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# Standing Committee on Health

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**EVIDENCE**

## Thursday, May 29, 2008

## Chair

**Mrs. Joy Smith**

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● (1000)

[*English*]

**The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)):** Order, please.

Ladies and gentlemen, good morning. Welcome to the health committee and welcome to our witnesses. We are happy to see you here this morning. I also want to welcome everybody in the gallery.

I would like to take a moment to read to you something that has been brought to my attention. I have to tell you, fellow committee members, that as an elected member of Parliament representing constituents in my riding of Kildonan—St. Paul, and as chair of this committee, I take great pride in the service we provide to Canadians as a committee and the important work that our committee does. We are one small but crucially important cog in the wheel of the democratic process that has enabled Canada to develop as one of the world's great nations.

I have to tell you that it troubles me gravely to tell you that for the first time in my career as an elected representative in Canada, and for the first time in living memory, our democratic process has been subverted by physical intimidation and threats of violence. I wanted to inform the committee of what happened here this morning.

One of the witnesses scheduled to appear today has been targeted for protest and intimidation at the site of his own professional practice. The witness, a doctor in addictions medicine who has treated more than 7,000 people in the past 18 years, was subject to a disturbing protest and an invasion of his office on Tuesday. He has received advice from the B.C. College of Physicians and Surgeons and his own legal counsel that he not appear before this committee, owing to concerns for his physical health and safety.

On May 27 he wrote that his office was being picketed by 20 angry people identified in their leaflet as “addicts”, accusing him of not listening to anyone and having his own ideas derived from an addiction to “drinking his own bathwater”.

He also indicates that staff at his pharmacy and his building and his own patients described demonstrators saying “vile and vulgar things” to them as they put leaflets in the faces of people entering and leaving the building, upsetting patients who were forced to cross the picket line and run an angry gauntlet. He says that some of his patients are middle-aged, and older patients felt quite intimidated and upset.

The doctor said, and I quote:

> I hereby request that l not be required to give live testimony on Thursday morning. l am very concerned that if l do so l will be subject to attacks including not only picket lines and vicious slander but also physical attacks at work or elsewhere.
>
> These people, presumably using addicts, are liable to attack me again, including, l believe, physically or in terms of my property in order to get what they want, which is to make sure that no one opposes them.
>
> This certainly makes the point that there is no way to engage in reasonable discussion about Insite. Anyone who says anything against Insite is vilified and attacked publicly.
>
> The fact that my office has been picketed today and I have been personally vilified and slandered, merely for voicing my professional opinion, speaks volumes about who the real 'ideologues' are in this matter and why so few people are willing to voice their misgivings about Insite. There is no room for dispassionate discussions about the merits of Insite, because so many of its proponents attack the person in order to stifle debate.
>
> That is not science. That is bullying.

Unfortunately, because he intended to testify by video conference, Dr. Donald Hedges' statement has not been translated. However, the full text of his English version is here, and I will provide it to the clerk for translation.

I hope I speak for the entire health committee as I extend my apology to Dr. Hedges for the distress he is enduring, and a hope that as a committee we never lose a witness to threats and intimidation again.

I wanted to bring this before my health committee today. I know each and every member of this committee is very distressed to hear the threats and intimidation that this professional doctor has undergone because he wanted to come and appear as a witness at this committee.

● (1005)

Thank you, ladies and gentlemen.

[*Translation*]

**Ms. Christiane Gagnon (Québec, BQ):** I have a point of order, Madam Chair.

Why did you make that statement before hearing the witnesses? It's as though you wanted to stamp the proceedings with the Conservatives' ideology.

[*English*]

**The Chair:** Thank you, Madame Gagnon.

I made that statement—

[*Translation*]

**Ms. Christiane Gagnon:** I'm a bit disappointed by your attitude, Madam Chair. When you speak on the committee's behalf, you should ask us what we think. You decided to make that statement on your own initiative. We would have liked to be notified in advance so that we could express our view of the situation. We can't say that we are concerned or that we disapprove. We weren't even aware of the statement. Before even hearing the witnesses, we appear alarmist because you stated that an invited witness had apparently received threats. You leave the impression that drug addicts who go to the Insite site could be dangerous to the public. That's at least what I understood from the interpretation. I'm a bit disappointed in your conduct this morning.

Thank you.

[*English*]

**The Chair:** Well, that is regrettable, but as chair of this committee I will say that when we invite guests to come to this committee, Madame Gagnon.... Dr. Hedges should have been able to come to this committee. He informed the clerk that he was fearful of physical abuse and intimidation and that he couldn't come.

**Hon. Keith Martin (Esquimalt—Juan de Fuca, Lib.):** I have a point of order.

Madam Chair, we have witnesses who have come from a long way away. I think you've made your point; maybe we should move on and listen to them.

**The Chair:** Indeed we should, Dr. Martin. Thank you.

Pursuant to Standing Order 108(2) and the motions adopted by the committee on May 8 and May 13, I'd like to welcome you to this briefing session on harm reduction programs in Canada. We're very happy you're here, and we're looking forward very much to all your presentations, with particular focus on the safe injection site in Vancouver.

I'd like to take one minute to go over the schedule for today's meeting. Until approximately 10:40 a.m. we will be hearing the presentations from the witnesses present in this room. From 10:45 to 10:55 we will be hearing from our other two witnesses by video conference. From 10:55 to 11:45 we will proceed with questions from members, and from 11:50 a.m. to 1 p.m. the Minister of Health will appear before the committee.

I would like to welcome all the witnesses who are here with us today, and I'd like to thank you for travelling all the way from British Columbia. It's a long way.

We have with us Dr. Thomas Kerr, research scientist with the B.C. Centre for Excellence in HIV/AIDS. We have Inspector Scott Thompson from the Vancouver Police Department. We have Mr. Donald MacPherson, the drug policy coordinator with the City of Vancouver. We have Ms. Liz Evans, executive director, PHS Community Services Society; Mr. Philip Owen, former mayor of the City of Vancouver; Ms. Heather Hay, regional director, Vancouver Coastal Health; and Dr. Colin Mangham, director of research, Drug Prevention Network of Canada.

Let's begin with Inspector Thompson.

I have to tell you that you each have five minutes for your presentation, and then we'll go into questions after hearing all the witnesses.

Go ahead, Inspector Thompson.

● (1010)

**Inspector Scott Thompson (Youth Services Section, Drug Policy and Mental Health Portfolios, Vancouver Police Department):** Good morning, and thank you for the opportunity to speak here today on behalf of Chief Constable Jim Chu and the Vancouver Police Department.

My name is Inspector Scott Thompson. I'm in my 28th year of combined police service as a current member of the Vancouver Police Department and a former member of the Royal Canadian Mounted Police. In 2003 I was part of the Vancouver Coastal Health project team for the supervised injection site, or SIS. In 2003 I was the author of the Vancouver Police Department's policing and operational plans for the SIS. I also developed and delivered the SIS orientation packages to both VPD members and Vancouver Coastal Health staff.

I was then on the ground in the downtown eastside for the first year of the supervised injection site's operation. I am currently in charge of the VPD's youth services section, as well as the drug policy and mental health portfolios.

For the VPD, the story of the SIS began in early 2002. Philip Owen was the mayor and chair of the Vancouver police board at that time. The VPD examined the question of an SIS during a facilitated managerial and executive process and came to two conclusions: one, that our expertise is in policing and public safety, not in health and health research, and therefore we should always be cautious when and if we choose to support or criticize public health initiatives and/or research, given that our expertise lies elsewhere; two, that regardless of whether we agreed with the concept of an SIS or not, we needed to be at the table.

As you likely know, in late 2002 a civic election in Vancouver resulted in Larry Campbell, now Senator Campbell, becoming mayor. The primary election issue was the SIS, and Mayor Campbell and others subsequently drove the process to make this concept become a reality.

As part of the application process for an exemption under the Controlled Drugs and Substances Act for medical research at the SIS, Health Canada asked the VPD what its position was. We replied that if a drug user is not engaged in disorderly, unlawful, threatening, and/or violent behaviour on the street or is wanted on an outstanding arrest warrant, it is unlikely they would be prevented or impeded by the Vancouver police from accessing the supervised injection site.

Just before the SIS opened, the VPD operations plan stated the following to Vancouver police officers:

> Police members have a broad range of discretion when dealing with drug use and drug possession in the City of Vancouver. This discretion includes options such as seizure of the drug, and/or arrest and charging of the person(s). This discretion lies solely with the police officer on the street.
>
> When dealing with an intravenous drug user found using drugs within a four block radius of the SIS...it is recommended that our members direct the drug user to attend the SIS to avoid a future contact with the police.

Our orientation package for SIS staff, and later our VPD drug policy, stated that “on a fundamental level, all health initiatives must be lawful”.

I submit that during the past five years members of the Vancouver Police Department have performed their duties in an exemplary manner in relation to the supervised injection site and that this performance represents the best traditions of a neutral, apolitical, and professional police service in a free and democratic society.

This brings me to the position of the Vancouver Police Department and the key messages I have been asked to deliver to you today. These key messages are the following.

One, the VPD agrees with the Canadian Association of Chiefs of Police position that illicit drugs are harmful. The high incidence of addiction to illicit drugs in Vancouver contributes to an inordinately high property crime rate.

Two, when the supervised injection site opened, the VPD position was that we were in favour of any legal measure that might have a chance of reducing the drug problem in Vancouver's downtown eastside. We're on record as supporting the SIS as a research project.

Three, the VPD's primary interest and mandate around the SIS has always been and remains public safety, not public health.

Four, our position is that as a police agency focused on public safety, it would be inappropriate for the Vancouver Police Department to comment on the medical merits of the SIS.

Five, we are reviewing the various studies on the SIS and the linkages to crime and disorder. We believe that further research needs to be focused first on whether the SIS and other services potentially facilitate and perpetuate the cycle of addiction and whether this has a negative impact on addicted individuals seeking treatment.

Secondly, it needs to be focused on determining the degree to which locating the SIS amid a concentration of other services hinders the neighbourhood's reputation, capacity, and ability to recover and flourish.

● (1015)

Third, it needs to focus on whether the SIS and this concentration of services facilitates the easier entry to, development of, and maintenance of a cycle of addiction.

Fourth, it should focus on whether the SIS, access to services, and/or the ready access to drugs in the neighbourhood draw vulnerable people from elsewhere in the region and country.

Finally, further research should be focused on determining whether the SIS and the concentration of services increases the geographical concentration of addicts into a small area, which may or may not increase the likelihood of communicable disease transmission.

In closing, the Vancouver Police Department is not going to be an active participant in the debate about the medical merits of the supervised injection site. We do urge further research into the areas we have identified.

Thank you.

**The Chair:** Thank you so much, Inspector Thompson, for your comments.

We'll now go on to Mr. Donald MacPherson.

**Mr. Donald MacPherson (Drug Policy Coordinator, Drug Policy Program, City of Vancouver):** Thank you for allowing me to present my views to the committee today.

I'm going to give some contextual information about our issues with harm reduction and the injection site in Vancouver.

It's an honour and a privilege to be able to speak to this committee.

I've been with the City of Vancouver for the past 20 years and have spent considerable time working with a wide range of individuals, non-governmental organizations, senior governments, and the private sector in seeking solutions to the issues we face in Vancouver regarding injection drug use, addiction, and mental health issues.

Let me first start with some contextual remarks regarding harm reduction in more of a global context.

l have just been to the 19th international conference on the reduction of drug-related harm in Barcelona, Spain, May 10 to 14. At this conference the global state of harm reduction was discussed and reports were heard from a variety of locales around the globe and from the executive director of the United Nations Office on Drugs and Crime.

Prior to the 1970s, injection drug use was primarily reported in North America and western Europe. By 1992, 80 countries reported injection drug use. By 1995, there were 121 countries reporting injection drug use, and in 2008, 158 countries now report injection drug use among their citizens. Injection drug use is on the rise globally and is contributing significantly to the global HIV pandemic and other health problems, not to mention the health care costs around the world.

The discussions and debates over harm reduction are also taking place around the globe. We are not at all unique in this regard in Canada. Since the early 1970s, a significant amount of research has been conducted on harm reduction interventions globally, and the evidence is clear that harm reduction interventions work to reduce disease transmission, protect the health of individuals and communities, and provide positive engagement of marginalized populations with the health care system.

The evidence that harm reduction works is sufficiently robust that major governmental and non-governmental organizations endorse harm reduction as an essential component of a comprehensive health approach to the problematic use of drugs. These include the joint United Nations program on HIV/AIDS, UNAIDS; the United Nations Office on Drugs and Crime; the United Nations Children's Fund, UNICEF; the World Health Organization; the World Bank; the National Institutes of Health in the U.S.; the Institute of Medicine of the National Academies in the U.S.; and the International Red Cross, to name a few.

Currently, 82 countries worldwide explicitly support the development of harm reduction interventions, including syringe exchange and outreach programs. My point here is that the threat of HIV/AIDS worldwide has forced governments to rethink the ways in which we deal with problematic drug use and how to balance strategies to address both the problematic drug use and issues of drug dependence or addiction and the transmission of HIV/AIDS and other blood-borne diseases among citizens who use drugs.

The UN itself is rethinking its approach, and this brings me to the comments made by Antonio Maria Costa, the executive director of the United Nations Office on Drugs and Crime, in Barcelona earlier this month. Mr. Costa clearly affirmed that the first principle of drug control efforts is public health and that the principle of public health within the international treaty system "has over time, receded from that position, over-shadowed by the concern with public security and law enforcement actions that are necessary to ensure public security".

On the international stage, the language of international drug control intended to unite the global community around enforcement of prohibitions against certain substances. According to Costa:

> The unintended consequence of this was that the demand for illicit drugs and related public health issues did not get the international focus and attention they would have if they had been detailed in the Single Convention on Narcotic Drugs of 1961.

These are significant words from the head of the UNODC. Fortunately, at the international level things are changing, and there is beginning to be much more of a focus on the rights of marginalized populations of drug users to adequate and appropriate health care.

