
Legislative Assembly of Alberta

The 30th Legislature
Second Session

# Select Special Committee to Examine Safe Supply

Stakeholder Presentations

Thursday, February 17, 2022
9 a.m.

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**Legislative Assembly of Alberta**
**The 30th Legislature**
**Second Session**

## Select Special Committee to Examine Safe Supply

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Allard, Tracy L., Grande Prairie (UC), Deputy Chair
Milliken, Nicholas, Calgary-Currie (UC), Acting Deputy Chair

Amery, Mickey K., Calgary-Cross (UC)
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* substitution for Tracy Allard

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## Standing Committee on Examine Safe Supply

### Participants

**9 a.m. Thursday, February 17, 2022**

[Mr. Jeremy Nixon in the chair]

**The Chair:** All right. Members, I'd like to call the meeting to order. [interjections] We will have order.

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

Thank you.

Welcome to members and staff in attendance at the meeting of the Select Special Committee to Examine Safe Supply. My name is Jeremy Nixon, and I am the MLA for Calgary-Klein and chair of this committee. Now I'd like to ask members joining us here live, starting to my right with the deputy chair.

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

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

**Mr. Turton:** Searle Turton, Spruce Grove-Stony Plain.

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

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

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

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

**Mrs. Frey:** Michaela Frey, MLA, Brooks-Medicine Hat.

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

**The Chair:** Thank you.

I'd like now to note for the record the following substitutions: Mr. Turton for Mrs. Allard and 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 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.

Those participating by videoconference are encouraged to please turn on your camera while speaking and to mute your microphone when you are not speaking. Members participating virtually who wish to be placed on the speakers list are asked to e-mail or send a message in the group chat to the committee clerk. Please set your cellphones and other devices to silent for the duration of our meeting.

All right. Up next we have the approval of the agenda. Can I get a motion for the approval of the agenda? Excellent. MLA Amery moved that the agenda for the February 17, 2022, meeting of the Select Special Committee to Examine Safe Supply be adopted as distributed. Any discussion?

All in favour, please say aye. Any opposed? That is carried.

All right. On to oral presentations. Hon. members, at our February 3, 2022, meeting the committee directed that invitations be made to 27 individuals and organizations to make oral presentations in relation to matters that fall under the committee's mandate. Each of our presenters will have 10 minutes to make their presentation, followed by 20 minutes for questions and answers with the committee members.

Our first presenter today is Chief McFee. Chief, welcome.

**Mr. McFee:** Thank you, Mr. Chair. Can you hear me?

**The Chair:** We can hear you, yes. You have 10 minutes to present, and then we'll open it up for Q and A.

**Dale McFee**

**Mr. McFee:** Sounds good. At the request of the committee I'm here to provide evidence-based policing position, obviously on behalf of the AACP, and the consequences of prescribed opioids. To be clear, I'm not here to give medical perspectives. I've seen the speakers list, and there are people far more qualified to do that than me. Local data is compiled for a comprehensive look at the history behind legalized and prescribed drugs, who consumes them, organized crime groups who profit from them, police efforts to impact illegal supply, and the overall impact on communities. From what we have gathered, if Alberta adopts a similar model as we see in British Columbia, based on what we know, it will fail.

We have looked at how the opioid crisis has evolved, especially for gangs and organized crime groups. Producing and trafficking drugs and other controlled substances continues to be a profitable endeavour for street-level traffickers, gangs, organized crime groups, and cartels. Organized crime groups and cartels have historically supplied the demand of illicit drugs, substances such as cocaine, methamphetamine – no need to move the slides; I'm going to get to them in a sec. Just a bit of a preamble. Thank you. Coupled with insatiable demand, fentanyl is much cheaper to supply as very little fentanyl is required to counterfeit drugs, and the higher potency increases demand, making it obviously far more profitable for cartels.

I will expand shortly on the evolving opioid crisis and even the legalization of cannabis. Gangs, organized crime groups continue to exploit simple supply and demand principles. Lessons learned from the evolution of the opioid crisis should not be overlooked, nor should other examples of regulated supply such as cannabis. In both cases consumer demand led to opportunities for organized crime groups, who were quick to introduce an unregulated illicit supply to run parallel to the legal and regulated supply. In the case of the opioid epidemic, what began as a prescribed pain medication has grown into an international health crisis of incredible proportion. Looking forward, we must consider the past to avoid similar outcomes.

I'd now like to just go into the presentation, starting on slide 1. The only way we can succeed is if we learn from the lessons of others who adopted a two-pronged model based on enforcement, obviously, and the health perspective. When we look at those lessons learned, they become quite obvious. Organized crime groups and cartels have repeatedly used the same strategy to expand and control commodities in high demand. From prescription opioids, legalization of cannabis, illegal drug markets are filling the supply and demand gaps our legislation and policies create. Let's keep in mind that they do not have to follow any rules.

Next slide. Even when you look at legal and illicit cannabis, illicit cannabis sold by organized crime groups is disguised as legitimate, with professional packaging. They have professional websites that resemble legitimate websites. The point: the cartels are innovative and will always have diversified to basically capitalize on the market. Every time legislation is just one dimensional, they will come out with a way to make it more profitable.

Next slide. If you follow the history of oxycodone, which started in 1996, oxycodone, introduced as OxyContin-brand pill and prescriptions, began to increase dramatically. Dependency

increased in the users through heroin or powerful synthetic opioids. This presented an opportunity for the illegal drug market. In 2012 OxyContin was being dispensed at 29 pills per 100 Canadians. In February 2012 OxyContin was pulled from the shelves, replaced by OxyNEO, as fentanyl, as counterfeited OxyContin, is introduced and skyrockets.

Next slide. As you can see, obviously fentanyl over the last several years has taken over heroin, and if you look at the far right and if you look at when fentanyl actually peaked, a thing that actually reduced fentanyl was the pill press. A member of your government was actually essential in bringing that legislation to effect. This led to the cartels yet again pivoting, becoming more creative, more innovative, and moving to a powder, which was the new way to actually produce fentanyl. When it did that, what happened is that it made it easier, but at the same time the potency got stronger, and then fentanyl has taken over the market, as you can see, from heroin. These things will always pivot with every move we make if it doesn't have a fulsome model to deal with it from a health – I always say law enforcement; we say in AACP a law enforcement, public health requirement.

Next slide. This slide is interesting because this is coming out of B.C., and B.C., through a survey, looked at 405 opioid users; 90 per cent prefer heroin or fentanyl available primarily through the OCGs, the organized crime groups, and 9.4 per cent prefer a prescription opioid. So if you strongly base the future on the past, the history of prescription opioids, it will likely diversify into obtaining illegal drugs and creating an expanded tool box for our OCGs. This is just language that I'm not sure is suitable, but if you were looking at this from a marketing tool, you would almost think that safe supply appears to be a marketing tool for opioid prescription based on the history, and that, for us, is a concern.

***9:10***

Next slide. These are some more B.C. stats that we have gotten through other law enforcement agencies and information through B.C. The one on the left is very interesting. It appears that even though B.C. went through the terminology, what they called safe supply, roughly between '18 and 2019, it would appear that the overdose deaths have drastically increased. Now, obviously, not knowing there, not B.C., and just getting the information, we can't say that that's the only reason, but it would make us as law enforcement ask the question: why is this, and has this contributed, or are there more things that are needed to deal with this in a comprehensive manner? For us, what we've been advocating at AACP is for a balanced approach, one that has, you know, the principles of recovery, as others have probably talked about, which really is access to services with significant enforcement on those that are bringing these large volumes of these harmful drugs, opioids, into our province and our country. The graph on the right shows you that most of these overdose deaths are due to fentanyl, which is what we're largely talking about today.

Next slide. When we look at what's happened, we look at fentanyl prices as a gram in Alberta: $75 a gram in 2017, peaks at $120 in 2018, and has remained at $150 for three years. So fentanyl obviously has a demand. It continues in demand because it is probably the potency that people are looking for, thus keeps the demand. If you look at meth and what's happened with meth, which is a lot of our violence as well, the price of meth from an ounce level went from $1,200 in 2018 and is now at $500. Again, both of these drugs are largely connected to organized crime groups. [inaudible]

Is there no next slide? Okay. I'll just give you some more information. Yeah. There's some more information here. Okay. There we go. These are just some of our recent seizures from our smaller Alberta towns just so that you don't think this is a city thing. Red Deer, operation repent: cocaine, weapons seizures, lorazepam, fake oxycodone, ketorolac , sennosides, oxycodone. High Level, Dahir: cocaine, weapons seizure, hydromorphone, tramadol, oxycodone. Red Deer, operation raffle: methamphetamine, cocaine, weapons seizures with OxyContin and assorted pills yet to be analyzed. Lethbridge, operation looper: cocaine and fentanyl seizures, suspected OxyContin yet to be analyzed.

The point of this is that when you're dealing with organized crime and you're dealing with a lot of the large dealers, whether it's a gang or, you know, significantly organized, they have a wide variety of products that they supply. They obviously have a cache of weapons. Obviously, this is one of those things where significant violence appears. The point is that what you see potentially could happen, what happened in the oxycodone crisis, is a diversification to turn the legal drug to expand the market and what they have to supply to cash in to get the stronger drug.

Next slide. These are just some of the recent seizures. These are mid-level investigations. As you can see, you know, fentanyl – and these are in the last few months – and methamphetamine are certainly the things that are predominantly controlling the drug markets in our province.

Next slide. When you go to some other further recent seizures, Project Essence, look at what we're starting to see. These are significant quantities in our province: 13.6 kilos of fentanyl, 11.9 kilos of fentanyl late-stage, 6.6 kilos synthetic opioids. You guys can read this. This is basically showing you that these are the same organized groups associated with violence, heavily associated with profit that often will exploit our vulnerable people and get people to use their supply. They have a wide range of products that they can put on the street. The point in trying to show all of these is that a simple approach to this legislation in relation to prescription is not going to control or change these people from exploiting that.

Recent seizures. Next slide. Again, four kilos of fentanyl, 1.1 kilos of meth. These are large quantities. This is a lot of potential overdoses in our province if these things aren't handled properly or if we can't get them off the street.

Next slide. The emergence of opioid prescribing: other provinces have done nothing, based on what we have of cursory overview. Of course, not an in-depth analysis. AACP is doing an in-depth analysis right now on this with an academic. Organized crime groups, we know, will take advantage at the expense of the vulnerable. We cannot let history repeat itself, and we must be able to support those suffering with addiction with enforcement and those profiting from vulnerability.

Do I have a couple more minutes, or do you want me to stop there?

**The Chair:** You can take a couple more minutes, yeah.

**Mr. McFee:** Okay. In conclusion, the emergence of opioid prescribing in other provinces has done nothing to curtail the overdose crisis. This causes us in law enforcement grave concern, that we would be jumping into something without knowing what the impact will be. At this stage we cannot confidently say that if we move forward with similar models that we see in British Columbia, organized crime groups will not take advantage at the expense of the vulnerable. We can't attack this problem by trying to outsmart the cartels. We will not win. Recent history has shown that, despite good intentions, legislative and policy change can have unintended consequences. Given the opportunity, organized crime groups and cartels will continue to prosper.

Changes in oxycodone regulation has led to high demand for high-potency opioids. Organized crime quickly filled the void with fentanyl and increasingly toxic synthetic opioids like carfentanil. Since the legislation of cannabis organized crime groups continue to service demand through illicit product, often mimicking regular

supply, from packaging to online sales to even doorstep delivery options that mimic SkipTheDishes or Uber Eats. Of course, these drugs are way more dangerous than marijuana. There's no reason to believe that prescribed opioid medications won't be counterfeited the same way as we have seen in the past. History has shown us that organized crime groups will always find new ways to make a profit. There will always be a new drug.

We need to be smart, cautious in our approach, and get away from being commodity based. We believe that we need to allow – law enforcement must continue to interrupt supply, hold traffickers and organized crime groups accountable. We also believe we will not arrest our way out of this. We can shut down as many drug supply chains as possible, but law enforcement cannot make sustainable changes alone. Changing policy and legislation needs to have meaningful outcomes. The solution, we believe, that needs to be created lies in reducing demand. We need to provide affordable, accessible treatment supports for our affected citizens. We cannot move forward legislation and policy changes without having treatment options in place first. We feel strongly on this.

You know, having looked at some of the things in the Portugal model, this support and this treatment and as close to on real-time treatment that we can get is a real opportunity for a breakthrough in this space. Let us put the health and safety of our vulnerable citizens first by developing a comprehensive approach on ways that we tackle this on both ends of the supply and demand, the enforcement end for those higher, higher level people that are hurting people not just one at a time – but, obviously, it goes to one at a time on the street. These are your cartels, your organized crime groups. Let's please get some supports in place for the many, many people we see struggling with addiction and are often seen dying on our streets. We believe we have to do both of these things at the same time.

Thank you. I'll take any questions.

***9:20***

**The Chair:** Thank you, Chief, for your heart on this issue and for your presentation.

The first MLA we have is MLA Stephan.

**Mr. Stephan:** Thank you for your presentation, Chief McFee. I think it's great to have the perspective of law enforcement as you serve in our communities. I happen to represent Red Deer. I notice that you had spoken or referred to some of the seizures there, and as a parent I echo your concerns and request for more drug treatment. If I had a child suffering under a drug addiction, I would want to love and support them to become free from their addictions.

