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Chair

Mr. Daryl Kramp

Standing Committee on Public Safety and National Security

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● (1540)

[*English*]

The Chair (Mr. Daryl Kramp (Prince Edward—Hastings, CPC)): Colleagues, I call to order the Standing Committee on Public Safety and National Security. This will be meeting number 35.

We have witnesses today from 3:30 p.m. to 4:30 p.m., and other witnesses from 4:30 p.m. to 5:30 p.m. Of course, this is televised.

We apologize to our witnesses for any technical difficulties we've had here today. We regret that. However, as the story goes, it is what it is, but maybe you're blessed if you can't see us.

Voices: Oh, oh!

The Chair: I meant that simply from a visual...but I guess we could take that a number of different ways. Maybe the chair is opening his mouth to some criticism here.

At any rate, let's go ahead.

We have with us Matthew Skof, president of the Ottawa Police Association. Welcome, sir.

Mr. Matthew Skof (President, Ottawa Police Association): Thank you.

The Chair: By video conference, we have Michael McCormack, president of the Toronto Police Association. Welcome, sir.

From the Toronto Board of Health, we have Dr. David McKeown, Medical Officer of Health.

Thank you very much, gentlemen, for being here today.

We will start with opening statements. You have up to ten minutes, if you wish, then we will go to our round of questioning. We will start in the order that I have the names down here as witnesses. It will be Mr. Skof first, followed by Mr. McCormack, followed by Mr. McKeown.

Mr. Skof, do you have an opening statement?

Mr. Matthew Skof: I do. Thank you very much.

I would like to thank the Ministry of Public Safety for providing me with an opportunity to speak to you today. As introduced, my name is Matt Skof. I'm president of the Ottawa Police Association.

I've worked in policing for 18 years and have had a vast and challenging career. I've worked in all patrol areas in the city of Ottawa. This included the downtown community district office in the ByWard Market, and in Vanier. For those of you who may be unfamiliar with these areas, they present unique challenges for police. They are more heavily populated, they have higher levels of homelessness, poverty, higher crime in both major and minor classes, drugs, prostitution, and mental health issues.

When I became a sergeant, I remained in the district working closely with the residents and businesses in the ByWard Market. I represented the Ottawa Police Service on many community committees that covered addiction problems, homelessness, prostitution, and mental health issues.

For the past three years I have been serving the membership of the Ottawa Police Association as president, representing 1,400 sworn police officers and 600 civilians. As president, I have been called upon many times to comment on the issue of supervised injection sites. I believe it is more appropriate to characterize safe injection sites as supervised sites. From a policing perspective these facilities continue the use of highly addictive substances. While I appreciate the argument that they are alternatives to shooting up in back alleys, the supervised injection sites perpetuate and encourage heavy, damaging drug use.

We are here today to consider public policy issues in relation to injection sites. In my view, it is crucial that within this debate we hold all the evidence up to the light for its full and careful consideration.

Last year I participated in a press event held by ministers Leona Aglukkaq and Steven Blaney, where new guidelines were introduced. At that time, questions were raised about the principal argument made by advocates of supervised sites, most particularly the suggestion that supervised sites decrease HIV infection rates.

You can see in tab 2...and unfortunately, I didn't have it translated. I wasn't sure if a speech had to be translated, so I apologize for that. There are 20 copies that will be translated for you, apparently.

I have carefully examined the data, and it does cause me great concern. I want to share that concern with this committee today.

When we examine the data, it is noteworthy that in Ontario, Alberta, Quebec, and Atlantic Canada the frequency of new cases of HIV has decreased, just as it has in British Columbia. This fact appears to have been overlooked in the arguments raised by proponents of supervised sites. Arguments that urge you to expand injection sites must be complete. When considering HIV rates overall, Ontario, Alberta, Quebec, and the Atlantic provinces do not permit supervised sites, and yet have comparable improvements in HIV data. Suggesting there is a nexus between supervised sites and improved HIV outcomes is tenuous. The evidence makes it clear that making that claim is incomplete.

At the heart of this discussion, though, is the fundamental question "Where will supervised sites be located?" Based on my experience, this question is often reframed to be "Which neighbourhood will be sacrificed?" This is given the fact that several square blocks are allocated to the transporting of illegal narcotics that are consumed at the supervised injection sites.

With regard to InSite, at tab 3 of my material the committee will find photographs I took last year when I attended a conference in Vancouver. My purpose in including these photographs is to illustrate the challenges the business communities and local residents face on a day-to-day basis. Nearly all of the properties had to go to great lengths, and at times significant expense, to ensure the safety of their clients and the security of their property.

Police encounter a number of issues in the areas allocated to supervised sites. Most concerning is that there will be a boundary in which the possession of illegal drugs will be tolerated. This area will become known to drug users and traffickers within hours of its creation. In creating injection sites, we create concentrated trafficking zones. Traffickers will carry only enough drugs to make small but frequent transactions. If stopped by the police, these traffickers will claim immunity, relying on the presumption of innocent possession within a known boundary around the supervised injection site.

If you look at tab 4, in the first picture you can see two males, one with a red knapsack and one with a green one. I observed the two males working in tandem while the male with the red knapsack trafficked drugs. In the second photograph, I observed the male in the camouflage pants traffick drugs to the male walking away from him in the brown jacket.

Both of these photographs were taken in close proximity to InSite. Neither of the two persons who purchased drugs walked into InSite, but went in the opposite direction. I stayed in the area for several hours and observed many transactions of this nature.

We return to the fundamental question of "Do you still want to live in this neighbourhood, or near it?" Before answering, it is necessary to consider that these surrounding areas have increased levels of prostitution, homelessness, and antisocial crime—theft, burglary, and swarmings. Clients of supervised injection sites often fall into these behaviours for the purpose of supporting their habit.

In tab 5, the photo was taken in an alley two blocks from InSite. The male did not live in the area, but attended for the purpose of dumpster diving and to find and sell anything of value. My observations were confirmed when I spoke directly with this individual. He was very candid with me that he was trying to support his drug addiction.

● (1545)

I have no reservations in telling this committee, based on my policing experience, that locating a supervised injection site brings an increase in crime. These crimes extend well beyond consuming drugs in a supervised location. Individuals who purchase drugs in these areas often walk away from the supervised location to shoot up in alleyways, stairwells, and parking lots within the local community.

At tab 6, I provide you with a photo of a group of people in front of the Carnegie Community Centre in Vancouver, blocks away from InSite and smoking what seems to be crack cocaine. I have to tell the committee that this photograph causes me a lot of concern. In my capacity as a police officer, I've coordinated several street-level drug projects in the ByWard Market and the Vanier area. At no time did I ever observe drug use in which the consumer smoked crack cocaine sitting in front of a community centre, nor have I ever observed someone smoking crack with such disregard for public scrutiny.

Let me be clear: I accept that we do have a drug issue in our community. I observed it at the street level, and often on a daily basis. When we consider alternative approaches to treating these conditions, we must be honest with each other. In Ottawa the distribution of rubber tips to limit the spread of disease from sharing crack pipes failed, because the users claimed they changed the taste of the drugs being inhaled. The needle exchange program required volunteer needle hunters to recover used equipment. Ottawa has many social programs trying to address these growing social problems. Supervised injection sites might have the best intentions, but they fail, increasing the attendant issues of trafficking, prostitution, theft, homelessness...and the list can go on.

Ottawa invests many resources into the ByWard Market, to name just one busy area, but adding a supervised injection site will only necessitate a significant increase in public funds. Based on my experience as a police officer, I would say that a preferred investment for a government would be one in rehabilitation facilities. Sadly, in Ottawa today there are significant wait times for persons who want to turn their lives around. This wait time leaves a vulnerable person at the mercy of their addiction on the street. We all know that getting a person to a place where they know they need help is half the battle, but we don't provide sufficient beds for them.

In closing, I would ask the committee to consider the following. As a sergeant working on the Ottawa streets, I would never be able to approach this committee and speak candidly. My message would have gone through any number of official police filters. I can speak to you today, however, because I am a representative of a police association in Canada.

As president of an association of professional police, I speak on behalf of my 2,000 members. My message to you today is as candid as I can be. My message to you is not censored by budget constraints, or through the lens of political interests. My message today is grounded in many years of working on the streets in Ottawa, with dedicated and concerned police officers and civilian members.

This concludes my remarks for the committee. As always, I'm available for your questions.

The Chair: Thank you very much, Mr. Skof.

Now we will go to the opening statement from Mr. McCormack.

Go ahead, please, sir.

Mr. Michael McCormack (President, Toronto Police Association): Thank you.

Good afternoon. My name is Michael McCormack. I'm the president of the Toronto Police Association. Here in Toronto I represent one of the most diverse communities in all of Canada. I also represent over 8,000 members.

First of all, I want to thank the standing committee for giving me this opportunity to speak to some of our association's concerns regarding amendments to Bill C-2.

I'd like to start off by stating that our association does not support the current configuration of supervised safe injection sites. I'm not here to argue the medical evidence, whether or not they reduce the number of deaths from overdoses or prevent the spread of infectious disease. I'm here to speak about our public safety concerns from a policing perspective.

The goal in policing is to improve the quality of life in the community by reducing crime and disorder and the fear of crime and disorder, and enhancing public safety, which is something that we do in the policing community. We believe supervised injection sites contribute to social and economic deterioration and further victimization where they are located. They do little to achieve our goal in policing, which is public safety.

I've worked—again, this is from a policing perspective—in 51 Division in downtown Toronto, which is a unique division. It has the second-highest density of government housing in North America; almost 90% of all the halfway houses and stationary homes in Toronto are located within the boundaries of 51 Division. I've worked there for almost 15 years, in major crime, street crime, dealing with all types and different levels of crime. What we found was that in a division like this, 90% of the crimes we dealt with were either drug or alcohol related. This is a big concern to us in the policing community.

When we talked about where we go, when we looked at all the anecdotal and other evidence around safe injection sites, and when we reviewed the evaluations of these sites, we were very critical of their methodology and the findings. We found that the public safety issues have been downplayed or not considered, or even poorly measured in a lot of this research.

