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Chair

Mr. Bill Casey

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● (0845)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call the meeting to order. Welcome to meeting 126 of the Standing Committee on Health. We're starting a new study today, and I'm sure we're all going to learn a lot, as we always do with these committees.

We welcome our witnesses and appreciate their time and expertise in this area, and we look forward to their remarks. Today's meeting is in two sections. We're going to hear from one panel first, and then we're going to suspend for a few minutes and have a second panel.

For the first panel we have Health Canada, represented by Suzy McDonald, assistant deputy minister, opioid response team—imagine—and Michelle Boudreau, director general, controlled substances directorate. From Public Safety and Emergency Preparedness we have Trevor Bhupsingh back. He is director general, law enforcement and border strategies. We also have Kimberly Lavoie, director, drug policy. From the Royal Canadian Mounted Police we have Chief Superintendent Paul Beauchesne, serious and organized crime and border integrity.

My understanding is that, among you all, you're going to have a 15-minute opening statement. I guess you're going to have to fight it out among yourselves as to who's going to go first.

Who's first? Suzy. That's great. You have 15 minutes.

Ms. Suzy McDonald (Assistant Deputy Minister, Opioid Response Team, Department of Health): In the collaborative spirit of the way we do all our work around controlled substances in Canada, I'll be giving remarks on behalf of my colleagues, but we're all happy to answer questions, obviously.

Thank you very much, Mr. Chair.

My name is Suzy McDonald. I am the assistant deputy minister for the opioid response team at Health Canada, but I'm also responsible for the regulation of controlled substances in Canada and the federal government's approach to drug and alcohol use under the Canadian drugs and substances strategy.

Problematic substance use is an ongoing health and safety concern in Canada. While the opioid crisis and cannabis legalization and regulation are often top of mind for Canadians, Health Canada is very much aware that a growing number of people are also struggling with methamphetamine use. In particular, we know that provinces such as Alberta, Manitoba and Saskatchewan are seeing increased reports of methamphetamine use, hospitalizations and interactions with law enforcement. Some first nations communities are also reporting significant health and safety issues related to meth use.

[*Translation*]

Methamphetamine is generally an inexpensive drug that can produce a short-term or a long-term effect, depending on how it is taken. It can be smoked, snorted, swallowed or injected. It can increase attention and energy and create an overall feeling of well-being or euphoria. However, its use can also lead to addiction and harmful effects, such as paranoia, aggressiveness and even psychosis. A methamphetamine overdose can cause convulsions, cardiac arrest, stroke and, in some cases, death.

[*English*]

We know that people use stimulants for a variety of reasons. These can include for personal enjoyment, to relax, to socialize, or to cope with pain, stress or other related trauma. Compared to other substances used in Canada, such as alcohol, cannabis and opioids, rates of meth use are relatively low. However, we are seeing reports that other drugs are sometimes mixed in with meth, including highly potent opioids like fentanyl, which further increases the potential for harm and increases the risk of fatal overdose. In fact, available data for some jurisdictions suggest that meth may be playing a growing role in overdose deaths where polysubstance or dual-substance use is involved.

The Government of Canada is concerned about all forms of problematic substance use, and we are taking action through the Canadian drugs and substances strategy, through our four pillars of prevention, treatment, harm reduction and enforcement.

In terms of prevention, we know that we need to take a broad approach, which includes both informing Canadians about the risks of meth use and addressing the underlying social determinants related to its use. This is a role that all levels of government undertake in Canada, along with a large number of non-governmental organizations.

● (0850)

[*Translation*]

We also know that public awareness campaigns will not suffice, as social determinants of health often underlie problematic substance use. For example, we know that homeless individuals or lower-income individuals are at greater risk of harm related to problematic substance use.

We also know that substances can be used as a coping mechanism by those who have experienced trauma, violence, social marginalization and loss of cultural identity. For aboriginal people, that may include the loss of language and culture, racism, discrimination and the intergenerational trauma of residential schools.

[*English*]

Through the Canadian drugs and substances strategy, the federal government is committed to working collaboratively to better address the social determinants of problematic substance use and develop upstream efforts to help prevent problematic substance use before it begins.

Moving on to the issue of treatment, the evidence clearly shows us that problematic substance use is a health condition that can be managed and successfully treated for those who are ready. Unfortunately, methamphetamine use is a very difficult condition to treat. To date, the most effective treatment options for methamphetamine use include psychosocial counselling and behavioural management approaches. Unlike opioid use disorder, where medication-assisted treatment is available, there are currently no drug-based therapies to treat problematic meth use. This is an area where more research would be useful.

I know from my experience in managing the federal response to the opioid crisis that there are simply not enough drug treatment services in Canada to meet the demand. To help address this gap, the federal government committed $150 million for an emergency treatment fund to help improve the availability of treatment options in Canada, including for those struggling with methamphetamine use. To date, five provinces have signed bilateral agreements with the federal government under the emergency treatment fund, including Saskatchewan, which is using some of the funds to enhance treatment services for people seeking help for substance use disorders, including crystal meth use.

ln addition, the federal government has made a number of investments in federal budgets to support expanded mental health and drug treatment services in first nation communities, including $200 million over five years, and $40 million ongoing, provided in budget 2018.

[*Translation*]

Harm reduction is a key factor of the federal approach to the opioid crisis. Unfortunately, there is no similar range of options for harm reduction related to methamphetamine use. More specifically, there are no drugs that can reverse the effects of a methamphetamine overdose, as in the case for an opioid overdose, which can be treated with naloxone.

The most common evidence-based approach in methamphetamine harm reduction focuses on reducing the risk of blood-borne infections, such as HIV and hepatitis C, which can be contracted by sharing drug-using equipment, such as syringes and pipes.

The Canada Public Health Agency is investing $30 million over five years through the harm reduction fund to reduce those risks by supporting projects in Canada that will help reduce the transmission of HIV/AIDS and hepatitis C among people who share equipment for using drugs by injection and inhalation.

[*English*]

Another key component to harm reduction is addressing stigma toward people who use drugs. In particular, the visible physical effects of methamphetamine use, coupled with sometimes very erratic and unpredictable behaviour, create a highly stigmatized image. This perception creates barriers when accessing treatment and other harm reduction and social support services, and it is something that we are committed to working to reduce to help ensure that people get the support they need.

For example, the Good Samaritan Drug Overdose Act encourages people to seek help in the event of an overdose by providing some legal protection for those who experience or witness an overdose. We hope this act will reduce the fear of police attending overdose events and encourage people to help save a life. As part of budget 2018, the federal government invested $18 million over five years for actions to address stigma toward people who use drugs, including a national anti-stigma campaign, which has just been launched, and training for law enforcement officers. Although much of what Health Canada is doing on stigma is done in the context of the opioid crisis, we are confident that it will also have a positive impact in other areas.

Drug regulation and enforcement is the fourth pillar of the Canadian drugs and substances strategy and remains a critical part of the federal government's approach. It encompasses a wide range of activities, including enforcement, regulation of activities with controlled substances and precursors, border control, financial surveillance and tax audit measures to reduce the profitability of drug trafficking.

Methamphetamine is controlled under the federal government's Controlled Drugs and Substances Act, as are many of the chemicals used in its production. Given that many of these precursors are legal substances, it can be difficult to control their availability and diversion. The RCMP is working in close partnership with chemical industry partners through the national chemical precursor diversion program to identify suspected criminals and organized crime groups that attempt to acquire precursor chemicals that can be used to produce methamphetamine. Health Canada continues to work with its partners, including the Canada Border Services Agency and the Royal Canadian Mounted Police, to examine options around scheduling and control of novel precursor materials.

While some methamphetamine is produced in Canada, a proportion of methamphetamine consumed in Canada is likely trafficked into Canada from other countries such as Mexico. The Canada Border Services Agency continues to work closely with its international and domestic law enforcement partners to disrupt the methamphetamine supply at the border.

Our partners at Correctional Services Canada are also taking a number of actions to reduce the demand for illegal substances, including methamphetamine, among the federal incarcerated population. These include preventing contraband from entering federal prisons, increasing awareness of the harms from problematic substance use and supporting innovative and effective treatment and harm reduction approaches, such as the recent implementation of a prison needle-exchange program.

I'd like to touch on one final area of the Canadian drugs and substances strategy, and that is the serious role of evidence. Evidence is the foundation of everything we do.

Supervised sites are another part of the government's harm reduction approach. Although the use of meth in supervised consumption sites varies widely across the country, preliminary data shows that up to 40% of visits to some sites in western Canada are by people who come to use methamphetamine.

● (0855)

[*Translation*]

The federal government supports high-quality research on substance use through the Canadian Institutes of Health Research and the Canadian research initiative on substance misuse.

The Canadian Institutes of Health Research are currently supporting a pilot project to identify effective interventions to reduce methamphetamine use among men who have sexual relations with other men, an activity that has been associated with an increased probability of contracting HIV/AIDS.

[*English*]

In addition, the substance use and addictions program is a federal grants and contributions program that provides $28.3 million annually to provinces, territories and non-governmental organizations that support evidence-informed and innovative initiatives targeting a broad range of legal and illegal substances.

While it is difficult to paint a detailed picture of the scale of the methamphetamine problem in Canada, we are committed to working with provinces and territories and key stakeholders to fill gaps in our knowledge. Health Canada, the Public Health Agency, Stats Canada and other organizations are exploring targeted data and research initiatives to better reach marginalized populations.

We are also working toward developing and implementing a Canadian drugs observatory that would act as a central hub to provide a comprehensive picture of the current drug situation in Canada, identify emerging drug issues before they escalate, track public health interventions and other control measures, and facilitate data sharing.

In closing, I would just like to say that we are deeply concerned about the growing number of Canadians who are struggling with methamphetamine use. Through the Canadian drugs and substances strategy, we will continue to work with provinces, territories, indigenous leadership and communities, people with lived and living experience and key stakeholders to address the issue using a comprehensive, collaborative and compassionate public health approach based on the latest available evidence.

Last, we have recently launched an online public consultation to inform potential next steps on the Canadian drugs and substances strategy. This consultation closes on December 4. We look forward to feedback from Canadians on how we can improve our approach to substance use issues in Canada, including our actions to address methamphetamine. At last count, I think we had more than 1,200 responses to that, so we expect a fair amount of analysis to happen.

In closing, thank you again for the opportunity to appear before you today to discuss what we believe is a very important and growing issue in Canada. We look forward to the presentations to this committee from other stakeholder groups and to the committee's forthcoming report and recommendations.

My colleagues and I would be happy to answer any questions you may have.

The Chair: Thanks very much.

You have a few minutes left, if someone else wanted to add a comment.

I wanted to ask a question for clarification. You mentioned crystal meth, meth and methamphetamines. Are these all the same thing?

● (0900)

Ms. Suzy McDonald: Those are all the same thing. In fact, there is a whole series of other words that we also use to describe this category. Meth, crystal meth and methamphetamines are all a category of drugs that are amphetamines, which can also be referred to as speed. The idea is that it accelerates your overall responsive system, as opposed to opioids, which depress that system.

