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Chair

Mr. Bill Casey

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● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Welcome, everybody, to the 135th meeting of the Standing Committee on Health. This is a new first. All our witnesses are here by video conference. It should be exciting, and hopefully we'll be able to get through it without too much technical difficulty.

First, from Saskatoon is Dr. Peter Butt, Associate Professor, College of Medicine, University of Saskatchewan. Then we have Dr. Réjean Thomas, Chief Executive Officer of Clinique médicale l'Actuel from Montreal. From Sarnia Police Service, we have Detective Sergeant John Pearce, and from the City of Toronto, we have Dr. Eileen de Villa, Medical Officer of Health, and also Jayne Caldwell, Policy Development Officer, Toronto Public Health.

Each group has a 10-minute opening statement, and we're going to start with Dr. Butt.

Dr. Peter Butt (Associate Professor, College of Medicine, University of Saskatchwan, As an Individual): Thank you very much.

The impact of methamphetamine on the prairies has been particularly devastating and certainly increasing year by year. I've provided a breakdown to you of the information on the supply side, the demand demographic that we're seeing with regard to the individuals who are using, the impact with regard to HIV, hepatitis C and IV drug use, keeping in mind that approximately 70% of the HIV that we see in this province is transmitted through IV drug use, driven primarily by opioids but increasingly by the injection of methamphetamine.

The people we have dying from AIDS are those who, in spite of the fact that care is available to them, are typically in psychosocial chaos because of their stimulant use. They can't simply make it to the pharmacy each day if they're on opioid agonist therapy to take their antiretroviral therapy for their HIV, and we lose them. We have a high mortality rate.

There are treatment challenges with regard to methamphetamine that are somewhat unique. Because of the potency of the stimulant, because of how long-lasting it is, it has significant challenges in the acute intoxication phase. At the extreme end, you will see people with psychosis who are very disordered, agitated, paranoid and potentially violent, but certainly many people under the influence take a small amount every day and are chronically impacted by its effects.

Also with regard to the acute treatment is the challenge that it poses in emergency departments when people present there, and the need for a calmer space for intervention if they're psychotic that doesn't necessarily require psychiatric intervention but does require protocols.

Then, of course, there's the phenomenon of sensitization where with increased use, people may be more inclined to have seizures, psychosis or what we call repetitive stereotypical behaviour.

Finally, there are challenges with regards to the stimulant withdrawal, not so much the acute withdrawal, which can indeed be problematic, but more what we call the post-acute withdrawal. Once the substance is out of the body, the problem then is what's happening in the brain in reverting to normal, which can take weeks or months. This is a high relapse period, a time of craving and a time where if there isn't adequate support, they're more likely to relapse. I've provided you with brain scans that show some of the changes that occur there. One could frame it as a form of chemically mediated acquired brain injury when you have a severe addiction.

I think what's important here is looking at what potentially could be a federal role in closing the gaps in care. I don't know if you want me to continue to explore them now or if you would prefer to explore them after others have made their introductory comments.

The Chair: That's up to you, however you think it would be best served. Perhaps you should continue because I'm sure you know a lot more about this than any of us, so you know the pertinent things.

You go ahead.

Dr. Peter Butt: I think what's important is that we should acknowledge the role of the Health Canada's emergency treatment fund bilateral agreements that have been struck, the funding that we have received within the province and the way that it's been utilized to improve the quality of care to address some of the surge issues that we've seen with methamphetamine. Unfortunately, at a provincial level, it doesn't translate into boots on the ground in terms of health care providers. We have to look to the province for that.

What we do need, though, is to look at ways that people transition. What we have is essentially a chronic disease at a severe level. Our system treats it with episodic acute care, a little bit of detox here and maybe 28 days of treatment there. They're not necessarily well connected; they're disjointed.