For example, one study used only three crime types for benchmarks: drug trafficking, assault, and robbery and vehicle theft. Notably absent were the other crimes that from practical experience we found were missing in the indicators linked to drug use, such as break and enter, shoplifting, theft from auto, fraud, prostitution, panhandling, selling of stolen property—not to mention the countless provincial offences.

What we find too is that it's really hard to measure these offences, because given the way.... We just looked at the report on unreported crime that the federal government puts out every year. We find that people who are using drugs—we consider them victims of drug abuse or addiction—are very reluctant to come forward and report when they are, in fact, the victims of crime, whether of theft, sexual assaults, or involvement in prostitution. That's something that really concerns us.

But overall, when I look at policing somewhere in Toronto, with such diverse and widespread communities in different pockets throughout this city, when we're dealing with people who are looking to use intravenous drugs—it's not only heroin, it's also MDMA and other types of chemicals that they inject—they call it jonesing, or needing a fix, for a reason. We have all these communities throughout Toronto, as I described, and we have different pockets where you have a concentration of drug users. It's not one area where all your intravenous drug users will be congregating or hanging out. We found in working in the projects that the drug users will go get their fix, and we will find needles and syringes in schoolyards, elevators, corridors, and stairwells. The drug addicts get their drugs, they need their fix, and they go to the nearest location where they can have a little bit of privacy. They'll inject and then move on from there.

● (1550)

The whole premise of having a centralized injection site really baffles us in the policing community, because you're taking a heck of a leap of faith to think that a person who's addicted to drugs is going to, for instance, go to wherever the drug dealer is, buy their drugs, get their syringes, jump on the subway or take a taxicab or ride their bike to go to a safe injection site, and then inject—and go through that process four or five times a day, which is what we find with intravenous drug users. It's not a once-a-day event and then they move on and their day is normal. They inject up to four to six times a day.

So the logistics escape us. There needs to be some dialogue around how this would actually work. How do people see that as being effective? We're very puzzled about how that would be applied to somewhere like the city of Toronto.

As I said earlier, most of the drug addicts that I've ever dealt with as a practical matter were forced into criminality to support their habit. Where are they going to get $100 to $200 a day, which is what it requires to support this addiction? They do it by supporting their habit with theft from autos, break and enters, and other types of crimes. With that addiction they're victims, but they're victimizing the community as well.

Again, when we're talking about safe injection sites or supervised injection services, you go where the market is. Drug dealers are, for lack of a better word, business people, and they're going to go where the market is. So if you have a safe injection site—this is some of the experience we've found from the Vancouver experience as well—drug dealers will go where the market is. They'll go where people are going to use.

If they're going to traffick, they'll congregate in the areas where they can sell to the users. When we have a safe injection site, we have people who are going to be using. The drug dealers are going to go there, which is further going to facilitate and increase the amount of crime and that type of activity in those neighbourhoods. So we're very concerned about the drug dealers going there and about further victimization of the addicts.

When I worked in 51 Division, I could look out the back gate of 51 Division and see a methadone clinic. That's quite a different premise: people are getting treatment, the product is on site, and it's managed. This is a very different concept. So we're very concerned about the practical basis for this and how this would work.

The other concern we have from a policing perspective is that we are the ones expected to police those areas and increase enforcement and our presence. When we looked at it, we found in Vancouver that there was a dip in crime around the supervised injection site, but there were, I think, an additional 83 police officers who were put into that area to police. We found in Toronto that whenever we increase policing into a community, there is a significant dip. Police presence does have an impact on crime. For us, the police, we're going to be left mopping it up and it's going to be a demand on police resources. Police need to be consulted and have more dialogue and evidence on how this is going to impact our already taxed police resources.

We have some real concerns about the practical basis of this. Again, I'm not talking from the health perspective. That's not what I'm here to do. I'm talking from a public safety basis. From the Vancouver experience, when the 81 police officers were surveyed, in I think 2008, the individual officers who worked in that area said that their perception and feeling was that there was no actual decrease in the indicators of that type of illegal activity, whether it was public injection of drugs—they were still cleaning up syringes and needles from all over that community—or the congregation of people in that area, including prostitution, and street-level crimes. We're obviously very concerned about that, and that's something the policing community is going to be left to deal with. So we need to have more dialogue and see more evidence-based discussions, as Matt referred to, around what the outcome is going to be and how this is going to work with these communities.

● (1555)

I'll conclude my remarks by saying that we feel there needs to be more independent research to provide a more balanced and inclusive review of the impacts of these injection services on public safety. We need to improve the body of research in this area with objective studies, evaluations, and measurables that all stakeholders can agree on. We feel that the measurables would include crime rates, disorder indicators, property values, other economic indicators, social indicators, and data gathered through the community, law enforcement, and multi-sector consultation.

We also need to explore other strategies, including education and prevention strategies, and judicial enforcement strategies—

● (1600)

The Chair: Could you very shortly wind up, please, Mr. McCormack?

Mr. Michael McCormack: —yes—such as investing in drug treatment courts with alternatives to incarceration and treatment centres. We feel that we need to focus more on treatment and that this is a band-aid solution to a bigger problem.

Thank you.

The Chair: Thank you very much, sir.

Now we will go to Dr. McKeown, please.

You're on, sir.

Dr. David McKeown (Medical Officer of Health, Toronto Board of Health): Thank you very much.

I'd like to thank the chair and the members of the committee for the opportunity to speak with you today.

My name is Dr. David McKeown. I'm the Medical Officer of Health for the City of Toronto and the executive officer of the Toronto Board of Health. My remarks today are presented on behalf of the board of health.

You should a have a copy of our full written submission.

My perspective is somewhat different from that of my law enforcement colleagues, because I come at it from a public health point of view. Toronto is one of several cities in Canada looking to implement supervised injection services as part of an evidenced-based, comprehensive approach to health services for people who inject drugs. As you know, potential operators of these services require an exemption under the Controlled Drugs and Substances Act in order to legally operate, and Bill C-2 sets out the proposed requirements for this exemption process.

The Toronto board of health considers the requirements in the act to be excessive and quite disproportionate when compared with processes for making decisions about other kinds of health services, and we urge the development of a more appropriate exemption application process.

The board also feels that the proposed bill is not consistent with the decision of the Supreme Court of Canada ruling on supervised injection. If Bill C-2 is passed as written, we believe it will be a significant barrier for any community or any health system in any province that has come to the decision that these services would serve both the public health and public safety interests of local residents.

Injection drug use, as we know, is associated with significant public health risks, including the transmission of blood-borne diseases such as HIV and hepatitis and, of course, overdose. The risk of overdose, in fact, is twice as high for injecting illicit drugs as for other forms of consumption. This risk increases when people inject alone, as no one is available to intervene or seek medical assistance in an emergency. Without a safe place to inject, some people turn to public spaces such as washrooms, alleyways, or the street.

Public injecting is not only an issue for people who are homeless. People living in shared accommodation, in shelters and temporary housing, or rooming houses may fear losing their housing if they're found to be injecting, and so will turn to public spaces.

Based on these and other risk factors, the Toronto and Ottawa supervised consumption assessment study, a research study, concluded that Toronto, with its pattern of drug use, would benefit from multiple small supervised injection services integrated into existing health services, which are already serving people who inject illicit drugs. This is a different model from the Vancouver InSite service. The Toronto board of health supports this model and this approach to expand a continuum of health services for the needs of this particularly at-risk population in our city.

As you know, in 2011 the Supreme Court ruled that the Minister of Health's decision not to extend the section 56 exemption for Vancouver's InSite service was not in accordance with the principles of fundamental justice, and violated section 7 of the Canadian Charter of Rights and Freedoms.

The Supreme Court also ruled that for future exemption applications, the minister must exercise discretion within the constraints imposed by the charter and aim to strike an appropriate balance between achieving public health and public safety goals, and both are important in this issue.

Furthermore, the Supreme Court said that the minister should generally grant an exemption where the evidence indicates that a supervised injection service will decrease the risk of death and disease—that's the health interest—and where there is little or no evidence of a negative impact on public safety.

The requirements set out in Bill C-2, we feel, rather than striking this appropriate balance are focused much more on public safety concerns without recognizing significant public health benefits. If we are truly to have respect for communities, we must recognize that harm reduction services such as supervised injection not only provide better health outcomes for people who use drugs but they may also help to improve public safety in local communities. For example, as we read the research, it is shown that supervised injection services can help reduce public drug use and the discarding of needles, and certainly do not increase crime.

People who inject drugs are, from a public health practitioner's point of view, among the most vulnerable members of our community, and they often struggle with complex health and mental health issues. They are much more likely to be victims than perpetrators of crime, and the profound stigma and discrimination they experience create barriers to their accessing mainstream health and social services that the rest of the community would use.

Broadly, harm reduction services tend to be effective because they're designed to be welcoming and non-judgmental, and they focus very specifically on the health needs of people who use drugs.

The board of health has a number of specific concerns about the requirements set out in Bill C-2, and I'm going to mention each of these briefly.

Demonstrating local need for a health service is a very reasonable requirement for an organization seeking to implement supervised injection services, whether making that case to the provincial government or for an exemption. However, producing scientific evidence on the medical benefits of these services should not be necessary at this point.

● (1605)

The evidence has been reviewed over and over again. The Supreme Court and many other health organizations have already recognized that these services are an evidence-based health intervention based on a wealth of peer-reviewed national and international research.

The exemption application process laid out in Bill C-2 requires letters from a broad range of officials outlining their opinions about the proposed service and identifying any related concerns, along with details of how the applicant will address those concerns. There really is no other health service that is required to obtain a consensus of opinion from a wide range of sector leaders in order to operate.

Bill C-2 also requires consultation with professional medical associations and a broad range of community groups. This breadth of consultation is likely to be beyond the capacity of most health service organizations or health systems seeking to implement these services. Furthermore, there's already widespread agreement among health professional organizations—the CMA, the CNA, and so forth —that supervised injection services should be available as a part of a comprehensive range of interventions in health facilities that serve people who use drugs.

The proposed bill also does not specify what would constitute an acceptable community consultation process, including the range and type of community groups to be consulted. Some community engagement is prudent, and in fact good practice, in order to inform local residents and businesses about the service, how it will operate, and to establish mechanisms for addressing any issues that might arise.