The Chair: We'll go right to questions now, starting with Dr. Eyolfson for seven minutes.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you very much.

Thank you for coming.

It's quite an honour to be able to do this today, because I had asked that the committee study this. I come from Winnipeg, and I spent 20 years as an emergency doctor in Winnipeg. One of the really surprising and rather frightening things is the rate at which this has taken off. I last practised emergency medicine three years ago, in the inner city at Health Sciences Centre. It really wasn't a big issue then. It was something that I didn't see. The substance itself has been around for.... I learned about it in residency 20 years ago. For a lot of reasons that we're still trying to figure out, it's just exploded.

Ms. McDonald, has anyone been able to figure out why there has been such a sharp increase in the use of this particular substance?

Ms. Suzy McDonald: I'll start, and then colleagues might have things to add.

The reality is that when it comes to all substance use, it is very difficult to determine the how and why people are using various substances in Canada. We can say that you are right that in fact there has been an increase. While we don't have exact data on who is using and why they are using or why they may be shifting use, we have some things that can provide a bit of insight. One is our drug analysis labs. From 2007 to 2017, there has been a 365% increase in the product seized and analyzed by labs at Health Canada related to methamphetamine, so we know it is being used broadly on the street. We know as well that those highest rates are in Saskatchewan, followed by Alberta, Manitoba and New Brunswick.

The other very interesting part for us is this idea of polydrug use. I think many users are in fact in this area of polydrug use. In Manitoba in particular, there were 35 deaths in 2017 related to methamphetamine, of which eight could be directly related. The rest had some sort of polydrug use associated with it. In 2016, there were four deaths associated with it.

Perhaps what's scarier is that there were 108 opioid-related deaths. Of those we see that there is a meth-opioid interplay. We also see meth being increasingly contaminated with fentanyl, just as other opioids are being contaminated with fentanyl. I believe that the increasing number of deaths related to methamphetamine use, just like the increasing number of deaths related to opioid use, is directly related to the poisoning of the drug supply with fentanyl.

Mr. Doug Eyolfson: Yes, sir.

Mr. Trevor Bhupsingh (Director General, Law Enforcement and Border Strategies Directorate, Department of Public Safety and Emergency Preparedness): Thank you, Chair.

Maybe I could add a few other comments to my colleague's views on this.

I think the other thing in terms of the unpredictability around the how and the why is largely that it's a marketplace as well and there's a constant flow of sometimes poorly regulated chemicals, which can be easily procured. To the extent that they are available, substances will go up and down in terms of usage. It's very difficult to really predict in terms of the cost, which is another factor for use. The cost of methamphetamine varies tremendously across the country. For example, on the west coast, where you could argue there may be greater access to precursors, the cost is somewhere between $30 and $50 a gram, whereas on the east coast, I understand it to be in the neighbourhood of three times to four times that cost for a gram.

All that is to say that market conditions and the availability of drugs is also a factor in the equation of figuring out what drug will be prominent. That is very hard to predict.

● (0905)

Mr. Doug Eyolfson: This sounds analogous to the change we saw in the market in the late 1980s, I believe, with cocaine. From what I understand, the classic cocaine hydrochloride that was sniffed was about $200 a dose, and when crack was developed, it was at something like between $5 and $15 a dose. That's what introduced cocaine to the inner city. It sounds quite analogous.

Switching gears a bit, we've talked about harm reduction, which is something I've always known about, and I really appreciate how much misunderstanding there was about it. A lot of people thought that harm reduction—supervised consumption sites and needle exchanges—enabled or increased use. From my reading of the academic literature, you did not actually increase use of these substances. You just simply decreased the harm with them.

I understand that there's very good data that supervised consumption sites do lead to improved outcomes with opioids. Is there evidence of the same benefit or a similar benefit in regard to meth?

Ms. Suzy McDonald: The evidence we have is not necessarily related directly to opioids. It's related to people who come into supervised consumption sites to use those various products.

Indeed, you are right. There have been a fair number of studies done and we have a very good literature to indicate that supervised consumption sites overall reduce harms and don't increase crime. There's no increased level of activity around those sites.

The emergence of supervised consumption sites in Canada is relatively new, and we are collecting data. As part of the work we do with each supervised consumption site, we ask them to report in so that we'll be able to have a much better understanding as time flows about the use of methamphetamine and harms related to that.

What I can say is that if you are using a substance within a supervised consumption site, you have immediate access to harm reduction measures. While naloxone indeed works for opioids, having practitioners present if you're having another type of overdose is very helpful in terms of being able to call for help or for immediate assistance. Those harms we expect will be reduced, but there have been no studies directly related to that, to my knowledge. Michelle might be able to correct me on that.

I think the other piece that's interesting to note is that people who are using methamphetamines are using supervised consumption sites. I mentioned that in my remarks. In fact, we are seeing increased methamphetamine use at supervised consumption sites in Kelowna, as an example. In areas where opioid use had been quite prevalent, we are seeing some shifts happening, and we're monitoring that very closely.

The other piece related to supervised consumption sites and harm reduction, as you know, is that because methamphetamine is used in a whole variety of ways, including through injection drug use or sharing of products, the ability to have drug-related items available for people coming into supervised consumption sites drastically reduces the risk of any kind of infection happening. Furthermore, it often puts people into contact with direct treatment providers or other health care providers.

The ability for people to come into those supervised sites, whether they're using an opioid, methamphetamine or cocaine, means that they have access to a wide range of services. That's why we have been putting a real emphasis on trying to ensure that people are not using alone and that we're able to get help for them immediately if needed.

The Chair: We have to move along now.

Mr. Doug Eyolfson: Thank you, Mr. Chair.

The Chair: Mr. Lobb.

Mr. Ben Lobb (Huron—Bruce, CPC): Thanks very much.

I want to build off a question that Dr. Eyolfson asked around the safe injection sites. Your number was that 40% of the people coming into safe injection sites now are using some form of methamphetamine. Is that correct?

Ms. Suzy McDonald: Not exactly. It's 40% of people in Kelowna, but the numbers vary drastically across the country and this data is not perfect data. It's being reported by supervised consumption sites, and we have some sites that have been reporting longer than others.

Mr. Ben Lobb: Okay.

Ms. Suzy McDonald: For example, we see that in Montreal cocaine remains the drug of choice. In Ottawa, it's hydromorphone. Again, in Vancouver, it remains heroin and other related opioids.

Mr. Ben Lobb: Fair enough. I just wanted to make sure that I had the number correct or incorrect.

For the cold medication that is used in crystal meth, if you don't have that, can you still make crystal meth, or do you need that cold medication as part of the recipe?

● (0910)

Ms. Suzy McDonald: I will let Michelle answer that.

Ms. Michelle Boudreau (Director General, Controlled Substances Directorate, Department of Health): Thank you.

The cold medication that you're referring to probably is pseudoephedrine, or the brand name Sudafed. People will sometimes call it that.

Certainly that is sometimes considered the faster way of making methamphetamine. However, the interesting thing with methamphetamine is that it is in a sense a chemically created product. If you think of Sudafed or pseudoephedrine as the precursor, then you can back that up and create a precursor to a precursor.

That's the challenge for us. There's always some creativity in other types of precursors.

Mr. Ben Lobb: When there's a seizure at a lab or from a street dealer, do they test that to see what the combination is in the meth that has been seized? Do you have a way to see if that pseudoephedrine is in there?

Ms. Michelle Boudreau: I'm not sure if my colleagues from law enforcement would like to answer that.

I could try, but I'm just wondering if you'd like to take that.

Chief Superintendent Paul Beauchesne (Chief Superintendent, Serious and Organized Crime and Border Integrity, Royal Canadian Mounted Police): There is one thing I could add, if that would help.

I'm certainly not a chemist, but what I can say is that when we go to these clandestine laboratories, a lot of the time we will find packaging of ephedrine, so we know that's an ephedrine that was used maybe in that process. In terms of chemical analysis, it's not—

Mr. Ben Lobb: This is part of my issue. I would say that there are drug makers probably around the world, but specifically in North America, who are making this product and it is going into the creation of this issue.

You can only do what you do, but why aren't we trying to focus more on that, to try to take that element right out of the equation? I'm not blaming anybody. I'm just saying that if this is one of the components to this disaster, why aren't we going at the drug companies to be accountable for every ounce that they're creating?

It just seems to me that they have free rein to do as they please. They're part of the problem is what I'm trying to say.

Ms. Michelle Boudreau: If you'll permit me, since I understand you're at the beginning of your study, I'll just talk a little about the Controlled Drugs and Substances Act and the regulations and schedules, and how I think it aims to do exactly what it is you are suggesting.

The Controlled Drugs and Substances Act, or the CDSA, is our framework legislation, and then we have various schedules under that, as you may know. Methamphetamine is on schedule I.

We then have a schedule that relates to these precursors. As you were talking about the ingredients that you would need to create something like a methamphetamine, there are very strict regulations around the precursors. If I look, for example, at the class A precursors, those are the type that are essential to creating controlled substances. The pseudoephedrine that you mentioned, and P2P, which is another common ingredient—

Mr. Ben Lobb: I'm sorry to interrupt. I hear what you're saying and I have some knowledge of that. I'm saying that we just heard from the chief superintendent that when they do seizures, these tablets are at the scene.

They're a controlled substance. Are these Canadian tablets, U.S., Mexican-made tablets? Where are these tablets coming from? What I've read is that Canada is pretty tight, the U.S. is pretty tight, and south of the U.S. could be a problem.

Is this right? Does Mexico do the same thing as us, or where's the gap here?

C/Supt Paul Beauchesne: Thank you for the question.

What I can say is that substances come legally into Canada, and then there are distributors within Canada who then ensure access for Canadians. As part of the national chemical precursor diversion program, we keep very close relations with those distribution companies, to be able to give us any kind of indication of something that's unordinary, not legit.

We work very closely. That information comes into our provincial, municipal and federal entities, and we follow up with those. That's part of the national chemical precursor diversion program.

Mr. Ben Lobb: In your program, have you identified gaps then, bad actors or people or corporations or entities that are not doing their solemn duty?

C/Supt Paul Beauchesne: We do get information and follow up on it. Some of those investigations lead to accusations, and some do not.

Mr. Ben Lobb: The other thing I want to talk about is on the treatment side. In Ontario, if you're addicted to heroin, etc., and you're on methadone, you do not qualify for an OHIP bed at a treatment facility. That is unfortunate, because usually if you're at that point, you don't have any money left.

Would somebody who is addicted to crystal meth qualify in any province to go to—I'll use the Ontario term—an OHIP bed that would be covered by the taxpayer?

● (0915)

Ms. Suzy McDonald: I'm not an expert in provincial requirements for various treatment beds.

The recent funding provided by Health Canada through the emergency treatment fund that's being negotiated with each of the provinces allows us to scale up all forms of treatment including treatment beds, where that's appropriate, and to make them available across the country. But provincial rules around how those are implemented vary among each province and territory in Canada.