I think something that would greatly help us is the federal government being more involved in therapeutic or supportive housing for people who can be housed in a therapeutic community, or supportive community between detox and treatment, and from treatment out into more of a recovery mode. They would have other wraparound services, social services for income support, transition to other housing, education, vocational training and so on, which are not necessarily in the purview of the federal government. We could find ways to target federal funds towards therapeutic housing to close the gaps, because recovery takes one to two years. Episodic acute care is not going to meet that need, but therapeutic housing may very well.

Where can we look for that? Certainly there are a number of ways that we could approach this. Perhaps there are ways to use tax benefits to get the philanthropic sector, the private sector and the public health care sector working together in partnership, in a 4P approach, if you will, so that this money can be used to support programs that normally would not be provided by the health sector alone. That includes housing and wraparound services.

Another way would be looking at how people donate or how philanthropists may come forward with money. Often it's a one-time example of their largesse, but, if there's a social impact that benefits the system of care, which is going to save money in terms of acute care and other health care costs, perhaps that could be recognized in terms of a social impact benefit of charitable donations, which increases the value or has a way of recycling it, so instead of once-only funding, we have a way of continuing to recycle that charitable sector funding.

Housing that's dedicated to this would be helpful. We can do that by enabling developers to dedicate an apartment building to drug and alcohol-free living space with support from the health care sector to create those therapeutic communities we need in order for people to recover.

I think we should also be looking at transitions from where people congregate, such as emergency departments. Rapid access to addiction medicine would help to get them stabilized, back out in the community and connected with community care. That sort of transition is important, but it's often not done efficiently.

The other area of congregation, however, is in our correctional system, in our jails. In Saskatchewan, 70% of the people in provincial corrections are there because of drug and alcohol problems. It's not a therapeutic environment. There are ways that we could enhance drug courts to look at more focused intervention, recognizing that a crime has been committed—or potentially, if they're only on remand—but also recognizing that there are ways that we can use this sector more therapeutically to get to the root cause of the crime and the problems in our community.

Is this something where we can use some diversion from correction money, from penitentiary money, into the health care sector, into the mental health and addiction sector, to increase the services? All too often these are court ordered, but the health care system doesn't have the capacity to deliver in a way that's going to have a sustainable impact over time and is going to prevent re-incarceration.

● (1535)

Finally, one other source would be the proceeds of crime. It's great that it goes to the police, but if this is related to mental health and addiction issues—and the majority of crime is related to mental health and addictions—we need more social work and police teams working in our communities to be more proactive to address some of these issues. We need targeted funding for treatment and intervention, as I described previously.

I'm trying to think of ways that the federal government could be involved in providing targeted funding through taxation, through charitable donations, through housing, through proceeds of crime, which could help us address this significant gap in terms of the continuity of care, the care that goes from harm reduction—which from a treatment perspective, is outreach and engagement—through detox as indicated, into treatment and transitioning on into recovery.

The best way to prevent this intergenerational transmission of addiction is through treatment and helping people to transition to recovery and become productive citizens. It can be done. It's frequently done, but often it's in spite of us, not because of us.

● (1540)

The Chair: Thanks very much for that, and thanks for your report too. It's very comprehensive and helpful.

Now we're going to go to Dr. Thomas.

[*Translation*]

Dr. Réjean Thomas (Chief Executive Officer, Clinique médicale l'Actuel): Good afternoon.

I am Dr. Réjean Thomas. I'm not an expert on addiction, but rather sexual health. I'm going to talk to you about the link between amphetamine addiction and the current epidemic of sexually transmitted infections, or STIs, HIV and hepatitis, particularly in downtown Montreal.

The Clinique médicale l'Actuel has been in existence since 1984. We are located in Montreal's Gay Village. So we have gone through the entire AIDS crisis and seen extraordinary progress.

What I'm seeing in the office today is catastrophic. It's something I didn't see three or five years ago. Increasingly, we have begun to see use of crystal methamphetamine, or crystal meth, in a population that is quite different from Saskatoon, but with the same harmful effects. Our clientele is made up mainly of gay men who don't have substance abuse problems. This population is relatively well-educated and financially comfortable.