Moving to the Vancouver context, what we are trying to achieve with the development of the four pillars drug strategy is to firmly acknowledge the importance of harm reduction to the development of a comprehensive approach that also includes drug treatment, prevention, and policing as critical components to the strategy. The supervised injection site is simply one piece of this effort to build a comprehensive approach to address this problem. There is a significant level of support for the full implementation of the four pillars drug strategy among the residents of Vancouver, including the supervised injection site.

From the perspective of the City of Vancouver, we have been satisfied with the remarkable amount of research completed to date on the injection site project, the oversight of the project by our local health authority—Vancouver Coastal Health—the cooperation of the Vancouver Police Department in implementing policing protocols for the project, and the level of community engagement that has been conducted throughout the implementation of the project.

● (1020)

Considering that over 2,000 individuals have died since the early nineties in Vancouver alone and that many more have acquired HIV, hepatitis C, and other medical complications as a result of injection drug use, we view the injection site project as an important part of our collective efforts to engage this population in health care interventions, to save lives, and to protect the community. We are working extremely hard at the local level in Vancouver to overcome the serious issues we face.

At this time, I would urge the committee to consider ways to move beyond this debate over harm reduction or injection sites, as it is costing us valuable time, energy, and, most importantly, the lives of Canadians. I urge the committee to consider the scientific evidence for all interventions and to find a way for all parties to work together to provide the leadership necessary to implement a truly comprehensive approach to problem drug use that acknowledges and demonstrates the right of all Canadians, including those who use drugs and their families, to have access to the highest quality of health care.

Thank you

**The Chair:** Thank you, Mr. MacPherson.

We'll now go to Ms. Liz Evans.

**Ms. Liz Evans (Executive Director, PHS Community Services Society):** Thank you very much for allowing me to be here today to address what I believe is an extremely important issue for Canada.

Growing up, I was never aware of the people who lived with severe addictions, whom I now know from working as a nurse in Vancouver's downtown eastside. When I was growing up, they didn't exist. They didn't exist within the same medical system, school system, dental offices, parks, or swimming classes I went to. But for the last 17 years, I've come to know hundreds of people who, for many Canadians, have never really been there.

I believe Canada needs a comprehensive, evidence-based drug policy in order to really "see" those suffering from addiction, a policy that understands the roles of prevention, treatment, enforcement, and harm reduction; one that is humane and defers to sound public health policies; and one that understands that death does not bring hope.

Unfortunately, like many decision-makers on this issue, 17 years ago when I arrived in the downtown eastside, I was out of touch. But I didn't realize it; I assumed I knew, and those I met taught me that things were far more complicated, that there were no perfect solutions—rather, many real-life individuals with stories.

I met Mary, who as a child spent many hours locked in a room by her foster family, emaciated, sexually abused, with a giant scar across her throat from where she had cut herself at age 13. By age 15, she was addicted to pills and alcohol, and by age 16, heroin and cocaine. To feed her habit, she worked the sex trade. She was raped, and unlike many other people, she felt she deserved what she got, that it was all her fault. For Mary, prevention failed. When she was alone as a small girl and had no one to talk to about her suffering, the expensive and poorly evaluated "just say no" ad campaigns didn't make any difference. She needed a human being. Prevention is critical, but it needs to be evidence-based and it needs to be relevant.

My father was a doctor, and as I was growing up, he always expressed the view that addiction was a tragedy. But his overriding sense was that addicts had failed. Not only was their addiction a failure, but it also spoke somehow to their moral character failing, making the criminal justice approach reasonable and necessary.

Mary, in her sex trade work and life of addiction, was arrested hundreds of times. She believed she was a criminal. Her interactions with law enforcement merely reaffirmed her self-hatred. Over the years of her life as a drug addict, enforcement failed to curb her habit. While enforcement touched Mary's life, it could not reach out to her. Policing alone cannot address the complex reality of her life and her health needs.

As a nurse, I had the naive and simplistic idea that treatment was the solution. I believed that help was just within reach and that people needed someone like me with the dedication to make it happen. I believed that people only had to ask and that health care would be there for them when they wanted it.

I realized after watching Mary and hundreds of others like her that trying to access the detox and recovery system with no long-term success was not so simple. Many hurdles exist, and if you live on the street, accessing detox and treatment feels like climbing Mount Everest. Treatment failed Mary. Treatment programs failed her because we desperately need treatment to be accessible and to work in tandem with other strategies. As a stand-alone response, treatment fails.

I have now understood that the vital piece that's been missing is harm reduction policy. Harm reduction begins by seeing the person in the context of their life and their pain, their ability, their fear, and their strengths. It starts from a place that says, I see where you are today and that's where we'll start.

Mary couldn't get counselling, because she was addicted. She couldn't find a safe house, because she was addicted. She developed HIV due to years of unsafe needle sharing, due to her addiction. She was often homeless, because she was addicted. Harm reduction says this isn't good enough. We watched Mary die of AIDS, and hundreds of others like her.

Harm reduction programs ultimately failed Mary, due to their lack of support and funds. As a result, Mary and hundreds of others became HIV-infected, reusing the same dirty needles when needle exchange programs were not supported. Harm reduction initiatives are there to see the marginalized drug addict's life as one to be helped and not to be ignored.

As we assemble the pieces of this puzzle, I understand more clearly where Insite fits. Insite, the supervised injection site, provides the vital link between the street and desperately needed support. It connects people to treatment. It acknowledges the challenges that street-entrenched addicts face head-on. Then it offers real help—help to stay healthy and help to stay alive.

Over one million injections have taken place at Insite since it opened, off the streets and away from local businesses. Not one of the "Marys" who stopped breathing during their drug use at the site died, because a nurse was there.

I wish as much as anyone else in this room today that this problem did not exist, but sticking my head in the sand will not make it go away.

● (1025)

Canada needs a drug policy based on wisdom and maturity, not fear and hatred. Without this, thousands will suffer, HIV will spread, violence will escalate, and thousands of needless deaths will continue across the country—deaths of citizens whom we don't see: children, sisters, brothers, mothers, and cousins who could easily have been us, and who have been with us all along.

Thanks.

**The Chair:** Thank you so much, Ms. Evans.

We'll now go to Mr. Philip Owen.

**Mr. Philip Owen (Former Mayor of the City of Vancouver, As an Individual):** Thank you for the opportunity to be here today to speak about illegal narcotics, emphasizing harm reduction and the supervised injection site, Insite, in Vancouver. It is difficult to cover this huge subject comprehensively in five minutes, but I will try.

Vancouver City Council unanimously passed an 85-page document called *A Framework for Action* in May 2001, seven years ago. It's a four-pillar approach to Vancouver's drug problems, and it emphasizes prevention, treatment, enforcement, and, most importantly, harm reduction—the four pillars.

This document is still intact, it is still accepted, and no one who has read this or commented on it has said to throw out this or that part, or that this is wrong, or that this assumption is wrong. It's an 85-page document; it's the foundation of our success in Vancouver.

All the harm reduction programs, facilities, and initiatives are essential and have proven to be justified and successful in this regard. The supervised injection site—I want to emphasize this—is just one of the many tools in drug policy reform. People think this whole thing revolves around the supervised injection site. I will explain the many other important aspects in a few minutes.

Harm reduction and a supervised injection site are cost-effective and they save lives. They improve public health and public order. What is the biggest problem we have in our cities today? Public health and public order. Think about the volume of money rolling around and getting in the hands of people who shouldn't have it. We must engage the addict and develop an exit strategy. That is the goal: to rescue these people.

These people start using drugs for a variety of reasons, and therefore many services are needed for them to change their lifestyle. The user is sick. And we have a national health care system. That's something we have to think about; it's a health issue, public health, public order. The user is sick, no question about it.

The goal of drug reform is abstinence. I hear over and over again that this whole issue is to enable and encourage the use of drugs, and that's not what it's about at all. The goal is to rescue, get them in the health care system, and create an abstinence-based program for users.

The war on drugs has failed in Canada and the United States. That's an absolute fact. I haven't time to prove it, but it's true. We cannot afford it any more. We cannot incarcerate our way out of this. People who have worked on the war on drugs—and I emphasize that—think you can incarcerate your way out of this. You cannot. You have to listen to the mayors. We should not be allowing more death, disease, crime, and suffering.

In June 2007, the United States mayors had their annual meeting in Los Angeles; 220 mayors were there. Rocky Anderson, the mayor of Salt Lake City, Mormon country, put forward a motion on the floor of that convention, and all the major mayors were there. The motion was that the war on drugs had failed. What was the vote? Two hundred and twenty to nothing. Every single mayor who was there said the war on drugs had failed. So we have to get down to the municipal level to find out what's really going on and get close to the reality.

We have to ask ourselves, are the current drug laws working? No. Are they effective? No. Do they make any sense? No, not at all.

There are over 100 supervised injection sites in over 50 cities in the world. I could talk to you about my discussions with the mayor of Frankfurt, Germany, and the mayor of Sydney, Australia. I've been to five international conferences in Europe. I've been to Kabul, Afghanistan; New York; around the United States; Stanford University; and across this country. I've visited lots of these supervised injection sites.

The media in Canada are playing up the fact that this is the only one in North America; therefore it's unique. That is not true. They've been in Switzerland for over 20 years and are very successful. You couldn't close the one in Frankfurt, Germany, or in Sydney, Australia.

● (1030)

How bad does it have to get before we act on drug policy reform? The operative word here, as I said earlier, is to develop an exit strategy that's abstinence-based.

The third main issue is engagement—

**The Chair:** I'm sorry, Mr. Owen. We do have time for questions. You are over time now, so if you would be so kind, you can save your comments for during the questions.

**Mr. Philip Owen:** Thank you.

**The Chair:** We will now go to Ms. Hay.

Ms. Hay, go ahead.

**Ms. Heather Hay (Regional Director, Addiction, HIV/AIDS, Aboriginal Health, Vancouver Coastal Health):** Thank you.

Thank you for the opportunity to present today. I am here representing Vancouver Coastal Health.

I've been a nurse for the past 35 years, and I've had senior leadership experience in health care. Most recently, for the past 11 years, I've been leading the public health response to the public health crisis on the downtown eastside.

Vancouver Coastal Health delivers a broad range of health care services. We have an operating budget of approximately $2.4 billion, and we serve over a quarter of the population of British Columbia. We invest over $110 million a year in the treatment of individuals with mental health and addictions issues. For every dollar spent in harm reduction, four dollars are spent on treatment.

The goal of our mental health and addictions services is first and foremost to keep people alive, second is to prevent the use of harmful substances, and third is to assist people to stop the abuse of all substances.

I'm here today to take you through a little bit of history. I'm here today to talk about a public health emergency that was announced in September 1997 in the poorest neighbourhood in the country, a neighbourhood that has an overrepresentation of aboriginal peoples, a neighbourhood that has 10 times less access to family physicians than any other neighbourhood in Canada, a neighbourhood that has a mortality rate 14 times the rest of the province, and a neighbourhood where people live in single-room occupancy hotels that have no access to handwashing or toilets. It's also home to 4,600 IV drug users. Ten years ago it was home to several epidemics—hepatitis A, hepatitis B, hepatitis C, transferrable TB, and overdose deaths—and the primarily underlying epidemic of intravenous drug use.

This is the context in which the supervised injection site came to exist. It was a public health response to a health emergency akin to a third world disaster zone. Traditional health care wasn't working to stem the tide; an innovative continuum of health care services was required.

The supervised injection site, known as Insite, is part of that solution. In June 2000, the Vancouver Coastal Health board of directors voted to support the supervised injection site as a vital part of our continuum of health care. The decision was a product of extensive consultation and research, which led us to believe that there was a public demand for safe injection sites in Vancouver. Such a site would assist Vancouver Coastal Health in meeting its health care mandate of providing appropriate and necessary health care to all the populations it served. The supervised injection site would facilitate contact with high-risk IV drug users, provide us with the means to reduce the spread of disease and deaths, and allow clients to access health care services and other social services.

The supervised injection site is operated by Vancouver Coastal Health in partnership with the Portland Hotel Society. Insite provides a clean place for people to inject drugs under a nurse's supervision. Insite offers clean injecting equipment and safe injecting education, which helps reduce the risk of transmission of infectious, blood-borne diseases like HIV/AIDS and hepatitis C. Insite offers treatment of wound infections and TB, inoculations for pneumonia and the flu, and access to addiction counselling and treatment on demand.

While clients of the supervised injection site may not choose to immediately access all the health care services offered at Insite, regular attachment to this health care facility, where clients develop trusting relationships with health care providers, makes them more likely to pursue detox, addiction counselling, and treatment.

Vancouver Coastal Health's direct experience in treating marginalized people with chronic addictions is that few people move to abstinence overnight. Few people go from being vulnerable and marginalized to becoming fully engaged in treatment and care. Few people get better without help and support.

Insite serves as a low-threshold access point for treatment services. For many people, Insite is the door from chronic drug addiction to recovery, from being ill to becoming well.

Vancouver Coastal Health has recently opened Onsite, which is directly upstairs from Insite, so that Insite clients can access treatment on demand with no wait time. Onsite provides transitional housing, home detox, a day treatment program, nursing care, one-on-one counselling, and support to Insite clients who are homeless and want to stop using drugs.

In addition to Insite and Onsite, over the last five years Vancouver Coastal Health has opened four other first-point-of-contact health care services. They are designed to be accessible to people whose chaotic lives and complex mental health and addictions issues make it practically impossible for them to access traditional health care services.

● (1035)

Currently, we're involved in the development of a 100-bed, long-term residential treatment facility for the clients of Insite who have both mental health and addictions issues. Without a doubt, the health care needs of people living in the Vancouver's downtown eastside are complex, and no single intervention is enough to transform this community—

**The Chair:** Ms. Hay, I have to interrupt you.

Thank you so much.

Ms. Hay, you will have the chance to answer questions. I gave you extra time.