Mr. Ben Lobb: Were they in negotiations with the provinces to say they need to make sure that people who have no money should qualify for those beds? Was that part of the discussion in those operating dollars in the emergency fund?

Ms. Suzy McDonald: It's a good question.

We set out the parameters that required how provinces would spend that money and what kinds of treatment forms would be allowable. We did not—

Mr. Ben Lobb: One quick question....

The Chair: You're done. Sorry.

Welcome to the committee, Ms. Mathyssen. You're up for seven minutes.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you very much, Mr. Chair. I'm very glad to be here.

This obviously is a significant study as we grapple with the cost of health care and issues around addiction.

Madam McDonald, you talked about research and not knowing so many things. Are we investing enough in research? Not just in drug use, but I'm hearing across the board that medical research is not what it needs to be if we're going to grapple with various issues.

Do we need more investment?

Ms. Suzy McDonald: I think we have recently made significant investments in the area of research related to problematic substance use. Through the Canadian Institutes of Health Research we have funded what's essentially a network across Canada, like the Canadian research initiative in substance misuse, which has four nodes across the country and is doing significant research in the area of all forms of problematic substance use. I referred earlier to an innovative study around men who have sex with men related to methamphetamine use. That is being done through them.

The reality is a recent analysis was done of treatment options for methamphetamine, a 2018 review of the literature, that indicated we do not have good guidelines for how to treat methamphetamine use. This is an area where more research can and should be done, both in Canada and internationally.

We are working with international partners to see if we can scale up that research to better understand how we can provide better treatment for methamphetamine users.

Ms. Irene Mathyssen: Thank you.

Ms. Kimberly Lavoie (Director, Drug Policy, Department of Public Safety and Emergency Preparedness): In addition to what my colleague from Health Canada said, we are also working with Statistics Canada to get a better grip on a complete profile of who the methamphetamine user is.

A study on opioids was recently done in Surrey, B.C., that took data from a number of different metrics to get a complete picture of who those people are. We're looking at using that methodology to do a similar study on methamphetamine use somewhere in western Canada. We're currently in negotiations with StatsCan on that.

Internationally we have a North American drug policy dialogue forum with both the U.S. and Mexico. Coming out of the most recent meeting on November 9 was a commitment to do a threat assessment on methamphetamine for North America.

Ms. Irene Mathyssen: Thank you.

Madam Lavoie and Madam McDonald, you've both touched on my next question.

You talked about the social determinants that lead to drug abuse and the classics: homelessness, poverty, unemployment.... We know the cost of poverty in this country is catastrophic in the human and economic cost.

I'm wondering what specific social interventions would be most effective if we want to prevent this particular social isolation, this increase or catalyst of drug abuse.

● (0920)

Ms. Suzy McDonald: I think this is an area that we've been paying a tremendous amount of attention to, and we have partnered with departments across the federal government. Really I think the first piece is sharpening this evidence base, so it's addressing key information gaps around the socio-economic data. Kimberley spoke a bit about a very important survey that starts to talk to us about which are the most important social determinants of health when it comes to substance-related use.

We certainly also believe that reducing stigma—and that means really helping people to understand that drug use is a health issue—is a key piece of what we're doing. I think the other part of it really is working with ESDC and other departments. The new poverty reduction strategy, the new housing-first strategy and so on are all areas where we've been able to influence and talk about how we can start to do a better job in integrating the various social determinants across the work we do.

Our chief public health officer in Canada talks a lot about resiliency in youth and how we build resiliency in youth. That's an area of focus for us as well. If we're able to address resiliency and mental health issues in early childhood, then we will be much better off in the long term in Canada.

Ms. Irene Mathyssen: Thank you.

We've heard for—and now I'm going to reveal how long I've been at this—30 years or more about the social determinants of health. We've heard from the Canadian Medical Association, the nurses, organizations in the field, and they keep coming back to housing, housing security. We don't have that in this country. In fact, it's been postponed.

Should we be looking at something concrete now instead of continually postponing it?

Ms. Suzy McDonald: I think the issue of housing security is one that's important for all Canadians. I know we are working hard to move that forward. I'm not an expert in that area but what I can say is that there are direct links between housing and problematic substance use in Canada. We were very pleased to be able to work with our colleagues to change some of their policies to ensure that someone is no longer required to be substance-free in order to access housing for some of their programs. We think that's a big step in the right direction.

Ms. Irene Mathyssen: Okay. I thank you for that.

I'd like to turn to Paul from the RCMP. You talked about the realities of money laundering and organized crime, and one of the things that occurred to me was the danger that a police officer faces in terms of intervening. In a community not far from me, there was an explosion. A meth lab exploded and it destroyed the house. It injured the family. Up until that moment, you'd wonder what was there.

What about the danger to police officers with regard to organized crime, these clandestine operations? Could you comment on that?

C/Supt Paul Beauchesne: These clandestine laboratories that are basically providing methamphetamines to the population are very dangerous explosives. I'm not an expert in the explosives category but there's also the matter of the effects on the person. When police are called to a situation in which someone may be on methamphetamines, obviously it's not a good situation.

We've all seen some of those interactions between police and people suffering from mental illness and whatnot. They are very front of mind for us. We're getting better at our training. We look at the four pillars of the strategy. Police officers over the years are getting much better. We have the tools to be able to intervene. We have the tools to be able to use the laws and to charge people, but I think we're really doing a better job in terms of the harm reduction and, when we get to those situations, we are more aware of being a gateway to services as an option instead of going through the courts and the justice system.

I think we've come a long way in doing that and the strategies. That's how we feed more into the global strategy.

The Chair: That's excellent. Time is up, sorry.

Ms. Irene Mathyssen: But Mr. Chair, I was just getting started.

The Chair: I know, but actually it's over.

Now we go to Mr. Ouellette. Welcome to our committee. I know you've been involved with this issue, so I'm sure you'll have some interesting input.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Thank you very much, each and every one of you, for coming. I really greatly appreciate the opportunity to ask a few questions.

I have very short questions. One of them is about schedule I, schedule III and the precursors using the ingredients. Schedule I has mandatory minimums of one to two years depending on the production, but if you are unauthorized to use the ingredients, it's a maximum of 10 years.

From what I've understood, is that so people do more importation of the actual drug, because it's more of a deterrent to actually producing it here in Canada? I've heard from the Winnipeg police that most of the drugs actually come from Mexico right now, using ingredients coming from China and India. Is that true?

● (0925)

C/Supt Paul Beauchesne: Yes, there are some cases, and you're getting that information directly from Winnipeg. You're correct.

Mr. Robert-Falcon Ouellette: Do you think the way we set up the schedule makes it so it's harder to detect the levels or the production of drugs? Instead of, “Oh, we see a lot of people are using ingredients”, we're making sure it's kind of covert because that makes that not a crime. However, it's because we can detect it that we can say, “Well, probably at this house they're probably producing something or doing something like that.” There might be a lab somewhere.

C/Supt Paul Beauchesne: Maybe I'll leave that part of that question to my colleagues in Health Canada, but what I can say, sir, when we're talking about the Controlled Drugs and Substances Act, is that, if you are caught in possession of methamphetamine, the sentences go up to about seven years. I believe that for production they go as high as life imprisonment. I thought I'd just add that because that would be under the Controlled Drugs and Substances Act, and I would maybe leave Health Canada to talk a little bit more about the regs, if that's all right.

Mr. Robert-Falcon Ouellette: You'd better be quick, though, because I only have seven minutes. As quick as possible, rapid fire, please, because I need to get—

Ms. Michelle Boudreau: Perhaps just proceed to your next question.

Mr. Robert-Falcon Ouellette: I was just wondering, how long is the high for meth? You described it a little, but just to have it on the record....

Ms. Suzy McDonald: I think it depends. When you use substances, it's very difficult to determine. It depends on how much you used and how concentrated that dose was. What we do see is that sometimes immediate psychosis, immediate very difficult effects, but in terms of how long that high lasts, what we can say is that it is very variable, and it's so dependent on what you're taking.

Mr. Robert-Falcon Ouellette: I've heard it's anywhere between 12 to 16 hours.

Ms. Suzy McDonald: I think that's realistic, but again, some of those immediate effects are in that first period.

Mr. Robert-Falcon Ouellette: Okay.

Does anyone know the actual cost of procuring meth on the street today?

Mr. Trevor Bhupsingh: I understand it varies across the country, sir. I understand that in British Columbia, in Vancouver, it's $30 to $50 for a gram. The only other jurisdiction where I somewhat know the cost is Moncton, where its street value is $175 a gram. That's what I've heard. I'm not sure if my colleague from the RCMP can add anything.

C/Supt Paul Beauchesne: My experience with the organized crime groups is that you have to be careful with just putting one amount on it, a dollar figure, because it's profit driven, and depending on supply and demand, that can vary. My colleague has given accurate numbers as I know them today, and when you're talking about the street, you have that street gram level, but you also have hits, which are called points, that are sub 0.1 of a gram. A gram would be approximately 10 hits. The minimum that you'd need to be able to consume would be 0.1 of a gram.

Mr. Robert-Falcon Ouellette: Yes. In Manitoba, from what I've heard, the hit can be had for free for the first few times, and then it's $10. Would that probably be accurate?

C/Supt Paul Beauchesne: That could very well be accurate, yes.

Mr. Robert-Falcon Ouellette: Do we have enough addiction treatment beds in the country currently?

Ms. Suzy McDonald: The easy answer to that is, no, we do not. We know that in 2014 there were 220,000 people waiting for addiction treatment services in Canada. That's part of the reason that we've recently made a big investment in making sure that treatment services are available through this emergency treatment fund. Each province is implementing that treatment fund in the way that best meets the needs of their provincial or territorial jurisdiction.

Mr. Robert-Falcon Ouellette: How does that relate to indigenous populations or even homeless populations, which might be more vulnerable? In Winnipeg we have 1,500 homeless compared to Vancouver, which has 2,000. Is there a proportionality to the vulnerability of populations across Canada for the offering of addiction treatments?

● (0930)

Ms. Suzy McDonald: If you're asking about the federal funds, I can explain that. The way that we provided the funding for that was by looking at the overall number of deaths within the jurisdiction as well as the overall number of hospitalizations. There is, indeed, an increased number of hospitalizations related to first nations communities, particularly in the provinces of Saskatchewan and Manitoba. We looked at hospitalizations and deaths and then overall population needs for each jurisdiction, but we looked at it in the context of opioids.

Mr. Robert-Falcon Ouellette: Okay.

You're also developing a drug observatory. How much money is going into that?

Ms. Suzy McDonald: Currently the way that we're developing that drug observatory is by taking the data that's being developed by all the various ministries and putting them together. That funding is happening from funding that we already have through the Canadian drugs and substance use strategy.

Mr. Robert-Falcon Ouellette: Will that be looking at the impact on crime levels and everything related to that? It sounds like it's the first time anyone has actually ever done that. From what I understand in the testimony, we don't have a lot of data on drug use, such as who's using it or when it's being used.

Ms. Suzy McDonald: The reality is that various organizations collect data, but we have never brought that data together in a coordinated and comprehensive way. My colleagues in the RCMP and at border services collect data. StatsCan and public health collect data. We collect data.