Slowly, for all sorts of reasons that are difficult to understand, crystal meth has arrived in the Village. Every day we see at least one, two, three, four or five patients with severe addiction. The problem with this drug is that addiction occurs rapidly. People are losing their jobs. They are businessmen and people between the ages of 16 and 72 who have lost everything and are being thrown out on the street.

This drug also creates a sexual addiction in individuals. We have to work on this double addiction, which makes it difficult to treat these patients. I have very few patients who have managed to get off crystal meth; it's a very long process. When these people in the gay community use detox resources, there is a lack of understanding of this double addiction, which leads to what we're seeing today.

For example, in 1998, there were three syphilis cases for all of Quebec, whereas now there are 1,000 a year. There isn't much AIDS prevention in Canada and Quebec, either. At first, this was most common among gay men, but now, women, some of whom are pregnant, have syphilis. Some children are even born with the disease.

The same is true for hepatitis C. In these groups, there are more and more cases of sexually transmitted hepatitis C, whereas it has always been said that this disease is transmitted more through blood and injections. The epidemic context is quite important, not to mention the human problems Dr. Butt mentioned, the psychoses and all that.

I have provided you with some data. Currently, we have about 2,500 patients with HIV and nearly 3,000 patients who are now taking what is called pre-exposure prophylaxis, or PrEP. It is HIV preventive treatment for gay men who we consider to be at high risk after asking them questions. Nearly 30% of people undergoing this treatment practice “chemsex”, meaning that they have sex under the influence of hard drugs. We aren't talking about cannabis or alcohol, but just hard drugs such as cocaine, GHB or crystal meth. Thirty percent of our customers is huge.

Evidently, you have to ask questions. People don't tell us that right away. Often they are our patients, and we learn this by asking questions. This drug is very insidious. People start smoking a little, like those who used to use cocaine from time to time at one time. Now people become completely dependent quickly, and it destroys their lives.

In addition, 30% of this clientele is under 30 years of age. These people use very strong drugs and earn a very average income. The most commonly used drugs are cocaine, ecstasy, crystal meth and ketamine. Our customers use very strong drugs. These 30% of our patients who practice “chemsex” have many more sexual partners, 34 partners in the past year. They have much more unprotected anal intercourse and are at high risk of contracting an STI after 12 months.

● (1545)

On average, these patients have almost 50% more STIs than people who don't use drugs.

Our data really show that our preventive treatment is aimed at a clientele already at high risk. It must be said that the treatment is very effective. We have no cases of HIV among all these patients. We have seen a reduction of nearly 50% in current HIV cases in the last two years.

We have incredible treatment, but at the same time we have clients with addiction, sexual addiction, STIs and HIV problems. I am talking about clients who are HIV-negative, but we see the same thing with our clients who are HIV-positive.

Sometimes people come in who stop their treatment—they are too unstable—and even do not take PrEP. This has difficult consequences: it is a very heavy clientele for which we have very few resources. We really manage to support these people between us, as doctors and nurses. We work with dependency centres, but their staff are not necessarily familiar with or comfortable with this clientele. There is really a twofold problem. This is what we see in at the Actuel clinic.

[*English*]

The Chair: Thank you very much for that. It certainly sounds like you have your challenges.

Now we go to Detective Sergeant Pearce for 10 minutes.

Detective Sergeant John Pearce (Sarnia Police Service): I'll try to take 10 minutes, but as I'm sure you'll find out, I talk rather quickly and off the cuff.

In the Sarnia area, we've been experiencing an extensive problem with crystal methamphetamine for close to 30 years. Recently, due to the changes in the structure of how methamphetamine is used, delivered and trafficked, we have come across the delivery of crystal methamphetamine. Prior to that, historically we were an old-school liquid methamphetamine community affected by biker-type methamphetamine from California back in the early days, the fifties and sixties. The problem is that crystal methamphetamine has become stronger, obviously, and more addictive, and it allows different delivery mechanisms that are enticing to certain individuals.