Some of the presentations we've heard have talked about the experience in B.C. with problems of diversion with the safe supply and how criminal groups would use the prescribed safe supply medications as currency, including those who are suffering under addictions and seeking to maintain themselves in their addictions using safe supply as currency to get unclean drugs, if you like, that give them a bigger high. Getting the biggest high possible for an individual suffering under addictions is often more important than something that may be considered safe, and I put that in quotes. I'm just wondering. From an organized crime group perspective, would safe supply potentially actually encourage more of their supply? Would it actually perhaps help them in dealing with their drugs?

**Mr. McFee:** Yeah. Thanks, MLA Stephan. It's a good question. I mean, if you remember that slide I had there from B.C., where it had the 402 users and roughly 90 per cent of the individuals preferred fentanyl and heroin and the other 9 per cent preferred prescription drugs, I think that's probably an indication right there. You know, if you are struggling with an addiction, what we've seen in the past, certainly if it's a severe addiction: you have access to getting free safe supply or free drugs – let's say that it's prescribed opioids – and if you want to trade up and get something stronger, that absolutely is a possibility. The cartels, as I said, are innovative, and organized crime groups are very innovative, so they can then take that at a very cheap price, and they can actually move that to other areas or other markets that maybe they don't have.

You know, not to give tangible examples, but let's just talk in potential examples. Pill form can maybe go to somebody younger or somebody that doesn't see this about using a needle and doing. Certainly, that could take place in a university setting or other settings. This has been a way that the cartels have worked for years, and to say that it won't happen in this one – I guess it depends on the extent it will happen.

But if you've got people addicted and don't have treatment options and you've got an endless supply and that's your only focus, you absolutely will find the way to get the currency, whether it's through that or through, you know, petty crime or thefts or whatever, to get the money to turn that into what you need to support your severe addiction. Again, that's just why we reiterate that we need both the systems in place, the enforcement partnered with the treatment. Nobody that I've heard, certainly in policing probably in the country but certainly in Alberta, wants to put people in jail just for a drug problem, but unfortunately it gets tied into many other things and the criminal activity, too. The point is that right now there's nowhere else to put them, so I think, as you've heard, those are things that are kind of must-haves, if I could say, those treatment options.

**Mr. Stephan:** Sure. Can I just ask a quick supplemental?

**The Chair:** Yes, sir.

**Mr. Stephan:** Do the police in British Columbia – have they stated a position, that you're aware of, in respect of safe supply?

**Mr. McFee:** Yeah. They came out with a position paper here not that long ago, and they're saying it a bit differently, I think. They want the supports in place. Obviously, they have a safe supply environment, so it's a bit of a different angle. Our angle at AACP is that we do not want safe supply at all till we get some supports in place. The same, you know, along the lines of decriminalization: we need these supports and treatment options that people can get into to help themselves and help others. That, obviously, will reduce the workload and the number of people that are coming into policing or into the justice system. The chicken and the egg: I would lean to getting the supports in place first before we take changes of legislation. Like we've seen with oxycodone, that could make it worse.

**Mr. Milliken:** Thank you, Chief, for being here. I very much appreciate it. It's a good, different point of view than some of the other individuals we've asked to come and give us their perspectives. I'm assuming that you probably have some connections to police in B.C. I'm just wondering if you could briefly expand on, perhaps, the experiences that you may have heard coming out of, say, East Vancouver with regard to how it has affected police resource needs in the area.

**Mr. McFee:** Yeah. I mean, anecdotally, police are still responding to overdoses, as you see. They've got other agencies responding with them, but there are certain ones that they have to do. I think the biggest thing is that, as you've seen in the graph that I showed, the crisis continues to grow and, obviously, compounded by – COVID, obviously, is going to have an impact on that with people struggling. You know, I think it tends to come on us. Do we want

to be dealing with overdoses? No. What we want to do is deal with the people that are creating and giving people the money or the product to overdose, and then what we also are seriously advocating is the appropriate on-demand supports to get these people healthy, as many as can, and I think that's the whole point.

I'll give you an example. We have Sublocade and Suboxone recently introduced by the government in our DMU. Our DMU is our detention centre, and that's been in there for two months. Sublocade and Suboxone, obviously, are a way between, you know, 24 hours and up to a month between the different options to get people to stop them from overdosing so they can actually get the appropriate intervention to hopefully get some help they need to deal with their severe addiction. Over the course of those two months we've had over 200 people take that up, so that's a positive sign.

That's what we're talking about, dealing with this differently. Take advantage of the opportunity by having those treatment options when you do attend these things, and if somebody does get to a position where they are surviving or potentially in recovery, can you try to get them off this tangled web or this hamster wheel they're on? You know, if your only option is to give more drugs, I don't think it's going to end well. It's just going to continue to see supply grow and, as you know, increase the profits of the cartels.

**Mr. Milliken:** Thank you very much.

Just to follow from that, policing then moving towards sort of the judiciary or court side of things, you used words in your presentation like "decriminalization." You mentioned Portugal. You talked about how we can't arrest our way out of this. What tools would you potentially like to see in perhaps conjunction with the regular criminal court system as an option instead of just handcuffs and detention? I'm not going to answer for you, but you mentioned Portugal, and they have sort of an offshoot with the commission for the dissuasion of drug addiction.

**Mr. McFee:** Yeah. You know, that's a great question, actually, and one of the things that we've actually kicked around. I mean, let's face it. As police services we don't want to just keep putting people who are struggling as addicts, with all kinds of things going on in their life, in jail because we know what happens when we mix low-risk and high-risk in jail; they all become high risk. But if there was some type of mechanism or partnership between police and health and if there was some type of administrative sanction or something that had some binding agreement where people had the choice to actually choose another option versus, let's say, a correctional facility or the courthouse, I think that would really, really potentially work. I think it was Portland that tried it. I don't think it went far enough. It was one of the U.S. states. But I think that with the right minds in the room focusing on treatment options with some binding power, giving that individual that's facing the crisis some options to choose – with every 2 out of 10 or 5 in 10 you get to choose properly and maybe get them on the road to recovery or treatment – I think you've created another tool in the tool box that would be very effective and, hopefully, would prevent a lot of overdose deaths and get some people's lives back.

***9:30***

You know, when I did the podcast with Tom Wolf from the book *San Fransicko*, that was the thing. It was an intervention point generally – and we've heard it over and over and over – a timely intervention point where some type of accountability entered, got them into some system with the right individuals, found them at the right time, when they said that they'd kind of had enough, and that's what led to recovery. That story is repeated over and over and over, but we've never unpacked that and put a process in place to make that story possible in each and every case.

**Mr. Amery:** Good morning, Chief McFee, and thank you for coming before this committee and raising some of the emerging concerns that you've highlighted in your presentation with respect to the law enforcement side of things. I wanted to talk a little bit about your slide deck because I found it particularly interesting that you raised the issue of organized crime groups and cartels. We've not heard that perspective thus far.

I just wanted to ask you: I know that you've only had 10 minutes to provide your initial comments and presentations with respect to some of the concerns that you're seeing, but in particular I wanted to ask if you could talk a little bit more about the supply-and-demand component that you reference in your slide deck, particularly on page 2 of the slide deck. You talk a little bit about supply and demand and how organized crime and cartels are utilizing, you know, the potential high-demand market to expand their role here in Alberta. I wanted to see if you can expand a little bit on what you've seen so far, what evidence you have that you can share with this committee to suggest that organized crime organizations and/or cartels are expanding their efforts in Alberta, and what you might be able to predict for the future if a safe supply or safer supply model comes here to this province.

**Mr. McFee:** Yeah. I mean, we base all our stuff on, you know, intelligence. We have a provincial intelligence agency, obviously, that links into the national intelligence agency, so we get intelligence from everywhere. A lot of the product that we're dealing with in relation to the cartels – I mean, obviously, they need to move that, and Canada is a country where a lot of stuff gets moved, but sometimes we actually turn into exporters of certain drugs as well. Some of the big takedowns that we've taken down over the last couple of years and the influence of individuals known to us being involved in those: those are the ties that you put together. So you're looking at it through an intelligence piece.

They're going to be here regardless of whether we have safe supply or not. What's happened, based on the history, is that they're going to be here, and that's something that we're always focused on. But the difference is that if you follow the OxyContin, if you follow what they did in marijuana, we think that if somebody is saying that they think this is going to stop that, it's not. They're just going to diversify and find other ways to put their product and collect maybe the safe supply and get the more potent product on the street. They're developing drugs all the time. Like, I mean, fentanyl several years ago wasn't a big thing. Now it is. OxyContin kind of came in and went out. You know, meth was up and down through the years. There will always be a new drug, and those are the individuals that spend a lot of time working on what that new drug is, and then they've got to push it out to the markets.

It was kind of a bit of a myth, actually. I heard one comment that was a little bit humorous over this difficult time that we've been going through with COVID. Somebody said: well, you know, overdoses went up because the borders are closed. Well, the borders have always been closed to illegal drugs. I mean, they just find ways to bring the drugs in, no different than anything else. I think it's always a concern for us. I'm not going to get into a lot of the details because this is a public forum, but I think that in relation to that, we get quite good intelligence in this area.

**The Chair:** A supplemental?

**Mr. Amery:** Yes. Thank you, Chief McFee, for that answer.

As you, I think, correctly identified in the presentation at the beginning, you mentioned that we have heard from numerous experts on the subject of safe supply. If I can summarize some

of the information that we've received, it's that these experts have quite consistently, I think, raised concerns about what they've described as addiction maintenance when describing safe supply, instead advocating, I think almost unanimously, for the strengthened model of addiction recovery.

We've heard that individuals almost universally continued to use illicit drugs in addition to safe supply prescribing, which, I think, inevitably increases the overall use of substances as a whole. When we talk about the supply and demand in the market that is being created potentially for cartels and organized crime, is this a cause for concern for you? Do you foresee a safe supply model which increases the amount of prescription opioids being distributed to individuals as an invitation to cartels and organized crime here in Alberta to operate?

**Mr. McFee:** Yeah. Again, it just diversifies their portfolio. There is always that ability. If the past is your predictor of the future, then, yes, there is a good likelihood that's going to happen.

On the other stuff that you mention, what we're saying is that we need many tools to fight this; you know, Sublocade, Suboxone in our cellblocks is one. Yes, there's going to be some safe consumption in relation to that because that's a state in time. But we need treatment. We need the ability to get people into a bed, the ability to get people into a recovery-oriented system where it has intervention, treatment, prevention, you know, and some of that is going to be enforcement.

The problem, how I see this, is that anything that you're putting in one-dimensional has never worked to date, and I'm not sure anything you put in one-dimensional will ever work because if it was that easy, people would have solved this a long time ago. Just to come out and say that this is going to fix our problem I think is probably the biggest overstatement that I've ever heard. In fact, when I look at that graph in B.C., where it's gone straight up since, it makes me ask a lot more questions. I think it's medical experts, law enforcement experts, you know, and some lived-experience experts collectively together, among others, who figure out how we actually build a system and not a program or a one-dimensional stream.

**The Chair:** Thank you, Member.

MLA Stephan.

**Mr. Stephan:** Thank you. I've really been interested in your answers, so I appreciate being able to ask another question, again from a law enforcement perspective. One of the concerns that we have heard from some of the presenters in respect of safe supply is that it institutionalizes and normalizes the use of these harmful drugs. I'm wondering: from your perspective in law enforcement, if we normalize and have increased use of drugs, does it naturally follow that there will be a rising tide of collateral crime in communities as individuals seek to, whether through organized crime directly or indirectly, maintain themselves in their addictions?

**Mr. McFee:** Yeah. I mean, you know, on organized crime, I would put it a little bit differently. Certainly, they're at the start of a lot of this, bringing it into the community. Then, when it gets to the street level, you know, they have other people that move the product for them, so they're really hands off. I think what you see, though, is that, obviously, if you have a severe addiction, you need to find the money or the capital to service that. Now, it could be through your medication, that's not strong enough for you. You want a stronger thing, so you want to trade it in for fentanyl or something harsher. If you're mixing fentanyl and you're living on the street because you've lost your ability to do that and all of a sudden you take meth, meth makes people violent. You've got to look at the combination of the drugs.

***9:40***

I think the whole thing here, too, that's really struggled with in Alberta right now and certainly in Edmonton is that it seems like open-air drug use is okay, and that also brings perception and harm to a community. Part of that is because we maybe don't have the adequate treatment facilities. We're focusing on, again, a one-dimensional thing, and we're just allowing this.

Those are some of the concerns I would have. I think that with some of the things that are being looked at, based on what the previous speaker said in relation to how you build a system, you know, we need to become the first in Canada to build the whole system here, and I think that if we get that right, those efforts will start to help in all aspects of this.

I've been in this business a long time, I've been in government as a deputy minister for a long time, and I'm always a bit miffed at how individuals and groups think they can just pass a piece of legislation and everything is better. I haven't seen it work yet, so I would like to see a focus on a system approach, as the previous speaker mentioned, a recovery-oriented system. How I see that: I see that as a conglomerate or continuum of services that meet the needs of every individual. I think that if we can do that in Alberta, we're going to solve the Cadbury secret, that's been missing for many, many years.