Our ability to bring that all together allows us the opportunity to start to really look for the first time—as Ms. Lavoie was saying—at the who, what, when, where and why. I believe that if we'd had a drug observatory earlier we would have been able to predict that we'd have an opioid crisis and we'd be able to give you better information on what the methamphetamine use looks like today.

Mr. Robert-Falcon Ouellette: I have one final question.

Have you heard of the Icelandic model on recreation?

Ms. Suzy McDonald: Absolutely. Our chief medical officer of health has been talking a lot about that model and exploring it and looking at other ways of bringing that to Canada.

We understand that there are some communities in Canada that have already started to try to implement that model. We're following up with them.

Mr. Robert-Falcon Ouellette: Can you give a short description of it?

Ms. Suzy McDonald: Essentially, the idea of the model is that you provide outlets for youth so that they're able to be involved in sports or other extracurricular activities early on. This diverts them from any possibility or any desire to move into illegal substances because they're very active and involved in their communities.

The Chair: Thank you very much. We're done there.

That completes our seven-minute round.

I want to ask one question. You said there are 220,000 people awaiting treatment. How many are in treatment?

Ms. Suzy McDonald: That number varies widely. The statistics I was giving were from quite a number of years ago.

We are doing some baseline surveys right now to figure out how many people are still waiting for treatment. The number of people in treatment varies considerably. It's increasing because of the recent funding provided. I don't have a figure for you for that today. Ask me that again in six months and I'll be able to provide an accurate answer.

The Chair: What's your best guess?

Ms. Suzy McDonald: I really can't guess.

The Chair: Now we move along to our five-minute round. We're going to start with Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair.

I would like to thank my colleagues who have asked questions so far. You asked half of my questions, so I'm a little bit irritated by that. The next time I'm going to ask to be first, Mr. Chair.

I'll start with the public education that is being provided out there. Ms. McDonald, you indicated that it's not working. Is it because there's a lack of it? Is it just not resonating, or is it not adequate? Maybe talk a little about that, if you don't mind.

Ms. Suzy McDonald: I'm not sure I said that it wasn't working, but I do think that there's more that can be done in the area of prevention and public education. I think there are two components to that. One key component is about prevention, writ large, and the role that we and the provinces and territories have in schools and in helping children to understand what drug use means and what drugs look like. A fair amount of work has been happening there, both at the federal level and at the provincial and territorial level.

I think there has been a change in messaging and in tone in how people are doing that across the country, from this mantra of “don't do drugs” to instead providing evidence-based information to children in the context of peer education and teacher education. That helps to move that forward.

The second piece I was talking about was this issue of stigma and the idea that many people see drug use as a moral failing. There is the lack of understanding around the fact that it is in fact a health issue—there is a serious health component to it—and that it can happen to anyone in any walk of life across this country.

● (0935)

Mr. Len Webber: Thank you.

I have a question for Chief Superintendent Paul.

Ben Lobb mentioned that a lot of the ingredients are coming from other countries. I don't know if you can answer this or not, but what are Canadian border services doing? How do they check for the drug when it does cross the border? Can it be detected by dogs? How are they finding the stuff? Obviously they're not, because the product is getting into the country. Can we do a better job at the border to prevent it from coming in?

Mr. Trevor Bhupsingh: I'm not going to speak for the Canada Border Services Agency. What I'll say is that they're using a mix of tools, including all sorts of intelligence and working with other sorts of law enforcement in different countries. In terms of detection methods, you will find a lot of these drugs, including methamphetamines, being distributed through mail systems, so they would use things like X-rays and detector dogs, etc.

There are a number of different tools that border services officers use in trying to identify illicit shipments of drugs.

Mr. Len Webber: I see.

When you do enter a meth lab, you indicated that in some cases you see the actual packaging of over-the-counter drugs—cold medication or whatever. Are the pharmacies throughout the country aware? I'm sure they are, but are they tracking the sale of their products, and if there are individuals coming in who are purchasing large amounts of this medication, are they tracking or monitoring or maybe just watching?

C/Supt Paul Beauchesne: Thank you very much for the question.

That's exactly what the national chemical precursor diversion program.... There is an acronym for it. We usually just use the acronym. I don't have to spell it out.

For me, it's outreach. It's outreach to those companies, as far as even Canadian Tire and Home Depot, to be able to make them aware. That is the part of the program I think is the most important. It is that information that we glean from our municipal departments, from our provincial departments, with the federal government, and then all together we try to attack the phenomenon or the trend in different ways.

Mr. Len Webber: I see. Okay.

Ms. Michelle Boudreau: Perhaps I could add a little bit. I know you're on time, so I'll try to be very fast.

Certainly pharmacies are aware, and colleges of pharmacy as well. For example, in Alberta and B.C., the college of pharmacy recommends that these products are kept behind the counter so that you have to ask. In some places they'll even take your ID, etc., and really try to control the amount to each person as well.

Mr. Chair, I wonder if you could permit me just one minute. I would just like to reply to the question we were asked about the time of the high. I know you're meeting later with the CCSA. From their report, you are quite right: It does depend on the route of administration and it can be as long as 12 hours. What is interesting here is the amount of time it takes to leave the body, compared to cocaine. With cocaine you can have 50% of it gone within an hour, whereas it takes 12 hours for 50% of the methamphetamine to leave the body. I just wanted to add that because you seemed quite interested.

Mr. Len Webber: On the treatment for someone who has overdosed from meth, there isn't anything, right? There is nothing like naloxone for fentanyl.

How do they treat people when they do come in?

Ms. Suzy McDonald: Essentially they treat the symptoms that might be exhibited. If it looks as if someone is suffering from psychosis, they might be able to administer a medication specific to psychosis. But with treatment, as I said, there is no immediate ability to reverse an overdose from methamphetamine.

Mr. Len Webber: Thank you.

The Chair: Dr. Eyolfson, you have five minutes.

Mr. Doug Eyolfson: I would like to thank Ms. Sidhu for giving me her time to continue to ask some questions.

I want to pick up on a thread we were on when my time ran out. We went, again, into harm reduction. I should qualify this. I don't think it's the panacea for all the problems, but it's an important pillar.

There is a lot of public misperception and, quite frankly, a lot of political push-back, depending on the province. The Government of Manitoba is showing absolutely no interest in pursuing supervised consumption sites. The Government of Ontario is starting to push back and is saying it wants to either close them down or at least restrict how many open.

Would you recommend that the provinces start embracing this as one of their pillars of treatment for this problem?

● (0940)

Ms. Suzy McDonald: I think that, when you look at the issue of substance use, you really need to have elements of all four of the pillars that we have set out at the federal level, which are prevention, treatment, harm reduction, and enforcement, all supported by evidence.

Harm reduction is an important pillar to any approach to substance use in Canada, and there are different ways you can implement harm reduction across the country.

Mr. Doug Eyolfson: Absolutely.

Another thing we talked about with harm reduction—and there seems to be, again, some push-back from those who don't understand—is needle exchange programs. Certainly on the needle exchange programs in prisons, there has been push-back from certain players there.

Just so we get this out there, because people don't understand, you don't have more needles out there in the system when there is a needle exchange. People are bringing back their dirty needles in exchange for clean needles. Is that correct?

Ms. Suzy McDonald: Generally what we would find is that, where needle exchanges are available, there are in fact fewer needles scattered about those sites. In fact, those are being returned and exchanged, so there is less needle debris associated with those sites—needle exchanges, supervised consumption sites or others.

Mr. Doug Eyolfson: Thank you.

You also said, and I just want to reiterate this, that needle exchange programs do, in fact, decrease the transmission of blood-borne diseases like hep C and HIV.

Ms. Suzy McDonald: The evidence is very clear that there is a decrease in blood-borne infections when needle exchange programs are present.

Mr. Doug Eyolfson: Thank you.

I just wanted to clarify something, as well. You talked about the symptomatic treatment, and this is something I understood from drugs like this. I've looked after a few cocaine overdoses in my time, and meth is rather different, in that it's more resistant to some of the sedatives you'd have to use. Sedatives like benzodiazepines, midazolam or Ativan were a big part of it, and this is rather resistant.

There's been some interest in the anti-psychotic drug olanzapine. It's come to our attention in the press that our first responders, our paramedics in Manitoba, are now able to use olanzapine for people in the field, in meth-induced psychosis. Should we be improving the awareness of this and encouraging more services to do this?

Ms. Suzy McDonald: It's certainly something that we're aware Manitoba has been pursuing. Anything we can do to help first-line responders to react immediately to overdoses, in whatever form they take, is helpful. It's absolutely something that we're looking into.

Mr. Doug Eyolfson: Thank you very much.

I have another minute. Ms. Sidhu, did you have any questions on this?

Ms. Sonia Sidhu (Brampton South, Lib.): No, thank you.

Mr. Doug Eyolfson: Thank you.

I guess I still have some other issues. They say that the....

The Chair: If you don't have any questions, we can move on, because we're running over.

Mr. Doug Eyolfson: Yes. I was going through and wanted to make sure I didn't—

Ms. Sonia Sidhu: Maybe I will ask—

The Chair: Do you have a question? Okay.

Ms. Sonia Sidhu: Thank you for being here.

As we know, the majority of meth available in Canada has been produced domestically, while some is coming from other countries as well. My question is to the border security person, or Mr. Bhupsingh, you can answer that. Have you found that this pattern has changed or stayed the same in recent years? Furthermore, should the government prioritize targeting domestic producers or shift to a tighter borders safety strategy?

Mr. Trevor Bhupsingh: Maybe I can start and I'll turn it to my colleague from the RCMP.

I don't think it's one or the other. I think it's both. We are certainly seeing that there is domestic production, but then we are also seeing precursors come from other countries that have been mentioned, and then being assembled here. Also, in some cases, we're seeing Canada being used as a transit country, where methamphetamine is being exported.

In answer to your question, I think it's probably a multitude of strategies to deal with the supply reduction side of it, just because there are many different elements to the supply domestically. Also, there clearly is a problem with precursors coming into the country and the regulation issues we talked about.

● (0945)

Ms. Sonia Sidhu: Are we tightening the rules more—

The Chair I'm sorry. Your time is up.

We have to go to Mr. Lobb.

Mr. Ben Lobb: Thank you very much.

Just building on the thing I was talking about before in my last round, of the five provinces that have come to an agreement have any allocated money to operational costs, or should I say treatment beds for people with no income or money?

Ms. Suzy McDonald: Each of the action plans is available online, and you can see what each province is doing individually.

In fact, yes, some have allocated funds to treatment beds specifically. As I said, Saskatchewan in particular has allocated funds specifically to methamphetamine use, and we expect that others might do the same.

Mr. Ben Lobb: That's good to hear.

I think Ms. Boudreau made a comment about having pharmaceuticals behind the shelf, perhaps.

I was at a Shoppers Drug Mart the other day, and the Aleve, etc., and any of the things for sinus infections that would be included in the making of these drugs were all there.

