.

The Chair: Thank you.

MLA Rosin.

Ms Rosin: Okay. Thank you. I, too, want to, I guess, dig a bit deeper on some of your data points. I'm not sure what slide it was on, but you had the graph showing that the U.S. had the highest rate of opioid distribution and then Canada second in the entire world. I'm wondering if that graph shows opioids prescribed or just generally consumed. It is just consumption? I just needed to confirm that for myself.

Dr. Tanguay: It is consumption based on the narcotic control board. What we do know is that prescribing in North America was well higher than anywhere else. Of course, Bayer is based out of Germany. You know, we see a lot more pharmaceutical influence there. But if we looked at Canada and the United States compared to the rest of the world, it's not even close that are prescribing.

Ms Rosin: Okay. But this data on slide 12 would include opioids consumed that are not prescribed, so those purchased on the streets or from safe supply.

Dr. Tanguay: Correct.

Ms Rosin: Okay. Then my second question is: how do those numbers change? How does the order of that graph change if we look at the numbers on a per capita basis? Oh, but that is out of one million people. Okay. So I'm answering my own question.

Dr. Tanguay: Yeah. This is per capita. You bet. Sorry.

Ms Rosin: Okay. No. Perfect.

Then you also mentioned that prescriptions are significantly higher in the United States and Canada. I'm wondering if you have any data that breaks down those prescriptions. Are we primarily prescribing opioids innocently to those who break an arm and need temporary pain relief, or are the bulk of our prescriptions being given out for more long-term sustainability or reliability purposes?

Dr. Tanguay: Yeah. I think that if we step back, that's a great question. The vast majority of the data that we're looking at has always been about prescribing opioids judiciously for pain, as much as needed to anybody who wants it. Now, of course, the U.S. and Canada are very different. The U.S. had a lot of these kind of pill mills where there was massive money being made by docs who ended up in jail. In Canada we didn't see that kind of stuff, but we have much more regulation by our own colleges to monitor and look at that. That was slightly different as well, but, you know, there was no doubt. We were trained as physicians that you can give as much as that individual needs to reduce as much pain as they need. It's up to us to keep prescribing till they're well and, if they get side effects, to rotate to another one.

Everything that you're seeing there was really just bad practice and a lack of resources for anything else to help and support physicians. They jumped on the train and believed they were doing the right thing, as was mentioned by the previous speaker. The majority of docs didn't do this to create harm. They did it because they believed they were doing the right thing. I believe the same thing of the docs who support safe supply. They aren't doing it because they want to create harm. They truly believe they're doing the right thing. It's just that the data isn't there to support it – we don't have any – and the previous data, in a similar concept, showed a lot of harms to our societies.

Ms Rosin: Two more quick, data-driven questions in that same vein. Is there any data from that data that shows the longevity of the drugs prescribed? You know, are some of them being prescribed only – we could go to the hospital with that first broken elbow and you get your little capsule to take home and that's all versus people who are getting prescriptions refilled month after month, year after year. Is the bulk of our prescriptions long-term or short-term based?

Dr. Tanguay: The bulk is long term. In fact, here's the sad part of what's happened. Now, to be clear, the Alberta pain strategy is an international leading strategy looking at the effects of opioid prescribing in emergency departments, prescribing after surgery, prescribing in primary care. The vast majority of opioids were going out to chronic pain patients on long-term treatment. Unfortunately, the quick response of "Oh, my goodness; look what we've done as a medical society; stop prescribing them" – we didn't actually stop prescribing in emergency departments or stop prescribing after surgery or stop initiating in primary care. We attacked chronic pain patients and forced them down.

You know, we then went around waving the flag, saying, "Look at us; we're reducing the amount of prescribing we're doing," possibly at a detriment to many chronic pain patients who were stigmatized as people, whose doctor told them "This is what you're supposed to do; this is how much you're supposed to take; this is what we're supposed to do to support you" and now being told, "Oh, you shouldn't be on this." "Well, I never asked for it. My doctor just kept giving it to me, and now I'm the bad guy." Most of the data is based on that, and most of the push and change has affected an unfortunate population of individuals that never deserved it in the first place.

Now, in Alberta we're making those shifts with the pain strategy and many working groups and looking at algorithms and protocols to follow so that if you come into emerg, here's the maximum you get based on whatever diagnosis it is, if absolutely necessary at all. If you have surgery, here's the maximum you get, if necessary at all. Here's a transitional pain program. If you're struggling, you will transition over to there. This is leading internationally. Michigan has a great program there under Dr. Chad Brummett and, you know, another TAPMI program out of Toronto, and that's about it. Really, these kinds of concepts are what we've got to do, stop going after the chronic pain patient who's just doing what their doc tells them to do in the first place and start working on docs to reduce the amount of initiating so that we reduce the overall burden of where these lead to.

I hope that also adds to that.

Ms Rosin: Okay. Yeah. Thank you.

I have one last question. Obviously, our rates of prescribed and consumed opioids differ vastly compared to the rest of the world. How do our rates of addiction to opioids compare to the rest of the world?

Dr. Tanguay: That's a great question. Opioids are one of the most addictive drugs we have outside of nicotine, which is much more addictive. You know, we're looking at about 20 to 25 per cent of all people who are exposed to an opioid will end up with an addiction. That includes chronic pain patients. Those are massive, massive numbers. We outprescribe, so we're going to have higher levels of addiction than anyone else in the world.

Then, of course, when you look at fentanyl, fentanyl is a North American phenomenon at this time. You know, we look at Australia. There's rarely a fentanyl overdose even though when we look geographically, it's closer and should actually have higher rates, but it doesn't. It is a North American phenomenon, and with that phenomenon, fentanyl is even more addictive than heroin is.