**The Chair:** Thank you, Chief. That does conclude our time for question and answer today. We sincerely appreciate you taking time with us and for your presentation. Thank you.

**Mr. McFee:** Thanks. I now see you've got the real expert coming in. Hi, Nathaniel.

Thank you.

**The Chair:** Welcome, Dr. Nathaniel Day. Thank you for joining us here today. We're going to open up right away for 10 minutes of presentation, followed by Q and A with our members. I'll pass it over to you right away.

**Nathaniel Day**

**Dr. Day:** Thank you for the opportunity to share my thoughts today. My greatest concern with the concept of safe supply is the unintended impact that these policies may have on the general public. As has been aptly described by previous speakers, increasing the supply of opioids will increase use, it will increase addiction, and it cannot help but result in increased death.

My colleagues who advocate for these policies desperately want good outcomes. We all want less death, but how can we actually achieve that goal? I agree with previous presenters that there does not appear to be any conclusive evidence to support safe supply. If we could snap our fingers and change all fentanyl into tablet hydromorphone, would we see fewer deaths? Perhaps we would. I predict that we would see our fentanyl-using community members require massive doses, far higher than we would expect, just to stave off their powerful fentanyl tolerance. The actual amount of opioid stimulation needed per person would be the same, but we have no evidence that adding hydromorphone or fentanyl or other opioids to the street supply via unregulated, unsupervised supply programs will do anything to diminish the existing street supply.

Availability, cost, and perception of risk all drive people's decisions. None of us would take a bungee jump if the person in front of us fell out of the harness. Perception of risk matters. Telling children, teens, and young adults that prescribed opioids are safe is dangerous. Why do

I say that? In the *Journal of the American Medical Association* a brilliant article asked the question: what's the impact of one opioid prescription on young people? Alan Schroeder and his team recognized that for many young people their first exposure to prescription opioids is from their dentist, you know, kids getting their wisdom teeth out.

They wanted to see if one short-term exposure to opioids changed the person's risk for addiction. They looked at youths who had never had prescriptions before and then did get a prescription from their dentist for an opioid. They found just under 15,000 youths, so 14,888 young people, in their database. They then took those young people and compared them to 30,000 kids who did not get an opioid from their dentist. Maybe they got Advil or something else. They then looked at these young people to see what happened over the next year. They actually ignored the first 90 days after that first prescription just in case, you know, the person had a bad experience and needed a refill or something like that or needed a repeat surgery. So they excluded the first 90 days and looked at 90 days to 365 days.

What they found is alarming. Of those who got one prescription of opioid from their dentist, 6.9 per cent of the 15,000 sought out more opioids in the following year. In the nonopioid group only .1 per cent got an opioid prescription in that next year. Worse yet, 5.8 per cent of the opioid-exposed group had at least one new health care encounter with an opioid abuse related diagnosis. Within one year the control group saw an opioid addiction diagnosis only .4 per cent of the time. This was an adjusted absolute risk increase of 5.3 per cent just from one short-term prescription. Who of us would gamble 5.3 per cent, or just over 1 in 20 odds, that their kid would develop a potentially life-changing opioid addiction just for the supposed benefit of some Tylenol 3s or some Percocets?

Opioids are not safe. There are good reasons why in health care we double sign for them, we lock them up, we are cautious about disposal of them, and it's for the safety of ourselves and of our staff, let alone the risk to the general public. Why are opioids so problematic? All of our brains have opioid receptors. These receptors are there to reward us for doing healthy things. We get natural opioid receptor stimulation from exercise, eating, having sex, feeling important, feeling cared about. All of those trigger a natural response that makes us feel content. When we lose those things – imagine food insecurity, the death of a loved one, a relationship breakup, or abuse – we have dips in activity, which results in feeling bad. Our natural system is always trying to be balanced. At baseline we feel normal.

Pharmaceutical opioids, with the exception of buprenorphine, latch on to the opioid receptor and turn it on full blast. Some are faster, and faster is always more addiction potential, and some are shorter or longer acting, but in the end they all trigger a massive surge in opioid activity. This feels amazing. I had a patient describe it to me as, quote, God himself coming down from heaven and giving me a big, warm hug. Close quote. This massive surge can be so powerful that we don't even pay attention to breathing. We overdose and die. This feeling is so powerful that we ignore pain. People who get opioid painkillers generally can still feel their pain, they just don't notice it. This ability to ignore pain – it doesn't cure or fix anything – is powerfully addictive.

Imagine all of your physical, emotional, social, psychological, or spiritual pain no longer front of mind. Away, for a while. The problem is that this surge lays the foundation of a giant trap. Our brains detect that the system is way out of balance and our brains start to adapt. Your brain knows that you could die from this. Because the system is out of balance, the natural rewards have also lost their meaning. Your life is headed for disaster so your brain starts down-regulating receptors. Fewer receptors results in a lower risk of overdose. It also allows your brain to get closer to baseline, back to normal.

But if we're taking the opioid for a high or we're using it to get pain relief, this adaptation is a problem. We're now taking the same amount, but it just isn't working. We go back to our dealer or doctor and tell them that we need more. We stop swallowing the pills and start chewing them or snorting them. Then we move on to smoking or injecting. We discover that our old drug of choice is best replaced by the most powerful drug we can find.

Every time we step up our game, our brain reacts by eliminating more receptors. Every time. It only takes six days for substantial neuroadaptation in the brain to a new dose, a new drug, or a new way of taking it. Now we have to use that higher dose or more potent drug every time, and if we don't, we get sick. Our natural system is now so damaged that we're profoundly below baseline without our drug of choice. We have physical, social, psychological, and spiritual pain in the withdrawal experience. People feel like they're going to die. We use our usual amount, and now we feel normal. We're trapped into using just to get out of bed, just to survive. Highs are, for the most part, a memory that we wish we could have today. This is why people cannot get euphoria long term and cannot take a stable dose for pleasure long term. Our brains just don't work that way.

***9:50***

Opioid agonist therapy allows a person to feel like themselves, to get their bearings, make some rational decisions about their life. It is evidence based, and there is strong evidence to support it. It gives improved personal and social outcomes and needs to be supported.

About five years ago late one night I was working on call at the psychiatric hospital in Ponoka. I was sitting across from a young woman in serious distress. She had been using opioids in the city. She discovered that she was pregnant. She was determined to get into recovery in time for her baby's arrival. She was started on methadone, did well, and took her baby home with her. She discovered that being a single mom away from supports was tough. She moved home to be near her mom. She was promptly cut off methadone by her treatment provider, presumably because she could not attend frequent appointments or get her daily medication from their financially connected pharmacy. Despite severe withdrawal and suffering she managed to stay off opioids for a few weeks but relapsed. Children's services were aware. They apprehended the baby. And she was there because she'd attempted suicide.

She had worked really hard at achieving sobriety and towards sustained recovery. Our disjointed system failed her, and for what? Her situation and others like it resulted in significant change for all Albertans. How could we stand by and let these tragedies continue?

We started what is now the virtual opioid dependency program, VODP. It is our mission to meet people where they're at and compassionately provide them with gold standard, evidence-based care no matter where they live and work. We found that people coming out of jail were not able to get care quickly enough. We found that emergency doctors were reluctant to start treatment because the clinics wouldn't pick up patients in time. The same thing was happening in in-patients, detox sites, and other places. People were dying on wait-lists, trying to get service.

Our harm-reduction colleagues are right to criticize how the system was working or not working for people. I totally understand their frustration that the treatment system was denying opioid-dependent people the evidence-based care that they deserved.

We developed our rural teams, case managers, addiction counsellors, peer support workers. We could now offer treatment in any riding, all across the province using technology. We developed our same-day start team: no more wait-lists. Today anyone in Alberta can start treatment the same day they need it just by calling one toll-free number: 1.844.383.7688. We're open right now.

We handled just under 500 new requests for service last month alone. People want accessible, flexible, and compassionate treatment close to home. We developed our transitions team. No more excuses. Start people in emerg, shelters, or corrections. Start them wherever. Send them to us, and we'll pick up that person's care before the next dose is due and connect them with real, local services. We have now developed a low-barrier team. We're supporting harm reduction sites, shelters, police detention sites, and other places.

We collect data. We see good results. We're extremely busy. All to answer the call of people trapped by opioids who trust that we will help them rather than turn them away. Alberta has become a national leader in opioid agonist therapy access. Just last year we were recognized by the Health Standards Organization as a leading national practice.

Yes, there is much more to do. I really echo Chief McFee's comments just earlier. There's a lot that we've been doing right, and we need to build on it, but we need to make sure that the system works altogether to help everybody.

Thanks.

**The Chair:** Thank you, Dr. Day, for your presentation.

I will now open it up for questions and answers. I have MLA Milliken up first.

**Mr. Milliken:** Thank you, Dr. Day. I appreciated your presentation. Though technically not putting a face to a story, I appreciated the story that you brought forward because it does help remind us that everything that we're dealing with here: these are lives and these are people. So it's very, very important work.

That said, we are also tasked specifically to, in some respect, anyways, focus in on safe supply. I was wondering if you, through your experience here in Alberta, can think of any type of safe supply or addiction maintenance that you think would qualify as safe?

**Dr. Day:** I think that, you know, we need to look at these options in sort of two separate broad categories. When we look at using opioids to stabilize somebody, like with methadone, for example, if we were to just give methadone out, say tablet form methadone, and anybody can take it, and they can take how much they want, what we would see is a rapid increase in methadone abuse diversion overdose. And that is not the purpose of opioid agonist therapy. Opioid agonist therapy is in conjunction with supervision, witnessing, therapeutic supports, and an attempt to stabilize a person and help them move forward in personal and social objectives so that the person's life stabilizes and they achieve great results.

When we look at sort of anything, so if we look at the Swiss model of giving people diacetylmorphine, or heroin, that is in the context of sort of a treatment framework and that could be effective, there's evidence to support it. But it's not really safe supply. When we're talking about safe supply as intended by the advocates – and I really echo comments made previously about how we have to be careful even around the terminology of safe supply, that that's a marketing term, that isn't a real term, and it's a marketing term that's an effective marketing term. There are no safe opioids.

Certainly, my comments about the risk of even one prescription of opioids for youths and teenagers: I really want to re-emphasize that there is no safe supply. But if we're talking about that model, which is the provision, dispensing, and almost flooding the streets with opioids of any kind, I don't think that there's any safe way of doing that.

**The Chair:** A supplemental?

**Mr. Milliken:** Okay. Then building off that, what, in your view, would be the established evidence-based, I guess, medical treatments for opioid addiction? Are they available in Alberta? And, therefore, should there be perhaps even more available here in this jurisdiction?

**Dr. Day:** Yeah. I think Alberta is doing a really excellent job at making sure that people have access to care. You know, VODP has done some amazing things for Albertans, but I think that the government of Alberta has done some amazing things for people as well. For example, we have our gap medication coverage program, which covers methadone, Suboxone, and Sublocade; Sublocade being the one-month injectable form of Suboxone. These are available, and they're covered. The gap program is just a really amazing program, and I know I have colleagues across the country that wish their provinces had what we have.

The one medication that we're missing and was referenced earlier is the long-acting naltrexone. That's a complete opioid blocker. It has very good efficacy. It's not available widely in Canada. It was brought in under sort of a special use and is not covered. That's a medication that should be considered. But, by and large, Alberta is using all of the tools that we have available to us, and I commend the government for doing that.

**Mr. Stephan:** Thank you for your presentation. One of the comments that some of the presenters have made – first of all, correctly identifying that the term "safe supply" is not a medical term and in fact the supply is inherently unsafe, that there is risk with that use. They've also talked about the concept of diversion to third parties. There has been evidence and experience in B.C. where, unfortunately, safe supply is diverted to third parties. I'm just wondering – of course, that is a risk that has been identified with safe supply. In your own practice I'm wondering if you've encountered individuals who have become addicted or even experienced, you know, serious health impacts, perhaps death, some of the other social destructive results because of using opioids that were intended for someone else but had been diverted to them? Could you speak to that? Can you think of any experiences where you've encountered that type of tragedy?

***10:00***

**Dr. Day:** One hundred per cent. Thanks. I appreciate the question. The fact of the matter is that we see people every single day who started their opioid journey with prescribed medications that were used by somebody else. We see that commonly, and it is a common trajectory for someone to receive an opioid from somebody else, to start using it, to become addicted to it. It takes about six days for there to be massive neural adaptation in the brain to the opioid, and then we see very quickly that the person's need for opioid escalates. It's very common for them to come to us at that stage where they're already using fentanyl.

**Mr. Stephan:** Can I ask a . . .

**The Chair:** Supplemental?

**Mr. Stephan:** Yeah. Yeah. Thank you. I really appreciate you talking about how you're seeking to treat and support individuals seeking to become free from their addictions close to home in their communities. I'm just wondering: in your experience, how important is that social framework for individuals seeking to become free from their addictions and whether or not safe supply encourages individuals to be around their social capital or to go into isolation in the use of safe supply?