One thing I was surprised by—and maybe I have never paid attention—was the self-checkout method. Just while we're sitting here, you could load your grocery bag right full of it, take it right through the wicket and no one would even know. Should we be asking pharmacies to...?

Maybe they want self-checkout to cut costs, but maybe, in order to get a box, you're going to have to talk to the pharmacist. Is that something we should be asking pharmacies to do?

Ms. Michelle Boudreau: We do work with the National Association of Pharmacy Regulatory Authorities, NAPRA, which you may be familiar with. It gives some guidance to the pharmacy colleges from province to province about things like where to keep products—behind the shelf or in front—and it is left to each individual province in the pharmacy college to make those determinations.

Mr. Ben Lobb: As someone with no experience at all in medicine or pharmacy, just in looking at it, it seems quite unethical to me. If this is a huge problem, it's a smorgasbord of products that you have access to. Hopefully, we'll have something on this in our report.

I have another question to mention. When you look at the list of pharmaceutical companies around the globe that sell these products, it's not millions but hundreds of millions and billions. In terms of that $130 million the government provided, it seems to me that all these pharmaceutical companies should have paid up as well if they were going to sell these products in the country. That's just an observation of mine.

They each should have chipped in $100 million, as far as I'm concerned. Was there any dialogue amongst the drug makers about helping out to create a bigger fund to leverage to help eradicate this issue?

Ms. Suzy McDonald: There hasn't been a specific discussion around the issue of amphetamines with regard to the pharmaceutical industry paying for treatment or other services related to that. As you know, there have been a number of discussions happening in the area of opioids and ensuring that we are restricting the marketing ability of pharmaceutical companies associated with that.

Mr. Ben Lobb: Okay. I think it would be great to have some of the pharmaceutical companies appear before committee to see if they have any generosity in their hearts around the Christmas season to chip in and help these dollars go further.

One other thing is on CIHR. Do they have any research programs that they are contributing towards to do research at universities or what have you on something to improve this condition?

Ms. Suzy McDonald: This is an area that we have been discussing with CIHR and with, as I said, this network that they fund across the country, which is called CRISM. There is one study under way. We expect that they'll be looking at these issues more broadly. The way the funding rolls out is that we have calls for proposals that come in, and we do expect that this is an area that we'll be able to shore up.

Mr. Ben Lobb: One quick last question is on the duty to report. If you're a realtor, you do a transaction and you think it's suspicious, you have a duty to report to FINTRAC, etc. We've heard a lot about that recently.

The point I want to make is about pharmacies and pharmaceutical companies. Is it anywhere in the law and in legislation that they actually have a duty to report suspicious activity, and where if they fail to do so, they can face criminal charges?

Ms. Michelle Boudreau: Perhaps I'll answer that question. With regard to the precursor chemicals and the scheduled chemicals under the CDSA, licensed dealers are required. There is a duty to report suspicious transactions to Health Canada.

The Chair: Thanks very much.

We're moving on now to Mr. Ayoub.

● (0950)

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Mr. Chair.

I will focus more on the uneven geographical distribution of the crisis, between the west—more specifically Manitoba—and the east. Aside from the sale price, what makes the situation different? Are other drugs more accessible in eastern Canada, or are criminal or contraband organizations better organized for methamphetamine production? Do you have an explanation?

Ms. Suzy McDonald: I will begin, and then I will yield the floor to my colleagues.

There is no easy answer. Of course, the price may influence behaviours. Users also have a certain mentality. As we have seen, it is clear that cocaine is the norm in Quebec. My colleagues will be able to tell you more about that, but the way drugs enter the country and their price may have an influence.

We believe that the fact that opiates have been contaminated for some time may have impacted the market. People no longer want to consume something that is 70% or 80% contaminated by fentanyl. They may turn to a substitute drug, but that answer seems too simple.

Many factors have to be taken into account, and that is why we really want to implement our observatory. Data from all agencies must be compiled to have an overview of the for, the when, the how and the why.

I don't know whether my colleagues want to add anything on how the products are entering the country.

C/Supt Paul Beauchesne: Thank you for your questions. I will answer in English, if that's okay with you.

[*English*]

I think it's a very interesting question.

Organized crime groups are profit-driven, and they don't care about anything else but the profit. Then you have to look at domestic production, those clandestine laboratories. Although I'm not saying it is, the closer they are to specific areas may have an impact on the availability of the product, which may be a contributing factor to why different areas have access to, maybe, meth, and then are seeing the results.

[*Translation*]

Mr. Ramez Ayoub: You seem to be saying that the majority of the production is local, contrary to opioids, which mainly come from outside Canada and enter the country in a variety of ways. You seem to be saying that these are local labs, close to users. So there would be more of them in Manitoba and the west. However, unlike Winnipeg, Vancouver seems to be dealing more with an opioid crisis than a methamphetamine crisis.

C/Supt Paul Beauchesne: I was talking more about a combination of the two: domestic production, but also entry into the country of precursor chemicals as well as the finished product, which is called “meth”. So there are actually three different aspects to that issue.

Mr. Ramez Ayoub: I will come back to the observatory, which may be a good idea. How far along are you in that file, both in terms of the federal government and the provinces? Some public health issues come under provincial jurisdiction, but others are the responsibility of Health Canada.

Ms. Suzy McDonald: Absolutely.

We have been working on implementing that observatory for about two years. We have consulted data-gathering organizations. Our minister also held discussions with provinces and territories in the fall. Everyone has agreed to move forward with the initiative, and our partnership has enabled us to have a good national overview of the opioid crisis. However, we must take things even further.

Currently, provinces and territories provide us with their data on opioid-related deaths and hospitalizations. However, that data should be cross-referenced with other information we provide to our partners in order to have a more complete picture.

The observatory's goal is really to ensure that every organization currently gathering data continue to do so, but that another organization compile all that data to provide the overview we need. We are working with Statistics Canada to implement that process.

● (0955)

[*English*]

Mr. Ramez Ayoub: Thanks. That's it.

The Chair: Thanks very much. Your time is up.

Now we'll go to Ms. Mathyssen for a short round of three minutes.

Ms. Irene Mathyssen: Thank you very much, Mr. Chair.

I wanted to follow up on what Mr. Lobb was talking about with regard to the drugs that are so readily available on the counters in the pharmacies, and talk about what happened in Ontario in 1992.

The government at the time said no to sales of tobacco in pharmacies because they were also selling drugs to address cancer. Big pharma pushed back and created a fund to get rid of this. Now tobacco is no longer available in pharmacies, but that government is no longer in power.

Given the reality of big pharma, have there been discussions with them about this situation and an ability to push back against what will be a very powerful lobby?

Ms. Michelle Boudreau: I know others may want to add, but I'll start just for a little clarity.

There has been a focus on products available in the pharmacy, but I think you've also heard my colleagues say that precursors are being imported. While there are products available in the pharmacy, they are there for legitimate purposes and we do have to keep that in mind as well.

For the most part, many of those products may not even fall within the regulatory scheme because of the quantity in the package. When we are putting a precursor on the list for control, we look at the legitimate purpose as well. Some of those packages that you may see in pharmacies technically may not even be on the precursor control list because of the amount in that package.

I think my colleagues were saying that when it comes to precursors larger volumes are being used that are coming in through other sources.

I'll let my colleagues with enforcement add if they wish.

Ms. Irene Mathyssen: Actually I have another question. I thank you for that.

In Manitoba, monthly emergency room visits by patients using methamphetamines have apparently increased by 1,200%. This has an impact on health care providers. My previous concern about the impact on police forces now extends to those health care providers.

The Manitoba Nurses Union is calling for heightened security in emergency rooms to manage the increase in violence that they say is related to the increase in meth. Are other provinces also witnessing an increase in violence to health care workers due to meth consumption? Has there been any discussion about how to address that? What kinds of safety mechanisms can be put in place for those health care workers?

Ms. Suzy McDonald: Certainly the safety of health care workers is a concern.

With regard to provinces and territories, the way we work with them is through a series of committees, so we do have a problematic substance use and harms committee that is made up of officials across governments. The issue of methamphetamine use has come up and is being discussed actively within that committee, including finding solutions for prevention and treatment with regard to it.

The issue specifically with regard to the protection of health care workers has not been discussed at that committee. No one has raised it specifically with me. That being said, as we noted earlier, the possibility of psychosis and violence associated with methamphetamine use could be a concern, and we could certainly talk to provinces and territories about the concerns they have about that.

The Chair: Thanks very much. The time is up.

Ms. Irene Mathyssen: Thank you.

The Chair: We haven't got time. We're going to go to another panel.

Mr. Robert-Falcon Ouellette: I'd like them to submit the emergency treatment fund bilateral agreements that have been signed.

Ms. Suzy McDonald: It's no problem. They're publicly available online. We'll get them to you.

The Chair: I want to thank all of you for doing what you do, because you're talking about people's lives and their health. It's a big responsibility you have, all of you. I want to thank you on behalf of the committee for what you do, and thank you for providing this information.

Now we're going to switch panels very quickly, as fast as we can. We'll just suspend for a moment and then hook up again. We have a video conference next.

● (0955)

——— (Pause) ———

● (1000)

The Chair: We're going to reconvene.

My message to the members is to try to keep your questions succinct. We're behind schedule. Every time we have five panellists, the answers are quite long and we run over. Almost every question answered today, I think, has gone over the time. I ask the members to keep your questions succinct, and I also ask our presenters to keep your answers succinct, as much as you can. We want to hear what you have to say, but try to focus on exactly what the questions are and give us those answers.

In our second panel, we have Addictions Foundation of Manitoba, Damon Johnston, chair, board of governors, and Dr. Ginette Poulin, medical director. From the Canadian Centre on Substance Use and Addiction, we have Dr. Matthew Young, senior research and policy analyst. By video conference from the Canadian Community Epidemiology Network on Drug Use, we have Dr. Sheri Fandrey, knowledge exchange lead, Addictions Foundation of Manitoba.

We are going to invite Addictions Foundation of Manitoba to make a 10-minute opening statement, then we'll go to the Canadian Centre on Substance Use and Addiction.

● (1005)

Mr. Damon Johnston (Chair, Board of Governors, Addictions Foundation of Manitoba): Good morning, Mr. Chair and honourable members of the committee. Thank you for inviting us here today.

I'm Damon Johnston. I am the current chair of the board of governors of the Addictions Foundation of Manitoba.

I will now let Ginette introduce herself.

[*Translation*]

Dr. Ginette Poulin (Medical Director, Addictions Foundation of Manitoba): Good morning.

My name is Ginette Poulin. I am the medical director of the Addictions Foundation of Manitoba.

It is a great honour for me to be here to discuss this issue we are currently facing in Manitoba.

[*English*]

While we do understand that there are issues with methamphetamine across the nation, certainly in Manitoba we've been seeing significant impacts that have been stressing not only our health care system but our social system and our justice system. We want to share a few reasons why we are seeing these particular impacts.

I will note that we prepared some packages for you. Although some of the information has been translated and is in both French and English, our apologies, not all of the material is in both languages. We will distribute those for those who wish.