I think this process is part of being a good neighbour for any health service, and it benefits everybody involved. However, it is not reasonable to expect organizations to consult with individuals and groups in the community who are not expected to be affected in any way by the service.

Bill C-2 also requires police checks for all staff who will work in the program for the previous 10-year period, including noting any drug offence convictions. Further, police check documentation is required from people whose country of origin is not Canada, if the staff member resided outside the country during the previous 10 years.

On a practical note, applicants can't really conduct police checks in advance of submitting an exemption, because they're not likely to be recruiting or retaining or hiring staff until they've secured the exemption and are ready to open. Furthermore, the need for police reports from countries outside Canada clearly discriminates against anyone who has emigrated from an area of the world that is war-torn or has an oppressive regime where the information is not likely to be available.

It also discriminates against workers who have past drug offence convictions but are now law-abiding and suitable for employment. Workers with that kind of first-hand knowledge of the issues facing drug users play a critical role in the delivery of harm reduction services, as they're often able to connect better with at-risk individuals because of their shared experience. Given that a key goal of these programs is to engage with at-risk individuals, to link them with health services, including treatment services, strategies such as employing peer workers who have past experience with drugs should not be impeded by the legislation.

Bill C-2 also allows the Minister of Health to request any other information deemed relevant. This is a very open-ended provision in the legislation, and depending on the inclination of the minister and the nature of the request there could be significant further barriers.

The bill allows the minister to give public notice of an exemption application, and the general public would have 90 days to comment, regardless of whether they have any relationship to the application or the proposed service at all. Both of these requirements could lead to cumbersome delays or impediments to implementing supervised injection services.

Legislation generally should provide clarity and certainty in public policy on whatever issue it concerns. An overarching concern with Bill C-2 is that there's really no indication as to whose opinions of support or opposition or what level and what type of information submitted would result in an application being accepted or denied. It has been the experience of other cities that once a supervised injection service is up and running, community concerns tend to either be addressed or not materialize at the level in which they might have been predicted.

This certainly has been the case in Vancouver, where both InSite and, perhaps more significantly because it's relevant to the model that looks more appropriate for Toronto, the Dr. Peter Centre have secured broad community support. The emphasis in Bill C-2 in demonstrating widespread support from many different stakeholders does not recognize the challenge of the poor level of understanding of the nature and benefits of supervised injection services in the general community.

Bill C-2 imposes an onerous and complex process on the approval of supervised injection services, which is unlike that for any other health service. There's no indication that provincial governments, which have constitutional responsibility for health services, were consulted in developing the legislation, nor is there any indication that health professionals or other organizations with expertise in supervised injection were involved.

● (1610)

Given this lack of process and the onerous requirements laid out in the legislation, we encourage the federal government to take the time to go back and develop a more appropriate, practical, and well-informed process for CDSA exemption; and further, that the application process be developed in consultation with the appropriate provincial public health, public safety, and community stakeholders.

Thank you very much, Mr. Chairman.

The Chair: Thank you very much, Dr. McKeown.

We will now go to our round of questioning, and we will start with Mr. Norlock, please, for seven minutes.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): Thank you very much, Mr. Chair.

Thank you to the witnesses for attending today.

Mr. Skof, you related to us some of your observations when you were in Vancouver—taking pictures, doing other observations. When you go to court as a police officer and present those to the court, would I be correct in calling that evidence?

Mr. Matthew Skof: If I had actually proceeded with criminal charges, then sure, absolutely.

Mr. Rick Norlock: That would be evidence.

Mr. Matthew Skof: Yes.

Mr. Rick Norlock: So when somebody says there's an evidence base, if you were putting together a case, that could be considered to be evidence toward an evidence-based case.

Mr. Matthew Skof: Absolutely.

Mr. Rick Norlock: Okay.

It was also mentioned by some people....

By the way, in your comments, when you related to your political "neutrality", shall we say, some people here disagreed, because I thought I heard a scoff somewhere.

Mr. Matthew Skof: No pun intended.

Mr. Rick Norlock: At any rate, getting back to the questions at hand, one thing that was mentioned by one of the witnesses was that some people who are being consulted may not be as qualified as others. As I remember the evidence of the minister, part of the people in the neighbourhood who should be consulted are parents and parental groups.

Do you believe that parents and business owners in neighbourhoods are qualified to judge whether or not they would like a supervised injection site in their neighbourhood?

Mr. Matthew Skof: I would say it's actually critical to have their opinion.

Mr. Rick Norlock: Would you say the police officers and people whose job it is to make sure that the public is kept safe are proper people to comment on a supervised injection site?

Mr. Matthew Skof: Absolutely, sir.

Mr. Rick Norlock: Would you agree that elected officials, such as city councillors or members of a provincial parliament or their government representatives, would be qualified people to consult with as to whether or not there should be a safe injection site in their neighbourhood?

Mr. Matthew Skof: Absolutely.

Mr. Rick Norlock: One other thing: when we were dealing with people who are required to have criminal record checks, since minor hockey assistant coaches and anyone involved in any kind of volunteer capacity in a community, especially in cities like Ottawa and Toronto, would come not only from parts of Canada, but other parts of the world, to your knowledge are most of these associations or most of these volunteers required to have criminal record checks?

Mr. Matthew Skof: They are, absolutely yes.

Mr. Rick Norlock: Do you think that's a good idea?

Mr. Matthew Skof: Since they are dealing with a potentially vulnerable sector of our community, then yes, I agree, they should have.

Mr. Rick Norlock: You'd also agree that drug addicts and people like that who would be in the vicinity of a supervised drug injection site would be vulnerable people?

Mr. Matthew Skof: I have expressed that before, and I absolutely do agree with that.

Mr. Rick Norlock: Thank you very much.

You related your length of service in Ottawa and the people who you supervise. Do you believe that every person who you supervise...?

I guess I should start from the beginning. As a representative of the Ottawa Police Association, would you have consulted with members of your organization, both civilian and uniformed, as to their opinions regarding supervised drug injection sites?

Mr. Matthew Skof: Yes, absolutely.

Mr. Rick Norlock: Would I be correct in saying there were probably some differences of opinion?

Mr. Matthew Skof: Yes, for sure—even from the members I supervised in the market as well.

Mr. Rick Norlock: Would I be correct in saying you would not be taking the stand you took here today if the majority did not share the opinion that you have shared with us here today?

Mr. Matthew Skof: That's correct.

● (1615)

Mr. Rick Norlock: So you represent a democratic organization, just as the members of this committee share a democratic institution called the Parliament of Canada.

Mr. Matthew Skof: I'm elected for a three-year term.

Mr. Rick Norlock: Thank you, sir.

Mr. McCormack, when you heard the evidence provided by your counterpart from the Ottawa police, do you as a police force regularly consult with civilians in and around the city and the neighbourhoods that you police, from the standpoint of the police organization itself—in other words, community consultations?

Mr. Michael McCormack: Yes, and in fact in every division we have in Toronto we have what we call our community police liaison committee formed of stakeholders within every community throughout the city of Toronto who we deal with on a regular basis. I was very much a big part of that in Regent Park. As I said, in Regent Park 90% of our crime, 90% of the stuff we dealt with, was either drug or alcohol related.

Mr. Rick Norlock: Given that there's no specific area that a supervised drug injection site is supposed to occur in, and that this legislation basically says the community must be consulted, in your stakeholder groups throughout the city, would I be correct in saying that those stakeholders represent a cross-section of the citizens of Toronto from, shall we say, less-educated to the very well-educated, from people who go to work with a lunch pail to people who go to work in the financial district?

Mr. Michael McCormack: Definitely. It would represent a cross-section of all society.

Mr. Rick Norlock: And some of them may even be medical professionals.

Mr. Michael McCormack: Exactly. Yes, they would be.

Mr. Rick Norlock: Are you aware of any consultations with those stakeholder groups surrounding the supervised drug injection site issues?

Mr. Michael McCormack: I participated in the discussion at St. Michael's Hospital from a broader level, more of a 10,000-foot level, talking about the supervised or safe injection experience in Vancouver and speaking to communities from across the city about our concerns from a policing perspective, but right now, at this point, I couldn't say for sure who has been consulted or who hasn't been consulted. I have to share Matt's concerns that it has an impact on everybody in the community.

Working in these communities, where there's high recidivism of drug use and drug abuse—it creates a big problem for the community. Although the doctors' comments are from the health perspective, when they are saying they know that the anecdotal evidence is there to support the health issues, when we are looking at the research documents that indicate 90% of the clients who visit an InSite are also injecting elsewhere, I'm trying to understand the benefit analysis of what we're trying to achieve here.

Not only that, but there was a 2010 detoxification success rate of InSite of around 1.6%, so there has to be a benefit to this overall. I'm just trying to wrap my head around where that is, from what the other witness was referring to.

The Chair: Thank you, Mr. McCormack.

Now we will go to Ms. Davies for seven minutes, please.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Mr. Chairman.

Thank you to our witnesses for being here today.

I just want to begin by saying that when the process for InSite in Vancouver began 11 years ago, there was a great fear from many of us—it was a controversial discussion, and a lot of consultation took place—that InSite would become this lightning rod, that it would be held up as a panacea for solving everything, and that everything would revolve around that. Of course, that's not the case. A safe injection site is really part of a solution. It's really part of an overall health strategy for dealing with injection drug users and drug overdoses and health and treatment and so on.

It's very interesting, because I saw the debate that happened in Vancouver and that eventually settled down. Now the facility is very well accepted. I see the same debate taking place here today. It is the fear that somehow InSite is responsible for every problem that we have with drug use. I think we should remember that the purpose of a supervised injection facility is primarily to prevent people from dying from drug overdoses and to help people connect to treatment options. There is a very well-used saying in the downtown eastside that a dead drug user can't get treatment. It's certainly a place to begin.

So it's very disappointing to me today to hear a representative from a police association pose the question “Which neighbourhood will be sacrificed?” It's very, very disappointing for me to hear that, because it makes me realize really just how much fear there is and how little understanding there is about what a supervised injection site means and what it actually does.