**Dr. Day:** I do think that keeping people close to home and keeping people connected in their communities matters. I think that there are lots of benefits to using the virtual approach that we've used, where our teams can reach people anywhere they're at. This includes, I think, an area that hasn't been raised but relates to the not-in-my-backyard phenomenon and of many addiction treatment service provisions.

When we started our virtual approach, one of the big questions on the AHS side was: how are we going to mitigate public concerns about adding addiction treatment into their community? But because we weren't congregating people in one location – you know, we were using telehealth sites, and currently we use Zoom as well, and we're connecting with people in their own homes in their own communities. We weren't bringing people into a new community. We weren't bringing people into a congregate setting where we have 25 people who all are struggling with the same addiction, all sitting in a waiting room, making connections, and hanging out. We actually have never had a complaint of a: not in my backyard; we don't want this in our community. We've never experienced that. I think with all of the approaches we take, we need to be careful that we are helping people as best we can who are in crisis, who are desperate and have needs and we are also bearing in mind that our approach can have unintended consequences in the community.

In terms of the latter part of your question around the impact of safe supply and connections with families and communities I don't know that I've got any evidence to speak to that.

**The Chair:** MLA Amery.

**Mr. Amery:** Thank you, and good morning, Dr. Day. Thank you for the information that you've provided and that you've brought forward today. I've found your profound comments to be compelling because you bring the actual real-world experiences to this committee, and I think that's incredibly important.

Dr. Day, we hear almost quite regularly about the terms that are being used in the discussion of the topics that this committee is dealing with. Some of those, like safe supply, safer supply, addiction maintenance, and so on and so forth: there's not necessarily any agreed-upon definition for these type of terms. Other of these terms are things like addiction reduction services and addiction treatment services.

Some people talk as though harm reduction services and addiction treatment services are in opposition to one another, and they may very well be, but there potentially may be some overlap here as well. I'm wondering if you can clarify for the committee what your understanding of these two terms are and whether they are in fact – do they operate in opposition to one another? Can they overlap, and how can we utilize that in further understanding the role of this committee?

Thank you.

**Dr. Day:** Yeah. I appreciate that. It's a false dichotomy to say that, you know, harm reduction services are in opposition to treatment services and so forth. I think that's very unhelpful. The fact of the matter is that there's a continuum of approach. I work in opioid addiction treatment, and I'm aiming to help every single person that I meet to work at their level, where they're at, to help them stabilize and then to help them make progress in their own recovery towards goals that they see as important.

I'll use an example. I recently started treatment for a woman who resides in one of the large urban cores. She lives in a neighbourhood where there are tents and open drug use and drug exchange. She's bounced in and out of treatment in her community and has struggled with homelessness herself. She begged us to not transfer her back to the face-to-face providers because she struggles to actually engage and attend appointments and that sort of thing on a regular basis. So we kept her in our program, and she chose to go with the now covered available tool Sublocade, which is the one-month, injectable form of Suboxone, or buprenorphine.

She continued to use while she was on Sublocade for the first little while. If you were looking at this from a pure treatment, you know, "You must be abstinent or we're going to cut you off" treatment, that would be the wrong approach, and it would not have been helpful for her. What we did is: we continued to engage her with case management, with counselling, with supports, and what we found is that because Sublocade is blocking most of the fentanyl and it's allowing her to think more rationally, her drug use actually has decreased substantially. Instead of using five or six times a day, she dropped down to using a few times a week and now is down to a couple of times a month. She's so well, actually, that for the first time in about a decade she was able to visit with her kids over Christmas.

We have been able to work with her. Are we reducing harm? Absolutely, we're reducing harm. Are we engaging her in treatment? We absolutely are engaging her in treatment. Are we engaging her in abstinence treatment? Well, we are working towards abstinence from opioids, but in terms of recovery, you know, "What are her goals of recovery?", the fact of the matter is that we don't know where she's going to arrive next year or the year after that. We're going to continue to work with her, we're going to save her life, and we're going to work with her where she's at. For all of us in the treatment world and for all of us in the, quote, unquote, harm reduction world we need to recognize that we are all on the same spectrum and we need our services to overlap and we need our services to help.

**The Chair:** Excellent. Thank you for that answer.

Any further questions from the committee? MLA Milliken.

**Mr. Milliken:** Thank you, Chair. Thank you again, Doctor, for being here today. We've heard evidence from individuals who have much more lived and direct experience than I do, from long-standing careers on these issues. One thing, obviously, that has been stated on the record here is that anybody who uses opioids ultimately will develop a tolerance to that opioid and will perpetually be trying to increase or need to increase. Is there an effective way to predict the tolerance increase? What I'm getting at here is that we've heard that for individuals in a safe supply program, that tolerance doesn't magically disappear, so you have to keep increasing the dosages. How does a doctor who's prescribing the dosages effectively predict what to prescribe as that tolerance increases?

**Dr. Day:** Yeah. From the perspective of safe supply or from harm reduction, prescribing for somebody, outside of buprenorphine, which is a very effective, safe medication where we do not see that gradual increased need in dose – we actually see very stabilized dosing, and we often see decreased need for dose over time, which is part of why we love buprenorphine. It works so effectively and can actually help us for people who have developed this social or recovery capital to complete treatment and come off medications. But with all the other opioids, really, we're being guided by the person's perception of their experience taking the opioid, so dose increases end up being guided by the person's feeling.

***10:10***

**Mr. Milliken:** Okay. Thank you for that. So then for all the other opioids, any of them being prescribed, what I'm trying to grasp here is that somebody who is on a safe supply of any other opioid that you – anybody who is on that safe supply will develop a tolerance.

It becomes the individual receiving the safe supply who essentially can influence how the amount of medication may change. So without necessarily having what I would call potentially a precise way of determining it, the prescription will in all likelihood, when it changes, be either too high or too low. I guess what I'm just trying – this isn't necessarily going to be a question. I'm just going to ask you if I'm missing anything here.

So if it's too high, then it will be more potent than needed, which in effect will increase the rate of increase of tolerance, which I think could be deemed as causing harm, which I think kind of conflicts with things along the lines of maybe, like, the Hippocratic oath. So it's either that or it's going to be too low, and then the individual with OUD will then look in all likelihood for other ways to get the amount that they need. I think that we've seen that the data has borne out that upwards of, like, 90 per cent plus of individuals on safe supply are also using other illicit drugs. I'm just – am I missing anything there?

**Dr. Day:** Yeah. You're not. The fact of the matter is that if I'm using fentanyl, so I'm ultra-high potency, and a physician or a group – because the fact of the matter is that the safe supply advocates don't really want physicians involved in this. If I'm on an ultra-high-potency drug and I'm replacing with just a high-potency drug, the fact of the matter is that that high-potency drug cannot meet my tolerance needs. I'm either going to have to switch to that ultra-high-potency drug or I'm going to have to take a ton or I'm going to have to supplement. We already see this.

There's already in the literature talk of safe supply programs in British Columbia where they're now providing fentanyl because hydromorphone just isn't meeting the needs. So we're either going to have to change what we're supplying to the ultra-high potency – like, I shudder to think: are we going to start supplying carfentanil? We cannot get there safely, and if we're oversupplying – so if I come in and my tolerance is here and, you know, the other 10 people before me needed here, as a program we just give them what we normally give to people. Now, I can either overdose on that medication, or, more likely, I won't need as much, but I'm going to bump it because it will allow me to feel more euphoria that day, and now my tolerance grows, which, I agree with you, is a harm, and I'm likely to take that surplus and I'm likely to turn it around and trade it if I'm even using it at all.

**Mr. Milliken:** Just to build off that, if in that last scenario it was witnessed, the tolerance would then probably even increase at a more rapid rate.

**Dr. Day:** Yeah. The benefit of sort of witnessing and a structure: if we shift this out of safe supply – because safe supply is not witnessed; it's not structured that way – and if we move into a, you know, treatment sort of perspective where we're witnessing, then I would expect that now we're involving physicians, for one, or other prescribers. I would expect there to be a far more rigorous approach.

The safe supply approach is giving people what they want. Treatment approach is saying: "Let's determine what your actual tolerance is, and let's try and replace what you're using from the streets with an equivalent amount. Let's stabilize you so that you can think clearly. We're giving you long-acting medications, not short-acting medications so you're all over the place. And then let's work at all of the other social factors that we can to improve your social capital and allow you to make, you know, meaningful change moving forward."

**The Chair:** Thank you, Dr. Day. Thank you, Member, for the question. We sincerely appreciate you taking time with us today. That does conclude our time for Q and A, and certainly you're welcome to join us for the rest of the presentation today.

We will take a very quick five-minute break. I apologize, Chief Standingontheroad. We've fallen a little bit behind schedule, but we'll be right back with you in a few short moments. If everybody can be back by 10:20, that would be great.

[The committee adjourned from 10:15 a.m. to 10:20 a.m.]

**The Chair:** All right. Welcome back, members, and thank you for everyone's patience.

I'd now like to welcome Chief Leonard Standingontheroad to the committee. Thank you, Chief, for being here with us today. We're going to open up for you for 10 minutes of presenting, and then we're going to open up to the members for 20 minutes of question and answer. Without further ado I will pass it over to you, Chief.

**Leonard Standingontheroad**

**Mr. Standingontheroad:** Thank you for allowing me to be a part of this committee, and I'd like to thank the people that invited me to this important topic. My name is Leonard Standingontheroad. I'm from Montana First Nation in Maskwacis. We're one of the four communities in Maskwacis, and we're on the southeast end. We're just off highway 2A, about five miles east. My community is 10 square miles with a population of 1,040. It fluctuates just about every month or week. We have people dying, so that affects our population. Also, we have babies being born. It's kind of, I guess, a norm for us.

To do a presentation on this very controversial issue for us as natives to have safe supply – and I know it's being done, like what the doctor said, in B.C. or perhaps maybe in the city. As far as when it comes to safe supply sites for our people, if it was to happen, I guess I wouldn't be able to stop it, but it's not our way of treating these diseases. I know there are programs for alcoholics and drug addicts. This problem has really kind of sneaked into the society regarding: like, first it was prescription drugs, and we got after the doctors for that. Now we have actual doctors doing the treatment of safe supply. When this thing got started, we were never really consulted or even informed of what was going to transpire, so that becomes problematic. Of course, you know, if I was to present this concept to my community members, they'd outright say: no; there are better ways to do things. But, of course, this problem is already out there in the dominant society and all over the world.

In trying to find solutions on how you deal with individuals when it comes to addictions to fentanyl or any addiction, you really have to look at the individuals themselves. In our society as natives, because of being suppressed for such a long time and trying to adapt to the dominant society, a lot of times we try to fit in, and then that's how people get themselves stuck in the addiction world with whatever substance that they use.

In dealing with the department, you know, when it comes to funding or even AADAC, they don't really try to help us. Now, it's only in the past few years that they're trying to do something to help us heal our people. In our communities we're infiltrated with drug dealers, and the RCMP are overwhelmed with trying to deal with drug dealers and all sorts of other crime activities. So it becomes overwhelming for our community program providers, and a lot of times we don't have access to the professionals that can treat the symptoms of drug addiction.

I myself have never experienced any kind of drug aside from alcohol. Alcohol was my choice of drug when I was practising. I sobered up 30 years ago. During those 30 years I've seen the

damage that it has done to our community members and the families and even the young people.

The systems that are created for controlling our population, like child welfare and group homes – you know, in my experience, when you have a problem child with special needs, you don't really know how to control them, so you drug them up just to make them behave so they can fit in with the other kids in the group homes. A lot of those factors come into play.

When it comes to trying to deal with the province or the feds, they do a lot of studies. The studies are there, but there's nothing being provided for us either by the province or the feds to give us funding to deal with this or even to set up some kind of a treatment centre on the reserve. Usually they just refer us to treatment centres. When people come and ask for help, I guess we put them on a waiting list for these treatment centres so that they can get in, but by the time they get approved to go there, they're back to their drugs or they're deceased. So that's that vicious cycle that's created by the system. You know, it really impedes us from doing anything to help our people.

Of course, like the doctor that was presenting, they never come to us to present their solution. Or even the government, you know. Like, now you're wanting our opinion on safe supply, which is probably already happening full bore, and we're just at the back end of it. It's just now that we're being informed of what the intentions are, so that's really problematic.

As far as presenting this to even other leaders, I'm sure that it would be totally rejected, but still we have to organize ourselves in such a way that we acknowledge it and learn from the people that are actually doing it to see how they're doing it. We have people in the cities that can't really live on the reserve because we don't have room for them, no housing. There are, I guess, a lot of factors that come into play that prevent us from actually getting involved, but there are other ways that we can help our people, and that's through getting them healthy, through nutrition or whatever means that we have besides drugs.

***10:30***

I belong in a program myself, AA, but that's only talk therapy, and a lot of times people don't want to join those kinds of organizations because of whatever; they probably have self-esteem problems, or they don't want it to be known that they're admitting to being alcoholics. You know, there are all kinds of factors that come into play.

But I guess that there's really not much more that I can add. I know my fellow chief: he's an expert on addictions and these sort of programs, and he's got all kinds of statistics. He'll give you a better picture of what is out there as far as our people are concerned. I guess I can't really add that much more because I'm a recovering alcoholic, but when it comes to dangerous drugs like this, I have no experience really to even know. So I guess that's all I can say for now.