**Ms. Heather Hay:** Sorry, I don't hear very well.

**The Chair:** Oh, I'm sorry. I'm just trying to be fair.

**Ms. Heather Hay:** Thank you.

**The Chair:** Dr. Mangham.

**Dr. Colin Mangham (Director of Research, Drug Prevention Network of Canada):** I'm glad to be here, but I came with some trepidation, being the only person at the table who is not all for this whole philosophy. But that's well known. While I've had similar treatment in some ways, at least my life hasn't been threatened yet.

I want to speak to the broader agenda and point out a few things for the committee, especially for those whose minds are not made up, especially for the elected representatives who should be setting drug policy with the people. I'll speak to you.

I was the author of one of three academic papers that all said essentially the same thing. I was embarrassed as a professional and as a graduate of UBC by the poor science and the misuse of data. It was allowed to stand in the media without correction. The media was making very positive, glowing statements without evidence.

The most telling thing I saw that never found its way into the media was that only a small percentage of drug users use Insite. It's not reaching the cocaine users. An even smaller portion use it for the majority of their injections. As I told CNN, it's like building a dyke out of chicken wire.

Why, then, is this still being clung to? I believe it's because it was never intended to be just a trial. In the year 2000, a Health Canada meeting in Mont Tremblant, Quebec, said, “The future of harm reduction among injection drug users lies with safe injection sites and drug maintenance programs”. In science, that's called coming to conclusions and then making everything fit.

From the body of people involved with Insite, you will not hear anything negative. I believe it's part of a larger thing that has had negative effects on treatment and prevention.

In the work I did, I found that the principal impact of Insite and the establishment of its parent philosophy, harm reduction, is that it has produced a void in incidence-reducing prevention. Whatever else anybody says, there is no incidence-reducing prevention. The program being worked on in Vancouver is a harm reduction program for high school students.

I've heard only criticism of primary prevention. One of the leaders said that prevention makes users feel deviant, while harm reduction makes them feel respected. As with many of these statements, that is very misleading.

There has been no expansion or innovation in treatment in Vancouver. There are people who aren't here because they would be intimidated and lose funding. They have told me that. They've said they have been told to stop asking for more treatment beds or they will lose their funding. The cost of $40 a day for a client hasn't changed in 40 years. “By their fruits ye shall know them”. I don't understand why treatment has languished, other than that there's not really a valuing of it.

It's on a collision course with enforcement. You will soon be hearing calls for changing the drug laws. It's wrapped up together. We're hearing it today. Public proponents of drug policy reform in the form of legalizing and regulating drugs include many policy-makers and advisors at the provincial and federal levels. They leave little doubt they want to change the drug laws.

I want to say to Mr. Owen, respectfully, that enforcement and treatment and prevention do work if they are used properly. Enforcement has operated largely through sanctions. The incidence of illegal drug use is only a tiny fraction of that of legal drugs, and the costs are less than half, even including enforcement costs. Why would we want to change that?

Simply put, Insite and its parent philosophy make the assumption that we can control outcomes in a free population without getting people off drugs. I've been called many names on this. There's a real intolerance of other views that makes me sad. I believe if you look into it you will see that many of the people involved with Insite are themselves involved in a broader movement. There are people in this room who've been given awards by the Lindesmith Center and the Soros Foundations for their work in drug policy reform and who have publicly called the drug laws the Berlin Wall.

These people have called me and people like me ideologues and themselves scientists. To such views they're entitled, but the assertion is made frequently by Insite supporters that they are following science; that the government ideology is hypocritical and false, and so is the unilateral engineering of policy.

● (1040)

I call on the committee, especially the elected representatives, to stop allowing a group of activists, whatever else they're clothed in, to dictate Canada's drug policies. The people of Canada—

**The Chair:** Dr. Mangham, I have to interrupt you now. My apologies.

**Dr. Colin Mangham:** —and elected officials need to set drug policy.

Thank you.

● (1045)

**The Chair:** Dr. Bennett, I'm going to ask you to please be respectful of all witnesses.

I read a statement here before committee for a reason this morning.

Mr. Tilson, I'm going to bring you to order, please.

I ask that everybody listen very carefully to every single witness in a respectful manner. We're all grownups here, and I think we can do that.

Thank you, Dr. Mangham, and all the rest of the people who are here.

We will now go to Dr. Kerr.

**Mr. Thomas Kerr (Research Scientist (Chief Researcher for Insite), British Columbia Centre for Excellence in HIV/AIDS):** Good morning. It's a pleasure to be here. I'm not an activist. I'm a professor in the Department of Medicine at the University of British Columbia and a research scientist for the British Columbia Centre for Excellence in HIV/AIDS.

I'm here today because in September 2003 our research group was contracted to conduct an arm's-length scientific evaluation of Insite. Before sharing the results of our work, I'd like to say a few things about science and the structure of our evaluation.

Let's be clear: peer review is modern science's greatest asset and provides the greatest protection against biased reporting. The scientific credibility of any given piece of research is therefore established only after a study has been subject to external scientific review by international experts and published in recognized public health and medical journals.

Given the controversial nature of the Insite initiative, we sought to conduct an evaluation that would stand up to the highest level of scientific scrutiny. To this end, we sought publication of our work in the world's top medical and public health journals, and only after a study passed the test of peer review and was published did we discuss it publicly. To date, there have been over 25 peer-reviewed published studies derived from our evaluation. I will summarize only some of the main findings today.

First, we have published three studies, including a paper in the *Canadian Medical Association Journal* , showing that the establishment of Insite led to reductions in public disorder related to injection drug use.

Second, in a paper in the prestigious British journal *The Lancet* and a follow-up paper in the *American Journal of Infectious Diseases*, we showed that the use of Insite was associated with large reductions in syringe sharing, the behaviour that leads to HIV and hepatitis C infection among injection drug users.

Third, we published two papers showing that the staff at Insite have reduced risks for overdose and successfully managed hundreds of overdoses. Remarkably, now over 1,000 overdoses have occurred at Insite and nobody has died.

Fourth, studies published in the *New England Journal of Medicine* and the journal *Addiction* revealed an increase greater than 30% in the use of detoxification programs among Insite users in the year after Insite opened. These works also show that Insite is connecting drug users with other forms of addiction treatment.

Recognizing the controversial nature of several studies of Insite, we also published studies that ruled out whether Insite was having negative effects. In a paper published in the *British Medical Journal* we showed that Insite was not promoting relapse or discouraging people from quitting drug use. A paper in the *American Journal of Public Health* revealed that Insite is not sending the wrong message and encouraging vulnerable individuals to take up injection drug use.

We have also shown, using police statistics, that the establishment of Insite did not lead to increases in crime. And to correct Mr. Mangham, many drug users have used Insite. In fact, over 8,000 have registered, and over 35% of injections involved cocaine.

In other words, a large body of research that has been accepted and endorsed by the international scientific community shows that Insite is really doing what it's supposed to do. It's reducing public disorder and HIV risk behaviour, promoting entry into abstinence-based addiction treatment programs, and saving lives that would otherwise be lost to overdose. The research also shows that Insite does not appear to be having any negative effects on the community.

I respectfully submit that this is the only research on Insite that has passed the test of independent scientific peer review and has been published in recognized medical or public health journals.

Today you have heard of studies that have criticized our research and you were told that these studies have been peer-reviewed. This is utter nonsense and factually incorrect. The only manuscripts that have criticized our work and Insite are those that appeared in the *Journal of Global Drug Policy and Practice*, including a paper written by Mr. Mangham.

Sadly, the mission of the host institution of the journal states that it supports efforts that vigorously oppose policies based on the concept of harm reduction. This is not a forum for academic debate; it is simply a website operated by a well-known anti-harm-reduction lobby group, namely the Drug Free America Foundation. The journal is not recognized by or indexed on MEDLINE databases, and the papers in question contain numerous factual errors.

Instead of doing what academics normally do, submit critical comments in the journals where individual studies are published, as in the debate over global warming, detractors like Mr. Mangham have merely aired their complaints in non-mainstream, fringe venues, such as the website operating under the name of the *Journal of Global Drug Policy and Practice*.

● (1050)

Today you'll hear anecdotes and opinions regarding the limitations of Insite. I urge the committee to remember that we are discussing very important public health issues, life and death issues, HIV infection, and overdose. Decisions regarding the response to such issues cannot be based on mere opinion and anecdotes; they must be based on the best available scientific evidence. All our studies contain sections that describe the limitations of the individual works. They would not have passed the test of peer review if they did not.

When it comes to Insite, the science is clear. Insite works and does not compromise other efforts related to prevention and treatment of addiction. Insite clearly must remain open. Accepting anecdote and opinion in this instance would be akin to recommending untested herbal remedies for life-threatening cancers.

Again, this is an evidence-based public health program that must be supported.

Thank you.

**The Chair:** Thank you.

We're going to go to two videos.

While our technicians are hooking them up, I want to thank all of you for your insightful comments.

We'll listen to the two videos and then we'll go to questions. We'll take one minute.

● (1050)

(Pause)

● (1050)

**The Chair:** We are now going to go to the two videos.

I have to tell the audience there is never a dull moment in the House of Commons. Those bells indicate a vote. I am now trying to find out how long we have.

I understand it's 25 minutes, and the videos are each five minutes long. We do have time to watch the two videos. I would ask the committee to take their seats. Mr. Temelkovski and Mr. Tilson, could you please be seated.

Sorry, ladies and gentlemen, I've just been given the rule book. The rule book supersedes everything. As I said, there's never a dull moment in the House of Commons. Therefore, when the bells are sounded for a recorded division, the committee meeting must be suspended immediately. The meeting is suspended until after the votes.

● (1055)

**Hon. Keith Martin:** On a point of order.

**Mr. David Tilson (Dufferin—Caledon, CPC):** He can't even make a point of order. You're out of order.

**The Chair:** If I could finish, please.

In order for the committee to continue, I need unanimous consent from the committee.

**Ms. Christiane Gagnon:** On a point of order, the message said we have to go to the chamber as fast as possible. To me, that's the time we vote.

**The Chair:** Do I have unanimous consent?

I won't have unanimous consent.

We will suspend until after the vote.

**Hon. Keith Martin:** I have a point of order, Madam Chair.

**The Chair:** I said go ahead, Dr. Martin.

**Hon. Keith Martin:** Thank you, Madam Chair.

There are two things. First, it is your jurisdiction to allow this to continue. That always happens in committees. Second, if you want to determine if unanimous consent exists, then you've got to ask.

You have two choices. One, allow this to go on for the next fifteen minutes, or two—

**The Chair:** I will ask.

Thank you, Dr. Martin.

Is there unanimous consent to continue this committee meeting right now?

**Some hon. members:** No.

**Hon. Keith Martin:** A recorded vote.

**The Chair:** Dr. Martin, if you don't have unanimous consent, the meeting is suspended until after the vote.

● (1055)

(Pause)

● (1135)

**The Chair:** Ladies and gentlemen, I would ask that we begin the meeting. Could you all take your seats?

We will now go into the video conference. We're going to have two different people. The first one is Dr. Neil Boyd.

Go ahead, Dr. Bennett.

**Hon. Carolyn Bennett (St. Paul's, Lib.):** I would like your advice, Madam Chair, in terms of the 40 minutes that we've now missed, as to whether we could move to extend the hearings by 40 minutes. Obviously the minister's time is quite often the least flexible, but would this panel be able to reconvene after the minister's appearance so that there could be a more extensive period of questioning by parliamentarians? It would be a move to extend by 40 minutes.

**The Chair:** Thank you.

Go ahead, Mr. Fletcher.

**Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC):** Madam Chair, I can do better than that. If there's agreement with the committee, the minister is able to come at 12:20 and stay until 1:30, so the original amount of time is still there.

**The Chair:** Thank you.

I realize we were interrupted, and certainly we can accommodate that.

Our revised schedule will be to have our two witnesses on the video conference from 11:35 to 11:45. Can we please begin?

Dr. Neil Boyd, please go ahead.

● (1140)

**Professor Neil Boyd (School of Criminology, Simon Fraser University):** Good morning.

**The Chair:** Good morning, Dr. Boyd. Can you hear us? I'm Joy Smith, the chair of the committee. Welcome.

**Prof. Neil Boyd:** Yes, I can hear you. Thank you.

**The Chair:** We're looking forward to your presentation.

**Prof. Neil Boyd:** Thank you.

I'll begin by making some remarks about the context of harm reduction. I think the meaning of harm reduction is both complicated and compromised by the manner in which we have historically defined drugs as legal and illegal. The most dangerous drugs to public health are the legal ones, irrespective of rates of use. I particularly note tobacco, which kills some 35,000 Canadians annually. Even when you look at the rates of use of both legal and illegal drugs in our culture, it's very difficult to see a drug with greater morbidity and greater potential for addiction than tobacco.

So I think we need to make the point that when we consider harm reduction, we are very much influenced by the kinds of cultural blinders we have around what we think of as a "drug". Who do we think of as a pusher, for example, a corporation that sells tobacco in a global context or a young man who sells small amounts of heroin or cocaine on the corner of Main and Hastings Streets? Both are arguably distributing legal and illegal drugs, but I think there are some open questions about harm and harm reduction.

So harm reduction initiatives can apply usefully to both legal and illegal drugs. All harm reduction programs acknowledge drug use, but they try to curb the harms of the drug and the harms of the policies that are attached to its use and distribution. In many instances, these are the harms of the law itself.

Think of designated driver programs for those using alcohol. We accept that young people will drink, and will drink to a point beyond .08, that is, to a level of impairment. Yet we bring in a designated driver program, which very few of us would oppose, but is an acknowledgement that despite what we do, some people will consume alcohol to the point of impairment, and that we need to protect young people from themselves.

Non-smokers' rights programs are arguably quite analogous to a supervised injection site, because we are protecting the public from unwanted smoke, in much the same way that one might argue that a supervised injection site protects the public from unwanted injection debris and from the risk of contracting disease from needles in their community, and so forth.