In terms of some of our numbers, certainly from the Addictions Foundation of Manitoba, which services most of the addictions services within the province, we are seeing growing numbers of concern. For instance, 48% of persons seeking help for addictions are reporting methamphetamine as their number one substance of use within the past year. That is in our youth population. We've also seen an increase of about 104% in our adult population reporting methamphetamine use. We've had a threefold to fourfold increase in deaths either contributed to or caused by methamphetamines.

We're seeing a product that is certainly more toxic and more potent. It certainly has longer devastating effects in terms of aggressivity and psychosis, leaving a lot of concern. We've had a reported 1,700% increase in presentations to emergency visits in the Winnipeg Regional Health Authority. From AFM's perspective, across the province there's been an increase in the proportion of use of methamphetamine in the southern region.

Certainly, when it comes to treatment, we are under-resourced. Many of you might be familiar with our Peachey report. That report came out about three years ago on our health system transformation. That's another particularity that's happening in Manitoba. We're undergoing new strategies, in the global health system as well our mental health and addictions, with the Virgo report that was released in the spring, looking at providing a less siloed effect, which is currently the case. The geography of Manitoba is very much concentrated. Over half of our population is within Winnipeg and the southern area.

What came out of both of those reports is that we need more funding. We need more services. Of our health budget, only 5.2% is allocated to mental health and addictions. The national average is about 7.2%. The recommendation from the Virgo report was to increase it to 9.2% to meet some of the gap that has been there. Damon will speak a little bit further about some of the funding. We have been experiencing cutbacks in terms of our climate currently, too, which is a challenge.

When it comes to crystal meth, for withdrawal management services and ongoing care we do have limited resources within the province. We're advocating for withdrawal management services for a longer period of time, given that the detox period for crystal meth requires a longer phase of that safe environment.

Certainly, we're seeing the impacts from the female and family perspective. Manitoba, as you may know, has some of the highest rates of children in care, secondary to apprehension. Again, when we look at our data, we're certainly seeing that women are more affected in both our youth and adult population. This is something that is of great concern for us as well.

I know that safety was brought up earlier. This is certainly a concern on the front of individuals, health care providers, and our judicial and legal services. Winnipeg Police Service is facing significant challenges on the street, facing a lot of aggressivity. You might have heard of claims of machetes tied to the hands, and of the health care provider stabbed with a pencil. When we're looking at safety concerns, that is a real risk. It's certainly something we are facing.

Again, for individuals, many who are under the influence are experiencing harm. We're seeing an increase in IV injection rates. This has gone up at least double in the last few years. There are also the rates of hepatitis C and other infections, such as infective endocarditis, that are secondary to use. Again, the longer this goes on, the more impacts we'll see in terms of that.

● (1010)

I think I'll pass it over to Damon.

Mr. Damon Johnston: Thank you, Ginette.

Very quickly, in 2018 we know that Canada and Manitoba announced a new health transfer agreement. Within the agreement, there was an allocation to the province of approximately $181 million over 10 years for improving mental health and addictions services. At this time, AFM and our RHAs have been directed to reduce annual budgets by 1% to 4%. This raises the question of where the federal money in the new agreement is being directed.

The City of Winnipeg—so our mayor and council—in September of this year unanimously passed a motion calling for an intergovernmental task force on methamphetamine use, with a mandate to identify treatment and prevention strategies. Council pledged to create its own task force if the province or Ottawa did not step up by November 19, 2018, which has already passed. At this point in time, we're not sure where all of that is, but we remain hopeful that something will be done. The recent throne speech in Manitoba did not make any commitment to a task force, but it did say that there would be some future announcements relative to that.

Just to close, I wear another hat in Winnipeg. I'm president of the Aboriginal Council of Winnipeg. In that role, I'm very aware of the impact of these powerful drugs on members of our community and other vulnerable communities, such as the homeless population and people in poverty. They are the least equipped to meet these challenges—and they're very real. In my job, my role, I interact with families in our community in many different ways. I've had direct experience with some of the nasty outcomes, effects, directly on families, particularly on mothers and children. It's a serious issue. We have a collective table of leaders in Winnipeg, and we will be advocating strongly for more attention to this situation.

Thank you.

Dr. Ginette Poulin: Perhaps I will add something to that. There's something important that we see in Manitoba, and I always like to reiterate this point when we talk about substance use and issues related to that. It's always important to take it to the deeper level and look at underlying causes, such as trauma. We know that in our population in Manitoba, we have a lot of people who have experienced trauma, particularly in their childhood and throughout their lifetime.

If you look at the ACE study, which is the adverse childhood events study, they are certainly more at risk for mental health, addictions and other chronic diseases. Sometimes as we view these trends where, in Manitoba.... I know that in the previous session, you were talking about how opioids are hitting other provinces. Right now, why are we seeing crystal meth? There are certainly impacts because of our population, the accessibility and costs. Many factors play into that.

Again, when we look at those underlying reasons, no matter the substance, if we're not addressing those deeper issues, we're just providing band-aid solutions. I think that's a big challenge that lies ahead of us as a nation, and not just for Manitoba.

The Chair: Thanks very much.

Now we'll go to the Canadian Centre on Substance Use and Addiction and Dr. Young.

I understand you're going to share your time with Dr. Fandrey. Is that correct?

Dr. Matthew Young (Senior Research and Policy Analyst, Canadian Centre on Substance Use and Addiction): That's correct, yes.

Thank you.

Good afternoon, Mr. Chair and members of the committee.

My name is Matthew Young. I'm a senior research and policy analyst at the Canadian Centre on Substance Use and Addiction, and an adjunct research professor of psychology at Carleton University.

CCSA was created in 1988, and we are Canada's only agency with a legislated national mandate to reduce the harms of alcohol and other drugs on Canadian society.

With me today via video conference is Dr. Sheri Fandrey, knowledge exchange lead at the Addictions Foundation of Manitoba and member of the Canadian Community Epidemiology Network on Drug Use. We welcome the opportunity to speak with you today and to assist you in your study of the impacts of methamphetamine use on Canadians.

To respect your time constraints, my presentation today will be brief. Many of the statistics I refer to are included in the methamphetamine summary that was released earlier this month. It was provided to the committee in advance of today's meeting.

Methamphetamine is a synthetic drug classified as a central nervous system stimulant. The immediate effects of methamphetamine include alertness, energy and self-confidence. It is important to note these effects differ from the sedation and respiratory depression produced by opiates.

Since 2015, approximately 0.2% of Canadians report in self-report surveys using methamphetamine in the past year; however, national survey data tells only a very small part of the story. There is considerable variation across jurisdictions in rates of methamphetamine use and problematic use tends to be concentrated among populations that are unrepresented in national surveys.

Although there are gaps in the data, what data we have suggests that since about 2010 there's been an increase in the availability, use and harms associated with methamphetamine in most provinces in Canada, but mainly in the western provinces. Specifically, between 2010 and 2015, the rate per 100,000 people seeking treatment for stimulants in hospital settings increased over 600% in Manitoba, almost 800% in Alberta and almost 500% in British Columbia. During the same time frame rates of those hospitalized for poisonings in Saskatchewan, Alberta and British Columbia doubled. Though these hospitalizations include other stimulants besides methamphetamines, data from other sources lead us to believe they are largely driven by increased harms associated with methamphetamine use.

We feel some unique considerations about methamphetamine are important to mention to the committee. In contrast to people under the influence of opioids or other depressive or sedative drugs, individuals using methamphetamine can be animated and energetic early on and feel increasingly lethargic, dysphoric, depressed and hopeless with intense craving as the drug wears off. This means that people who use methamphetamine can be challenging to treat, and when in public spaces can attract attention from the public or authorities.

In addition to public health concerns about dependence and other harms directly arising from youth, methamphetamine is sold and bought in an unregulated market. Therefore, methamphetamine can contain adulterants and contaminants that can cause health harms. There is evidence from drug-checking programs across the country that there have been samples of methamphetamine testing positive for opioids. This fact is a significant concern as overdoses are more likely among people who do not and are not expecting to use an opioid. It is challenging, however, to know how common this is or why this may be occurring. Many suspect inadvertent cross-contamination.

However, as noted, the data we have at the national level is poor and the data we have at the provincial level is often very different from province to province. As a result, not only is it difficult to accurately assess the harms associated with methamphetamine use in Canada, but it is challenging to know where to target our efforts aimed at reducing these harms.

Finally, it is important to note that methamphetamine use is a very stigmatized behaviour, not only among the general population but among service providers and people who use drugs. This stigma further increases the marginalization experienced by people who use methamphetamine and places additional barriers to those seeking and accessing help.

I'll now turn to Dr. Fandrey to speak about the impact of methamphetamine use at the community level. Sheri is a member of the Canadian Community Epidemiology Network on Drug Use, or CCENDU, led by the CCSA. CCENDU is a nationwide network of community-level partners who share information about local trends and emerging issues in substance use, and exchange knowledge and tools to support more effective interventions in data collection.

● (1015)

Dr. Sheri Fandrey (Knowledge Exchange Lead, Addictions Foundation of Manitoba, Canadian Community Epidemiology Network on Drug Use): One consequence of there being abundant, high-potency and inexpensive methamphetamine widely available in Manitoba is the increased likelihood of those individuals injecting methamphetamine using very large doses. This likelihood increases the potential for challenging behaviours and serious overdose.

Further, powdered cocaine is frequently adulterated with or substituted with powdered methamphetamine. This substitution can lead those who purchase a product, thinking it is cocaine, to use too much, with an increased potential for adverse physical and psychological effects.

Manitoba systems and services struggle to address the harms of methamphetamine on several fronts. Emergency room visits related to methamphetamine have increased in Winnipeg from an average of 10 per month in 2013 to 240 per month by the end of July 2018. Presentation at the emergency room is frequently related to psychiatric symptoms, including paranoia, delusions and aggressive behaviour. These psychiatric symptoms generally result from high doses of methamphetamine and can distract from critical and potentially life-threatening effects on the heart and brain. This complex presentation requires a coordinated response from medical, mental health and social services.

For people who use methamphetamine at a high intensity, intravenous injection is the preferred route of administration, further stressing both medical and harm reduction services. Injection poses risks related to sexually transmitted and blood-borne infections such as hepatitis C, HIV, and bacterial endocarditis.

People who use methamphetamine at a high intensity and who are street involved can be reluctant to engage with medical services due to stigma and the requirement to be abstinent. Not completing the course of treatment reduces its effectiveness and can increase the possibility of treatment resistance with corresponding increases in intensity and the cost of the treatment. Enhancing supportive harm reduction services is critical to increase awareness of risk, reduce harmful practices and engage a reluctant, transient population in accessing further services, including treatment for addiction.

The first two to three weeks after stopping methamphetamine use present a range of challenges including volatile mood, profound depression and excessive need for sleep as well as cognitive and memory deficits. The window of opportunity for someone using methamphetamine to access detox or addiction treatment can be short. Ready access to non-medical detox can be a critical step in the process of recovery, as it allows an individual to withdraw from methamphetamine in a supportive environment, which increases the potential for success.