Thanks.

**The Chair:** Thank you, Chief, for sharing with us and giving us a picture of some of the challenges in the community. That was very helpful.

We're now going to open it up for question and answer with the members, and first up we have MLA Amery.

**Mr. Amery:** Thank you very much, and good morning, Chief Leonard. Thank you for sharing some of the experiences that you have seen first-hand within your community. I certainly think that your presentation here today and the subsequent question and answer will help address some of the emerging issues for the Indigenous communities.

Chief, in the beginning of your presentation you mentioned that you do not see safe supply as a plausible approach to addressing addiction recovery and substance abuse. You also discussed with us, in some detail, some of the challenges within your own community and certainly with other communities around you. You said very clearly, I think, that there are better ways. I am certain that you have some insight to some of the treatment methods that you've been exposed to that assist in recovery from substance addictions. I wonder if you can elaborate for this committee on some of the treatment and addiction-recovery methods that you have witnessed, that you are aware of, that have had positive impacts on the community and what advice you might have for this committee to pass on to government as to what works for your community and abroad and what simply doesn't work. Can you give us some advice on some of the methods that you say are better, some of the methods that have had very positive impacts on Indigenous communities that you're aware of and then perhaps tell us what you don't think we should look into as well?

Thank you.

**Mr. Standingontheroad:** Yeah. Thanks for that question. When I decided to sober up, it happened in such a way that when I was getting released from jail, they have a program – they call it prerelease – where you get released early for good behaviour. When they were doing inquiries in my community, the report came back negative, that they didn't want me back, so I had to find other, alternative means to get myself out.

Of course, I had to go to a treatment centre, and that was my sixth treatment centre for me. I was 40 years old then, and I knew I needed to do something. What really helped was listening to the people, but people are traumatized. I don't know, but when they were a child – or something happened during their life, and they didn't deal with it. You know, in the outside you go to a therapist or a psychiatrist, but we don't have that in our system. Of course, when you're an alcoholic, you get so centred and selfish. You don't want anybody to know about your problems, so you don't want to deal with it.

When I was in treatment, I was told that you have to let out everything that happened in your life, and for me as a young man, when I was 26, I lost my wife. My wife committed suicide in front of my eyes. And when the RCMP came to my house that time, they took me in and threw me in a drunk tank, and the next morning they took me to the morgue, and I had to identify my wife, that it was her. And that was it. They just let me go. They didn't provide any assistance for me to deal with the trauma, and that kept on for 17 years till I decided to sober up. I was told that I need to talk about that, so those are some of the things that need to happen.

Of course, I wasn't very healthy, so I got healthy by being in jail, having good food and exercise and being amongst people that are in the same situation as me, maybe worse but similar. You know, problems with alcohol, family, life: those are the things that aren't provided.

A person can sober up off the reserve and try to come back, to fit into the community. The supports aren't there. You're back in that same environment that you're trying to get away from, and we don't really have specific programs for that being funded by the department, to help our young people to refer us to a medical centre or a community program that's geared to provide for our communities. Our population together with the other nations is probably about 18,000. There, again, that cycle happens. You get put on a waiting list and a therapist, or whoever, a counsellor, gets overwhelmed, and you may never get to see the individual in a month or so. The system reeks of discrimination. That happens for us. It's just impossible to deal with individuals in a timely manner so they can help them recover. As a result, they have to go out and

live off-reserve. And our own spiritual leaders, you know, they get overwhelmed, too, with the clients wanting to see them.

**The Chair:** Thank you, Chief.

**Mr. Amery:** Chief Leonard, thank you very much for that insight. I know that, you know, we've been doing this for a couple of days now at least, and we've heard from countless people both in Canada and the United States – doctors, journalists, lawyers, Indigenous leaders – throughout. A lot of the common themes that we've been hearing about are the importance of having community and family structure and supports on the path or the road to recovery.

***10:40***

You know, you spoke a little bit about your own personal experiences, and I want to thank you for that because it's very difficult to come before a committee and speak about personal challenges and tragedies, so I commend you, and I appreciate that you have come here before us to share your very personal story with us.

But I want to talk a little bit: how important do you think that family structure and community structure is to recovery, whether it be for alcohol addiction or substance abuse or anything like that? One of the things that we heard from some of the experts is that those who are addicted to various substances sort of isolate themselves from their families and their communities and that the continued use of these substances means that those individuals continue to stay away from friends and family. One of the components of recovery is to reintegrate or to reintroduce oneself to community and family supports, so I'm wondering if you can comment on how important you think family is and community is to recovery and whether or not it was a leading factor for you in your own recovery and what you've seen in and around your community as well.

Thank you.

**Mr. Standingontheroad:** One of the important things when you're, say, a man or a wife: when you're going through recovery, you have to include the families or even young kids, not necessarily counsel them but inform them of how addictions affect families because it's kind of a ripple effect, and we need to include the elders, you know, I guess, the grandfathers, the grandmothers. I imagine that families have their own family counselling when they're dealing with recovering people.

To be able to allow us to have control over this – I wouldn't say venture, but this issue of helping recovered addiction people or alcoholics, we have to provide the funding in a place, because a lot of times we get referred to the outside, and a lot of people are reluctant to move outside our communities, and we can't force people to move off the communities just to get their help.

When it comes to getting professionals into the community to come and provide the assistance in even setting up programs for nutrition or activities for families, the timelines that they give us even just to try and come up with a concept or a plan – and a lot of times, you know, it has to be proposal driven. We have to come up with a business plan. We need to simplify those processes or maybe expediate them. We have experts that can draft up a proposal in a day and submit it, but then we wait for the funding to be approved. Those kind of challenges we have within our community, and by the time anything happens, you know, either the individual gives up or the family moves on to something else, and they tend to get discouraged. Those are the things that we face within our community. It seems like we have to ask for what we want to do with our people because we don't have the means to readily fund anything.

**The Chair:** Thank you, Chief.

I now have MLA Turton.

**Mr. Turton:** Yes. Thank you very much, Mr. Chair. Thank you very much, Chief Leonard, for coming here today to tell us about your experiences and, obviously, your story about recovery. Thank you for your service both to the community as well as to the province of Alberta by being here today.

MLA Amery asked, I think, some very pertinent questions about the role of family and integration of individuals back into their communities as a key aspect of a successful recovery. I guess my question to you, Chief Leonard, is that you did talk about how many of your residents in your community have had to go to the larger centres for that initial step, you know, to go down the path of recovery just because those programs and services might not be as accessible in the smaller communities such as yours. I guess my question is: what are examples of positive programs that you've seen that have had a positive effect on helping many of your residents and family members and community members that have been able to take part in some of those programs? What are some of the positive programs and services that exist today where you've seen positive success stories that we should perhaps be either looking at strengthening or else expanding?

**Mr. Standingontheroad:** I think most native communities get funding for prevention, any kind of prevention like drugs, and a lot of times the funding is not really – we get shortchanged on the types of programs that we want to have for our people. Maybe only a few people are eligible because we don't have the funding to provide it for everybody. Our population is over 1,040, and perhaps half live on the reserve. A lot of people are, you know, self-sustaining; not everybody is in dire straits. In my community I have 12 clans. That's 12 different last names, and there are several that are destitute. I've seen families die off just from alcoholism or drugs. They OD, and it really devastates the family. How do you deal with multiple families to try and provide the counselling or even any kind of support system for them and expect them to be in a program while they're dealing with their trauma? I guess those kinds of issues are facing the communities.

Even the service providers get overwhelmed, and they can only come in at a certain time to our communities. But if we had the funding – we're in the process of doing that, hiring a full-time provider for our community members so we can deal with their issues. As leaders we're not really involved with the families. We only bring in the supports, and we get reports on how things are going. Lately we've been having funerals just about every week, and any time a funeral happens, business just dies in our communities. A lot of the interference that happens to keep these things going is so slow that we don't really see the results, I guess. Those are the challenges that we have.

***10:50***

**Mr. Yao:** Thank you so much, Chief, for taking the time to speak with us today. Our current government is doing a fantastic job of allocating a lot of resources and finances to addiction services, adding beds and whatnot. Our First Nations people are in a unique situation in that they're on reserves and are provided services by the federal government. Can you explain the resources that the federal government has provided? And those supports: are they adequate? How would you value the efforts by the federal government in these regards?

**Mr. Standingontheroad:** Well, in our community I guess the only entity that really benefits from that is child welfare. They get a lot of funding to deal with the families. But a lot of times we have to go off-reserve to rent space so we can hold these gatherings or programs because the facilities that we have are filled to the brim, so we can't really fit them into our facilities. A lot of times the

families themselves can't really get to the programs unless we provide transportation. Those kinds of things: you know, the government is willing to provide funding for that and even the province.

A lot of times we have such a turnover of these; for instance, the director for social services. We have turnover maybe once or twice a year, and when we have good people, non First Nations, that come to work for us, it seems like they have their own agenda. They have experience in the First Nations. Then they move on and go on to a better-paying position. Those kinds of things happen, and they kind of interrupt our processes. We're saturated with social workers graduating from college, but we can't really provide the employment for them because it's such a small community.

We do get a lot of funding, but one of the processes that really impedes us is the reporting. We have to report for every dollar that we get. If we miss a report day deadline, then they withhold funds, and it just distresses our employees. Those are the systems that are in place that kind of hold up everything. We have to be in compliance with the province and the feds when it comes to reporting.

**The Chair:** Thank you, Chief. That does conclude the time that we have for today. I sincerely appreciate you joining this committee, for sharing your story and the experiences in the community with us today. It was very enlightening and helpful. Thank you for your presentation and your time. We appreciate it.

**Mr. Standingontheroad:** I'd just like to thank you for allowing me to be a part of it. Thanks.

**The Chair:** Thank you, Chief.

Next up we have Dr. Vesta Warren with the Alberta Medical Association and it looks like a couple of other members. Dr. Vesta, maybe if you can introduce who's with you today. I'm going to open it up to you for a 10-minute presentation. I apologize; we've fallen behind on our schedule. Sorry we're starting a little late, but I will pass it over to you right away. Without further ado, Doctor.

**Alberta Medical Association**

**Dr. Warren:** Thank you very much for extending an invitation to the Alberta Medical Association to come today to a very difficult and complex discussion. I have Dr. Tally Mogus and Dr. Monty Ghosh, both specialists in the area here today.

**The Chair:** Sorry. Doctor, before you get going, we will share the PowerPoint presentation from our end over here, so just let us know when you want us to move to the next slide. Yeah.

**Dr. Warren:** Okay. I think if you can bring up the presentation . . .

**The Chair:** We're going to do that right now. There we go.

**Dr. Warren:** All right. If you want to go to the next slide. From the Alberta Medical Association's perspective, the AMA does support evidence-based interventions and recognizes that the opioid crisis has impacted thousands of Albertans, whether directly or indirectly. There are a number of diverse opinions regarding opioid use disorder and the drug poisoning epidemic that we're in. I think all AMA members can agree that this is an issue that needs to be addressed urgently. The presenting physicians that are here today are representatives of the AMA section of addiction medicine. They are not speaking on behalf of the organizations at which they work.

I'm going to turn it over to Dr. Ghosh to begin.

**Dr. Ghosh:** Thank you. Next slide. First and foremost, we want to thank the government for allowing us to be here today to talk about this important issue. We also want to thank the government for supporting evidence-based treatments that already exist. The government has increased free-of-charge access to OAT. The government has increased navigation supports for those who are using substances to supportive programs such as a recovery-approach program which exists. The government is dealing with some of the root causes of substance abuse issues such as trauma, poverty, colonization, and racism through its CSS branch. The government is increasing naloxone kit distribution, and they are increasing free-of-charge access to evidence-based, outpatient, and residential treatment programs. Last but not least, we want to encourage the government to continue to look at the IOAT program and expand it as possible. Of course, the government is currently looking at expanding supervised consumption sites, which we're very grateful for.

Next slide. Despite all of these interventions, however, many Albertans are not accessing our current suite of services. We know that there's a drug poisoning crisis that exists, where high-potency fentanyl analogues, benzodiazepines, and antiparasitics are contaminating the supply. Because of these high-potency analogues we need to down larger and larger doses of naloxone to reverse these overdoses, sometimes six to eight vials of naloxone. The typical naloxone kit only has four vials, which is up from three, where it was before. Due to these factors and others, 2021 has been the worst year for the opioid overdoses that have happened in Alberta.

Next slide. When we look at the overdose poisoning crisis, we look at it through the lens of public health. There are four branches for this lens. There's enforcement/regulation. There's prevention, harm reduction, and treatment. Safer supply falls under prevention and harm reduction.

Next slide. One of the most important diagrams in public health in relation to substances is this U curve. It's called the public health U curve, and it has been shown to be true for alcohol, for cannabis, and for other substances as well. We know that if we have a very unregulated market where there's tons of prohibition – I should say: an unregulated criminal market – you have lots of harms to society and health. As we move towards decriminalization, harm reduction has moved down that curve, and we decrease those harms. The sweet spot, however, is the bottom of the curve, where there's responsible legal regulation. As soon as we start to have some unregulation, we start to see more harms again. Right now with alcohol, for example, we're up in the higher end of that curve. We're seeing lots of people who have liver cirrhosis or liver damage because of alcohol concerns. Again, we need to get to the sweet spot of responsible legal regulation.