Of course, needle exchange programs for injectable drug use are another form of harm reduction. If we think about the regulation of cannabis by age and location of use, this could arguably be a harm reduction program. None of us wants grow ops in our neighbourhoods, and none of us wants the violence of the trade, so one could see regulation of that industry as a harm reduction program, it seems to me.

I'll speak specifically now about supervised injection sites. They attract what my colleague Dan Small has called “wounded individuals”—not working class, upper-middle class, and middle-class people who are injecting cocaine or heroin in a party atmosphere one might see as self-indulgent, but people with profound substance abuse and mental health problems.

The liberal notion of de-institutionalization, the liberal reality of de-institutionalization in the 1970s, has arguably given birth to many of these problems. But if supervised injection sites did not exist, these people would not stop using drugs. They would use drugs in more dangerous and unhealthy circumstances, as 95% of them continue to do today, without potential access to diagnostics, immunization, treatment, and what I think is the most important point, the beginning of a dialogue that might lead to a healthier lifestyle that avoids the possibility of HIV infection and that leads to better diagnostics and more immunization.

I won't repeat the commentaries and cite the many research reports that demonstrate the health benefits. Others have done that and will continue to do that. I will say, as a criminologist, that the supervised injection site has not promoted crime. Our detailed temporal and spatial analysis of the neighbourhood suggests that it did not work to attract drug dealers or property criminals, and in fact there was a modest reduction in public order in the neighbourhood.

● (1145)

Additionally, it appears to have benefits to cost ratios of between 2:1 to 8:1, depending on the model of analysis employed and the costing framework that is adopted.

In an ideal world there would not be any need for a supervised injection site, but we do not live in an ideal world. If we care about helping people who are severely disadvantaged, I think we will see quite clearly the many benefits that flow from harm reduction, with respect to both legal and illegal drugs, and in this specific context, in the form of the supervised injection site in Vancouver.

Thanks very much for your time.

**The Chair:** Thank you, Dr. Boyd. Thank you for your patience this morning and thank you for your insightful comments. I appreciate that.

We'll now go to Dr. Montaner.

I'm just going to interrupt for a minute to let you know that the Czech delegation is here today, joining us in our committee. Welcome.

We'll now go to Dr. Montaner.

**Dr. Julio Montaner (Director, British Columbia Centre for Excellence in HIV/AIDS):** My name is Julio Montaner. I am the director of the B.C. Centre for Excellence in HIV/AIDS in Vancouver. I'm the chair of AIDS research at the University of British Columbia and the director of the HIV program at St. Paul's Hospital Providence Health Care. As of two years ago, through a democratic process, I was elected president of the International AIDS Society, which is the largest body that brings together health professionals in the field of HIV and AIDS.

I'm coming in front of you today not really to talk about the results of our research, which I believe has been clearly and emphatically demonstrated to you earlier today by my colleague Dr. Thomas Kerr. He is abundantly familiar with the research evidence, the cost-benefit of this intervention, which has been alluded to by the previous speaker in quite clear terms. I would like to give you a sense of why we are investing in this kind of research, this kind of program, and where this fits in the continuum of our struggle and fight against HIV and AIDS in this country and at the international level.

Our group has been fighting HIV and AIDS through research. I should mention that our group has collected a total of over 350 peer-reviewed publications on various aspects of HIV and AIDS and over 150 in the field of HIV and drug addiction.

We had made some substantial progress fighting HIV by the mid-1990s. In 1996, we were instrumental in the discovery and distribution of the so-called modern HIV treatment, a highly active antiretroviral therapy. It goes by the acronym of HAART. HAART, the so-called cocktail, changed the lives of people affected with HIV in that it basically turned the disease into a chronic, manageable disease. It not only allowed us to control and prevent HIV from becoming AIDS, but also, as we have published recently, it prevented transmission of HIV from infected individuals to their partners or to those involved in close relationships with them.

In 1996, in view of this overwhelming evidence, already we felt there was a moral imperative to do something to expand the benefit of antiretroviral therapy to those who needed it but had difficulty accessing the programs. Working together with my colleague Michael O’Shaughnessy, we had previously identified a new upswing in HIV infections emerging from the downtown eastside in Vancouver. For that reason, working with other members of the B. C. centre, we put together a number of studies, including the Vancouver intravenous drug usage study, a cohort that taught us a great deal regarding the needs of individuals living in that very impoverished area of our city.

As a result of that research, we became critically aware that something needed to be done to facilitate entry into the health care system of this very marginalized group of individuals. We were similarly concerned that the status quo, business as usual, was not acceptable in view of the fact that the rates of acquisition of hepatitis C, HIV, and other infectious diseases, including subcutaneous infections and heart disease, were going up and we could not find any way to stop it. Suffice it to say that the rates of hepatitis C surpassed 90% in this population, with HIV rates in excess of 30% in some subgroups. This is as high as you have seen in the worst affected areas of the world, Botswana and the like.

For this reason, we felt compelled to mobilize our resources to try to do something to bring some form of order and health care to these people's lives, assuming they wished to avail themselves of this proposition.

● (1150)

Needle exchanges, and later on the supervised injection site, emerged out of this. The evidence is quite clear. Through engagement in the supervised injection site, through the good work of Vancouver Coastal Health and the Portland Hotel Society, these addicts have now been able to engage in appropriate health care in increasing numbers. In some instances, they have been able to reduce their consumption. They have been able to better manage episodes of overdose, decrease hospital admissions, and so on—

**The Chair:** Thank you, Dr. Montaner. I'm sorry to interrupt you, but I did give you more time. I want to thank you for your video presentation. We need to go to questions now.

Could we begin, please, with Dr. Bennett?

**Hon. Carolyn Bennett:** Thank you very much, Madam Chair.

I'm pleased to be joined on our side today by two of my colleagues who are also physicians. I think they feel as strongly as most of the medical community in Canada that there seems to be a change in Canada's policy, preferring ideologies over science and evidence.

We have seen young patients who suffered from incest or from some other condition who ended up with an addiction. Personally, we know stories of patients who have died before they had the chance to turn their lives around. We know of many patients who, because of their addiction, now are living with HIV/AIDS and hepatitis C.

It's very sad to have had to ask for this special hearing today. We thought Canada would be a leader on this. I think to have some of the witnesses who are with us today who were there, particularly Mayor Owen and the committee you put together on your framework for action on the four pillars in 2004.... I would ask if you would table that framework for action for us.

I'm also upset at the difficulty in our country at this time...that the Chief Public Health Officer for Canada has remained particularly silent on this. Mr. Kerr, I understood you met with the public health officers for Canada. What was the reception of this idea?

Could all of you tell me what consultation took place in order to remove the fourth pillar of the drug strategy for Canada, and were you consulted?

I would also like to bring to you from my city of Toronto a plea from the public health department there, that they would like to be able to do supervised injections in their needle exchange programs in a decentralized way, like cities like Barcelona, like all of that.

What would be your advice to the Minister of Health about granting exemptions to other public health agencies and departments across the country?

Then I would like your advice on the minister's May 14 announcement that says the $10 million for new treatment services has to be for abstinence-based treatment. This sounds remotely like a Bushism, in that clinical research shows that methadone maintenance plus counselling outperforms abstinence. And who is the Minister of Health to dictate to you in clinical settings the only possible way of receiving federal government funding?

If you could just start there....

● (1155)

**The Chair:** Who would like to address that question?

Mr. Kerr.

**Mr. Thomas Kerr:** I believe there was at least one question directed to me, pertaining to my presentation and consultation with the Health Council of Canada. I was invited to make a 45-minute presentation detailing the findings, the peer-reviewed literature, from the scientific evaluation of Insite.

I believe I was asked to characterize the response. It was overwhelmingly positive. Our team was congratulated for producing such a large body of evidence in a short period of time. The medical health officers from different areas of Canada expressed an interest in expressing some kind of support for this initiative. I wasn't privy to exactly what form that would take, but I think it's well known that several medical health officers, including the provincial medical health officer of the province of British Columbia, have been very vocal in their support of this initiative based on the scientific evidence to date.

With regard to the question of the removal of harm reduction from the drug strategy and the release of the anti-drug strategy, no, our group was not consulted on this matter.

**Hon. Carolyn Bennett:** Were any of the others consulted?

**Mr. Donald MacPherson:** The removal of the harm reduction pillar from Canada's drug strategy was met with quite a bit of concern in Vancouver. We spent a considerable amount of time and energy under Mayor Owen's leadership in developing the harm reduction approach in the four pillars, getting the acknowledgement and getting the community to come along and realize, which they have, that harm reduction is an absolutely critical component of any comprehensive strategy.

In my earlier talk, I was trying to say that the rest of the world, including the UN Office on Drugs and Crime, which is a very conservative UN body, is acknowledging that harm reduction is absolutely essential, from both a human rights perspective and a public health perspective, and more and more countries are bringing harm reduction into their public policy frameworks. So I urge the committee—and the federal government—to consider how important harm reduction is...the removal of that from the framework.

**The Chair:** Thank you very much, Mr. MacPherson.

We'll now go to Madame Gagnon.

[*Translation*]

**Ms. Christiane Gagnon:** Good morning. Thank you for being with us today.

This isn't the first time the Insite site has been threatened with closing. I remember going to Toronto at the time of the HIV-AIDS meeting. There was a demonstration in Vancouver. I had joined the group to support funding for the Insite site.

Mr. Mangham, I felt somewhat concerned by what you said. You say you are a researcher and are able to say you aren't satisfied with the scientific research on harm reduction and addiction control, and that it has produced no results. However, we sense that there are different ideologies. Other people in the field and other researchers have come to utterly different conclusions. Two witnesses told us by videoconference that, for them, this is a health issue. Not only are we thinking about the reduction of effects, but you also have to consider other objectives that are being pursued by one of the pillars of harm reduction, the Insite site.

What does it offer to that population, which in any case would use drugs in conditions that are perhaps harder and more dangerous for the public? You said that you didn't approve of the research, but that you were explaining your point of view by citing your figures and the type of research that you've conducted to contradict the scientific research, which was objective with respect to the objective pursued.

● (1200)

[*English*]

**Dr. Colin Mangham:** Thank you for the question.

As a point of clarification, I have never said—or not corrected when asked—that what I wrote or either of the other two articles or papers that were done was primary research. They're critiques of research, which are quite appropriate. You look at published research and at the interpretation and you make commentary.

In my case, the Royal Canadian Mounted Police had asked for a second opinion, because frankly, as I understood it, in some cases they were being told they didn't really have an opinion or shouldn't have one. I don't agree with that.

So I looked at the research. I've taught graduate classes. You can have a first-year graduate student read research and just critique it from the viewpoint of whether what is being said fits here. What I saw—and I would invite anyone to read those papers—is that there were many non-findings.

For example, to not have a drug overdose death at Insite is what I would call a "straw horse" finding. My goodness, I hope nobody dies at Insite of an overdose, with a nurse sitting there. That doesn't translate to saving lives. To make the statement that you've saved their lives.... You can't make that. And 2% to 5% of injections in the downtown eastside taking place—I believe I'm right here—at Insite is not going to reduce disease.

I have never said that I or anyone else—because we don't have the data; we haven't been given the data to go off and run it or to conduct primary research.... But to critique research is very appropriate.

I will say that a graduate student in statistics could have read what I read and, I sincerely believe, have come to the same conclusions. I have done research for the government wherein there was incredible pressure to succeed. I don't know; that's one possibility, but I can't get inside people's heads.

I don't have any personal disrespect. My own and the other two pieces question what's been made of the research, question whether to do no harm justifies the expenditure. I went the furthest of them and suggested that there is a strong.... One of the things I resent is this idea that somehow opponents are ideological, but those for Insite are not. No intelligent person could read what's been said and examine the tenor of the defences of Insite and not see very clear ideology there.

I would like to say also, in answer to the question about harm reduction—why the pillar has been taken out—I think what happened had to do with the way it came about. As a practitioner in the field, I saw very quickly that what was going to be four pillars was becoming one pillar. In other words, harm reduction was the guiding philosophy and was changing treatment, prevention, and enforcement into its own image, so that prevention was no longer prevention but was talking about problematic use.

I think the government reacted to that: "Wait a minute here. Canada's going to philosophically change to a softer, more liberal view of drugs"—one that I would hope most parents, grandparents, and others wouldn't really want to see. And that's what I think they did.

By the way, I wasn't consulted either.

There's your answer.

● (1205)

**The Chair:** Thank you, Dr. Mangham.

We'll now go to Ms. Davies.

**Ms. Libby Davies (Vancouver East, NDP):** Thank you.

How long do we have for questions and responses?

**The Chair:** It's seven minutes.

**Ms. Libby Davies:** First of all, my thanks to the witnesses for coming today. It's been good to hear both your expert experience and the experience from the community that was presented by the Portland Hotel.

In some ways, it's surprising that we're here in 2008, debating and studying harm reduction. As I believe Donald pointed out, 82 countries around the world support harm reduction. I think many of us had assumed and thought that the programs we have here in Canada were working. They're well received, they work at the community level, so why the heck are we here today still debating this issue? I think we know why. We'll have an opportunity to hear the minister later.

Insite is in my riding in East Vancouver, and I can tell you that I'm very glad it's there. I remember when it began. It was very controversial. Many of you were involved in the struggles that took place within the community. Now, without a shadow of a doubt, Insite has the support of the local business community, the Chinatown business community, the police, the board of trade, the premier of the province, the health minister—the list goes on. In fact, I can't find anybody who doesn't agree with Insite, other than Mr. Mangham and the minister.

So I think one of the issues we are dealing with is that people get hung up on the terminology, this term "harm reduction".

Heather, you made a reference to low-threshold services. Mr. MacPherson, you mentioned that the city had talked a lot about the importance of low-threshold services. Neil Boyd mentions Mr. Small from the Portland Hotel Society, saying that Insite serves wounded individuals. We're talking about getting people in the door, off the street and in the door.

I wonder if Heather and Donald and maybe Liz could talk a little bit more about what low-threshold services are, to try to get across the idea that we're talking about things that actually work. We have more than enough evidence of it. But what are low-threshold services, and how do you describe them?