To just give one quick example, earlier in the summer this year there was a spate of bad drugs on the street in Vancouver. There were public warnings issued by the police department. There was a number of overdoses. In fact the police department issued statements and e-mails urging drug users to be extremely cautious and told them to go to InSite. It was a public health advisory from the police department who were seeing what was taking place on the street.

To Dr. McKeown from the Toronto Board of Health, thank you very much for the excellent brief that you sent in. One of the concerns that I saw in your written submission, and I think was echoed in a brief from the Canadian HIV/AIDS Legal Network and the Canadian Drug Policy Coalition, is that in effect Bill C-2, and I would like to focus on the bill, doesn't ever indicate what level of information, research, opposition or support would actually result in an application being accepted or denied. So in effect there is never a threshold that is given.

I would like to ask you whether or not there is any other service you provide where you might have to meet criteria where that would be the case, that you are actually going into a unknown situation where you have no idea what it is you actually have to meet. It seems to me with this bill that the criteria are so open-ended, with no threshold established, how would you ever know that you'd collected enough information or enough opinions?

● (1620)

Dr. David McKeown: It's also my reading of the bill that there is that uncertainty. As I said in my remarks, I think legislation should provide a clear process and certainty when it comes to legal approvals of processes.

Furthermore, this really stands out. I can't think of another health service that requires a vote from so many different interests. If you think about it from a patient point of view, you're going to see your doctor and why should the doctor's neighbours and the local officials have a say in what services you can get from your doctor?

Ms. Libby Davies: Yes, I do think that's a very pertinent point. In fact, this is a question that we put to the department officials just a couple of days ago. We asked what other health service in Canada has to meet this kind of criterion—or any criteria, for that matter. What was interesting was that their response was, well, they didn't really know, because of course health services are approved by provinces and not the federal government—which begs the question of why the minister, in the first place, is so inserting himself or herself into this debate, because the Supreme Court of Canada laid out the five broad areas, but this has now gone far beyond that.

I'm just curious to know, is there any other situation that you are aware of where you actually have to in effect get permission from a police department to provide a health service?

Dr. David McKeown: I cannot think of any, although, as I've said, I think there is a process that is appropriate to go through, not the process that's laid out in the legislation but just as a matter of a good neighbour approach, that the representatives of the local community and businesses and local police are important stakeholders.

In fact, in places where supervised injection services have been successfully implemented—of course, we're familiar with InSite, the one example in Canada, but there are many places around the world where they have been successfully implemented—there has been a good partnership with the police so that what the police do to maintain public order fits well with the health objectives of the service.

Ms. Libby Davies: I would agree that having their involvement and consulting with local jurisdictions, with police, is a good thing to do, but to actually make it a legal requirement of the bill makes it very difficult.

In terms of Toronto's situation, I know there has been work under way to look at a supervised consumption site. Can you tell us what work has been done and how you envisage that service being part of a health strategy in Toronto? How far ahead are you in that work, and where are you now given that you're facing this bill?

● (1625)

The Chair: Very briefly, please.

Dr. David McKeown: I think the most important piece of work done was the TOSCA study, which looked at health needs in Toronto for injection drug users and what the health benefits would be of the implementation of that service. It did demonstrate that with a model of supervised injection embedded with other primary health services that serve drug users, three sites, for example, would provide a significant benefit in the areas in which the sites were located. That was a feasibility study, if you like, that incorporated a large amount of information about drug use in the community, the impact of supervised injection, infectious disease rates, and overdose. It took us much closer to a model that I think is suitable for our patterns of drug use.

There really is no area in Toronto that is like the downtown eastside in Vancouver, and the InSite model is not appropriate, in my view, for the patterns of drug use in Toronto. However, embedding supervised injection as a service with other primary health services, in community health centres, in existing harm reduction services, I think is very appropriate. That's the direction in which the board of health has pointed us.

The Chair: Thank you very much, Dr. McKeown.

We will now go to Mr. Carmichael, please.

Mr. John Carmichael (Don Valley West, CPC): Thank you, Mr. Chair.

Thank you to our witnesses for joining us today.

As I've listened to your opening comments and some of the early questions, I must admit I am alarmed. I'm not overly surprised, but as my colleague opposite mentioned, there appears to be an introduction of fear into this. However, fear was part of the initial debate in the original InSite development, and that debate has settled down.

As I listened to both Mr. Skof and Mr. McCormack, I'm not sure what has settled down. It sounds like the reality, from your perspectives....

In my limited time, I'm going to address my questions to both Mr. Skof and Mr. McCormack.

It sounds to me that the issue is as significant as it was at the beginning of the InSite debate and discussion, with users injecting, as Mr. McCormack said, four to six times per day. Where do they get their drugs? How do they pay for them? They turn to crime.

That is a difficult part of this equation in terms of balancing where we as a committee are going to take this bill. During our first meeting on this bill, we heard testimony regarding how the government's national anti-drug strategy aims to prevent drug abuse through its prevention action plan.

Mr. Skof, could you comment on the importance of continuing this strategy and any work your police force may do collaboratively in this regard? Then I'll ask Mr. McCormack the same question.

Mr. Matthew Skof: Thank you.

I think it's important for everyone to know that I have never advocated based on just a position of abstinence. I've always sat as a representative of the police, as well the association, on every harm reduction committee available in Ottawa, including COMPAC, as Mike was mentioning, a community-based police advisory group. Our strategies aren't just enforcement. The police have to engage in multiple aspects of it, and it can't be in isolation. We obviously consult with the community just as much as we're advocating here for the health community to make sure that we're consulted as well when it comes to this bill.

With regard to having a strategy, it can't just be one focus. You have to have multiple strategies, and they work in conjunction with law enforcement, which is our primary function. We can't just do law enforcement without consultation with the community, and to resource and access all the other programs available as well. That's how you have the highest success rate.

Mr. John Carmichael: Thank you.

Mr. McCormack.

Mr. Michael McCormack: First of all, again, where we want to see the emphasis....

I want to clarify a couple of things. This not fearmongering. This is not fear. We're coming to it from a very practical and business case oriented discussion around this bill, around InSite. The doctor brought up a great point. I started off my discussion by saying that we're very concerned about the way InSite's been run in its current configuration. That is the Vancouver model. It's completely different, and it's not a cookie-cutter model that can be applied everywhere. That was the first statement.

The next thing is that we try to get treatment. We try to get people off drugs. We do it through drug treatment court. We try to streamline our people into the health system. We want to get people off and away from drugs.

What we're trying to do is emphasize the point that, when we're looking at these types of issues like supervised injection sites, there are a lot of balls in the air sort of thing with different resources. And when we're talking from a policing perspective, we're giving you a boots-on-the-ground perspective on the types of issues we need to deal with. We need to deal with the resources that are going to be required. We need to look at that. We are not looking at a treatment place where people go and they get the...as I said, I compared it to a methadone clinic. This is quite different.

We have to look at it with a really broad brush and a different lens to ensure that all the resources and all the stakeholders.... It is important that the police have a role in this, because we're the ones who inevitably have to deal with it in a positive or negative way.

● (1630)

Mr. John Carmichael: Thank you for that, Mr. McCormack.

I think Mr. McKeown did stress quite clearly that one model doesn't fit all, and I think that point is well taken this afternoon. I appreciate that comment.

I wonder, Mr. McCormack, what your sense is from colleagues across the country as to their thoughts on injection or consumption sites. Are they concerned, and have you heard any ramifications to policing and police resources from colleagues across the country as to the demands on their available resources?

Mr. Michael McCormack: Yes. I spoke to the people in Vancouver. That's where we were looking. InSite is the program everyone is looking at as the benchmark.

When we look at what happened in Vancouver, for instance in eastside, they had to put an additional 81 police officers into that community, into that area. There is a demand on police officers. There is a demand that they are there. Not only that, in talking to our Canadian Police Association president, Tom Stamatakis, who represents the Vancouver officers, there is the issue of police officers going in after midnight or the early hours of the morning and picking up syringes and stuff. It wasn't that the people were going to InSite and using inside the actual facility. A lot of the people go outside. They still inject on the street.

I have to agree with whoever brought up the comment—I agree with it on a different level—that InSite is not the cure-all, and it's not the major fix. That's a big concern for policing.

So it is a demand on police resources, and as I said, we're going to have to look at it. When we're talking about the federal strategy on policing and the demand on police resources and police budgets, this is something we really need to be involved with and we need to look at it from a business case scenario.

Mr. John Carmichael: Thank you, Mr. McCormack.

I have one minute left, so I'll address this to Mr. Skof.

In your mind, is there any other involvement police should have with the consultative process as we go down this path?

Mr. Matthew Skof: From what I've seen from the tabled legislation, I think associations and police departments are both going to be provided an opportunity. As I've expressed, I just want to make sure that when people are looking at it from a police perspective the whole spectrum of policing is considered.

As long as the associations, which I believe are already inclusive in the legislation...I think it's acceptable, what we have.

Mr. John Carmichael: Thank you very much.

The Chair: Thank you very much, Mr. Carmichael.

On behalf of the committee, I'd certainly like to thank Mr. Skof, Mr. McCormack, and Dr. McKeown. Thank you so much for testifying and answering our queries today with regard to Bill C-2 and its implications.

Thank you once again. We will now suspend for a change of witnesses.

● (1630)

(Pause)

● (1635)

The Chair: We are back in session. We have three more witnesses with us here today.

From the Canadian Association of Chiefs of Police, we have Chief Bryan Larkin, chief of police from the Waterloo Regional Police Service and of course a member of the drug advisory committee. Welcome, sir.

From Safer Ottawa, we have Chris Grinham, representative. Thank you, Chris.

From REAL Women of Canada, we have Gwendolyn Landolt, national vice-president. Thank you very much.

We will take your opening statements. As we are a little pressed for time, if you can shorten them a little bit the chair would certainly appreciate that, as would our witnesses and our questioners so that we can hopefully get as many rounds in as possible.

We will start off with you, Chief Larkin, for your opening statement, sir.

Chief Bryan Larkin (Chief of Police, Waterloo Regional Police Service, Member of the Drug Advisory Committee, Canadian Association of Chiefs of Police): Thank you, Mr. Chair.