Next slide. There are two predominant models of safe supply. The first is the prescription of pharmaceutical-grade substances such as non-OAT opioids and stimulants to individuals who are at risk of overdose. This is done through the regulation by physicians. The other model is a nonprescribed approach where the government actually regulates this and directly sells pharmaceutical-grade opioids such as fentanyl, heroin, and other substances for recreational purposes to displace the current toxic drug supply.

Next slide. In regard to the physician model or the prescribed model, different levels of regulation can cause different levels of risk. For example, if this was prescribed by a physician and dispensed in a controlled environment such as a supervised consumption site, there's lower risk. However, if we provide patients with take-home carries, where they can take their drugs home, or we provide them with a month's worth of drugs, for example, that could be at higher risk.

I'm going to pass this over now to Dr. Mogus – next slide, please – and she can speak to diversion.

*11:00*

**Dr. Mogus:** Thanks, Dr. Ghosh. One of the controversies around safe supply is diversion, and certainly it's a legitimate concern as diverted opiates can cause harm to opiate-naive community members. People may be assaulted or pressured to give their supply to gangs, and also these tablets can be sold to buy fentanyl. Diversion can actually be minimized or eliminated through certain models of safe supply, and that would be supervised consumption of these substances.

This model is actually happening right now, running out of Vancouver, called the Molzen model out of the Portland Hotel Society. I have a quote there on the slide just on their process. Basically, what they do is that the person would come to the overdose prevention site or supervised consumption site. The tablets are actually provided in the site, the nurse crushes them, and the patient decides if they want to inject, take it by mouth, or snort it nasally. After they're done, if they've injected, they actually have to return the cooker and syringe to the nurse. At that point they're monitored for a certain amount of time, and they can leave. This eliminates diversion almost entirely.

Next slide, please. The next concern with safe supply that we've heard about is injection of tablets meant for oral use. We know that long-acting formulations of opiates such as Hydromorph Contin and Kadian certainly can lead to the increased risk of heart valve infections and skin and soft tissue infections. There has been no evidence so far to date, evidence-based studies that have been published, that have demonstrated this same risk with short-acting hydromorphone tablets or Dilaudid.

There are ways actually to further reduce these risks, if you were to inject an oral tablet, with certain filters, sterile technique, using sterile water, cleaning the skin before injecting, and those sorts of interventions. The other, you know, way to reduce this risk almost entirely is to use medications that are actually meant for IV use. Diacetylmorphine or hydromorphone, which are used in the injectable OAT models, would reduce this risk as well. The other thing I'd like to add is that the risk of injecting street drugs, especially if done in nonsterile conditions like an alley, should be considered higher risk than the injection of tablets in a sterile environment.

Next slide, please. The last concern – and I think it is a misconception – that we have heard with safe supply is that it is a treatment for opiate use disorder. Now, it is not meant to be a treatment for opiate use disorder. Safe supply is a public health measure to reduce drug poisoning deaths. It's not to say that there aren't any ancillary benefits that can be seen in different safe supply models, but the goal is to keep people alive, and I think we need to remember that when talking about how important this intervention can be.

I'll hand it back to Dr. Ghosh for more discussion on the emerging evidence on the benefits of safe supply.

**Dr. Ghosh:** Thank you. Next slide. At this time we have limited evidence for safe supply as defined by the committee. There is evidence for the intravenous opioid agonist treatment program that was discussed by Dr. Somers, but that can't be directly extrapolated for all safe supply models because of these themes that Dr. Mogus has spoken about such as therapeutic aspects and diversion. There's some qualitative evidence, however, from people of lived experience that have expressed that safer supply might be helpful to them. Any model of safe supply that is done should aim to maximize benefits while minimizing risk, again trying to get to the bottom of that U curve.

Next slide. Some signals exist that this might be helpful, and this is coming from Ontario. Some of the program evaluations – not proper research, again, but program evaluations – show that there could be a third reduction of justice involvements, a third reduction in six-month overdose numbers, ED visits as well as a half reduction in illegal activity. But some of the limitations of this are that there is no information provided on diversion, adverse outcomes, or the impact that this has had on communities. There was one published study, however, that looked at this and showed that safer supply at one year had similar retention rates to methadone programs and opioid agonist treatment programs that exist.

Next slide. This is our suggestion. Our suggestion, because of the lack of evidence that's out there that's either pro or against this, is that we create a pilot program for safer supply with regulation to minimize or eliminate the risk of diversion, again trying to get to that sweet spot in the bottom of that U curve. It should be done to allow individuals to avoid using the contaminated drug supply, and the pilot should be jointly evaluated by both the government as well as an independent reviewer from an academic setting so that it passes the necessary ethical and legal reviews that are required from any sort of study. Either the study would be done in Alberta, but it could be national as well.

Next slide. Components of this model that should be explored include the purchasing and dispensing of a regulated supply of fentanyl, heroin, or other substances that are used in a supervised setting. The cost of these recreational opioids must be less than the cost of the illicit drug supply and must be witnessed and not diverted, and it should provide access to free therapeutic options such as OAT and IOAT, which are shown to have improvement for clients, shown to provide treatment options for clients. There should be continued access to harm reduction interventions such as naloxone kits, sterile syringes, needles, et cetera, as well as wraparound services such as access to housing, income support, identification, which Dr. Somers had previously mentioned.

We do feel that this measure actually helps address some of the concerns that Dr. Humphreys had yesterday so that it provides adequate supplies for people who need them, ensures that people who do not use opioids don't receive them, and improves population health and provides public safety.

Next slide. We also ask that the government continue to go forward with the evidence-based treatments that it's already doing such as the expansion of OAT programs in corrections, police departments, and shelters; the expansion of gap-coverage programs; the expansion of regulated therapeutic programs such as IOAT; as well as continue to expand supervised consumption services if at all possible and other evidence-based outpatient residential treatment programs which it's already doing.

Next slide, and this is our last slide. We are, of course, in the throes of a crisis. We've thrown everything at this crisis, including the kitchen sink, and it's still not good enough. We need to continue to expand evidence-based interventions that already are occurring and also include things such as IOAT and the continued expansion of SCSs such as an inhalational model as well as recovery-oriented services. Ideally, we should try something that's radical, that's outside thinking, that's different, and evaluate this. I think we owe it to the Canadian public to sort of see if this intervention will work by providing the rigorous academic requirements that are necessary to actually adequately understand what safer supply is.

Next slide. Thank you so much, and we're open to questions.

**The Chair:** Thank you for your presentation. We'll now open up. I have MLA Yao up first.

**Mr. Yao:** Thank you so much for taking the time to speak with us today. Just to start off, for the benefit of not just Albertans but all

Canadians, can you briefly explain what the AMA's roles and responsibilities are? I personally thought that the College of Physicians & Surgeons might be more appropriate considering their job is to regulate the practice of medicine in Alberta. The last I heard from the AMA publicly was regarding fee schedules, negotiations with the government. Can you please clarify your position as the AMA?

**Dr. Warren:** Yeah. The Alberta Medical Association is an organization of physicians that has multiple roles within the community. Only one arm of that is our arm with compensation for Alberta physicians. No matter who they are employed for, whether it's fee for service, working with Alberta Health Services, or if you're a medical examiner, we represent all physicians. We also represent patients in Alberta, and one of the mottos within the AMA is to do no harm, so this definitely fits within what we as physicians do. All physicians work on the front line, and we have as much care for Albertans and for our patients as anyone does. We want to see healthy Albertans. We are dealing with this opioid crisis on a day-to-day basis, so we're bringing forward the expertise of Alberta physicians who work in these areas for you today to be able to bring this before you.

**The Chair:** A supplemental?

**Mr. Yao:** Yeah. Can you just clarify your very first line, your stance for the AMA? You said that presenting physicians are representatives of the AMA section of addiction medicine and are not speaking on behalf of the organizations in which they work. Can you just clarify that the statements that you make are your personal opinions and not representative of all of the physicians that the AMA encompasses or even those within the addictions medicine division?

**Dr. Warren:** Monty, do you want to speak to that?

**Dr. Ghosh:** Yeah. Absolutely. The reason why we added the organizations piece is that we do work for not-for-profit organizations that we're not representing at this table. We, again, work within the sector, we work on the front lines, but we are representing ourselves at this as well as the addiction medicine section. Yes, indeed, the addiction medicine section does have diverse opinions. We have tried to take the sort of middle ground with this because opinions are on both sides of the spectrum here. We have physicians who are extremely supportive of safe supply and believe that we should be putting this as public health policy and doing it right away, and there are physicians who are dead against it and say that this should not be happening at all. We are taking a pragmatic approach by saying that we don't know enough about this intervention and we need to study it and evaluate it to understand it better.

***11:10***

**The Chair:** MLA Yao, one more?

**Mr. Yao:** Yes. Can you just clarify? A lot of the expert testimony that we have had so far indicates that even the concept of safe supply is a misnomer and that these drugs that are provided are not safe in any way, shape, or form, yet you have a slide that demonstrates that the evidence-based suggestion going forward is that we should expand all the programming surrounding this issue. You stand by these claims that these all need to be expanded and that there is no evidence contrary to that opinion?

**Dr. Ghosh:** Maybe I should clarify that. The statement that we're making is that we should continue to expand evidence-based supports, which the government is already doing. These are opioid agonist treatment programs, residential treatment programs, IOAT programs as well as programs for supervised consumption services. We're not talking about safer supply. What we're thinking about for safer supply is that we need to study it and do a pilot program to sort of address the concerns that have been discussed by previous panel members, previous panel presentations as well as, you know, to demonstrate to people who are thinking that we should be doing this as well that it maybe can be done, but we just don't know where it lies – right? – in terms of benefits and costs and harms and wellness. This needs to be explored further, and this should be done in a regulated manner.

**The Chair:** MLA Rosin.

**Ms Rosin:** Okay. Thank you. If I understood your recommendation correctly, I believe it is for the government to begin selling recreational opioids at a cost below market value on the street. I'm going to put this in very plain language. It will be a yes or no question. Is the Alberta Medical Association recommending that the government of Alberta become dealers of illegal, illicit drugs for recreational purposes?

**Dr. Ghosh:** This isn't a yes or no question, and I don't think I can answer that as a yes or no question.

**Ms Rosin:** It sounds like it was by your recommendation.

**Dr. Ghosh:** It's my recommendation that we need to do something about this crisis and that this is one potential model to look at and that we do it in a studied setting, in a supervised setting that minimizes harms to the population and does the best it can do for the population who is at risk.

**Dr. Mogus:** Just to be clear, there are multiple models of safe supply. On one side of the spectrum what we're talking about in a potential model could be, you know, IV medications given in a supervised clinical setting to people, and on the other end of the spectrum – and this is part of, you know, the model of safe supply although right now it is outside of a legal framework within Alberta – is taking this totally out of the hands of physicians and putting it into public health responsibility and actually having recreational pure pharmaceutical grade drugs sold to patients at a less rate to displace the illicit opiate supply.

Those are very different models, and, you know, we're not saying that we should absolutely do one or the other, but I think starting out in a model within an SCS or within an overdose prevention site, where there is less chance of diversion and people have access to health care and housing supports and social supports and things like that, would be probably a reasonable place to start. If that shows benefit, then certainly perhaps down the line we could consider the other models. As of now that's part of the spectrum of safe supply, but it's certainly not necessarily the model that we're advocating for doing a study on.

**Ms Rosin:** Okay. Then I will ask one follow-up question, which is: if the government were to embark on such a pilot project, what would the Alberta Medical Association say to the statistic that has been derived from jurisdictions such as British Columbia and San Francisco, who do have safe supply programs, where 80 to 90 per cent of users of safe supply are also doing fentanyl and purchasing street drugs on the side?

**Dr. Mogus:** Certainly. I can speak to that as well, Dr. Ghosh. As I said before, the goal of safe supply is to keep people alive. It

displaces a portion of their illicit fentanyl use, which reduces their risk of dying because people are dying from illicit fentanyl, not from injecting pharmaceutical opiates to the same degree. So the goal is to keep people alive. It's not necessarily a treatment to get people off illicit fentanyl, if that makes sense.

**Ms Rosin:** Okay. So I believe what you're saying, just to confirm, then, is that the intention of safe supply is to keep people alive by keeping them off fentanyl, but the intended outcome is also to not keep them from not doing fentanyl. It just seems a bit as though this sword is two-sided to me. From what I heard, it's that the intended outcome of safe supply is to keep people off fentanyl, but we recognize they're still doing fentanyl, so the goal is not to keep them from doing fentanyl; it's to keep them alive from doing less fentanyl.

**Dr. Ghosh:** It's not to do street fentanyl, actually, and doing it in a way that's safe.

If I may, Dr. Mogus, the idea of actually running a pilot is threefold. Number one is that we don't have good enough data right now to show the pros or cons, and we owe it to the Canadian public. Number two, the data that does exist about concerns about this are done in a non drug-poisoning paradigm. They were done during the heroin paradigm. Things are very different right now. Number three is that we're hearing spatterings of people and sparks of evidence from certain programs that suggest that this might work, but they're not done in a high-enough quality fashion.