**Ms. Heather Hay:** Low-threshold services are based on putting out health care services and wrapping them around the client where they're at. Access to primary health care and to some of our clinics—we implemented five new sites in the downtown eastside in 18 months—is oftentimes still a barrier for people coming through the door. So it's really about bringing health care to where the people are at.

At Insite, we have provided services to over 7,000 people. We saw over 14,000 nursing interventions last year. That means that in walking through the front door, that client can get nursing support, wound and skin care, immunization, access to addiction treatment, and cures for their flu. Also, they can talk to somebody if they want to move to a place of recovery and change their life. If we weren't there, that client would be in an alleyway, a hotel room; they would be in a variety of other places in the neighbourhood, living in chaos and not accessing treatment services.

We have a contact centre, which is a low-threshold service. It contacts people from the street, gives them the skills they need to transfer from low-threshold services to higher treatment regimes. We also have peer-to-peer workers, and that's also low-threshold services, because oftentimes professionals themselves are barriers to enabling people to access treatment. We also carry a stigma towards this client population. It's very important for us to work in partnership with the community and peers in a low-threshold way.

● (1210)

**Ms. Liz Evans:** Thanks for the question.

Low threshold really, to me.... Heather has explained it, but ultimately I visualize it in my mind as like a triangle. If you think of the bottom of the triangle as the base in which we collect people into the system and the peak of the triangle as where we exit them in terms of treatment, the bottom of the triangle has to be broad and it has to be on the street. We have thousands of people in our community who are addicted and homeless and suffer from social problems, and a traditional mechanism of health care delivery just doesn't reach them.

The bottom of the triangle is a way of engaging people such that they will receive and accept the service. If we raise the threshold and say, "These are the conditions by which you need to receive your health care", we automatically have excluded hundreds and sometimes thousands of folks.

So the argument and clearly the evidence that shows that low-threshold programs engage people is really, I think, treatment. Without the injection site, we would not be engaging a whole ton of people into treatment. We know that's a fact, because we know now, since we've built the Insite/Onsite program above it, that just since the fall we've had over 250 people through the detox and treatment centre right above the injection site. Again, that's a low-threshold form of treatment, because we know that without that detox and treatment program being attached to the injection site, they would never come through the door. We've had over 50 folks, just since the end of September, go into long-term treatment as a result of walking in the door of the injection site.

And the 5% reference to the number of addicts who use the site regularly as being the ones we are attempting to target, who are the folks who are the most marginalized and the ones who are the least likely to use traditional medical services—

**The Chair:** Thank you.

**Ms. Liz Evans:** Can I just mention one quick thing? If the percentage of drug addicts in the community who have access to the site is low, it's because the site itself is at absolute maximum, full operating capacity.

**The Chair:** Thank you, Ms. Evans.

Mr. Fletcher.

**Mr. Steven Fletcher:** Thank you, Madam Chair. I'll be splitting my time with Mr. Tilson.

I think it's important to be clear on what the exemption actually entails. There seems to be some misunderstanding here.

All the activities Ms. Evans and Ms. Hay raised—wound protection, needle exchange, psychological help, nursing care, all those things—will occur regardless of whether the exemption is extended or not. That's clearly something that Insite does, and I think everyone supports people getting treatment. And as you say, it's important to have treatment close to where these people reside. The issue of the exemption only deals with the illegal use of narcotics, and I think that is a very serious issue.

My question is to Mr. Mangham.

You mentioned the percentage of drug injections. I have the study here, and your memory served you well: it is less than 5% of all injections that occur at Insite. I wonder, if it's only 5%, whether that doesn't undermine a lot of the harm reduction. If 95% of injections are occurring outside of Insite, I assume a lot of harm is occurring away from Insite.

**Dr. Colin Mangham:** If 5% are happening there, then that goes to say that 95% aren't, but I think the problem is that this is not surprising. Probably there needs to be more discussion and objectivity than there was. For quite a few years—and I'll say this from personal experience, and it's the truth—if you didn't agree with harm reduction, you weren't at the table, especially in British Columbia.

That pre-buying into the philosophy makes one defensive of anything it has. That's human nature. I like Chevrolets and I'll defend them even if they're junk. Likewise, I suppose, on a more serious level, I'll defend prevention, and some people may not like primary prevention. I love it.

Likewise, I don't have anything against that, but when it's unilateral and you exclude and put down and even threaten the people who disagree with you, then you're not interested, I don't think, in that 95% and whether we can do better.

One thing I want to say is that the sad status quo we're talking about—and by the way, nobody here thinks anyone in the downtown eastside or anywhere should.... I would love to help them; we're not talking about letting people die. I think there are better ways that haven't been looked at.

There was no control group, there was no other intervention, and the status quo was created by years of not doing anything about treatment. So it's a little bit hypocritical to trash the status quo that was set, because for years you've been talking about harm reduction and were not really interested in treatment. That's what's happened.

● (1215)

**Mr. Steven Fletcher:** Thank you. I'm running out of time already.

I think that's why the government is investing tens of millions of dollars in Insite.

By the way, I empathize with those people who were threatened. I got a little taste of what you're maybe alluding to when my constituency office was visited by some Insite activists and it was vandalized, which is not very helpful in the public debate.

Anyway, Mr. Thompson, has the police presence increased around the Insite facility?

**Mr. Scott Thompson:** Initially, during the first year, we had some additional funding through Vancouver Coastal Health in the Vancouver agreement to provide two extra police officers on the block for the timeframe when Insite was opened. The area already had a strong police presence in terms of police officers on foot patrol. At the end of that year the funding ended, and we were then left with our regular complement of police officers on the street.

**The Chair:** Thank you, Mr. Thompson. Thank you, Mr. Fletcher.

The minister has arrived.

We're going to take a three-minute pause to get things reorganized.

Thank you.

● (1215)

(Pause)

● (1220)

**The Chair:** Would everyone please take their seats so we can resume? Thank you so much.

We're very pleased that the Minister of Health, Minister Clement, could join us today, along with the deputy minister and Dr. Butler Jones. I'm very happy that we have time to listen to the minister's presentation. Following that, we will have questions and answers.

Go ahead, Minister Clement.

**Hon. Tony Clement (Minister of Health):** Thank you very much, Madam Chair.

Good afternoon, ladies and gentlemen.

[*Translation*]

Good morning, ladies and gentlemen. Thank you for taking the time to be here, and thank you for providing me with this opportunity to speak and to respond to some of the statements made here today.

As Parliamentarians, we have a common desire and duty to understand our country, examine options on future public policy choices and then recommend or make decisions that will be in the best interests of Canadians. It is no different with this Committee's work, nor in my work as Health Minister.

[*English*]

We are all here because we want the best for all Canadians. This includes those who are addicted to drugs and who need our help and support and those who are not involved with drugs and seek to protect their kids, their families, and their communities from the crime that inevitably accompanies the development of a drug culture.

You've heard from numerous witnesses today who no doubt hold strong views regarding the topic of harm reduction and how we can best help people addicted to drugs as they work to get their lives back on track.

Earlier this week we received a decision from Justice Pitfield of the B.C. Supreme Court, who has deemed Canada's Controlled Drugs and Substances Act in violation of section 7 of the Charter of Rights and Freedoms and has declared Vancouver's supervised injection site a “health centre”. With his decision, Justice Pitfield has provided an exemption for Insite to continue operating until June 2009.

At this time I would like the record to show that I respectfully disagree with Justice Pitfield. While I understand and share the desire to show compassion, this is a misplaced compassion. Addicts need treatment. This is why I have announced over $150 million in treatment funds in the past few months. I am convinced of the value of treatment because as health minister I have spoken with people addicted to drugs, people who were formerly addicted, researchers both at home and abroad, mayors, councillors and other elected officials, police officers, advocates of all persuasions, and of course parents and kids who desire only to be free of the scourge of illegal drugs in our society.

When I visited Insite over a year ago, I also visited other facilities in the downtown eastside to examine how they do things, why they do them, and what the impacts are.

If there's one thing I've learned, it's that people believe what they believe, earnestly and resolutely.

This is an area of public policy without very much mushy middle.

So given the significance of the decision to appeal or not to appeal, I would like to offer this committee my assessment of Insite, based upon the factors that are, in my opinion, the most relevant. Those factors are twofold: science and public policy.

● (1225)

[*Translation*]

Science helps guide public policy, no doubt, but public policy takes into account a wider scope of issues, including society's criminal justice aspirations, as well as the principles and ethical framework with which we hope to animate our policy decisions. All of these are relevant in our examination of Insite and all need to be considered.

[*English*]

On the question of science, let me assure you I've read many of the studies that have been published on Insite. These studies have the weight of publication as well as some articulate proponents who insist that their positions are the correct ones. Many of the studies are by the same authors who, quite frankly, plough their ground with regularity and righteousness. Indeed, while in our free society scientists are at liberty to become advocates for their position, I've noticed that the line between scientific views and advocacy is sometimes hard to find as the issue on Insite is developed.

When these papers were reviewed by the expert advisory committee that served at arm's length to the government and by Health Canada and by science authorities in Canada and around the world, the results can only be described as mixed. For example, Insite did cause an uptake in treatment; yet from 2004 to 2005, only 3% of Insite clients were referred to long-term treatment. The studies were so inconclusive that the report suggests a number of new research directions, but no one can say whether another five years of study would provide any more answers.

Second, the expert advisory report concludes that research on Insite is uncertain. For example, after five years of intensive study, researchers still aren't sure whether Insite makes any difference at all in the transmission of blood-borne diseases, including HIV/AIDS, or whether Insite's benefits with respect to injection are greater than the $3 million annual cost. Throughout the expert advisory report, there are numerous caveats on the limitations of the research.

Finally, what do we know specifically about supervised injections at Insite? Here we must set aside the other services provided by Insite, such as needle exchange or condom distribution, which take place, quite frankly, in many other settings across Canada and are irrelevant to supervised injections.

But we know this: Insite is dominated by a group of about 500 regular clients. Up to 97% of injections, or 4.4 million injections per year, occur outside of Insite. Since Insite opened, there have been 50 overdose deaths per year in the downtown eastside. There is no direct evidence that the SIS influences overall death rates. In fact, according to the expert advisory committee, Insite saves about one life per year.

My job as health minister is to balance that one life against any possible negative effects of supervised injection that might take one life elsewhere, and it is a difficult job. Some read these statements and think they are clear victories for supervised injection, but I think we can do better than saving one life per year. And we must do better.

Furthermore, there are other studies that cast doubt on supervised injection. Garth Davies of Simon Fraser University concluded in a recent peer-reviewed article:

> Previous studies [on safe injection sites] are compromised by an array of deficiencies, including a lack of baseline data, insufficient conceptual and operational clarity, inadequate evaluation criteria, absent statistical controls, dearth of longitudinal designs, and inattention to intrasite variation. This review suggests that much of the commonly-cited evidence regarding the effects of SIFs cannot be substantiated.

And in a feasibility study last year of an SIS in Victoria, the Centre for Addictions Research of B.C. said “there is to date no epidemiological evidence of reduced infectious disease transmission...among clients” in supervised injection sites; that “the cost-effectiveness of [SISs] is difficult to ascertain”; and that the evidence of the effectiveness of SISs is “less conclusive than supporters... might have wished”.

In that report, one drug user stated, “I think it's ridiculous to have a Supervised Consumption Site when people need housing, shelter, and basic needs first.”

Let me now consider the public policy, for while the science is mixed, the public policy is clear.

● (1230)

[*Translation*]

Let me turn now to the issue of public policy, in particular crime and crime prevention. Some advocates have claimed that Insite has made crime in the downtown east side either better or at least, no worse.

[*English*]

It is true that the total crime rate has not escalated with Insite, but it is also true that Vancouver police added 65 beat officers to the streets of the downtown eastside simultaneously with Insite's establishment. Many police officers feel this is the real reason crime statistics have not skyrocketed. In fact, the EAC report noted that addicts typically need to spend about $35,000 per year to support their habit and that about $350,000 worth of crime needs to be committed to obtain that $35,000. So, ladies and gentlemen, we are talking about hundreds of millions of dollars worth of crime against the law-abiding members of the public.

We, as parliamentarians, are also sworn to uphold the rule of law. We would lay down our lives for it, and when we speak the plain truth, call crimes what they are, we are standing up for and showing respect for the rule of law. There have always been and there always will be people who break the law. That does not mean, however, that we abandon the law. Chaos would reign if we did.

Inspector John McKay from the Vancouver Police Department, a duty officer in the downtown eastside, which houses the SIS, has written of the chaos occurring as a result of the opening of the SIS, and he also clearly sees the slippery slope and warns us of what may come next. Inspector McKay writes, and I want to quote him somewhat extensively:

> In 2001, the City of Vancouver rolled out their strategy called the Four Pillars Approach, which included the federal government providing an exemption to the Controlled Substances Act for an SIS in the downtown east side.
>
> To support the enforcement pillar of the four pillars and realizing the potential for complete chaos, VPD assigned 65 police officers to a five-block area around the SIS. They eventually became known as the beat enforcement team.
>
> I was assigned as the officer in charge in September prior to the SIS opening.
>
> The SIS opened in September 2003. Lattes and t-shirts were given out to addicts. A portion of the facility was designed to be able to be used as a drug inhalation centre.
>
> Upon the opening of the SIS, Vancouver Police Department agreed not to arrest and charge anyone going to the SIS with illegal drugs in their possession within a five-block radius of the SIS. Instead, police were to walk the addict to the SIS from anywhere within the five-block area.
>
> This no-charge policy creates a culture of entitlement with the addicts who simply have to say they are going to the SIS and are now immune from prosecution.
>
> The culture of entitlement was supported by the Vancouver Union of Drug Users, which holds an annual anti-police rally outside the 312 Main Street station where the beat enforcement team personnel work.
>
> In 2006 the culture of entitlement was so bad that addicts were openly using drugs at bus stops, school grounds, and business fronts. With the support of the crown, Vancouver police advised Vancouver Coastal Health personnel and the SIS that anyone caught using drugs, inhaling or injecting, at these locations would be charged criminally. This was loudly supported by the public however VCHA accused the VPD of not supporting harm reduction.
>
> In 2004, Mayor Campbell held the Mayor's Conference on Drug Prevention Strategies. The prevention strategy that was arrived at was to legalize all psychoactive drugs so that addicts wouldn't be harmed by a criminal conviction and stigmatization. In 2004, I attended the SIS steering committee meeting which included the VCHA, the RCMP, the Portland Hotel Society, and the authors of the four pillars strategy. Vancouver Coastal Health wanted to activate the inhalation portion and proceed with assisted injections. This motion was quashed by me and my position was supported by the VPD executive. In 2005, I attended one of several monthly scheduled meetings with the Vancouver agreement people. This meeting is to determine the vision in 2006 and beyond for the DTES; their vision includes a place where certain Criminal Code sections and the Controlled Drugs and Substances Act do not apply.