[*Translation*]

Good afternoon, everyone. I appreciate this opportunity to appear before you today.

[*English*]

It's a pleasure to be here.

By way of introduction, my name is Bryan Larkin. I'm the serving chief of the Waterloo Regional Police Service. I've been a police officer for 24 years. I sit as a member of the Canadian Association of Chiefs of Police drug abuse committee. As well, as a community builder, I've had the opportunity to serve as the chair of the board of directors of the Stonehenge Therapeutic Community, which is a residential drug treatment centre that provides a full spectrum of addiction services, including supported housing, for Waterloo and Wellington counties. This opportunity, coupled with my policing experience, has provided me tremendous insight into the social challenges and the impact of substance abuse in our communities.

CACP president Clive Weighill of the Saskatoon Police Service and I would like to express our sincere appreciation to this committee for allowing us the opportunity to contribute to this important community safety and well-being discussion, which ensures local community input into decision-making on potential safe injection sites within our communities. On behalf of Chief Weighill, I'd just like to make a quick statement.

As law enforcement leaders, we always focus on ensuring the safety of our communities. Our officers are the most vulnerable among us. We are dedicated to the protection and security of the people of Canada. Likewise, our colleagues in the Canadian Armed Forces proudly serve Canadians by defending our values, interests, and sovereignty, both at home and abroad, and we'd like to join in mourning their loss.

We've all been shaken by the recent tragedies in Saint-Jean-sur-Richelieu and here in Ottawa. It was truly an unprecedented week for all first responders, but, as is typical with Canadians, such tragedies bring out the best in our people, our leadership, and our collective resiliency. Parliamentarians and staffers from all political parties are to be commended. Through a moment of terror to uniting in resolve, you each provided incredible leadership and have demonstrated that we will not be deterred, nor will we continue to stand still. We will move on as Canadians do.

We'd also like to recognize the House and Senate security staff, including one of our own CACP members, Sergeant-at-Arms Kevin Vickers. We'd like to make that statement before getting into this important discussion.

As many of you are aware, the CACP, through its 20 committees related to public safety and justice, contributes extensively to the House and Senate committees. For your own background, the CACP represents in excess of 90% of the policing community in Canada, which includes federal, first nations, provincial, regional, and municipal police leaders and services. Our mandate is clear: it is the safety and security of all Canadians through innovative police leadership.

In 2007 the CACP adopted a drug policy that was developed through our drug abuse committee. This policy sets out the position of our CACP members on this very important national issue that has a direct impact on Canadians and our communities on a day-to-day basis.

I'll give you a brief overview of the CACP drug policy. Our strategy is balanced. We believe in a balanced approach to the issue of substance abuse and abuse within Canada. It consists of prevention, education, enforcement, counselling, treatment, rehabilitation, and, where appropriate, alternative measures as well as judicial diversion of offenders in order to ensure appropriate support as well as to counter Canada's drug problems.

Our mission is very clear. Our goal is to transition to a healthy lifestyle in order to provide a second chance at life. We believe in a balanced continuum of practice distributed across each component. In addition, the policy components must be fundamentally lawful and ethical, must consider the interests of all, and must strive to achieve a balance between societal and individual interests. We believe that, to the greatest extent possible, initiatives must be and should be evidence-based.

The CACP supports the principles being established as a part of this bill, in particular the need to balance public safety with public health. In fact, that is the future of community well-being. The future of community safety is more collaboration and enhanced integration.

The CACP is not making a specific statement with regard to supervised consumption sites. Our position is that the decision to support or not support supervised consumption sites is a local community issue. It must be localized.

We are pleased to see a clear process that will provide criteria for community consultation prior to a decision being made by the Minister of Health. As all of you know, there are 90 safe consumption sites across the world, two of them in Canada, and we would concur that there's no one unique or cookie-cutter approach. The needs, the demands, and the impacts vary from community to community.

Bill C-2 establishes 27 criteria that an applicant must meet before a supervised consumption site is granted by the Minister of Health. One of these criteria requires that the applicant make contact with and obtain the input of local police services, as noted in proposed paragraph 56.1(3)(e):

> a letter from the head of the police force that is responsible for providing policing services to the municipality in which the site would be located that outlines his or her opinion on the proposed activities at the site, including any concerns with respect to public safety and security.

● (1640)

I want to thank and acknowledge and applaud the inclusion of such.

Again, the CACP maintains a neutral position on the actual merits of safe consumption sites. Our focus is on public safety and security. This is why we believe that while law enforcement is an integral part of the decision-making process, we are simply one stakeholder. We are one partner. It is the greater community response that is required. It is the collaboration that is the spirit that builds healthy and strong communities in Canada.

We want to reiterate that every community is unique, and that is reflected, we believe, in the spirit of the bill.

Thank you very much. *Merci* .

The Chair: Thank you very much, Chief Larkin.

We'll now go to Mr. Grinham, please.

Mr. Chris Grinham (Representative, Safer Ottawa): Thank you very much.

I would also like to thank you for inviting me and granting me the opportunity to speak today. As mentioned, my name is Chris Grinham and I am co-founder of a non-profit group named Safer Ottawa. My wife and I founded Safer Ottawa in 2007 to address the issues of discarded needles in our area.

From 2007 to 2010, we spent spring, summer, and fall cleaning up needles, crack pipes, and other discarded harm-reduction equipment from the streets, parks, churches, daycares, businesses, and residential properties in Lowertown, Sandy Hill, and the ByWard Market. By the end of 2010 we had collected over 6,000 needles and 27 gallons of harm-reduction equipment off our streets.

It was at this point that we realized that we needed to do more. To improve the situation and make our streets safer, we focused on three areas: involvement, education, and awareness.

For involvement, we worked with the City of Ottawa, Ottawa Police, the Ottawa Needle Hunters to create and implement a rapid needle-response program for cleaning up discards when found, as well as to redesign and improve the strategies used for proactive needle hunting.

For education, we worked with Ottawa Public Health, Ottawa shelters, and various outreach programs and agencies to ensure that clients were properly educated on safe disposal locations and techniques, and informed on the risks and hazards of discarding their equipment where others may come into contact with it.

For awareness, we worked with the residents, community associations, and Neighbourhood Watch programs to ensure that residents were aware of the dangers, aware of what to watch out for, and aware of what they should do should they find discarded needles or other equipment.

In short, in order to improve the situation of discarded needles in Ottawa, we had to involve, consult, educate, and work with the community, health organizations, municipal government, Ottawa police, and other partner agencies. This strategy has been very successful. The issue of discards in Ottawa is significantly better than when we began. This very effective form of collaboration and inclusion is the goal of Bill C-2.

It is no secret that our organization has been vocal in opposition to the implementation of supervised consumption or injection sites in Ottawa. This is not from any moralistic “drugs are bad” or “drugs are illegal” standpoint but, rather, our stance is the culmination of years of researching the subject, meeting with the experts, and sitting down with agencies that advocate on all sides of the issue. Why then do we support Bill C-2, which is, in essence, a bill that puts into place a framework to implement a site we oppose? It is because implementing such a site is ultimately not our decision, and because in our experience we have encountered several individuals in professional capacities that were providing information that was inaccurate and incorrect, something we believe to be extremely dangerous, especially when dealing with subjects as important as addiction and disease.

Our first encounter was back in 2009, when our then medical officer of health, Dr. David Salisbury, insisted that the needles we were collecting off the streets of Ottawa were not coming from the needle exchange program but rather from other sources. He suggested a syringe black market, Hull needle distribution sites, and the largest offender was, according to him, Ottawa pharmacies. He said legitimate purchases from pharmacies and other sources present a significant portion of needles on the street, something the pharmacists of Ottawa took great exception to. This, of course, was not correct.

More recently we've had to contend with comments from Dr. Mark Tyndall, head of infectious diseases at the Ottawa Hospital and vocal advocate for a supervised injection site in Ottawa. Earlier this year in an *Ottawa Sun* article, Dr. Tyndall made several comments in support of supervised injection sites that were incorrect and misleading, not the least of which was that HIV rates in Ottawa are probably the highest of any major city in Canada. The truth is that not only is the HIV rate in Ottawa not among the highest, it is in fact among the lowest. He then went on to say that injection sites prevent overdoses. However, this again is simply untrue. In fact, InSite's own data not only shows that overdoses happen regularly at their facility, but that they have increased two and half times since 2007 and 2008.

In 2007 and 2008 there were 197 overdoses at InSite, and in 2012 up to 497. We were told in an e-mail from Vancouver Coastal Health that during the 2013 calendar year, there were 616 overdoses at InSite. In fact, just this month there was a two-day period where 31 overdoses occurred. InSite has claimed that no overdose deaths have occurred on the premises. While that may be true, what they cannot tell you is whether or not a death has occurred from an overdose at InSite once a client has left on their own or in an ambulance. We have made several freedom of information requests to Vancouver Coastal Health and the B.C. ambulance services, and the answer is simply that this information is not tracked. So it is impossible to state definitively that no deaths have been caused by injection drug use at InSite.

● (1645)

You may have heard that in Ottawa there are 40 overdose deaths per year. This is true, but it is always quoted, or almost always quoted, out of context. Usually advocates will quote this number when discussing how injection sites prevent overdose deaths, suggesting that through association these 40 deaths could have been prevented with a supervised injection site in place. What they neglect to mention, or perhaps are simply not aware of, is that, of these 40 overdose deaths each year, three or four are attributed to injection drug use.

For these statistics and more we have supplied an Ottawa snapshot. Unfortunately, we were not aware it needed to be bilingual, so it will be translated and supplied to you later.

It is our belief that by ensuring proper and effective consultation, Bill C-2 will address the problem of incorrect, inaccurate information, which we believe to be imperative. The issues of addiction, with aspects ranging from homelessness to mental health, from crime to harm reduction, and disease transmission are extremely complex and, in many cases, so interwoven that in order to address one you must address several others in tandem. These issues simply cannot be looked at from one side. They cannot be dealt with from a purely medical response or a purely criminal response.