The other thing with the drug that I find makes it attractive in this particular community is that we have a very blue-collar socio-economic makeup, and this is a cost-effective, affordable and easily accessible drug. The issue now is that we're starting to find out that it is easy to manufacture, and also, it is somewhat dramatized, I guess you could call it, or publicized more through commercialism and the Hollywood-type of exposure, which makes the drug more attractive and possibly allows people some peace of mind when they're taking it. For the most part, a lot of them don't even know what it consists of or how it's manufactured. When they hear the word “amphetamine” thrown into something, I think it gives them some sort of an idea that it's a pharmaceutical-grade type of drug that has been around for a long time.

Historically, we know that amphetamine has been around for over 200 years, for other uses and purposes, but certainly not to this extent, and it was never made up of these types of chemical compounds that we're seeing now, which of course are being closely regulated and controlled through amendments to federal acts such as the Controlled Drugs and Substances Act. It controls a lot of these precursors and the chemicals themselves. In particular, pseudoephedrine was a big one we had problems with years ago, but now we're starting to find out that these individuals, through their own entrepreneurial skills or intense fortitude, tend to be able to manufacture the stuff on their own, sometimes in quick and easy quantities that are easily accessible.

These are not just the compounds that we see on a daily basis and are manufactured at a high level though organized labs. These are even the impromptu, unsophisticated uses in the development of crystal methamphetamine by individuals on the street and otherwise. That makes it more attractive to a different socio-economic group, too, and as was alluded to earlier, we see more and more that it's starting to affect a younger generation. Before now, it was reserved to a certain age group, the mid-to-late thirties into the fifties. Now we're seeing people as young as early or late teens wanting to experiment with the drug and quickly realizing that this isn't the type of drug you experiment with because it's so addictive. When they become addicted to this particular drug, they realize there's certainly no point of return for them once they get into the exposure, the symptoms and the side effects of this drug.

Keeping that in mind, this creates a whole new problem, because now we're dealing with other issues. We have our opioid pandemic, so to speak, in our own area here as well as nationally. However, from the standpoint of this city, we've traditionally been a meth community, prior to the opioid crisis evolving in the early 2000s. Still to this day we find out that people are starting to get involved in the crystal methamphetamine trafficking trade, where they're holding drugs out to be crystal methamphetamine but which we later find out test positive for fentanyl. There are things like that, where people are not doing their research and aren't interested in checking their source, so to speak, or attempting to identify the source or mechanism of the drug.

● (1550)

We just had an incident in Ontario close by here where drugs were held out to be crystal methamphetamine and tested positive for fentanyl. As anyone knows, if you have an amphetamine addiction and you throw opioids into the mixture, it's a recipe for disaster and we're definitely going to have overdose issues.

Locally here, we do have overdose issues, not just on opioids but in crystal methamphetamine. We're struggling right now with funding for our own detox rehabilitation housing here. We've been able to open up a seven-bed detox centre statically through our Bluewater Health hospital. However, we've been pushing for a 24-bed delivery system for several years and it seems like it's been caught up in some financial bureaucracy at the federal and the provincial level.

I know the local MP has certainly been an advocate for us and has certainly been pushing for the funding. I think we are going in the right direction here for identifying that crystal methamphetamine addition, methamphetamine addition in general, is very addictive and very volatile. It is a somewhat different scenario when we're dealing with people coming off the addiction or treating the addiction and trying to get them to some sort of realistic future off the drug. What we're having problems with right now is just getting them to some sort of detox program when we suggest to them that they have been seven days free of the drug and to carry on with therapy after that. That is where we're at right now; it's a very similar trend to other drugs that I alluded to.

It sounds like a lot of us are on the same page. The big thing right now is there is a spike in STIs in the community and in the county in general, and a lot of them are relative. One of the big side effects of amphetamine is some of the sexually active side effects that it does cause with the trend of the stimulant. With that in mind, it certainly segues into the fact that there are issues to deal with other than psychosis and the mental health issues we are dealing with as a direct result of the drug. There are also the other side effects that have to do with sexually transmitted infections. This drug is one of the few drugs that encourages sexual behaviour and can stimulate that as a side effect, indirect or otherwise.