You know, the idea that, "Oh, if we offer somebody hydromorphone, they'll stop their fentanyl": that's insane. It doesn't follow pharmacodynamics or pharmacokinetics. It's not a true understanding of physiology and biology. An individual who's highly tolerant of fentanyl will not benefit from any safe supply unless it's fentanyl. We cannot just judiciously hand out fentanyl. So we're in a catch-22. Everything we're talking about simply won't work.

Anyway, coming back to your question. Yes, we have higher rates because we have higher access and higher prescribing.

The Chair: Perfect.

MLA Amery.

Mr. Amery: Thank you, Chair. Thank you, Dr. Tanguay, for your presentation. I do want to go back to slides 8 and 9. Essentially, they're effectively the same graphs. But I wanted to chat with you a little bit here. I see in the graph – and I think you've talked about this fairly extensively following my colleague's questions, but I

wanted to touch base just a little bit on a different line of questioning. The graph describes, I think, a general trend even with respect to any and all of the lines here. Generally they're travelling in an upward trajectory, starting from maybe late '90s, early 2000s, and then they continue on that upward trajectory up until the graph ends in 2015. At slide 21 you show another graph which provides us with a little more data, more recent data, I should say . . .

3:10

Dr. Tanguay: A little more up to date.

Mr. Amery: Yeah.

. . . which continues with that upward trajectory. One of the things that you emphasized throughout your presentation was that one contributing factor was related to physician mentalities, specifically the belief that ongoing palliative care was an important and, you know, right thing to do in these cases for continued treatment. Can you tell me and the other committee members whether or not the physician mentality still exists today in that sense that physicians feel a sense of duty and obligation to continue with palliative and ongoing care for people with addictions? What other factors, if that isn't particularly the case, are continuing to contribute to this upward climb?

Dr. Tanguay: Those are great questions. I'll start with the first one about doctors. Then I can hypothesize on the second one. The first one: look, I think doctors are highly educated and have no interest in creating harm. They're also some of the most passionate people out there. Most have gone from high school to university to medicine to, you know, not a lot of real-life experience and just really believe everything they're doing is about benefiting the outcomes of patients. Very little education on looking at systemic policy, looking at systems as a whole.

Physicians get highly trained and highly narrowed: they see a tree, and they forget that there's even a forest around. That's not all of them but many. You know, when you're passionate about your chronic pain patient – "I have to help them" – it's because they only see that tree. They don't realize that that pain patient may be diverting to another person, to another person who – that other person may die. That same thing is occurring now where we now learn that that was the problem and we shift over to these passionate safe supply prescribers. They also see the same thing: I am taking care of this person; if they divert, it's safer than the fentanyl.

But they miss the point that the problem is that the more access to that substance, the more likelihood of addiction; the more likelihood of addiction, the more likelihood of transitioning from safe supply to fentanyl because it's more potent and more likely to provide what they're looking for. We have to remember that opioids all come with tolerance and dependence, tolerance meaning that you need more and more and more to get the same effect, even more and more and more to not get sick. The dependency part: if I don't have it, I get sick. And the sickness is no kidding around. It's one of the worst feelings that many people can go through. You can talk to a lot of chronic pain patients who have had to get sick, unfortunately, even people who've had surgery and were on meds for a few months and then stopped and got sick. Now you take that and you amplify it by 100 because all their PTSD symptoms come back, all their mental health symptoms come back. It's a horrific process for people. We're putting them in these positions.

Why are we here today? I don't think physicians are here to harm people. I think most of them understand, you know, that if we're just freely prescribing dangerous medications, we have problems and consequences. I think that's really stepped up. There are still a lot of passionate people who believe in things, but it's a belief.

Why are we still here today? Honestly, I would say that a lot of it has to do with an unwell system. A lot of people want to take a look and say: "What is this province doing? What is that province doing?" Until it's all under one envelope and we're all looking at it like one piece, we have a bunch of pieces to a puzzle that aren't working together. We have harm reduction facilities not working with recovery facilities, not working with addiction medicine facilities, all under different leadership and different connections, so we've never made the puzzle. I have no question in my mind that Alberta is leading the way in a lot of these ways in developing more and more treatment and processes and protocols, but until we've built it altogether, it's hard to know what a good system could look like until it's actually a puzzle. We cannot evaluate one piece of a puzzle; we need to make the puzzle. At this time that puzzle has not been made although significant effort has been put in over the last couple of years to make that puzzle. Really, I think that we have an unwell system, a lack of access to good mental health resources, a lack of access to trauma therapy, a lack of access to these pieces.

Then the second part is the stigma. Stigma doesn't break until it's okay to ask for help, and we haven't figured out how to make it okay. Right now most people feel that the only place they feel okay is where we're continuing a community of harm in a lot of these programs, and until we have good recovery resources inside and embedded inside harm reduction facilities, we're going to really struggle with that. But that's opinion, pure opinion.

The Chair: Thank you, Doctor, for joining us today. That does conclude our time for Q and A. I sincerely appreciate you taking the time for your presentation and for the work that you do. Thank you very much.

Dr. Tanguay: Thank you.

The Chair: That also brings us out of the oral presentations component of today's meeting.

We're on to other business. Is there any other business that the committee members would like to discuss or bring forward at this time?

Hearing and seeing none, the date of the next meeting begins at 9 a.m. on Thursday, February 17, 2022.

With that, if there's nothing else for the committee's consideration, I'll call for a motion to adjourn. Mickey Amery moves that the February 16, 2022, meeting of the Select Special Committee to Examine Safe Supply be adjourned. All in favour? Any opposed? That is carried.

[The committee adjourned at 3:16 p.m.]

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