As we did with Safer Ottawa, in order to begin tackling these issues, you must first bring everyone together from all sides. Let all opinions be voiced and heard. Doing so helps to ensure that whatever strategy is developed, it will be the one that has taken the most into account with the most accurate information, thus being the best solution that has the most positive effect.

This is why we support Bill C-2 as it is designed.

Thank you.

The Chair: Thank you very much, Mr. Grinham.

We will now go to Ms. Landolt, please.

Ms. Gwendolyn Landolt (National Vice-President, REAL Women of Canada): Thank you very much, Mr. Chairman. I very much appreciate being invited to come here to speak.

REAL Women of Canada was an intervenor in the Supreme Court of Canada case on the drug injection site in Vancouver. Our organization was the only one of 15 intervenors that did not have a financial, personal, or professional interest in the outcome of that case. Our concern was entirely based on the addicted individual and the implications for his or her family and society.

It is essential that any discussion on Bill C-2 and drug injection sites to which Bill C-2 relates is based on factual evidence. Evidence indicates that InSite, which is the only drug injection site in North America, has given rise to very serious problems, which Bill C-2 is trying to address.

During the debate in the House of Commons on Bill C-2, reference has repeatedly been made in the debate that over 30 peer-reviewed studies indicated that InSite was purported to have curtailed crime and disease, and led to a 35% reduction in deaths caused by drug overdose.

The crucial point that was not disclosed during the debate in the House of Commons was that these 30 studies on lnSite were all carried out by the same individuals from the British Columbia Centre for Excellence in HIV/AIDS, located at UBC, who were one and the same activists who had lobbied for the establishment of the drug injection site in the first place. As a result, they had a personal interest, as well as a conflict of interest, in ensuring that InSite be deemed successful. That is, their research was carried out for the purpose only of supporting the political objective of continuing the operation of InSite.

According to information obtained under the Access to Information Act, between 2003 and 2011 these same researchers from the B. C. centre at UBC, who had previously lobbied for the injection site, have received over $18 million from the Canadian lnstitutes of Health Research to carry out their research on lnSite. All their studies were peer-reviewed only by supporters of the drug injection facility. Also, these researchers, contrary to standard scientific procedures, have refused to share their data with other researchers so that their studies can be replicated. Without exception, these advocates and researchers concluded that the injection site was reducing harm and death rates for addicts.

One such study on lnSite was published in a British medical journal in April of 2011. The study erroneously claimed that there was a 35% reduction in overdoses in the 500 metres surrounding lnSite, while in the rest of Vancouver, the rate decreased by only 9%. However, an international team consisting of three Australian medical doctors, a Canadian academic, and an American psychiatrist found serious and grave errors in the study, which entirely invalidated its findings. Also, a B.C. coroner's report has shown that overdoses actually increased in the area by 14%, or 11% if population were adjusted, between 2002, before the site opened, and 2005, when the study was carried out. Other evidence further contradicts the claims of these advocates and researchers from the centre at UBC that this InSite has been successful and that Bill C-2 is redundant.

One study that is never, ever reported is in fact the government's own expert advisory committee on drug injection sites. The federal government established an expert review committee to determine whether the claims of those supporting InSite were legitimate. The findings of the expert committee were released on March 31, 2008. The expert committee found as follows. Only 5% of the drug addicts in the area used the drug injection site, and of these, only 10% used the facility exclusively for their injections.

In other words, 90% of the drug addicts continued to inject their drugs on back streets, alleyways, etc., leaving their contaminated needles behind.

● (1650)

Two, there is no proof that the site has decreased the instance of AIDS and hepatitis in drug addicts.

Three, there is no indication that the crime rate has decreased.

Four, only 3% of InSite clients are referred to treatment.

According to Inspector John McKay, responsible for policing the drug injection site, 65 police officers from the Vancouver Police Department are required to patrol the five-block area surrounding InSite in order to control the crime. The police officers are prohibited from charging addicts with possession, and instead are obliged to escort them to the injection site.

The drug addict or casual observer obtains illicit drugs of questionable purity from a drug trafficker in the area, which he or she then brings into the site for drug injection purposes. The drug injection site, in fact, becomes a honeypot, a meeting point for drug traffickers.

According to the government's expert committee, it is estimated that each addict causes $350,000 worth of crime each year in order to purchase drugs from a trafficker to feed his or her addiction. It is not surprising, therefore, that in 2006 Vancouver had the second-highest rate of violent and property crime of any major city in the United States or Canada.

These are some of the reasons why more than two dozen major European cities have signed the 1994 European Cities Against Drugs declaration, opposing drug injection sites and free distribution of drugs. Officials from Berlin, Stockholm, London, Paris, Moscow, Oslo, etc., have embraced the principle that the answer to a drug problem does not lie in drug injection sites.

Another problem has arisen with the Vancouver drug injection site. In November 2013, an audit was undertaken of InSite, which is operated by the Portland Hotel Society. The audit revealed that the directors and executives used much of the approximately $21 million per year that it received from the federal and provincial governments for their own personal use. The examples include wining, dining, travelling, staying in luxury hotels, flower arrangements, hair salons, spas, and limousines, all being placed on the business card of the association administering InSite. The co-executives and the board have been dismissed, but it indicates that keeping the drug addicts on drugs only enhances those who are supposed to be helping them. It only helps mainly those who are operating InSite.

Well-off individuals such as doctors, lawyers, airline pilots, can afford to obtain treatment for their addiction. It is the addicts without money or support who are shuffled off to InSite, where they inject themselves continuously with street drugs, which only deepens their addiction. This results, eventually, in the addict having further degradation and often a terrifying death. The problem of drug abuse is not solved by enabling drug addicts to use more and more drugs, or assisting them in using a drug injection site.

The real question we must address is whether addicts should continue to be marginalized and manipulated—or should they be helped with treatment, so as to return them to healing, and to a normal life with their families? It is obvious that a compassionate society should not kill addicts by furthering their addiction, but rather should reach out to them by way of treatment.

Bill C-2, which seeks to provide a moderating influence on the problems that have arisen with the InSite drug injection site in Vancouver, has shown how necessary it is to curb the abuses that have taken place. Moreover, there are better and more competent ways of dealing with drug addiction than the proliferation of drug injection sites.

The criminal justice system today serves as a major engine that gets addicts into treatment and recovery. The drug courts make recovery possible for thousands of offenders each year. In fact, according to experts in the field in the United States, 50% of people in treatment are there because of referral by the criminal justice system.

● (1655)

International research indicates that treatment of drug addiction actually increases when drug enforcement occurs. That is, positive results flow from drug enforcement in that one of the aftermaths of police operations is that there is a marked increase in the proportion of drug users seeking treatment. This is because drug courts allow the conviction to be suspended if the offender agrees to take treatment and be monitored through regular urinalysis and counselling. Those who complete the drug-free program receive a suspended sentence or conditional discharge. Those who fail are required to return to the regular court system for sentencing. When offered a choice between drug conviction or treatment, the addict invariably chooses treatment.

● (1700)

The Chair: Mrs. Landolt, could you wrap up, please?

Ms. Gwendolyn Landolt: Yes, thanks very much. I just wanted to add—

The Chair: Go ahead.

Ms. Gwendolyn Landolt: —that Bill C-2 is essential to try to moderate the terrible tragedies that are taking place in Canada with regard to the drug injection site in Vancouver.

We have done a brief where all this and the police statement are referenced for you to read, and all the studies backing up what I said are in our brief, if you care to read it.

Thank you very much, Mr. Chairman.

The Chair: Thank you very much, Mrs. Landolt.

We will now go to the rounds of questioning. We will start off with seven minutes.

Ms. James, please.

Ms. Roxanne James (Scarborough Centre, CPC): Thank you, Mr. Chair.

Thank you to all of our witnesses for appearing.

When the Minister of Health appeared before committee in our last meeting, she stated that this bill would give greater clarity and transparency for her, the Minister of Health, via consultations with a wide range of stakeholders. One of those stakeholders pertains to a very direct and specific clause in this bill, and it has to do with seeking input from the chief of police in the city or municipality where the applicant seeks to establish an injection site.

I'll direct my first question to you, Chief Larkin. Would you be in favour of that specific clause with that particular stakeholder?

Chief Bryan Larkin: Yes, absolutely. The CACP and in fact all chiefs across Canada applaud that inclusion, because it really integrates the whole process to safe communities and the well-being of communities. It takes the issue of social determinants of health, which policing is looking at significantly as it relates to crime, and actually turns it into a community discussion. Hence, we feel that's absolutely necessary and we applaud that inclusion. It's a step in the right direction.

Ms. Roxanne James: Are you concerned at all about a potential increase in crime related to an injection site in a particular area? The reason I ask that question is that in the first hour we had two witnesses, and one of them asked which neighbourhood would be sacrificed. He went on to talk about the fact that illicit and illegal drugs will be transported in and around that area. In fact, he talked about a perimeter, or even a border, that goes around an injection site that will allow someone to freely walk in that area without any ramifications from law enforcement. So there were some concerns there. He also talked about increase in other crimes.

The other witness we had in the previous hour said very specifically that in many cases drug addicts support their addiction by committing crimes. He went on to talk about an increase in property thefts, and so on, in particular areas. Of course, as someone in law enforcement, you know that drug dealers will go where markets are.

So having said that, and kind of reiterated what the first witnesses said, are you in agreement with those types of issues pertaining to an injection site?

Chief Bryan Larkin: Yes, to a certain extent. I think you have to take it in context. I think there are some myths, and I think there are misconceptions. That is the importance of the localized discussion; the important piece of this is when you drill this down. In Canada, we're looking at two public policy experiments and they're both in Vancouver, which from a chief's perspective is unique. There are many communities that have drug issues. In fact the tentacles of drug and substance abuse reach across Canada—east to west to north to south.

That being said, what we experience on the west coast in Vancouver is something that no other communities in our country are experiencing. I think you have to look at it and localize it. You have to look at what the current crime rate is in the area. For example, if we met the 27 criterion and we were going to open up a safe consumption site and create this process, what is the current crime rate? You have to look at the benchmark. What is the potential to create those types of pieces?