From what I've heard so far anyway, we're all on the same page, even if we have different socio-economic backgrounds or different issues relevant to crystal methamphetamine or amphetamine in general, and I'll be interested to hear everyone else's comments.

● (1555)

The Chair: Thanks very much.

Now we'll go to Dr. de Villa, for 10 minutes.

Dr. Eileen de Villa (Medical Officer of Health, City of Toronto): Good afternoon. Thank you, Mr. Chair and members of the committee, for the opportunity to speak with you today.

As you've heard, my name is Dr. Eileen de Villa and I am the Medical Officer of Health for the City of Toronto. In that capacity I and my organization, Toronto Public Health, serve a population of about 2.8 million people. I am joined today by my colleague Jayne Caldwell. She's a policy development officer in Toronto Public Health and works quite actively in the work we do at Toronto Public Health in respect of drugs and drug use among those who live in our city.

It's my understanding that you have been studying the impacts of methamphetamine use in Canada since November and have heard quite a bit of evidence from a variety of experts on these issues. For the purposes of our remarks today, we will focus largely on Toronto.

As you are aware, just as a little bit of a reminder, methamphetamine is a stimulant, along with other illicit drugs such as powder and crack cocaine and pharmaceutical drugs such as amphetamines. Historically, here in the city of Toronto, we've seen more harms resulting from the use of cocaine, although we can say that methamphetamine use has been increasing and has risen in recent years.

Looking at the impacts of any substance use, methamphetamine included, we need to actually understand why people use drugs and the context in which they use them. Looking at our particular data, I can say that rates of stimulant use are low in the general population, particularly for methamphetamine. The most recent Canadian community health survey data tell us that 4% of Toronto adults have used methamphetamine in their lifetime. The use of cocaine, by contrast, was more frequent, with 2% of Toronto adults having used it in the past year and 9% of Toronto residents indicating that they've tried it at least once in their lifetime.

We know through our practice here that, when people have issues with alcohol and with other drug use, it's often a symptom of much larger issues. For example, the prevalence of substance use is much higher among people who are experiencing homelessness than it is among those in the mainstream population, and this is certainly the case in Toronto. It is, however, important to note that substance use, in and of itself, is not necessarily a cause of homelessness, particularly for most people in Toronto. In fact, last April, when the City of Toronto, with its partners, conducted a count and survey of its homeless populations, only 5% of people surveyed noted addiction or substance use as a reason for their being homeless. Substance use among people who are experiencing homelessness is often associated with unmet health care needs, and over half of the respondents in this survey reported at least one type of health condition. Specifically, it was 57%.

Our harm reduction program in Toronto Public Health provides a range of health services to vulnerable people who use drugs. People can receive nursing care, methadone treatment, care for communicable diseases such as hepatitis C and HIV, and much more. We also operate a supervised injection service, where people can consume pre-obtained drugs under supervision. Between October 1 and December 31 of 2018, there were 9,460 visits to our supervised injection service. The data from the Works, our supervised injection service here in Toronto, show that in about three-quarters of the 9,460 visits to that service, people actually used opioids. ln about one-third of visits, people used amphetamines or methamphetamine, and cocaine stimulants were used 4% of the time, with other drugs being used about 3% of the time.

These data are consistent with a Health Canada survey of Toronto adults who were street-involved and used drugs; some 30% of them reported crystal meth use in the past year. However, crack cocaine use was much more prevalent, used by 75% of those adults. Historically, methamphetamine use in Toronto has been more frequent among street-involved youth. ln a 2013 study, 54% of street youth in Toronto reported using crystal meth.

● (1600)

While each person's motivation is different, some people use stimulants such as methamphetamine for practical reasons, to help them stay awake, to have more energy and to focus on tasks. This is true for people from all walks of life. For example, here in our city, we know that women who are homeless have said that they use crystal meth to stay awake at night because they fear of being vulnerable if they fall asleep. People also use stimulants to boost their confidence, to enhance sociability, as we've heard from other presenters today, and to enhance sexual activities. We've also heard today that crystal meth is sometimes used by gay, bisexual and other men who have sex with men to maximize pleasure and sociability with sex partners. We also know that some people use various drugs, including stimulants, to help them get through opioid withdrawal symptoms.