Increasing the length of detox to provide support to an individual throughout this vulnerable period would enhance the potential success of the next steps in addiction treatment and recovery. Ensuring smooth transitions from detox to treatment or supportive housing is key to success.

Prior or ongoing trauma is common in people who use methamphetamine at a high intensity. In many cases, methamphetamine use is a direct response to experiences of physical and sexual abuse and trauma. Restricting services and resources to those requiring abstinence ignores this reality. All services for this population need to be trauma-informed and must include resources for those who cannot or will not stop using.

Methamphetamine use occurs across a spectrum, from occasional use of snorted powder to daily intravenous injection. While attention and resources must be allocated to those experiencing the greatest harms, effective prevention and early intervention are key to limiting the scope of use and ensuring lower intensity use does not escalate.

● (1020)

Dr. Matthew Young: Though the rise in methamphetamine harms observed over the last 10 years is not as great as those associated with opioids, this increase should not be ignored. The federal government could capitalize on those investments already made to address the opioid crisis by using them to address the increase in the use of methamphetamine.

These measures include continued prioritizing and investing in better data and knowledge sharing on drug use and harms in Canada through continued development of the Canadian drugs observatory, which the committee heard about in the previous session, and support for the Canadian Community Epidemiology Network on Drug Use; investing upstream to reduce inequities in the social determinants of health and increase resiliency and self-efficacy in youth; reducing stigma by promoting understanding of substance use as a health issue, increasing the availability and accessibility of an evidence-informed, client-centred continuum of services and supports; supporting interventions to reduce harms specific to methamphetamine use, such as outreach education, needle exchange, pipes that reduce burns and cuts and other methods to reduce the spread of communicable disease; and finally, investing in low threshold housing.

CCSA will continue to coordinate collective efforts, connect partners, gather and share evidence, identify emerging issues and address stakeholder needs according to our mandate.

On behalf of Dr. Fandrey and the CCSA, I would like to thank the committee for the opportunity to speak today on this important issue. We will be pleased to respond to your questions.

The Chair: Thanks to all of you for your presentations. It's certainly an incredible situation that you're dealing with. Hopefully, we can add something to help you.

We're going to start our seven-minute rounds with Mr. Ouellette.

I know that you'll keep your questions succinct, but if we can keep the questions succinct and the answers succinct, we might get through this.

Mr. Robert-Falcon Ouellette: I'm going to ask all my questions right off the bat and let you answer them.

How many beds are actually needed? If you had all the resources you needed in order to address this issue—because it is a huge safety concern in the inner cities and also in indigenous communities—what would you need?

Should we have other models such as recreation for youth, like the Icelandic model? I know that AYO was talking about that. What's the value versus the safe consumption sites in terms of some of these other questions? What do you want the federal government to be doing?

● (1025)

Dr. Ginette Poulin: If I may, I'll begin. Certainly, I would say that all of those are important aspects.

Again, one of the things that's a challenge within Manitoba is that geography-wise we're spread out, and the tendency is for services to be concentrated in the Winnipeg region. We know that we need more and better local services throughout the provinces. When we're talking about beds, I would say that we need to support services so that they're local throughout, and it could be proportionate, certainly, to populations.

Again, to the rest of the services, my concern is that when we look at only withdrawal management or only treatment beds, they're only one spoke in the wheel. We need all of them to function together for that wheel to turn.

You also mention, for example, other things such as investing in extracurricular activities and other supports. We know that people who are engaged in activities have purpose. They have things to build their confidence and to build their skill sets. They're less likely to be seeking highs and pleasures from other ways, and they have less time for diversion. Certainly, those would be things that we would enforce.

There's one of the things from the federal aspect that I think would be nice if there are going to be funds. For example, as Damon mentioned, we can look at models—for example, with our Manitoba Liquor and Lotteries—where a certain percentage that is given has to be provided to services such as the Addictions Foundation of Manitoba, among others, and to organizations that are actually providing those services. Then we can see the accountability and the transparency of those funds and see them go directly to services. I think that's something that's certainly helpful.

I don't know, Damon, if you want to comment further on that.

Mr. Damon Johnston: No.

Mr. Robert-Falcon Ouellette: How much?

Dr. Ginette Poulin: Like I said, if we're already under-serviced at 5.2% in terms of our mental health and addictions and the Virgo report is saying to increase it to 9.2%, I would say even higher, to 10%—

Mr. Robert-Falcon Ouellette: What are the wait times?

Dr. Ginette Poulin: Wait times are variable, because people in the north might be accessing services down south. Again, that's where that concentration is.

We do need to improve access more equitably throughout the province, which can in turn help to reduce that wait time, and to also look at transition instead of people cycling through: showing up four or five times repetitively in emergency, for example, getting into detox, but then not having the bed and treatment to follow that. Then there are breaks in that continuum of care. From the health perspective, I guess, we need that seamlessness to be in place to help support this. I think it's kind of multifactorial in that way.

I wouldn't be able to say specifically how many per location.

Mr. Robert-Falcon Ouellette: Dr. Young.

Dr. Matthew Young: Is there a specific aspect that you'd like me to comment on?

Dr. Ginette Poulin: Any of the above.

Voices: Oh, oh!

Dr. Matthew Young: Certainly, further investment in treatment is important, absolutely. Treatment is usually delivered at the provincial level, so it's difficult for me to just give a sum. Certainly, though, further investments in treatment are required.

Mr. Robert-Falcon Ouellette: Does anyone believe that the meth problem could expand beyond the prairie provinces?

Dr. Ginette Poulin: As we look at other trends, certainly things move, and I would say that there's a kind of “drug of the day”. We know absolutely that the jurisdictionals don't fit with just the borders. We see movement, and I certainly would see that as a possibility—absolutely.

Dr. Matthew Young: Yes. Oftentimes, it's about supply and demand. As supply increases and moves into different areas and people have access, that's very possible.

We have seen an increase in all provinces. We've focused on the western provinces, but there has been an increase in all provinces. It's not something that's uniquely affecting—just particularly affecting—the western provinces.

Mr. Robert-Falcon Ouellette: What's the impact on indigenous communities?

Mr. Damon Johnston: Again, someone mentioned that there's a lack of data in some places. We don't have any numbers about the scale of methamphetamine use in our community. We know it's high.

I'm located right downtown, on Higgins Avenue. We have a park beside our centre. We've taken as many as 300 needles a week out of that park.

We're seeing, as I said earlier, direct impacts on some of the families we're working with. A mother will become a user, and then the children are apprehended. The healing period for the mother can be very extensive. I've been working with one family for over three years. Finally, they got the mother to a better place.

Mr. Robert-Falcon Ouellette: Damon, you live in downtown Winnipeg. What's the impact on the neighbourhood and life in the downtown core?

Mr. Damon Johnston: It's huge. You see people on the street every day struggling to survive. Some die. It's right in your face. I mean, you can't ignore it.

● (1030)

Mr. Robert-Falcon Ouellette: Does it make you feel safe? Is it safe?

Mr. Damon Johnston: No, absolutely not.

Again, because there are different approaches in each province and territory, in the Manitoba example, we don't have a provincially approved safe injection site. Some organizations are doing this on their own. They have a room set aside and they try to accommodate that need.

There are some other things going on. I'm part of a large group set up by one of our local business leaders, called the alliance for public safety and community wellness. One thing we're looking at is the Calgary model of a 24-7 drop-in centre, so that people who are on the street, who have nowhere to go, can avail themselves of a multiplicity of new services—things like managed alcohol programs, etc.

Again, often the place where a certain government is, sometimes is not as amenable to making these things happen as in other jurisdictions. That's why you see these differences.

Dr. Ginette Poulin: I was going to add that, with homelessness, that's really important too. We are seeing increasing homelessness within Manitoba. Crystal meth is a strategy to help maintain your equities on the street, meaning that you stay awake longer, you can fend off people who might be a threat and you can survive on the street. That is a tool, in that aspect.

Again, when it comes to harm reduction, we certainly haven't fully embraced that within Manitoba, and I think that is a challenge. When it comes to the first nations populations, anecdotally, while we don't necessarily have all the data, I can say that at least 50% of the people accessing care for crystal meth locally within AFM are certainly first nations.

That's just to give you an anecdotal number.

The Chair: We have to go to Mr. Lobb now.

Mr. Ben Lobb: Thank you very much, Mr. Chair.

Just so Mr. Ouellette knows—and I'm sure he does know—in southwestern Ontario, where Ms. Mathyssen and I are from, we are unfortunately very familiar with the meth issue in our communities.

If I were a homeless person in Winnipeg today and addicted to crystal meth, and I said that I'm ready for treatment, what would happen to me? Do I go right into a facility? What happens?

Dr. Ginette Poulin: It could be variable. If you were presenting with either psychosis or some kind of emergency, you might present into the emergency department.

Typically what's happening is that people are presenting to our non-medical detox, which is the Main Street Project. It has about 20 beds for females and about 30 for males. From there, you could be transferred into our Addictions Foundation Manitoba treatment programs, which reside within Winnipeg. We have a male and female 28-day program.

We also have—

Mr. Ben Lobb: Just so we know, with the 28-day program, how many beds are available for that?

Dr. Ginette Poulin: In female, we have just about 30, and the male, I think there are 36 or 40. That's specifically in Winnipeg.

Then, we have—

Mr. Ben Lobb: To Mr. Ouellette's point, there are 1,500 homeless in Winnipeg. I'm not saying that all 1,500 are on crystal meth, but there are probably a few who have tried it.

Dr. Ginette Poulin: Yes, many of them.

Mr. Ben Lobb: I'm not criticizing. I'm just saying that 36 is probably 500 too few.

Dr. Ginette Poulin: Yes, and that's why we're saying that globally we need more service.

Now, those are just within Winnipeg. We also have many who will go to residential treatment programs in either Thompson, Brandon, or Ste Rose.

That increases some capacity, but we are grossly unmatched when it comes to—

The Chair: Mr. Lobb, Dr. Fandrey wants to make a contribution here.

Dr. Sheri Fandrey: As well as treatment beds, I think we have to recognize that not everyone can or will access treatment when they are using methamphetamine. The overlap between serious trauma and methamphetamine use is striking. For that we need responses other than detox and treatment beds, which are critically important, obviously, but we need some sort of response for people who are not able to stop using for reasons of trauma.

Further to that, if the expectation is for people to become abstinent to go into treatment, we need much better supports for trauma. We haven't really been addressing the trauma issue around crystal methamphetamine. As people access services—which would be great—we need to respond to the emergent need for trauma services. Honestly, the wait times for trauma services are longer than for addiction services and they are less plentiful.

Mr. Ben Lobb: When you speak of trauma services, are you talking about counsellors and therapies and that type of thing?

Dr. Sheri Fandrey: Yes.

Mr. Ben Lobb: The $130-million emergency fund is a first step, I'm sure, but again, to be realistic, $130 million is not going to fix the problem. You had mentioned the lottery and gaming corporation has to provide services for people with gambling addictions. It's the same thing in Ontario. Am I wrong to say that the pharmaceutical companies, pharmacies and the like that are associated with this epidemic should have to chip into that fund and perhaps make it $800 million?