There's lots of discussion about what our friends in Vancouver have been doing, but I can tell you that we have a member from the organized crime section who sits on the drug abuse committee. It's a misconception that Vancouver police officers do not enforce the law within the 500-metre radius, which is often recognized. I think one of the pieces around that, though, is that the Vancouver Police Department will tell you that within the 500-metre radius, since 2003 drug overdose and calls for service related to drug overdoses have been reduced by 35%.

That being said, calls for service and demand on police is up. Some of that is around deployment strategies and the Vancouver Police Department deploying more resources there, which will naturally generate more calls for service; it's wherever we direct police officers. The Canadian chiefs have a simple message here: we can't arrest our way out of substance abuse issues. We cannot arrest our way out of a public health issue. In fact, it is silly and not a financially innovative concept anymore. We need an integrated approach. We're significant supporters of the national anti-drug strategy, and hence our message is that it has to be a balanced approach. This bill clearly starts that discussion.

● (1705)

Ms. Roxanne James: Thank you.

Are you in support of this legislation? I'm not sure if I heard you say yes or no.

Chief Bryan Larkin: Yes. The CACP is in support of the legislation.

Ms. Roxanne James: Okay.

We heard from a witness in the first hour—I put it on my BlackBerry because I wanted to make sure I said it correctly—that he was concerned that the measures in this bill were excessive compared with any other public health services that are offered.

Having heard from the first two witnesses, and the concerns with crime and other issues that might be in the area, can you think offhand of any other public health service that might...? I'm trying to word this the correct way, because we're not here to talk about the merits of InSite or injection sites. That's not the purpose of the bill. It's about community consultation and making sure that local law enforcement has a say.

Can you think of any other publicly administered health service that may cause the same degree of concern that we heard from the two representatives in the first hour?

Chief Bryan Larkin: I listened to the witness testimony and certainly understand some of the concerns, but I can't think of anything off the top of my head. I think it's a discussion. One of the lessons we learned, if I can use the harm reduction strategy, was around methadone clinics. I think police chiefs would argue that there was not enough consultation with law enforcement around the placement and the location of methadone clinics, and hence created a significant impact on policing because it creates community concerns. There's very little consultation when you look at the implementation of a methadone clinic.

Ms. Roxanne James: Thank you.

Sorry, I don't mean to cut you off. I have one minute left.

Chief Bryan Larkin: Sure.

Ms. Roxanne James: I just want to say to Mr. Grinham, thank you very much for the service that you provide. I just wanted to put that on the record.

I do have a question for Ms. Landolt. I looked at your biography. It indicates that you were a crown prosecutor, you had a legal career and a private practice, you specialized in certain issues, and you also have written extensively on Canadian constitutional issues.

Do you have any concerns with this bill with regard to—

Ms. Gwendolyn Landolt: Sorry, I didn't hear the question.

Ms. Roxanne James: Do you have any concerns with regard to this legislation with the charter, based on your legal background?

Ms. Gwendolyn Landolt: The Supreme Court of Canada said there has to be a balance between public safety and public health. It seems to me that Bill C-2 is desperately trying to create that balance. The court ordered a proliferation of drug injection sites to go forward, providing there was that balance. I find that Bill C-2, within the margins that the court gave the government to bring in legislation, has attempted to do that very important job of balancing the two aspects of drug addiction.

Ms. Roxanne James: Thank you very much.

I suspect that my time is up.

The Chair: That's it. Thank you very much.

We will now go to Ms. Davies. I do believe you're splitting your time.

Ms. Libby Davies: I think Marjolaine will go first, and then me.

The Chair: Fine.

Carry on, Ms. Boutin-Sweet.

[*Translation*]

Ms. Marjolaine Boutin-Sweet (Hochelaga, NDP): Thank you, Mr. Chair.

Over the course of this study, we have received a half dozen briefs, and I have read them all. To my surprise, the choice of witnesses is not at all representative of the views expressed in the briefs. It's quite the opposite.

For example, the Canadian Association of Nurses in HIV/AIDS Care recommends that the bill be withdrawn and a new bill be drafted. Moreover, the Canadian Bar Association, through the National Criminal Justice Section, which represents 37,000 lawyers across Canada, states the following in its brief. I will read you one paragraph of their brief, since the association has no witnesses here in committee to speak on its behalf. The following is stated in the brief:

> However, other parts of the Preamble reflect a continued emphasis on prohibiting illicit drugs. This approach ignores overwhelming historical and current evidence that prohibition drives the drug supply underground and increases violence and debts associated with drug activity and overdoses. Not only dangerous, this approach has proven expensive and ineffective, even after decades and endless public funds to allow it to succeed.

The Canadian Bar Association and many other stakeholders are rather advocating in favour of harm reduction when it comes to illicit drugs and addiction. I think that the establishment of supervised injection sites leads to harm reduction. We should rather participate in the establishment of those sites, as the association suggests in its brief.

Mr. Grinham, you appear to be saying otherwise. What is your response to the association's statement?

● (1710)

[*English*]

Mr. Chris Grinham: It has been our position, as I've said, from the research that we've looked at—and we've looked specifically at Ottawa—that the numbers that are often quoted are either quoted out of context or quoted without the full information. As I've said before, it's important that the entire story be told and that everybody be heard from all sides.

[*Translation*]

Ms. Marjolaine Boutin-Sweet: Did you know that studies conducted in other countries point to the exact same conclusions as the Canadian studies?

[*English*]

Mr. Chris Grinham: Yes, I have heard that there have been studies in other cities. I've also heard that there have been lots of studies to the contrary, and studies that show.... We have the Swedish model that has shown that treatment and enforcement has worked extremely well. We have San Patrignano in Italy—

[*Translation*]

Ms. Marjolaine Boutin-Sweet: Sorry to interrupt you.

Am I to understand that you have not consulted the studies that lay out the benefits of supervised injection sites?

[*English*]

Mr. Chris Grinham: I have read several of the studies. I haven't read them all, of course.

[*Translation*]

Ms. Marjolaine Boutin-Sweet: Okay. Thank you.

Mr. Larkin, the Supreme Court declared that, if a supervised injection site meets the 26 criteria provided for in the current legislation, fulfills the criteria for decreasing the risk of death and has no negative impact on public safety, the minister should generally, and I quote, “grant an exemption”.

Do you agree with that?

[*English*]

Chief Bryan Larkin: Well, yes, the Canadian chiefs are supportive of Bill C-2 if it meets the 27—

[*Translation*]

Ms. Marjolaine Boutin-Sweet: I am not asking you whether you agree with the bill, but whether you agree with the Supreme Court's statement.

[*English*]

Chief Bryan Larkin: Yes, this is part of the process here. If the Minister of Health...and it meets the localized piece, police chiefs are saying that there is value to trying this and experimenting with it. I think that's the thrust.

[*Translation*]

Ms. Marjolaine Boutin-Sweet: Okay.

I want to complete my question. Do you think the terms that set out the exceptional circumstances included in the bill are in line with the judge's proposal?

[*English*]

Chief Bryan Larkin: That's a complex question. From a chief's perspective, yes and no. I guess there's an easy way out there, with some neutrality, but there are aspects that, yes, we believe it does meet, and other aspects that we still have concerns about.

I think our position is very clear. This is a public health issue. We're really focused on safety and security, but our message is always about transitioning, not the perpetual use of drugs. There has to be a transition.

[*Translation*]

Ms. Marjolaine Boutin-Sweet: Thank you.

I would like to yield the reminder of my time to my colleague.

[*English*]

Ms. Libby Davies: Thank you.

I have just a minute and half, so very quickly, I think unfortunately a lot of misinformation has been put forward by a couple of the witnesses today.

Just to come back to the expert advisory committee from 2006, they do say clearly that there's no evidence of increases in drug-related loitering, drug dealing, or petty crime in areas surrounding InSite. They also said there was no evidence that supervised injection sites influenced rates of drug use in the community, or increased relapse rates among injection drug users. They also pointed out the cost-benefit studies that show that for every dollar spent, there is a saving between $0.97 and $2.90. That's from a very conservative review that was done by the minister.

So unfortunately, much of your information is very false, and I think, really, attacking peer-reviewed studies—

● (1715)

Ms. Gwendolyn Landolt: I object to that. It was what the report said. I don't say it's incorrect.

Ms. Libby Davies: I'm not asking you a question.

I would like to ask Chief Larkin—

The Chair: Excuse me, Ms. Davies. You can agree or you can disagree, but we don't need any accusation and we don't need any more comment; just please proceed.

Ms. Libby Davies: Chief Larkin, this bill sets out very onerous legal requirements for an application to come in. A question was posed on whether or not there any other services that would cause disruption or concerns in the community. I could think, for example, of homeless shelters that sometimes are very controversial, or mental health drop-ins. Do you think they should be subject to legal requirements by the federal government? Obviously there are often municipal consultations, but would any of those kinds of services, in your opinion, require a federal legal requirement to be approved, which is what we are requiring here?

Chief Bryan Larkin: No. Those are localized issues, and in terms of the responsibility for those, from the chief's perspective, really they are funded either provincially or municipally, and hence the regulations and the pieces that work within that should be within that framework.

This is a significant piece. It's an amendment to a federal piece of legislation where affordable housing and mental health housing are not necessarily supported.

Ms. Libby Davies: Yes, but the minister's only—

The Chair: No, excuse me, your time is up. I'm sorry.

We will now go to Ms. Ablonczy, please.

Hon. Diane Ablonczy (Calgary—Nose Hill, CPC): Well, this has turned out to be a very exciting session.

I was just blown away, Ms. Landolt, when you said that all of these studies that are positive about the health benefits of InSite are done by the same individual. Is that really true? I'm sorry to sound doubtful, but....

Ms. Gwendolyn Landolt: Yes, that's exactly what under the Access to Information Act—

The Chair: One moment, please. There's a point of order.

Mr. Randall Garrison (Esquimalt—Juan de Fuca, NDP): On a point of order, Mr. Chair, although members enjoy privilege for things they say here, I think we should give a warning to the witness, if she is alleging professional misconduct, that she does not enjoy that privilege in this committee and could be subject to a suit.

The Chair: Fine. I'm sure the....

Your question is in order. Carry on.

Hon. Diane Ablonczy: Okay.