There is indeed the potential for harm as a result of methamphetamine use. As I am sure this group would know, both those via video conference and those of you in the committee room, our illicit drug supply has become increasingly toxic with potent opioids and many other drugs. Many people are coming to our supervised injection service here is Toronto because of fear of overdose from the current drug supply. In Toronto, for example, there have been occasional reports of opioid overdoses following the use of drugs that the individual believed to be a stimulant.

People also intentionally combine the use of drugs, including stimulants and depressants. They do this for a variety of reasons, including to help modulate the effects of one drug over the other. However, drugs can combine in a person's body and act together to cause severe reactions, and even death. While most accidental deaths are now caused by non-pharmaceutical, illicit fentanyl, in some cases, stimulants are also a contributing cause of death with opioids.

In fact, between May 2017 and March 2018, preliminary coroner's data on accidental deaths caused by fentanyl in Ontario shows that cocaine contributed to just over one-third of these deaths, and methamphetamine contributed to about 14%. In Toronto, however, cocaine contributed to over a half of accidental deaths caused by fentanyl— that's 53%—and methamphetamine contributed to 12% of these deaths.

In fact, in most cases of deaths in Ontario in which stimulants were a cause, other drugs also contributed to the person's death. In preliminary coroner's data for 2017, 90% of deaths in Ontario caused by methamphetamine, and 86% of deaths caused by cocaine also had another substance contributing to the death.

The number of deaths in Ontario where cocaine or methamphetamine either directly caused the death or was one of the drugs causing death has risen sharply. In 2012, 14 deaths across the province included methamphetamine as a cause of death. This number rose to 217 in 2017. And just a reminder, this is preliminary coroner's data. The number of deaths by cocaine toxicity alone or in combination with other drugs also increased during this time period from 142 deaths in 2012 to 587 deaths in 2017. Again, I'll remind you that this is preliminary coroner's data that I am giving you.

Some people struggling with substance use do seek help from treatment programs. For several years in Toronto, crack cocaine has been the most common stimulant for which people sought treatment. While this is still true, the number of treatment admissions for crack cocaine use declined by 4% between 2012 and 2018, from 32% to 27%; and there was a rise in admissions for issues with cocaine powder, from 16% to 23%, and methamphetamine, from 4% to 12%.

In addition to treatment programs, Toronto has other dedicated supports for people who use stimulants. Many harm reduction programs that provide education and supplies for safer drug use have focused efforts on educating people about stimulant overdose.

● (1605)

There are also resources for gay, bisexual and queer men. For example, the AIDS Committee of Toronto has health promotion materials and support groups specifically targeted at these groups of men.

In Toronto's downtown west end, St. Stephen's Community House has a new crystal meth pilot project to support people who frequently use withdrawal management services and hospital emergency departments. In addition to providing case management support and connections with health services, front-line workers are trained in how to support people who use crystal meth.

The Ontario Harm Reduction Network also plays a critical role in this issue. It brings together evidence from cross-sector experts, including people with lived experience, to train people around the province on many issues related to substance use. Last year, it held webinars focused on methamphetamine and was overwhelmed by the demand for these sessions.

The Chair: Dr. de Villa, we have to go to questions now. I'm sorry. I know you're not quite finished. I hope we'll be able to get to the rest of your material through questions.

We're going to start our seven-minute rounds with Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Chair.

Thank you for your testimony.

My first question is to Toronto Public Health.

You talked about peer support groups. How are they giving support to the meth user population? What kind of support are they using?

Ms. Jayne Caldwell (Policy Development Officer, Toronto Public Health, City of Toronto): The AIDS committee of Toronto has personal support groups, so they have people come in—men—for psychosocial support. They do different things. They also have outreach workers in bathhouses, for example.