Number three, it's just logic. Let me ask you guys as a panel. If you were in the throes of your addiction and you had to take a drug, or a poison, and you were offered two glasses of poison – one glass of poison was a known quantity of poison that if you drank a full glass of that poison, you would die, or you had another glass where you did not know the potency of the poison; you could die from taking a sip of it, or you might not die at all by drinking the entirety of that glass – which glass would you choose? Which glass would you let your child choose? That's really the crux of the logic behind this.

**The Chair:** I have MLA Amery up next.

**Mr. Amery:** Thank you very much, Chair, and good morning to you, doctors. Thank you for coming and providing your input here before this committee. Over the course of the past two and a half days, I think you have been following a little bit about that, this committee has heard from many contributors, including distinguished doctors, professors, leading experts throughout Canada, the United States, and, in fact, abroad. If you have been following some or all of the testimony of this committee, the sentiment appears to be consistent that there is still little evidence or at least the evidence is still unsettled with respect to whether safe supply has a net positive effect on addressing substance abuse. I think a lot of times we talk about the extremes: safe supply prevents overdoses. That's a very important metric to look at, but there are other things that we need to consider as well such as the health impacts, the societal impacts, economic, and so on and so forth.

One of the things that I think I took from some of the information that we received is that, when you look at the metrics and based on all the information that this committee has received, those who are receiving substances through safe supply do not, in fact, appear to be recovered, and I think that addiction recovery is an important – probably the most important – component for people who are addicted to these substances. Now, they do not appear to be reintegrating into society. They do not appear to be forging links with their families or their communities. They do not appear to be weaning off these substances, and, in fact, as my colleague had said earlier, they appear to be using not only the controlled substances but also illicit substances as well.

We've seen, I think, from a number of experts who have come before the panel that most if not all of those who are in safe supply programs are in fact also using street-acquired or illicit drugs, and I think that's an important component for us to keep in mind here. We've heard that safe supply doesn't necessarily curb the health impacts of substance abuse, and even some of the experts have come forward to suggest that the B.C. model, where safe supply is operating, has not actually decreased the number of overdoses in that jurisdiction either. We just heard earlier today that for those who are addicted to substances, increasing dosages are generally required to achieve the intended effects, and that dose from today likely has to be increased as time goes on in order to achieve that effect.

***11:20***

You know, doctors, I do approach this entire safe supply concept with an open mind, but I am a little bit concerned about adopting a pilot project in this province when we already have examples of pilot projects or even full application of the safe supply model in other jurisdictions, without first reviewing the outcomes of those as well. If it is actually true in the B.C. model that overdoses have, in fact, increased, I find little benefit to applying a pilot project here and applying a trial period with respect to a safe supply pilot program when the stakes are incredibly high.

Now, that was a long preamble, and I apologize, but I wanted to establish some context for what I think is a fairly straightforward question. You're advocating for responsible legal regulation. I think the stakes are incredibly high here. I think you would agree with that. What is the end goal here with respect to those who are addicted to drugs or other substances if we recommend a model of addiction maintenance, safe supply, this pilot program? Where do we go from there, and how does it actually get people into recovery rather than dependency?

**Dr. Ghosh:** Dr. Mogus, can I take this one?

**Dr. Mogus:** Yeah.

**Dr. Ghosh:** I think the end goal here is twofold. One is to keep people alive and keep people safe. I know that's debated based on some of the data that you've seen, but, again, that's not evidence based. It's not fully established in the literature. They're still analyzing and studying it.

Not every context is the same. Vancouver is very different than Alberta. We already know this. Despite us doing everything that we can, even without a safe supply model in Alberta right now, the numbers are still riding high. They're still rising; they're not decreasing. Safe supply may impact this, and safe supply might not. We just don't know as of yet. We just don't have that data.

I do think that the other thing that we want to keep as an outcome is keeping the population safe and not causing undue harm, unintentional harm to both society and others through mechanisms like diversion. So we have to do this in a responsible manner. We have to really do this in a way that's responsible to both people in society but also responsible to our patients as well and physicians, too. That's one of the things that we have to definitely do.

Are you okay with repeating your second question – I apologize – the second part of your question?

**Mr. Amery:** I think really the question was whether or not we have an answer to what the end goal is here, which I think you've kind of elaborated on. If we do recommend a model for, you know, what I would call – I mean there are a million different terms for this –

addiction maintenance, ongoing maintenance, where do we go from there?

**Dr. Ghosh:** I do think that . . .

**Mr. Amery:** We've got – sorry. I just want to kind of clarify because I'll use this as my supplemental. You know, we've got this proposed pilot project, where a regulated supply of substance is being provided to individuals, and that's sort of where it stops for me. What happens next? How do we get people into recovery if we are going to continue to provide them with the substances that put them in that position to begin with?

**Dr. Ghosh:** Yeah. I think it's totally not mutually exclusive, for sure. I agree with you a hundred per cent that we need to keep getting them supports, wellness supports, so access to housing, income support, that Dr. Somers has mentioned – that can be crucial to getting people into recovery – giving them mental health supports, getting them access to treatment programs should they choose or want it. Not everyone is ready, but we can work on that with them by developing a relationship with them. The IOAT program has been a great example of this, where people are working with people who are using substances. They establish a trusting relationship where these clients will engage with health care professionals or other professionals to access wellness supports.

Recovery is still possible with this, and I strongly believe in recovery. I'm a full advocate for recovery, but I think it takes time to get people to that point of wanting recovery. That's what we can work on while we are providing them with at least a safe, stable supply so that they're not using something that's made in someone's basement or someone's garage or someone's bathtub. This is a pharmaceutical-grade alternative that provides them with supports and keeps them alive and away from stuff that's inappropriately manufactured.

**The Chair:** MLA Milliken, about two and a half minutes left here.

**Mr. Milliken:** Sure. Thank you very much for being here today. I really appreciate it. I also appreciate that we're looking at a potential request, I guess, from the three doctors here for, potentially, a pilot program.

I'm going to ask a question that I've even stated, if you've watched any of the previous panel members or stakeholders – I've asked one question throughout it. Just putting aside the ask for a pilot – right? – we're here to obviously look at safe supply. I get that the two, again, used the term – I'll use it in this case – not necessarily mutually exclusive, but just for the moment. With regard to sort of a quantitative logic – and I'll try to do it pretty much verbatim to some of the others.

This committee is tasked with examining several aspects of safe supply, including whether there is evidence that a proposed safe supply would have an impact on fatal or nonfatal overdose drug diversion or associated health and community impacts. With that in mind, to your knowledge, to any of the three here, is there any quantitative evidence that access to a safe supply of opioids or other substances for people who are addicted to or dependent on these substances reduces their likelihood of suffering a fatal overdose? I'm asking that question because one of the terms that has been used here today has been that the efforts for safe supply are to "keep people alive." I think that everybody is coming to it with that as the perspective, as the end goal. So is there any quantitative evidence out there that safe supply essentially keeps people alive?

**Dr. Ghosh:** Dr. Mogus, can I take this one again, or do you want to take it?

**Dr. Mogus:** Sure. Yeah. I think this just points to the importance of looking at that question in an Alberta context. We have signals from the multiple studies that are going on across Canada, qualitative evidence that people are using less street fentanyl and therefore are at less risk of overdose. We need to study this here to find the answer to the question because right now we don't have the information in an Alberta context at all. So I think that just points to the importance of doing the pilot project.

**Dr. Ghosh:** Or even in any context, for that matter. We completely agree that there's no data to show the pros or the cons of this model, but that's what we need to do. We need to sort of study in a well-established, rigorous manner through legal, through ethics, in a way that really delineates this. I think we owe it to everyone to know. Again, we're coming with an open mind that it can potentially cause harm, too. There's no doubt about that. There's no one denying that there are potential harms. You've heard it from the panel before. But there could be potential benefits as well that we're hearing, and we just don't know, and I think we need to know.

**The Chair:** All right. That does conclude our time for this conversation with the AMA today. Thank you very much for being here today and for your presentation. You guys can feel free to sit around for our next presentation. We appreciate your time.

Next up, we have Chief Eric Shirt. If you can join us at the table. Thank you for being with us here today, Chief. We will open it up for you to be able to give a 10-minute presentation.

Actually, while we're waiting for the Chief, we may need to go past noon. Just to get unanimous consent from the table that we can extend beyond noon for this meeting. I'll ask one question. Is there anybody opposed to us going beyond noon for the meeting today? Seeing none, that is carried.

Welcome, Chief. We will pass it over to you right away. Thank you for being here.

**Eric Shirt**

**Mr. Shirt:** Thank you. We're good people, all of us in this room and in the province. We want the best for our families, for our kids, and communities. That was one of the reasons we signed Treaty 6. I know you must all be tired, so I will try not to repeat what was said, but I haven't heard any other than this last presentation, which causes me some concern.

***11:30***

Thank you for having me and Chief Leonard here. I want to thank Marcel for personally visiting us and inviting us.

Most of the people you see on the streets are Aboriginal, so he was right to invite us. It might be useful to ask us: what is the impact that safe supply will have in our community? Is this a solution, or will it create more problems? Today I want to express my concerns, but I also want to talk about solutions.

In 2021 there were 110, 160 overdoses, 2,000 deaths a year. That's too many. In my research the other thing that kept coming up was accidental overdose, and I thought: did they ask that person if it was an accident? What I do know is that this disease is progressive and chronic. It doesn't get better. Eventually you take a drug not to get high but just to keep the horrors away, you know. Intertwined with moments of sanity is the overwhelming sense of hopelessness. During these bouts of DTs and withdrawal you have thoughts of suicide. It happened to me. When I sobered up, I weighed 142 pounds, completely malnourished. I see brothers and sisters on the streets on more deadly drugs, where you see the body visibly eating itself. The body eats itself to keep the vital organs alive. You see it in your teeth, in your skin, in your weight, your muscle tissue. How do we address that?

In 2021 there were 6,000 visits per month to emergency rooms for misuse of opiates, amphetamines, and now cocaine, over 2,000 hospitalizations per month for these reasons. Every week there were 150 EMS, you know, emergency events. Is this what we want? Is this an improvement from five years ago? What is going on there?

The name "safe supply" reduces the perceived risk of trying this stuff. When marijuana was legalized, you saw it go up, and we're moving towards that with these opiates. Safe supply replaces dependence on drug traffickers on the street to drug traffickers from government. Is that what we want? Distributing drugs does not create healing relationships for those that seek recovery and those that can provide that care. One of the things to completely understand here is that addicts, alcoholics do not like where they're at. They do not like the misery that their addiction brings. They don't like going to jail, losing their kids, losing their family, losing their jobs, losing their health, but that's the nature of the illness. If the help is nonjudgmental, they come in. They come in.

Safe supply. We need to stop creating these, maintaining Albertans' addictions without addressing the root causes of addictions or empowering folks to lead healthier lives, this warehousing them on the streets not in the shelters. We keep them medicated, and it's happening throughout all the services that are supposed to care for people. You have group homes that have kids on Ritalin. You have people in these homes that are on drugs, okay?

The right place that sustains supports for sustainable recovery from chronic substance dependency is not on the streets. It's not distributing drugs at a safe consumption site, where folks continue to injure their own bodies. These drugs don't provide health; over time they damage the body, the various organs in your body. We need solutions other than offering free, less dangerous drugs, death due to drugs at the end of very painful and personal journeys. We appreciate that the government supply, you know, may reduce infections, crime, and hospitalization, which we hope can reduce barriers to accessing meaningful recovery programs.

Right now there are over 30,000 Aboriginal people who experience problematic substance use and want help but can't get that help. They do not want to maintain their existence, whether those drugs are supplied by dealers or the government.

Safe supply does not address the fundamental addiction and mental health challenges that they're facing. It proposes to maintain the majority of tens of thousands of Albertans with chronic substance dependency in a state of ill health, with all the associated personal, social, and financial costs. It's we as a people of this province who bear that cost, and it keeps going up.

What's the average cost to provide for street people? You might say it's nothing, but the costs, in the studies that I've seen, can be up to $100,000 and over. That is outrageous, you know.

How much time do I have?

**The Chair:** Three minutes left, sir.

**Mr. Shirt:** Okay.

Do you have any questions?

**The Chair:** Yes. We can open it up for Q and A now if you'd like.

**Mr. Shirt:** Sure.

**The Chair:** Yeah. Perfect. We've got lots of time for Q and A. We'll start with MLA Yao.

**Mr. Yao:** Thank you, sir. Thank you so much for the honour and the pleasure, Chief Shirt, to be here to speak to us today. I'm wondering if you'd expand on your very first comments that you made, which were regarding our previous presenters. I wonder if you could expand on your thoughts there.

**Mr. Shirt:** Excuse me. I'm sorry; I have trouble hearing you.

**Mr. Yao:** Some of the first comments you made were regarding our previous presenters. I was wondering if you could expand on your thoughts on that.