Ms. Gwendolyn Landolt: We applied under the Access to Information Act, and we found that $18 million was given to the same three individuals who lobbied for InSite in 2001-02. They were given this money to carry out studies, and without exception, every study showed that it was absolutely the most successful endeavour ever undertaken. They found nothing wrong with it. Other professionals, psychologists and researchers, have criticized their studies. The Australian team, and two out of Vancouver—Simon Fraser—also found these studies were very flawed and unacceptable.

Under section 56 of the Controlled Drugs and Substances Act, an exception can be made for the use of drugs for research or medical reasons. The loophole to set up InSite was for research purposes, so for these activists who wanted InSite, it behooved them to be sure that everything was very successful...so the loophole would show, the research would show, that this was a wonderful idea and a great concept.

That's where every single one of the studies quoted was by the same three who had lobbied for InSite from the very beginning.

Hon. Diane Ablonczy: Well, I look forward to looking at your brief on that, because I didn't know that. I hope no one else did either, because a lot of people hang a lot of their arguments on these studies.

Mr. Grinham, it seems to me that the real issue here is one of the minister needing enough information to make an informed decision about whether a facility like that should go ahead. In a sense, we're not arguing in this committee about the benefits versus the not-benefits, although obviously you're going to get into that. But it seems to me that the real issue is that none of us, and probably not many of our witnesses, has a reasonable apprehension that such a facility is going to be next door to the house where we and our families live. It seems to me that this puts a certain ivory tower distance between some of us as decision-makers—and, if I can say so, police officers—and the people who actually would be personally impacted by such a facility. But a lot of these individuals are not highly educated or not connected, I guess, to the levers of power, you might say. I think Ms. Davies represents such an area. That's why I think the minister feels there needs to be the kind of consultation that she's putting forward in this bill.

You seem to be the only witness so far that we've heard who has an on-the-ground insight into the sort of people who are reasonably likely to be impacted by a facility like this. I'm just curious as to why you think the minister would need to hear from such individuals, and how we can make sure that their input is in fact garnered.

● (1720)

Mr. Chris Grinham: Thank you.

I think it's very important to have a broad range of consultation. I don't think consultation should be limited to people with Ph.D.s. I think there are people from all walks of life who have valuable input and valuable information who can help us sculpt and build a proper response to a drug problem in a neighbourhood.

My wife and I live very close to the area that would be impacted. In fact, and people may not be aware, Dr. Tyndall has actually already built a supervised injection site in the city of Ottawa. It is on Murray Street. It is fully functional. It is not in use officially, but it is there and it is two blocks from my home.

That being said, this isn't a NIMBY thing where I don't want a supervised injection site in my backyard. I have all sorts of places that dispense needles. I have five or six homeless shelters within walking distance of my house. We live at the epicentre of the problem here in Ottawa.

The people who live in Lower Town, Sandy Hill, and the ByWard Market are a little bit more seasoned and understanding as to the complexity of these problems. I think that those people can bring a lot of valuable insight not only to the effects that this would have on the community. A lot of us happen to know and get familiar with the people who are on the streets and the effects that these issues would have with them.

It is an unfortunate comment that we have heard many times over the last eight years that the wealthy get treatment and the poor get harm reduction. We have always seen that to be true. The reality is that what we're really lacking in this city is treatment, and everybody you'll speak to from any side of this point in Ottawa....

You can open up a supervised injection site if you wish, but it is not going to do anything in any way to deal with the root cause of the problem, which is addiction. The people who live here know that. It is those people that the minister needs to hear from, not just people who have a vested interest, not just people who have written the studies, but everybody from all walks of live who are able to say, “This is what I know, and this is the one piece of information that I can provide to you to help you make that decision.”

The Chair: You have 30 seconds left.

Hon. Diane Ablonczy: Thank you.

I guess my question is this: do any of you witnesses feel that there are just too many hoops, I guess, in this legislation? That's been the objection we've heard, that there's too much consultation, too much input, too much research needed.

You all seem to be in favour of this, but does anybody feel that this is too much?

The Chair: Thank you very much, but we're out of time. We'll have others questioning now.

We will now go to Ms. Fry.

You have seven minutes.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Mr. Chair.

My question is a specific one. It's a yes-or-no answer, and it's for Ms. Landolt.

I would like to ask Ms. Landolt if she is accusing the University of British Columbia, the BC Centre for Excellence in HIV/AIDS, and the researchers of professional misconduct.

Yes or no, please, Ms. Landolt.

Ms. Gwendolyn Landolt: We have raised this issue with the government—

Hon. Hedy Fry: Yes or no, Ms. Landolt.

The Chair: Excuse me, Mrs. Fry, a response from the witness cannot be directed. It can be asked for and requested. At that point the witness has an opportunity to respond as they so choose. You have every right to ask whatever question you wish. The witness can respond accordingly.

Hon. Hedy Fry: But I can interrupt the witness if she goes on.

The Chair: Yes, you can.

Hon. Hedy Fry: Thank you.

Ms. Gwendolyn Landolt: We have raised this with the government, with the Minister of Health, and we have also raised it with the other government authorities because of the ethical considerations involved, and also because of the fact that so much concern is raised by these flawed studies that it has to be investigated.

We are undergoing, and hopefully there will be a response—

● (1725)

Hon. Hedy Fry: Thank you, Ms. Landolt.

Chief Larkin, you mentioned that you support the bill. I don't think anyone around this table is deciding there is no need for a legislative framework. It's obviously clear from the Supreme Court that there is need for a legislative framework. But I want to also congratulate you for pointing out the need for this to be specific with regard to the region, the city, the town, etc., which is really important.

I belong to the group of people who are saying that this bill just goes a little too far and is a little too intrusive on cities, municipalities, etc., and what they did.

I would like to tell you I was a minister responsible for the downtown eastside and the Vancouver agreement when this was brought in. One of the key issues we looked at when we were looking at this research project was crime rates, so we had to bring in the police on it; the need for a supervised injection site based on the number of addicts and the deaths that had occurred; the regulatory structures in place to support the facility, which came from the province, which came from the municipalities, which came from the Vancouver Police Department; and of course, the other resources such as money, etc., available. In doing so, we also had two years of extensive public consultations with the people who live in the area, with the people who didn't even live in the area, with Vancouverites in general.

So all of the requirements that the Supreme Court put down, which are those five broad requirements, were in place when we brought in the supervised injection site.

At the end of the day, there was clear evidence from the Vancouver police, who still support it, that crime rates went down, that public disorder went down, etc. I won't go over that. We agree, the minister needs to hear from the provincial minister of health, from the municipalities, etc. But the point is that if you're going to get all these answers as a yes from the various people who the Supreme Court said you need to ask and that this bill says you need to ask, do you not think it's really very intrusive of the Minister of Health, who's the federal Minister of Health, to then question the people who are hired? It is obvious that this is part of the provincial jurisdiction, the police jurisdiction to get criminal checks, etc. That's kind of intrusive in provincial and municipal jurisdictions.

The big questions should be asked and the answers should be given, but that really in-depth intrusion is what many of us oppose and are concerned about.

Chief Bryan Larkin: I'll speak specifically on the policing perspective around whether or not a chief would feel it would be intrusive, because that's the area I represent. The reality is that oversight and accountability are all parts of what we deal with.

In short, no, I don't think there's an element of intrusion. In regard to that layer of accountability, that layer of responsibility amongst chiefs of police in reporting federally, because they do have control, the CDSA, I think there's value to that and it's something that we would support and partake in.

Hon. Hedy Fry: I agree with you. Obviously then the chief of police in the area would write a letter stating, we have done due diligence and here is what we think. That is what I'm hoping that this bill will eventually do, say that the chief of police has said we've done due diligence. The Minister of Health, the chief public health officer, the municipality—we have done due diligence in conformity with the five pieces that the Supreme Court asked for: here is what we present, including public consultation, and here is what we've found.

This is as opposed to the very in-depth question of the Minister of Health must need to know who is being hired, what's being hired. When InSite was brought in, the regulatory mechanisms came out of the province, the city, the chief of police. They all saw to it that all of those were met. So I think my concern is that this is a little too intrusive.

How much time do I have, Mr. Chair?

The Chair: You have a minute and half.

Hon. Hedy Fry: Thank you.

Mr. Grinham, this is just a short question. You make sense, obviously, because the consultation was done with many groups within the downtown eastside when this began. Many groups that actually opposed InSite now support it wholeheartedly, including business communities. The Chinatown business community, the Chinatown residents community, and many of the residents who lived in the area originally opposed it, but they were willing to see what the research project showed. They themselves found, as did the police, that in fact their streets were more livable. There was a decrease in traffic. People didn't come from elsewhere to shoot up in the downtown eastside.

I agree with you about public consultation, but I also wanted to point out that in the one place where it was done, these groups, that originally opposed it for the first year or two, after the third year suddenly became in full support of it.

I think we are all in agreement with what you're looking for with regard to public safety, but the balancing is that in fact InSite did increase the number of beds for treatment by its existence. So your argument about treatment is well taken, and this was shown to work in InSite.

● (1730)

Mr. Chris Grinham: Is there a question?

Hon. Hedy Fry: The question is, were you aware of that?

Mr. Chris Grinham: I'm aware of all sorts of different information that's come out of InSite from treatment, from drug use, and from overdose and whatnot.

Hon. Hedy Fry: Communities as well.

Mr. Chris Grinham: Community support, community non-support; I think you can find people who support InSite. I think you can find people who don't support InSite. Our concern has always been to make sure that those people are consulted before a site is developed, not after.

I know it is sometimes considered easier to ask for forgiveness than for permission. What we're asking for—

Hon. Hedy Fry: Are you aware that this happened in Vancouver?

The Chair: Your time is up, Ms. Fry.

Mr. Chris Grinham: —is to make sure that permission is asked for and not forgiveness later.

The Chair: Thank you very much, Mr. Grinham.

Our time has now expired for the day. The bells are going as well.

On behalf of the committee, I thank our witnesses very kindly.

Ms. Landolt, Chief Larkin, Mr. Grinham, thank you so much for appearing before the committee. Your comments are sincerely appreciated.

We are adjourned.

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