Inspector McKay is not writing in an ivory tower. He is the duty officer responsible for the five blocks around the SIS. He is not out to win any popularity contests. He speaks the plain truth. He sees the slippery slope that we step onto when we decide to ignore the rule of law.

● (1235)

In 2006, Vancouver had the second-highest rate of violent and property crimes of any major city in the United States or Canada. Law-abiding Vancouverites are beginning to see that what has been presented as a "victimless crime"—the drug trade—is not victimless at all.

[*Translation*]

Canada's approach—looking the other way while crimes are committed—is now becoming an international issue. The International Narcotics Control Board, an agency of the United Nations, has named Canada in its annual report for several years now as being in violation of a number of anti-drug treaties and conventions.

[*English*]

Let me now speak of how our government sees harm reduction and how it fits into our new national anti-drug strategy. We see harm reduction as being represented within the other three pillars of enforcement, prevention, and treatment.

This is why, for example, I announced $111 million in treatment funding for the provinces and territories last month and $30 million for aboriginal addictions programming. On May 14, together with Mayor Sullivan, I also announced a $10 million fund dedicated solely to Vancouver's downtown eastside—

**Hon. Robert Thibault (West Nova, Lib.):** Madam Chair, on a point of order, are you going to give him one more minute?

**Hon. Tony Clement:** —money that will fund 20 brand-new treatment beds for female sex workers and will allow a team of doctors, nurses, and therapists to go out onto the streets to find and help the hardest-to-serve individuals.

Today, colleagues, I am very pleased to announce that in addition to the $10 million for Vancouver, our government will provide $2 million extra, dedicated to aboriginal-specific addiction services within the downtown eastside. We are consulting with local NGOs right now to best determine how to use that money.

[*Translation*]

As Federal Health Minister I am trying to lead by example in this area, because I believe it is the right thing to do; we need to close the gap in treatment options that exist for the rich and poor in Canada.

[*English*]

Wealthy people who become addicted to drugs can check into expensive rehab centres for months at a time, if that is what is required to help them. But for the poorest of Canadians, who live in conditions of extreme poverty, enslaved by an addiction for which full recovery is possible, we have been offering supervised injection, needle exchanges, and crack pipes. We have been offering drug maintenance rather than drug treatment. We have been sending the message: "We have given up on you; we do not expect you to recover."

Vancouver mayor Sam Sullivan, just a few weeks ago in an editorial in *The Globe and Mail*, called the SIS "palliative care". This echoed the report of a committee struck by the British Columbia Medical Association in 1997, which called harm reduction "the palliative care of addictions medicine".

Palliative care is what you give someone when there is no more hope. It is end-stage treatment when every other solution has failed, and we just wait for people to die. But injection drug users do not necessarily have to die; there is still hope for them. Even if they fail treatment the first time, we can help them to get up and try again. In purely medical terms, it is unethical to offer palliative care when treatment could help.

There is a notorious lack of treatment beds in the downtown eastside—

**Hon. Hedy Fry (Vancouver Centre, Lib.):** I have a point of order, Madam Chair, please.

**Hon. Tony Clement:** —and while I would quickly assert that people at Insite have the best of intentions, I think the site itself—

**Hon. Hedy Fry:** I have a point of order, Madam Chair, please.

**The Chair:** Yes, Dr. Fry.

**Hon. Hedy Fry:** With due respect to the minister, I would like to know how much longer his presentation will take.

**The Chair:** It's about two minutes, Dr. Fry.

● (1240)

**Hon. Hedy Fry:** We had set times for other witnesses.

**The Chair:** You have a whole 15 minutes; you're first to ask questions.

**Hon. Hedy Fry:** That's not my question. We have cut off witnesses.

**Hon. Robert Thibault:** Respect is commanded, and this guy is not doing it.

**The Chair:** Dr. Fry, he has two more pages. You have 15 minutes after that to examine the minister. Could we continue?

**Hon. Hedy Fry:** Madam Chair, I wasn't even allowed to finish my question on my point of order; I was disturbed by other people in the room. I would like to ask a question.

We gave other witnesses a set time, and most of them were cut off before they were able to finish what they had to say. I would like to suggest that the minister wrap up as soon as possible, please. He's gone well over 15 minutes.

**The Chair:** Okay, we'll do that. Thank you.

Go ahead, Minister.

**Hon. Tony Clement:** Thank you.

There is a notorious lack of treatment beds in the downtown eastside, and while I would quickly assert that people at Insite have the best of intentions, I think the site itself represents a failure of public policy, indeed of ethical judgment. I suggest, then, that while the science is mixed, the public policy is clear.

Further, I want to talk about the ethics of diversion. Every dollar spent on the supervised injection site diverts a dollar away from treatment leading to full recovery.

Let me do the math by giving you an example. The 20-bed treatment centre I announced on May 14 will be able to treat 80 women per year, or 400 women, over its five-year lifespan. With just this amount alone, one in four female sex workers in the downtown eastside will now have the opportunity to escape the cycle of addiction, of violence, of victimization, crime, and abuse. It's an initiative of which I'm very proud and something for which I commend our partner, the Vancouver Coastal Health Authority.

If the $3 million per year used now to operate Insite were to offer treatment beds instead of injections, 1,200 more female sex workers could receive help over the same five-year period. Together, we could guarantee that every female sex worker in the downtown eastside would have an opportunity to escape their sad existence over the next five years. They could have hope for a better life.

Female sex workers now make up 38% of the visits to Insite. Is it wise or ethical to use this money to help keep them on drugs instead of getting them off the streets? Is this compassion? I would assert that it is not.

As mentioned, the evidence is that Insite's injection program saves at best one life per year—a precious life, yes, but I believe we can do better than that, and we must do better than that. We can do better than simply warehousing people addicted to drugs for palliative care.

If it were my son or daughter trapped in the misery of the downtown eastside, I would want health workers—and more importantly I would like my government—not to give up on my child, but to help me win him or her back, back into society and into health and wellness. That is what this government's national anti-drug strategy is all about and what we need to think about when addressing the exemption at Insite.

This much I know as health minister. The illicit drugs that are being injected as part of harm reduction at the supervised injection site are harmful to human health. There is no debate about this. The long-term effects of injecting heroin include collapsed veins, infections of heart lining and valves, abscesses, and liver disease. Pulmonary complications and pneumonia occur more frequently in street heroin addicts. Cocaine can result in cardiac or respiratory arrest. Additives and impurities found in many drugs purchased on the street may not dissolve readily and may result in clogging of the blood vessels that lead to the lungs, liver, kidneys, or brain, causing infection or even death. Sadly, we expect and see about 50 deaths by overdose in Vancouver each and every year.

In my opinion, supervised injection is not medicine; it does not heal the person addicted to drugs. Each and every injection, along with the heroin and cocaine injected, harms the person. Injection not only causes physical harm, it also deepens and prolongs the addiction.

Programs to support supervised injections divert valuable dollars away from treatment—

**Hon. Hedy Fry:** This has become a half-hour presentation.

**Hon. Tony Clement:** —and government-sponsored supervised injection sends a very mixed message to young people who are contemplating the illicit use of drugs.

For these reasons, Madam Chair and fellow committee members, I can inform you today that I will be asking my colleague Rob Nicholson, the Minister of Justice, to appeal Justice Pitfield's decision at the earliest possible opportunity.

Thank you, and I'd be happy to take your questions.

**Some hon. members:** Hear, hear!

**The Chair:** Order. I would ask that we keep order so that everyone may remain in the room.

We're now going to go to questions. We'll begin with Dr. Fry, for 15 minutes. Thank you.

● (1245)

**Hon. Hedy Fry:** Thank you, Madam Chair.

I have been a physician practising for 22 years in central Vancouver, in the middle of the city. I have had many patients who were addicted, many patients who were in the sex trade. I have had a great deal of experience on this issue.

I wanted to put that down. I was also the federal minister responsible for the Vancouver agreement that oversaw the inception of Insite, so I am fully aware of what went into the details of it, why it was set up, and what the project was about.

The Minister of Health has referred to the rule of law. He referred to the fact that a particular police officer who worked on the drug squad had some negative things to say about Insite. I would like to quote Kash Heed, who was the commander in charge of drug policy for the Vancouver Police Department at that time. Mr. Heed is now the chief of police for the West Vancouver Municipal District. He fully supports Insite's results. He believes it has achieved its main objective, which was a decrease of public harm and an increase in public order.

The Vancouver Chinatown Merchants Association, who were opposed to the setting up of Insite at the beginning, are now fully in support of it. They have seen crime rates drop, and they feel they are able to walk their streets now, so they support it. I am speaking about the people who live in the area, who have worked on this and who know. I think the commissioner in charge of drug policy and the business community there have fully supported Insite.

However, the minister speaks very much about the fact that this has not worked. Madam Chair, you've heard that over 2,000 people died in the 1990s. Insite was not set up for every single drug user. Insite, as I can tell you, having been involved, was set up to look at a very high-risk population of users. These are the people who do not access health care services. These are the people who will not go to treatment. These are the people who have the highest incidence of infectious diseases, because of their intravenous drug use. These are the people who needed help and who were dying.

You have heard that the people accessing Insite have experienced zero deaths—zero deaths, Madam Chair. In 2005, 2,270 people went to health services withdrawal facilities; in 2006, 1,828 people attending Insite did the same thing; in 2007, 2,269 people attending Insite went to treatment and detox services. So this is not one death, Madam Chair. It depends on how you value people's lives.

The minister speaks to the rule of law. I would like to refer to Justice Pitfield's response. When Canada argued that the Controlled Drug and Substances Act, subsection 4(1), did not offend section 7 of the charter, Mr. Pitfield was clear. He said:

> In the alternative, ss. 4(1) and 5(1) of the CDSA are unconstitutional and should be struck down because they deprive persons addicted to one or more controlled substances of access to health care at Insite and therefore violate the right conferred by s. 7 of the Charter of Rights and Freedoms (the "Charter") to life, liberty, and security of the person, and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

> Canada argues that if s. 4(1) of the CDSA offends s. 7 of the Charter, it is saved by s. 1 as a law that is a reasonable restraint on s. 7 rights in a free and democratic society. In my opinion, the law compels the dismissal of the claim.

He also went on to suggest that in fact the principles of fundamental justice are amongst the most important in society, and any law that offends them, mainly the right to life, the principle of life and security, has been offended by the minister's proposed actions.

I want the minister to respond to me about how the ability to save one life, which the minister so casually dismisses, is an extremely important thing. Just because that life is not worth the minister's time doesn't mean it's not important.

How can a minister who is supposed to protect the people of Canada with regard to health and safety refuse to administer life-saving services to a group of people who will die if they do not get it?

**Hon. Tony Clement:** Thank you for your comments and your question. I agree with you that every life is precious and every life is worth saving. That's precisely the point of my argument: the best way to save lives, the best way to ensure that we have compassion in our society, is to treat those who need our help and to prevent others from getting on drugs in the first place. And while that one life that was projected—

**Hon. Hedy Fry:** Minister, could you please answer my question?

**Hon. Tony Clement:** —to be saved by Insite is precious, if we can save 10 lives or 50 lives or 100 lives, that should be our aim and objective. I believe that through our plans, as a government—

**Hon. Hedy Fry:** Thank you, Minister.

**Hon. Tony Clement:** —the national anti-drug strategy—

**Hon. Hedy Fry:** Madam Chair, may I ask the minister a question?

**Hon. Tony Clement:** —will save many more lives than Dr. Fry proposes to do.

● (1250)

**Hon. Hedy Fry:** Madam Chair, the minister has given me his answer. I've heard it very clearly. I would like to continue.

**The Chair:** Committee, excuse me, I have one thing to say, and I'm going to be clear on this.

At the beginning of this committee meeting today, I read an account of a terrible—

**Hon. Hedy Fry:** I hope you're not taking up my 15 minutes.

**The Chair:** —incident that happened where one of our witnesses could not come because he was intimidated.

I'm fair with the time with everybody. I'm not taking your time away.

**Hon. Hedy Fry:** Thank you.

**The Chair:** All I'm asking is that everyone be respectful and then you will get a chance to ask.

Dr. Fry.

**Hon. Hedy Fry:** I would like to ask the minister to focus on the question I asked and respond to it. I have heard the minister's principles in his speech. I don't really need to listen to that any more.

The minister said he believes that certain things are more important and the number of lives is more important. As physicians, we do not trade in which life is more important and in numbers like that. That is an offence to me as a physician to hear someone say that. I wanted to put that on the record.

Secondly, the minister spoke about what his own research people told him. I wonder if his research people were peer-reviewed. Insite was peer-reviewed by 21 peer reviews, international peer reviews following international principles of research. Did the minister have his report from his advisory council similarly peer-reviewed?

I would like a quick answer, yes or no.

**Hon. Tony Clement:** Well, it was an independent—

**Hon. Hedy Fry:** Yes or no?

**Hon. Tony Clement:** —evidence-based scientific approach to the research. I would defend that. They were scientists. I listen to scientists.