**Mr. Shirt:** Probably the best way to explain that is to, you know, give you a quick history. Where are all these people coming from? In order to answer that, you need to look at the conditions on the reserve but also at our current treatment services. The average age of death in Saddle Lake is 54 for women, 46 for men. Most of the deaths are caused by preventable, treatable chronic degenerative diseases like alcoholism, diabetes, drug addiction, cardiovascular diseases. When you look at that, what you see is the tip of a rapidly rising chronic disease iceberg. What we see is problematic, very, very problematic, you know, and I'll describe that in a while.

***11:40***

What we don't see that's coming up, we should be highly concerned about. Children in care. There are 52,000. Sixty-nine per cent of them are native. That's 35,880. Those women and those men that had those kids, did they choose that loss? Most of that was alcohol and drug related: chronic degenerative disease, preventable and treatable. I've seen these kinds of talks about research. Yeah? Research. That scares me because it justifies not a solution; it's something that's going to cause a long-term problem. Where are those mothers? Do you honestly believe those mothers chose that loss? When the parents have a preventable disease, shouldn't we help them?

These kids are now showing up where? On the streets as they age out from social services, in the inner-city high school, in a prison, sent to homeless prisons. The majority of kids, the majority of the homeless people in St. Paul now have come from there. This should be one of the things that we should be looking at, not on doing experiments on us. I mean, Leonard and I came from the streets.

Back in 1973 I came back from the University of Santa Cruz, where I was working for about two and a half years. Within one month of arrival Richard Anthony, head of AADAC, and hon. Neil Crawford approved the funding proposal for Poundmaker's Lodge. The success of that was really immediate. When I look back, the success was in the training that we provided the staff. But not only that, our cooks cooked everything from scratch. I can attribute my sobriety to living with a farm girl from Saskatchewan who cooked three meals a day from scratch. That's the foundation. The foundation of all human functioning is the fuel for your heart to function, you know. Every function in your body – physical, mental, emotional – uses fuel. That was one month. That was really quick, okay?

In the early '80s the funding for the new facility in St. Albert was presented to Premier Lougheed and his cabinet, and within a month they approved it. That was good. We are also aware and happy that Premier Jason Kenney is adding more beds and encouraging innovation like San Patrignano, which is based on principles of lifestyle recovery.

In the '70s a leader in the field of addiction said that alcoholism hasn't been improved in any way in the last 25 years. It's still true today. Most still operate on the Minnesota model, with small variations. Okay. I want to spend a few minutes talking about that. Can I have the first slide? You take a look at that, and what does it say? It's something that almost, like, you don't want to look at it or do research on it. Studies have reflected that about 46 per cent of individuals relapse within 30 days of leaving treatment; 85 per cent will relapse within a year. The National Institute on Alcohol Abuse and Alcoholism, NIAAA, evidence shows that 90 per cent of people go back to using within four years.

If you look at the next slide, this is a study of 26 treatment programs. Twenty-three per cent stayed sober for one year; 7 per cent stayed sober after four years. A lot of them had a lot of lingering psychological symptoms. Lifestyle based and nutrition based: 89 per cent stayed sober for one year; 74 per cent stayed sober after four years.

Now we go to that original slide with the pyramid. Why I want to look at this is to understand the disease process. The disease moves this way. It starts with how our body metabolizes alcohol and then moves upwards. The damage it causes at the physical level has symptoms. All of those are psychological symptoms. Like, our treatment approaches currently are not wrong; they're just incomplete. We need to address those psychological symptoms, but what we ignore in most cases is the physical damage, and that physical damage is primarily nutrition based.

If you look at the damage in there – neurotransmitter depletion, mental health, hypothyroidism – what they find is that about 35 per cent have it, but is that a testing requirement at treatment centres? No. What are the symptoms of hypothyroidism? Depression, irritability, fatigue, lethargy, sudden anger, you know? Things that you need constant therapy for.

If you take a look at hypoglycemia and you look at dry drunks, they're just like that; a mirror. Yet we don't address those things. People leave there with that kind of damage, and that's why they return back to drinking because those symptoms – you can't talk yourself out of that damage, that physical damage. A lifestyle program starts with that, but the thing about the lifestyle program that we're proposing is interesting. Next slide. Oh, I have one in the wrong order. Let's back up. Okay; maybe it's not in there.

Let me talk about that, the lifestyle centre that we're proposing. It's the right place, you know. It's safe. It's free from any toxic influence, the right people, highly trained, the right time that it's wanted. The thing about that is that most people want help.

I was in Calgary at a meeting on 104th Street in Tim Hortons. Sometimes a lot of meetings go on there. I was in line. And this young girl, probably in her 20s, you know, came up to me and asked me: can you buy me a cup of coffee? I said: sure. She was quite unkempt. I asked her: what are you on? She looked at me and she said: yeah; I use opiates. I didn't say anything. A little while later she said: you know, I keep trying to go to a detox centre, but I can't seem to get in. I don't know if that's rules, regulations, filling out forms, you know? What we know is that people do want help. They don't like the misery that this stuff brings.

The fourth thing in there is the right program. In there was a cultural component. A cultural component is all about reunderstanding traditional food wisdom. Every culture has that. We had it, too. Chief Long Lodge in 1884 said, "I want no government medicine. What I want is medicine that walks." Give my people good food, and they will get better. My grandfather on my dad's side: his solution to everything was [Remarks in Cree] feed him, because he understood that the body will do everything the Creator wants it to do if it has the good fuel.

An educational component about the disease, skills component, life skills, occupational, problem-solving, interpersonal skills. Occupational I really emphasize in that program. Why? Because we want people to look at getting a job as quickly as they can. The best relapse prevention program is a job. But a lot of these people that will be coming in there have no job history, so they're going to have difficulties.

***11:50***

But the thing they need to learn is the philosophy of going for it, going for it. Had a no? It's just one step closer to a yes. That kind of philosophy: you need to apply, you need to go out and get a job, and if you don't like that job, you want to improve, look at educational opportunities and what you can get in there.

The nutritional component. There again, if you consider the persons coming in there – when I sobered up, I had no cooking skills. Residential schools: I didn't learn any cooking skills or food preparation. When I sobered up, all I knew was how to make what you'd call highway steak, which was baloney and white bread. I mean, that's not healthy. I was lucky that I met that girl; you know, it saved my life. So in terms of the nutritional component it's a therapy but, you know, a personalized therapy based on the assessment of that physical damage. You can focus it, and we have a good team of nutritional doctors and lifestyle doctors that are working with us. The thing is that we can get that done.

The recreational component. Again, it's not about gym and all that stuff. This is all about just a yoga mat and looking at how you can keep healthy and what are the games that you need to relearn. But focus on that. We want some of these behaviours to be habitual, like, let's say, with the room, cleaning your room, so that when you come back in the evening, you feel good because it's nice and clean. If it's dirty – simple things but really important things that we want to habituate.

Nonmedical detox. A counselling component. Aftercare apps. This is an interesting one because there are so many ways to do the aftercare, especially if you have the apps. We'd like to work with a provider and say: can you give them two months' free access? Why? Because you can have your program in there and see where you're at – are you in the red zone, white zone, you know, different zones 1, 2, 3, 4? – and what you need to do in those areas. So it's right there, but they'll need that also to get their jobs, to access other services that'll, you know, help them continue good health.

The next slide. This one: lifestyle diseases. They are triggered by the food environment that runs in a family. You think about that. A lot of times people say that it's the genetics. I think there is some genetic susceptibility, but it's the food environment. The kids are raised in that. The kids are raised in that, and that food environment also includes alcohol and drugs. They're raised in that, and guess what? Boom; it just multiplies. More and more people are being affected. Lifestyle disease requires various cognitive, behavioural, and nutritional therapies to develop the capacity for continuing self-care.

One of the things that we want to focus on here is that these are individuals. We want to give them the tools, the skills, the information, and help them recover their health because we know they can solve their own problems. We have to give them the dignity of solving their own problems.

Yes. Go ahead.

**Mr. Milliken:** Thank you, Chief, for allowing me the opportunity to ask a quick question, and it's going to be in the context of all of your knowledge. Our committee has been tasked with regard to examining several aspects of safe supply, and that includes, I think, your knowledge. What would be your views of safe supply or the provision of opioids to users within the context of your approach to the treatment of addictions?

**Mr. Shirt:** I see no role in it – you know? – in terms of my view. We'll keep them on the street longer, but they'll suffer longer, and the progressive damage increases. Like we were showing, that physical damage and, you know, the biochemical damage that happens doesn't go away. Talk therapy doesn't fix it. It requires that intervention. You fix that, and the ability of people to deal with trauma, crisis increases.

When you have trauma, let's say, your body uses what to deal with that trauma? Fuel. If that trauma is continuing and chronic, you

bankrupt your system, and no amount of counselling will ever correct that. I mean, you look at the Holocaust, in a way, and I think of the people there. You know, they became healthy because of their traditional food wisdom and the focus on that.

Yes?

**The Chair:** MLA Yao has a question as well. I just wanted to make sure we got him in in time.

**Mr. Yao:** Again, Chief Shirt, thank you so much for your wisdom and knowledge. Throughout your presentation I heard you mention things about nutrition. I heard you talk about nutrition. I've heard you talk about housing. I've heard you talk about family supports. In your opinion, do you feel that these are things that are very proactive towards helping people recover from addictions?

**Mr. Shirt:** Yeah. The basic premise is this: you fix the bottom, and you give people the skills. A lot of times they will solve their own problems. It's like when we first started Poundmaker's. People would come to our centre, and they'd talk about their home situation. The message that we gave them is that if you came from skid row, when you leave here, we don't want you to go back, and if your situation in your community is the same, we don't recommend you going back until you have managed to gain your health. In that sense, you need to look at solving your housing problem. You need to solve these issues that will make your life better, and they will. You know, people will move on. That's the nature of people.

I think it's, in a lot of ways – there was an old friend of mine who used to say: "You want to look at how we help people. One is called cruel kindness." You take away that ability to solve their own problems. Tough love is also helping them be responsible to move on their own issues. That has a compounding effect because it goes down to other family members, to your kids, you know? Can we do that? We've proposed to the government to start up a lifestyle centre of excellence, a treatment program, and we would like to do that because we know the results are so, so different.

**The Chair:** Chief Shirt, that does conclude our time for today that we had scheduled. Have you got another closing point?

**Mr. Shirt:** Yeah. I want to thank you again for coming here. Just teasing.

Safe supply. Again I go down to the business, that it costs $100,000 a year in terms of those individuals. Currently the cost for detox is about $300 a day, $150 a day for a treatment program. With a lifestyle centre it's pretty much the same cost, but it's about $12,000 for a 90-day stay for individuals, and they come back super healthy, and the recovery rates will be higher. The thing is that with safe supply you're talking about adding the cost of that safe supply into that $100,000. Does that make sense? Whereas what we're talking about in terms of the kind of care we're proposing – and this is a solution, and it's coming from me, Chief Roger Marten, Chief Leonard. We've come from the streets. We've looked at everything in terms of these last decades, and we've seen the result. There was that vital component missing.

***12:00***

We can do it for $12,000 a person and keep them off the streets and keep them healthy to become functioning members in our community that contribute to the tax base and everything.

**The Chair:** Thank you, Chief, and thank you for all the work that you've done in the addiction field over the years. We really appreciate you sharing your experience, your wisdom with us. Thank you.

That now concludes our time for presentations today and brings us to other business. Is there any other business that the committee members wish to bring forward at this time? MLA Yao.

**Mr. Yao:** Thank you so much, Chair. I think these days that we've been listening to stakeholders have been absolutely fantastic. I feel actually very, very comfortable in moving ahead with a report based on what we've heard, but I wish to continue to learn more. To that effect, I'd like to move a motion to expand the list of invited stakeholders to make oral presentations. My motion would be that

> the Select Special Committee to Examine Safe Supply invites the following individuals to make oral presentations to the committee commencing March 21, 2022, and concluding no later than March 25, 2022, subject to the committee's availability to meet: Dr. Perry Kendall, who is a former chief medical officer of health for British Columbia, and he's the current CEO of Fair Price Pharma; Dr. Mark Tyndall, executive director of the BC Centre for Disease Control; Erys Nyx, who represents the Drug Users Liberation Front; Dr. João Goulão, director general for the intervention on addictive behaviours, from Portugal; Cheyenne Johnson, the executive director of B.C.'s centre on substance abuse; Zoë Dodd, safe supply program director for Toronto; Corey Ranger, the safe supply program operator for Victoria; and Amber Fort, the executive director of Pastew Place Detoxification Centre in Fort McMurray.

**The Chair:** Thank you, Member.

Before we can discuss the motion, we have to approve that

> we would consider the motion,

so I will ask the question. All in favour of considering Member Yao's motion, please say aye. Any opposed?

> That is so carried.

Do we want to put that up, that motion from Tany? There you go.

Any discussion from members about the motion?

Seeing that there is no discussion, all in favour of MLA Yao's motion, please say aye. Any opposed?

> That is carried.

Is there any other business that committee members wish to bring forward now?

All right. Hearing and seeing none, we will move on to the date of the next meeting. That will happen at the call of the chair.

Adjournment. If there's nothing else for the committee's consideration, I will call for a motion to adjourn. MLA Turton moves that the February 17, 2022, meeting of the Select Special Committee to Examine Safe Supply be adjourned. All in favour, please say aye. Any opposed? That is carried.

[The committee adjourned at 12:05 p.m.]

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