● (1035)

Dr. Ginette Poulin: I would love to see that. One of the challenges, when it comes to addictions, is that it is so multifactorial and layered that we all need to be part of that solution. If we could engage other parties, such as pharmacotherapists, absolutely, I think there would be benefit to that.

Mr. Ben Lobb: Is there any other country—I know it's not in every country but I think it's in quite a few—that is doing well at this prevention, or any...?

Dr. Ginette Poulin: Sheri may want to follow up on that.

Certainly in Manitoba we've been looking to some of the protocols and those are.... Earlier someone mentioned the olanzapine within the emergency medical services, but there can even be safety protocols for providing the environment within health care delivery, such as not having anything dangerous around and not using things that will escalate. We've been looking to New Zealand and Australia and certainly the U.K. for these kinds of protocols.

Sheri, do you have anything from the research aspect that you perhaps want to elaborate on?

Dr. Sheri Fandrey: I think Australia has been a leader, certainly in the English-speaking world, in terms of how to approach methamphetamine issues. They have been dealing with issues equal to, and possibly greater than, what we're experiencing for at least 20 years. They have put a lot of time, energy and resources into addressing all of the different facets. They have an approach that is much more focused on harm reduction, that is much more pragmatic and that meets people where they are rather than putting any kind of stipulations on them, such as, “You must follow this path or you must be abstinent.” They have had a great deal of success in minimizing the worst harms from methamphetamine use.

Mr. Ben Lobb: I am sorry but there is one last point I would like to make and I am running out of time. I have talked to many police officers about this issue and they say that, unlike anything else, crystal meth will steal your soul. It's not something that you can quit and then a year later be back doing your life. Is there anything out there for the one in a hundred who actually cure themselves of crystal meth but need support forever? What's out there now for that?

Dr. Ginette Poulin: I think what is really important is not only, like you were saying, the effects neurologically on the brain but to have ongoing supports for any other underlying mental health issue. We haven't really touched on that but most often residual depression and mood changes are experienced and need to be addressed along with that. I think that if we are omitting these things from the picture, if we're not addressing them, then we're missing the mark in conjunction with that power of the crystal meth, that high that it gives.

The Chair: Yes.

Mr. Ben Lobb: Is there any more time?

Dr. Sheri Fandrey: I think social supports are very important as well. They are possibly even more integral than what we've been talking about to this point. Helping people find other ways to cope, finding ways to increase their ability to react successfully in the world.... People do recover from meth and the rate of recovery would be more than one in 100. It's not easy and that's why supports of various kinds need to be in place. The opposite of addiction isn't abstinence. The opposite of addiction is connection.

Mr. Ben Lobb: In Winnipeg, then, or Manitoba in the broader sense, where is all this meth coming from? Is there 20% being made in Manitoba? Is it all coming across the border? Is it coming in through the airport? Where is this drug coming from?

Dr. Sheri Fandrey: A great deal of it is coming from outside of the borders. There has been little or no evidence of small-scale, clandestine labs in Manitoba in the last several years.

Mr. Ben Lobb: When it comes in, where is it coming in from?

Dr. Sheri Fandrey: The Winnipeg Police Service has indicated to me that about 80% of our supply is coming from Mexico, from the Mexican cartels. To a large extent, it's being shipped by semi-trailer. It lands in British Columbia outside of international waters. It's brought into secluded places and then is brought across the country for distribution. A small amount of it seems to be produced in British Columbia as well. These are super-labs producing vast volumes of methamphetamine of a very high potency.

The Chair: I'm sorry I have to end that even though it's very interesting.

Ms. Mathyssen.

● (1040)

Ms. Irene Mathyssen: Thank you very much, Mr. Chair.

Mr. Johnston, Dr. Poulin, Mr. Young and Dr. Fandrey, thank you for your advocacy. It's very clear to me that you are advocates that we desperately need, so I'm very grateful for what you do in terms of community and talking to folks.

I'm going to ask my first question to Dr. Poulin, but please feel free to jump in and add things.

Doctor, I hear that you're a rock star in your community because of your advocacy. You talked about the fact that most of the services are in the south, not available in the north. There has to be a tremendous cost in terms of accessing, bringing people from the north to the south. I wondered if you could talk a bit about your advocacy in that regard.

Dr. Ginette Poulin: Certainly when we look at cost for northern transportation, it's astronomical, and typically has been, but even the ease of that process.... Persons might have to go from The Pas, down to Winnipeg, and then get up to Thompson, so there's a lot of rerouting. We know opportunities are always lost the moment that people are not essentially handed off door-to-door, so I think that is a growing concern. We're continuously advocating for, certainly, more services and more ability.

I always say we need to not only have the local service, not just transportation, but we also need to have the expertise supported within those regions. One thing that we're doing is within our RAAM clinic models. We haven't really spoken about those yet, but those are rapid access to addiction medicine clinics. We are providing services for crystal meth as well as other substances. We have those five pilot sites located in Thompson, Brandon and Selkirk, and then in Winnipeg.

We're trying to infiltrate within those areas and start building capacity. One of the areas that I do other work in is with international medical graduates, who are a large portion of the providers within our rural areas within Manitoba. Building connections and support through that avenue is another way to assist with that. Again, I think we need to consider when it comes to finances that aspect as well.

Ms. Irene Mathyssen: Thank you.

Mr. Johnston, I notice you're wearing the moose hide. I want to thank you for making it very clear that the concern here in regard to violence against women and girls is very much a part of this.

You described cutbacks in terms of the Manitoba budget. I'm sure you're not an expert in terms of exactly what that budget said, but I wondered in terms of those cutbacks whether there is any idea where the money is going. You said that health dollars are being redirected. I wondered if you could comment on the fact that the federal government doesn't make requirements of provincial governments. There has to be, I think, strings attached.

Who is benefiting from all of this money that is flowing? What would you like to see in that regard?

Mr. Damon Johnston: The first thing is more transparency to the public about where those monies are going.

Something that may be affecting some of that is that when the new government came in, in Manitoba—I think they're in mid-term now, or just a little past—they announced a major effort to transform our health system.

I view some of that as positive in the sense that, for example, many practitioners and those of us who are closer to mental health and addictions, appreciate that they often co-occur in individuals. I'm on the board of CMHA Manitoba and Winnipeg, and I have been for a while. For a long time there's been a consensus that we need to bring those two closer together in the health system structure. That's good news.

We had the Peachey report, we had the Virgo report, and I think I understood the government has now set up an implementation committee. Many of us are hopeful that the health transformation in Manitoba will lead us to a better place, but that transformation causes system challenges because people are trying to adjust and they're trying to appreciate in a real sense what all that change means. It affects morale and that affects the performance of people in their jobs. This is a big thing.

● (1045)

Dr. Ginette Poulin: I think that's where we're left questioning when we see the Peachey report on having a focus on mental health and addictions, the Virgo report saying we need increased funding, and then we're being asked to cut back annually—1% to 4% over the past few years—not only with Addictions Foundation of Manitoba, but other delivery of mental health and addictions as well. It leaves us a little perplexed as to where the money is coming from for us to help augment our services. It just highlights that.

I think one of the asks that would be helpful is if you could provide the means to allow mechanisms to provide more certainty and sustainability, as I was saying earlier, with the accountability coming to health organizations such as ours so we could see the money coming more directly for those of us providing the services.

Ms. Irene Mathyssen: Thank you.

In 1996, Roy Romanow said that mental health care services were the orphan of the health care system and it sounds as if the orphan is still a reality there.

I wanted to talk a bit about the impact of poverty. As you know, we now have a new measure for poverty, the market basket measure. Based on the old system, there used to be a reckoning that 19% of seniors lived below the poverty level and now with this changeover to the market basket, it's fewer than 5%, magic by manipulating numbers.

I wonder about the impact of poverty on these traumatized populations: indigenous populations, those people who need interventions. How are you seeing poverty contributing to this malaise?

Dr. Ginette Poulin: Absolutely that is a contributing factor and is concerning, given that we have a higher percentage. I think we're facing this issue of poverty dependency more and more in our social system.

Again, a lot of trauma is surfacing in many ways. We know that. Again, in literature these people are more likely to experience it, given that it's a large risk factor in addictions and substance use. When we look at strategies that include things like housing and other social supports that are basic requirements, I think that is a crucial part of the solution.

The Chair: Time's up.

We're beyond time now, but I'm going to go for one more question from Dr. Eyolfson.

Doctor, could you ask your questions quickly?

Mr. Doug Eyolfson: Thank you, Mr. Chair.

The only one that comes to mind right now.... We've talked about this a lot, we've had a lot of drug issues, and I found this in my previous career. There's a huge interplay between mental health, drug addiction and substance abuse in general. We know that a very large proportion of drug use is by those with underlying and as yet undiagnosed mental health issues who are attempting to self-medicate, even teenagers.

We've diagnosed schizophrenia in teenagers brought on because of their drug use, and it turns out they were taking drugs because they were hearing voices. In this population it's very hard to track meth in particular, and as you said, Dr. Young, these people are often under-represented in surveys.

Do we have any idea of the proportion of those who are addicted to methamphetamine right now that have underlying mental health issues, whether it's a severe mental health diagnosis like schizophrenia, bipolar illness or anything like that?

Dr. Matthew Young: We don't really. We have some one-off surveys or one-off studies, but really, we don't know.

One of the recommendations in here was that we need to invest in what my colleagues from Health Canada were talking about, which is a good national drugs observatory, so that we truly understand the nature of the issue. I've heard it referred to. I forget where, but it's said that most drug crises are really a crisis of despair mapped upon an unsafe drug supply. When you put those two things together, you get a very toxic mixture that does great harm to our communities.

Dr. Ginette Poulin: Anecdotally, we're certainly seeing high percentages of persons who have co-occurring conditions. One of the innate challenges that we have is that, because our system is siloed and funded, mandates are based on someone dealing with mental health and someone else dealing with substances. They present to the door for services for mental health and are told they need to go deal with their addictions before they can access the services for mental health, and then it's the chicken and the egg. They are bouncing back and forth, and we're missing the mark grossly. Again, we need to have strategies that can look at this collectively and address the issues as a whole. That way, we can break it down and move past this silo strategy for addressing this, because it is not working.

● (1050)

Mr. Doug Eyolfson: Thank you.

You're making me perversely nostalgic for my previous job because we found the same thing. Someone would come in and say, “I have mental health issues. I have addiction. The addiction people won't take me in until I get help for the mental health. The mental health people won't take me until the addiction—

Dr. Ginette Poulin: Unfortunately, we're still in that position today.

Mr. Doug Eyolfson: We're still there.

Okay, that's all I have to ask.

Thank you to the committee for it's forbearance on this extra time.

Thank you very much for coming.

The Chair: It wasn't extra time. You were entitled to that time.

I want to thank the witnesses so much. I want to thank you for what you do too, because you have a tough job. You're talking about lives, health, young people and enormous problems, so thanks very much for what you do.

The meeting is adjourned.

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