**Hon. Hedy Fry:** Was it peer-reviewed, Minister?

**Hon. Tony Clement:** Was it peer-reviewed?

**Hon. Hedy Fry:** Yes or no.

**Hon. Tony Clement:** It wasn't for publication in some journal.

**Hon. Hedy Fry:** Was it peer-reviewed, yes or no?

**Hon. Tony Clement:** It probably was not peer-reviewed for publication, but all of those people—

**Hon. Hedy Fry:** Thank you, Minister.

**Hon. Tony Clement:** —are expert scientists...but I know you don't want to hear the answer.

**Hon. Hedy Fry:** You haven't answered my question.

**Hon. Tony Clement:** You never want to hear the answer, but that's okay.

**A voice:** Maybe you would like to define “peer-reviewed”.

**Hon. Hedy Fry:** The minister believes very much in prevention.

**Mr. David Tilson:** I have a point of order.

**The Chair:** Mr. Tilson.

**Mr. David Tilson:** We've listened very politely to Dr. Fry's—

**Hon. Hedy Fry:** Madam Chair, I really do not wish to have—

**The Chair:** Don't interrupt, Dr. Fry.

**Mr. David Tilson:** She's even interrupting a point of order, for heaven's sake.

The minister speaks and she literally heckles him. It's most inappropriate. If she has something to say, she's free to say it. She can use her time, but she has no right to heckle a witness. It's most inappropriate. We're honourable members of Parliament and she should act like one.

**The Chair:** I would say—

**Hon. Robert Thibault:** I would like to speak to the same point of order.

**The Chair:** Monsieur Thibault.

**Hon. Robert Thibault:** Madam Chair, on Mr. Tilson's point of order, when members of a committee have the floor for the allotted time, they can choose how they want that time spent. They can ask questions or make comments.

**The Chair:** Yes, they can.

**Hon. Robert Thibault:** They can interrupt a witness if the witness is abusing their time. Usually what happens—and I'll remind you of this—is the witness takes the witness position and gives a 10-minute presentation. When it's a minister, sometimes we let it go for 15.

Today the minister chose to speak for 25 minutes, and he was attempting to repeat his propaganda during the member's time. She objected to that. She stopped that. That's absolutely normal, Madam Chair.

**The Chair:** Mr. Thibault, I am asking that all committee members be respectful of one another. I'm asking that you do not heckle. I'm asking you to allow the minister to answer.

I'm asking you to ask your question. No one will interrupt you. I'm asking you to allow the minister to answer your question.

**Hon. Hedy Fry:** Madam Chair, with due respect to the chair and to the minister, I am not heckling the minister. I asked the minister at the very beginning of my question to give me a simple yes or no. I did not get a yes or no. I got a repeat of what I already have here on paper, what I have listened to and read. I have so many questions I need to ask this minister that I will have to choose.

**The Chair:** Can you continue and ask one, then?

**Hon. Hedy Fry:** My time is spent in getting efficient questions and efficient answers. That is not heckling, Madam Chair.

**The Chair:** Can you ask your question?

**Hon. Hedy Fry:** The minister has to be respectful of what the questioner asks of him.

**The Chair:** Dr. Fry, can you ask your question?

**Hon. Hedy Fry:** Thank you.

Madam Chair, I have another question of the minister. He has removed harm reduction from the four pillars and now there are three pillars of drug policy nationally.

The question I would like to ask the minister is this. Does he disagree fundamentally with the concept of harm reduction, which is a hallowed public health principle not only in substance abuse but in any public health pillars dealing with public health problems? Harm reduction simply means you reduce the death, mortality, and morbidity in patients while you are getting them to treatment and to where you can help them. You decrease the amount.

Madam Chair, I want to say that as a physician I have had patients who were addicted, who have told me when I tried to help them that they didn't care. All their friends had died before the age of 30. They were going to die, so they didn't really care.

What harm reduction does...and what Insite has done is it has given these people hope that they need not die, hope that they need not get a deadly illness, and that has given them the ability to seek help, to seek detox, and to seek treatment, as you have clearly seen in the results. This is a group who would never have done that before.

The minister has therefore focused on prevention. One of the things we see from Health Canada is that the minister, through Health Canada, has put out a series of advertisements with regard to prevention. Madam Chair, I want to suggest that in fact in the United States that is exactly what is being done. The National Institute on Drug Abuse in the United States has evaluated the national media campaign in the U.S., which is extremely similar to the one in Canada, and it has said it is not effective.

So I would like the minister to tell us why he is embarking on an ineffective course of action. May I have a short answer from the minister, please?

● (1255)

**Hon. Tony Clement:** Thank you for your question.

First of all, we haven't removed harm reduction. We believe that harm reduction occurs with enforcement, with prevention, and with treatment, and that is the best way to get harm reduction to people who need it.

In terms of the media campaign, we of course test drove the media campaign and it was found to be highly effective. After 20 years in which the federal government did not advertise about drugs on the airwaves, parents wanted to know how to have the conversation with their kids. They wanted to have some help from the government on how to broach the topic of drugs with their kids, and that's what this media campaign is all about. Certainly it has been test driven, and I think it will be effective.

**Hon. Hedy Fry:** Thank you, Minister.

May I direct my question to the Chief Public Health Officer of Canada?

The World Health Organization and the United Nations have accepted harm reduction as a component of any effective comprehensive drug strategy. In fact, they have made it so that any aid delivered by a foreign country with regard to drugs must have a harm reduction component attached to it.

Madam Chair, the question I want to ask the public health official is this. Given that the World Health Organization and the United Nations have spoken to this, given that the Parliament of Europe and the Parliament of Australia have accepted safe injection sites, and throughout Europe they have accepted them as effective harm reduction now for 10 years, given that Australia has also accepted safe injection sites as effective harm reduction and life-saving measures, does the Chief Public Health Officer of Canada agree with the United Nations, with the World Health Organization, and with the effectiveness of the science on drug policy and harm reduction with regard to safe injection sites? Is the science effective? Has it been appropriately peer-reviewed?

**Mr. David Butler Jones (Chief Public Health Officer, Public Health Agency of Canada, Department of Health):** I think the science speaks for itself. The debate speaks for itself.

Public health advocates for a comprehensive approach to issues: the gathering of evidence on promotion, prevention, diagnosis, treatment, harm reduction, and identifying and addressing any underlying factors or determinants within each and all of these areas.

Individuals, communities, health regions, and governments then choose what to fund and to support. Having been one who's established harm reduction programs, including things like needle exchange, at a time when people viewed it as potentially illegal, I understand that very well.

Public health then works with others across these realms, using what resources and evidence we have to minimize harm to the individuals, to reduce the risk to others, and to increase health and well-being. That's our job. We provide the advice, the best advice we can. Governments and jurisdictions, as appropriate, make their decisions and have their political context in which they make those decisions.

**Hon. Hedy Fry:** Thank you.

Then, Dr. Butler Jones, based on the evidence and the 25 international peer-reviewed studies that have been done on the results of Insite, do you concur that the evidence is there and that this is an effective component of a harm reduction strategy?

Do you agree with that or do you disagree with it?

● (1300)

**Mr. David Butler Jones:** I think all of those activities are part of a harm reduction strategy, so I'm not disagreeing with the science at all. It is part of it, but the decision is one that governments make.

**Hon. Hedy Fry:** I understand that, Dr. Butler Jones; however, as the Chief Public Health Officer of Canada you have two hats to wear. One role is to speak out and to be an advocate and to protect Canadians. If you believe that the evidence shows that a particular piece of strategy would save lives and would bring people towards lower mortality and would help them to get detox and treatment, should you not advocate for that, Dr. Butler Jones?

**Mr. David Butler Jones:** First of all, there are different levels of advocacy. I speak to these issues; when these questions are asked of me, I respond to them. I have read the data. It is, as I have said, part of a public health approach to dealing with harm reduction, in addition to the important role that prevention and dealing with the basic underlying determinants are for that.

So I do speak to those issues. I do not go out and speak on every single issue. There are many, many of them, as you know.

**Hon. Hedy Fry:** Thank you.

But then in your role as the Chief Public Health Officer, have you advised the Minister of Health that this is strong evidence and that therefore it should be included in an effective strategy to decrease addiction in Canada?

**Mr. David Butler Jones:** The minister, I think, recognizes that harm reduction is part of the strategy.

**Hon. Hedy Fry:** Have you asked him?

**Mr. David Butler Jones:** As other ministers who have been around this table might recognize, it's inappropriate to speak of personal advice to the minister. I've told you what my position is on my view of the science and my view of harm reduction as part of a public health approach, and of the respect in which I hold Parliament and others in the decisions they make and the way they move forward on those choices.

**The Chair:** Thank you, Dr. Butler Jones.

Madame Gagnon.

[*Translation*]

**Ms. Christiane Gagnon:** Thank you, Madam Chair.

Minister, since 2006, you have taken a number of actions as a result of which we are not surprised today by the tangent you want to give to harm reduction. We sense various ideologies. You're saying that yours is based on ethics, but on what ethics?

Is it a moral ethics or an ethics that aims to provide the best possible support for individuals coping with substance abuse? Exactly what kind of ethics is it?

Earlier we were talking about ideology. You weren't here at the time of the international AIDS conference; you didn't have a word to say to the public. You were absent. We waited for you; we called for you.

**Hon. Tony Clement:** That's not true.

**Ms. Christiane Gagnon:** You came, but because you were asked to. You didn't show any leadership. The international community had looked to you.

**Hon. Tony Clement:** That's utterly false.

**Ms. Christiane Gagnon:** Read the articles. Pardon me, minister, but, when the conference was held, I believe you had to be pushed a number of times to get there more quickly.

A very long time ago in Quebec, you prohibited a completely inoffensive book entitled *Drugs: Know the Facts, Cut Your Risks*. That was a matter of $1 million. That book, which had been approved by Quebec's health minister, Mr. Couillard, provided information on various aspects of the drugs in circulation, their effects, the risks they entailed, the laws involved and available help. How could a book like that lead our young people to take drugs lightly? We see that there is a mentality, a strategy behind all that. One sense is that there is censorship.

You say you're concerned about public opinion. However, I get the impression that your public opinion is the one that directs your ideological orientation. We hear other stories, regardless of whether they come from researchers or people who are working hard to fight the increase in substance abuse or to help people coping with AIDS or Hepatitis C.

I'd like you to try to defend your position. Earlier you said this was a matter of ethics. In your view, addicts need clothing and housing. I think we all need that. We aren't opposed to your strategy, but we would like to know what will happen if you implement it. As for the assistance you want to offer, you have to understand that some people won't accept it. They say it's a part of the population that is marginalized. Harm reduction can't stop all drug use. The point, for example, is to stop the spread of HIV-AIDS and hepatitis C, to see that other people aren't infected. That's one of the goals of Insite.

I think you're headed in the wrong direction, minister. Like you, I think the objective is praiseworthy, but it can be achieved without a place like Insite being closed. You say you want to support the entire network that's working in this field and to increase funding for HIV-AIDS assistance organizations, but, of the $84 million allocated in 2008, $16 million has been withdrawn. You say you encourage research for a vaccine, and I agree with you: we have to do it. However, you don't seem to be allocating resources to the field in order to better combat the spread of drug use, HIV-AIDS or Hepatitis C.

● (1305)

**Hon. Tony Clement:** Allow me to respond in a few words.

As I said in my speech, it is important to make a decision that takes into account the opinions of scientists, of course, but also public policy. I said that various opinions were given by the scientific community. My conclusion is that public policy, on the other hand, is clear.

[*English*]

From our perspective, it's the combination of reviewing the sciences, as Dr. Butler Jones so aptly put it, and combining it with public policy that gets you to a decision about the health and safety of Canadians. That's the same method used by me, and I dare say by other ministers over the years. That's how we come up with positions.

With respect to Insite, there's a court decision and we are going to respect it. If it is overturned, then it's a different story. But if it is not overturned, the decision of our courts trumps the decision of legislators as well as the decision of parliamentarians, the decision-makers on Parliament Hill. I respect that. It's the way the system is. I was explaining to you how I make decisions based on science plus public policy—it's a combination of those. In this case, my best advice is that the science is mixed, but the public policy is clear. That's my perspective.

[*Translation*]

**Ms. Christiane Gagnon:** They are mixed, but what is the alternative? You say you want to provide people with more help to get out of drug addiction. That's a praiseworthy objective, but I don't think you're providing all the necessary tools to the various stakeholders working at the grassroots level to solve this kind of problem. You seem to be putting your head in the sand by saying you want an ideal society, without substance abuse. The substance abuse problem is present in all countries. If drugs didn't circulate in the market, people would find other ways to get them. Some people have trouble living in our society. They take drugs or sniff glue and make every effort to find a way to escape. That's a social ill.

Since you've been in your position, you haven't done enough to help the community. For example, people working in the fight against HIV-AIDS are waiting for money, which isn't available. There haven't been any calls to tender. You know what I'm talking about. The program has a budget of $16 million. You're saying you've developed an extraordinary strategy to fight HIV-AIDS, but the money isn't there. Allow me to doubt your sincerity and ability to help out society.

● (1310)

**Hon. Tony Clement:** We have to increase that ability, of course. We also have to do something in the areas of treatment, housing and mental health. Each of those areas is part of a more effective policy.

**Ms. Christiane Gagnon:** Minister, why was that book withdrawn from the market? One would think you don't want people to be informed. We could address another type of high-risk behaviour, such as smoking.

[*English*]

**The Chair:** Madame Gagnon, your time is just about up. Could the minister please answer?

[*Translation*]

**Hon. Tony Clement:** Read the book. Some passages aren't related to the policy of our government or of our society.

**Ms. Christiane Gagnon:** On what page?

[*English*]

**Hon. Tony Clement:** The book says, here's how young people like to look at drugs, and it gives a whole list of reasons to take drugs. I don't think that's the right message, quite frankly.

[*Translation*]

**Ms. Christiane Gagnon:** You have to understand how a society works.

[*English*]

**The Chair:** Thank you, Madame Gagnon. Your time is up.

Ms. Davies, go ahead, please.

**Ms. Libby Davies:** Thank you, Minister Clement, for appearing here today. I've listened to your presentation carefully, and in fact I've followed every public utterance I could find that you've made. This issue of what's going on in the downtown eastside is very dear to my heart.

There are a number of comments I'd like to make. I think what's really at the heart of this debate, what is disturbing to me and a growing number of people in Canada, is how the Minister of Health makes a decision based on public policy. You have said that it's a difficult decision to make. But what's at the heart of this debate is how you as the Minister of Health make a decision about whether or not Insite continues and how you respond to the recent court case.

I find this very disturbing. On the one hand, you have continually said that you are seeking more information, that you want more studies. Even today in your presentation you have said that you'll be looking for new evidence or new assessments. On the other hand, you are asking the Minister of Justice to appeal the important decision that was made on Monday in the B.C. Supreme Court. Moreover, the so-called anti-drug strategy that your government brought in has clearly dropped harm reduction. Now you're trying to say that harm reduction is part of the other three pillars, but it was clear what the continuum was. I don't think anybody doubts that the government consciously dropped harm reduction. That's being cut out of your program. When we look at Bill C-26, which brings in mandatory minimum sentencing for drug crimes, we can that see the direction you are going in is enforcement. That's where the priority is.

I think we face a very serious situation. As the Minister of Health, you are in effect denying all of the research that has been done. I don't think it's acceptable that a minister should be able to cherry-pick one police officer or one study that wasn't even peer-reviewed.

Yes, there are diverse opinions, but your job as the minister is to weigh up all of the evidence, just as Justice Pitfield did, who is actually a conservative judge. I find this very disturbing. It raises questions about how the government is making public policy decisions.

Second, I think it is problematic when things are presented as either/or. Somehow if you're for harm reduction, you're against treatment. No one is saying that treatment is not a critical part of the solution. We need more treatment. But as we heard earlier today, to have low-threshold programs that draw in chronic and hard-to-reach users is a critical public health policy. I don't understand why you don't get that. I really don't.

The only conclusion I'm left with is that it has to do with an ideological agenda that you cannot deviate from. The research would show us that engagement at the street level leading to other interventions—treatment, detox long term—is part of the continuum. So I can't understand why you don't intellectually understand this.

The four-pillar approach that was begun in Vancouver was a bottom-up approach. It's quite concerning that a government would refute all of the work that's gone on at both the local and provincial levels. We now have everybody on board with this in B.C. and across the country. You're now the last remaining barrier to Insite's continuation.

I have two questions for you. Even if treatment were available to everybody who needed it, the most extensive programs, we'd still probably be capturing only 10% to 20% of the people who need it. What is the obligation for the remaining 80%?

● (1315)

The World Health Organization has guidelines that make it clear that, as public health policy, we have a responsibility to keep people free of disease and to keep them healthy. That's what Insite and harm reduction programs are partly about.

Are you not abandoning your responsibility under the WHO guidelines as the Minister of Health? Even if you're putting everything you can into treatment, you're still leaving a lot of people outside the loop, particularly those people who are very difficult to reach.

My second question is this. What is your understanding of low-threshold services? I'll stay away from the term “harm reduction” because it's like a big, red flag at this point. But what is your understanding, as the Minister of Health, of low-threshold services, and what is your government doing to provide those kinds of important low-threshold services to this drug-user population?

**Hon. Tony Clement:** Thank you for your comments. I appreciate them.

First of all, let me state for the record and make it crystal clear that this was never about closing Insite. I don't have the power to close Insite. I didn't want Insite to be closed. It was about whether there would continue to be an exemption under the Controlled Drugs and Substances Act.

Insite does other things. They do some referral, not as much as I'd like, but they do it. They do treatment now. They didn't at the beginning, but now they do. They do needle exchange. I have nothing against needle exchange. They distribute condoms. I have nothing against the distribution of condoms. These are all aspects of harm reduction that our government has no complaint about.

I want to put that on the record, because sometimes I read statements like “Clement is going to close Insite” or “Clement wants to...”. I don't have the power to do that, and second, I don't want to do that. So I want to put that very clearly on the record.

My understanding of low-threshold services includes needle exchange, condom distribution, and a number of other facets of activities that occur at Insite or around Insite. We have no difficulty with that. Indeed, we want to support that as best we can. That's why I announced $10 million directly for the downtown eastside, to get the teams out there on the street to identify people who can be helped, and to specifically....

When I visited the downtown eastside, I was appalled by the lack of beds available for sex workers, most of them women. It was appalling, and quite frankly almost criminal. One of the things I want to do with that $10 million is make sure the women of the downtown eastside, the sex workers of the downtown eastside, have beds specifically available to them. And I'm very proud of that announcement of two weeks ago.

Second, you asked about the treatment impacting on 10% to 20%. The injection site only impacts a certain number of people in the downtown eastside, and those who use it only use it 10% of the time. So when we talk about the panacea, the fact of the matter is that the injection site has been tried and the evidence is now in that very few people use it—97% don't use it, and those who do use it only use it for 10% of their injections. So if I want to do something for Canada, if I want to do something for the downtown eastside, I will put my eggs in the basket of treatment and prevention.

● (1320)

**Ms. Libby Davies:** Minister, with all due respect, you cannot blame Insite for the fact that it only serves 5% of injections.

**Hon. Tony Clement:** It's not a question of blame.

**Ms. Libby Davies:** It was a pilot project. If anything, that would be an argument that it needs to be opened 24 hours a day and that we need to have other facilities in other communities, some in the downtown eastside and some in other neighbourhoods, in order to provide that service, just as we would have with needle distribution.

If you say you don't want to close Insite, why are you saying today that you're going to be appealing or you're going to ask the Minister of Justice to appeal the court decision?

**Hon. Tony Clement:** I think I just spent 25 minutes telling you why, so I won't go over that ground again.

**Ms. Libby Davies:** But the position you hold is completely contradictory.

**Hon. Tony Clement:** Insite does a number of things. One of the things they do is facilitate injection drug use. They need an exemption from the Controlled Drugs and Substances Act in order to do so.

The issue before me was whether that exemption would continue. That was the issue before the court, or it should have been. That will certainly be the issue on appeal, if appeal is decided upon.

I just wanted to put it on the record because I hear people saying, "Clement is about to close Insite", or "Advocate saying Clement wants to close Insite". It's not true. It simply isn't true. I don't even have the power to do it.

**Ms. Libby Davies:** Thank you.

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

Mr. Fletcher, I understand you're sharing your time with Mr. Tilson.

**Mr. Steven Fletcher:** I'm going to try. How much time do I have, Madam Chair?

**The Chair:** You have 10 minutes.

**Mr. Steven Fletcher:** Great.

Thank you, Minister, for coming to committee. In particular, thank you for adjusting your schedule due to the votes today. I think people should understand that there was an interruption in today's meeting, and it would have been very reasonable for the minister to have cut short his visit to our committee. He chose not to. He chose to be here to answer questions from all parties, and I think that is a refreshing change from perhaps other health ministers in the past who have tried to dodge this issue whenever possible. So I appreciate it.

Minister, let's be very clear here. I know you've said it, but I want to be absolutely crystal clear, black and white. Do you think Insite should be closed down?

**Hon. Tony Clement:** No, I do not. I think there are worthy services that occur there and should continue to occur there. They are funded by the Province of British Columbia through the Vancouver Coastal Health Authority. Indeed, we have added to the budget of the Vancouver Coastal Health Authority with our $10 million announcement for the downtown eastside in terms of the treatment services.

**Mr. Steven Fletcher:** We've heard about science a lot today. I wonder if you would expand on your comments about public policy and the importance of public policy in making these types of decisions.

**Hon. Tony Clement:** I think science is one of the issues that must be taken into account when it comes to a public policy decision. Certainly, as we've discussed, there are many different ways to look at the science; there are many different ways to look at the advocacy surrounding the science. Sometimes the advocates advocate the science and sometimes the scientists advocate their conclusions. We've had a state of that in this particular case.

That's all part of the process. Indeed, I want to state for the record, if I might, that should another exemption application come forward, I have a duty to once again look at all the evidence and once again turn my mind to it in a way that gives due process. So I'm not resigning from that obligation that I have as health minister. But science is part of it.

Then when we get to the public policy, there are other issues. When you start to peel away at crime, for instance—and I've heard some of the advocates say that of course they know crime didn't go up. Okay, well, let's look at what happened when Insite was created and did open stores: 65 more police officers in a five-block area were added to the mix. It is no surprise to me that crime did not go up.

But as you heard through some of my remarks, when you look at what has to be accomplished in order to get the $35,000-a-year cost of the fix, it's $350,000 worth of crime. That's a cost to society. That's more innocent victims being affected by the scourge of this terrible disease. So, to me, the public policy is clear: get people off drugs and ensure that as many people as possible don't get on the drugs in the first place.

● (1325)

**Mr. Steven Fletcher:** I have two more questions, and then I'll pass to my colleague, Mr. Tilson.

Do you have any concerns about the medicalization of illegal drugs? Secondly, are illegal drugs, like heroin, harmful in themselves, or is it possible to live a normal life with an addiction to a substance like heroin?

**Hon. Tony Clement:** On the latter, I'll leave it to Dr. Butler Jones to answer that one.

Certainly, the trend has been to what is called "medicalize" illicit injection drugs, and perhaps other drugs as well. By that, what we are saying is that somehow this is a health choice. It's not a health choice; it's an addiction. Call it what it is: it's an addiction, not a health choice. It leads to very unhealthy consequences. To call it a "medical choice" or a "health choice" really condemns people to a slow, painful, and terrible death. I don't want to do that, and I don't think any Canadian wants to do that.

In terms of the second question, I don't know if Dr. Butler Jones wants to weigh in on that.

**Mr. David Butler Jones:** Obviously, the greatest harms come from the connection with criminality, disease through unsafe needles, or social and other problems. The use of drugs is extremely complex, as are addictions, whether it's to alcohol, nicotine, heroin, or other drugs. They often have similar effects, similar problems. Some people manage them better than others. Designating the implications would make for a long discussion. It's often very individual.

**The Chair:** Mr. Tilson.

**Mr. David Tilson:** I have two areas I'd like to ask the minister to comment on.

The first has to do with safety. I understand and support the principles of needle exchange, the treatment, condom provisions, the counselling. I think we all encourage that, but it's a safety issue. I look at Alcoholics Anonymous, where the whole principal is abstinence.

We're lobbied continually by groups such as Mothers Against Drunk Driving. We even passed a law some time ago about being impaired while driving a motor vehicle.

As I understand this, someone can drive up to this site, park their car, take their drugs in, receive assistance in being injected under the observation of a government official, and then get back in their car and drive away.

Is that an incorrect interpretation? I'm taking an example that is unlikely to happen, but it could happen.

**Hon. Tony Clement:** It could happen. Not many of them have cars, but—

**Mr. David Tilson:** I would suspect that.

**Hon. Tony Clement:** —I understand what you're trying to say.

**Mr. David Tilson:** The possibilities of this issue are expanding. If it's successful, it could conceivably expand across the country.

**Hon. Tony Clement:** Some of the advocates honestly believe this is the right thing to do. They believe an injection of an illicit drug is their right, and they object to any government authority in this area. That's a discussion that libertarians will have with people not of that particular persuasion. I'm the health minister, so for me it's health and safety. That's the ultimate bottom line for me.

● (1330)

**Mr. David Tilson:** I'd like your comment on something both you and Dr. Fry mentioned. It had to do with the United Nations. Specifically, I'd like for you to comment on the international drug control treaties.

There is a quotation that comes out of Victoria. It's from the Canadian Press, March 7 of this year, and I'll just quote a couple of sections:

> A United Nations monitoring body wants the Canadian government to close Vancouver's safe injection site and end the distribution of safe crack kits in Toronto, Ottawa and on Vancouver Island.... The distribution of drug paraphernalia, including crack pipes, to drug users in Ottawa and Toronto, as well as the presence of drug injection sites, is also in violation of the international drug control treaties, to which Canada is a party.

Can you comment on those treaties?

**Hon. Tony Clement:** Those comments come from the International Narcotics Control Board, which is an agency of the United Nations, just as the World Health Organization is an agency of the United Nations. I think we should be absolutely clear on this: the International Narcotics Control Board had some severe criticism of Canada and questioned whether we were living up to our international conventions.

Canada's point of view is that we're at present in conformity, because this is a time-limited exemption for research purposes. I think it starts to stretch credulity if this exemption continues indefinitely, but generally I'm sensitive to this kind of criticism.

I think they have a point. I should also state for the record that some members of this committee have said that Europe has gone another way. Some countries in Europe have gone another way. But interestingly, some countries that we seem to have an affinity with—they like hockey and have a lot of snow—have gone in a completely different direction. Sweden, for example, has taken a line different from Holland's, different from Australia's. They've decided to enforce, to prevent, to treat. And they have one-third the incidence of drug use that we have.

**The Chair:** Thank you so much, Minister, for coming today and taking this time to be here. It is very much appreciated.

I also want to thank Dr. Butler Jones and Deputy Minister Rosenberg.

**Hon. Robert Thibault:** A point of order. You said we were going until 1:40.

**The Chair:** One minute.

I would also like to thank the witnesses who came today as well.

I know that time is running out, but we do have one point of order.

Mr. Thibault.

**Hon. Robert Thibault:** You said the committee was meeting until 1:40, and that leaves us 10 minutes.

**The Chair:** No, it's 1:30.

**Mr. Patrick Brown (Barrie, CPC):** A point of order, Madam Chair.

**The Chair:** Mr. Brown.

**Mr. Patrick Brown:** I note there are 10 minutes of the Conservative time that were not used, so if there were another 10 minutes, it would be to finish our time. We're losing time to accommodate the committee's schedule.

**The Chair:** That's right.

The meeting is adjourned.

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