They do a range of work. There's not one type of support, but I think many agencies work like that with different populations. The Works in Toronto Public Health also offers specific support, based on the individual person's needs. The person may need help, for example, with crystal meth, but also with housing. Typically, these programs will try to serve a range of needs.

Ms. Sonia Sidhu: Dr. de Villa, can you describe what tools, programs and resources are presently available to help parents and educators prevent substance use among youth and promote early education so they don't use crystal meth and other substances?

Dr. Eileen de Villa: I can start off with that a little bit. We certainly have a number of programs directed toward young people and for parents and caregivers of young people. We have a number of programs in schools that are not necessarily specific to any one substance or drug but talk about substance use on a broader basis, and that would include substances like methamphetamine.

Do you want to talk about specific methamphetamine programs, or is there anything that we...?

Ms. Jayne Caldwell: I'm not sure. I would just say that successful programs to prevent substance use also address other determinants of health. They're also working with parents around decision-making, communication and safety, and substance use might be one of the subjects they cover. It might not be the main subject. There are a range of approaches out there.

Ms. Sonia Sidhu: You said there's a rise in meth use from 4% to 12%. Where did you get that data from?

Dr. Eileen de Villa: This is in respect of the number of treatment admissions for methamphetamine, and I will tell you the exact source for that. That is from our drug and alcohol treatment information system, courtesy of our colleagues at the Centre for Addiction and Mental Health, right here in Toronto.

Ms. Sonia Sidhu: Thank you.

My next question is to Detective Sergeant John Pearce.

What are some of the best practices related to training health service providers and law enforcement officers to help them overcome the stigma related to drug use?

● (1610)

Det Sgt John Pearce: Once a year we undertake training for several hours.

We meet with people and members of the community at large through Canadian Mental Health, through addiction services. We go over trends and research data locally about what we're finding in addiction concerns, treatment concerns and admission concerns.

We collaborate on a regular basis on issues of drug concerns: whether we have a specific type of drug problem, some of the side effects caused by the drug, some of the repeat clients we're dealing with and the resources required to deal with them as well as the concerns we have about dealing with them if they're in crisis at the time, whether it's a medical or a physical crisis, a mental health issue, and how we're going to combat that and get them the treatment they need.

We've obviously discovered they don't need to necessarily be in custody if a potential criminal allegation is made, or a criminal scenario. We try to diagnose and facilitate the corrective action to take, whether it's to simply call in a crisis worker from Canadian Mental Health, whether we realize from arriving on scene that the individual is in medical distress, along with their addiction issue. But do they need to go to the hospital? Do we need to get them sent to a medical facility for treatment? Sometimes it's a secondary issue.

I think the big thing is that we need to get on track with educating everybody consistently, and it has to be done at least on an annual basis. We're all on the same page. We extract the resources of all the services available, and we come to a common ground on what we're doing to facilitate the needs of the community.

When we come into contact with these people, they're normally at that stage of their addiction, psychosis or medical issue where they've come to the attention of the public at large, where they're acting out and we have to intervene. It's not necessarily as it was in the past, where it was a law enforcement issue and they just needed to be arrested, handcuffed and taken to the police station.

Ms. Sonia Sidhu: Dr. Butt, we heard the challenges of meth use: seizures, withdrawal, need for long-term treatment. There has been some talk of telehealth treatment. In what ways can telehealth treatment help meth addicts?

Dr. Peter Butt: It may have a role in rural and remote areas that are having problems accessing care, but it still is a capacity issue.

Frequently what we see in more rural and remote areas is a primary role through non-insured health benefits, first nations and Inuit health, and the national native alcohol and drug abuse program, NNADAP, with their counsellors providing that within the community more on site.

I think that the distribution of methamphetamine that we see in the province.... From my understanding we don't see a lot of local labs from our police services. Rather, it seems to be coming from out of province or indeed out of country, coming in from Mexico. The distribution tends to be more in the larger and regional centres rather than farther out into smaller rural and remote communities. This isn't to say that it doesn't get marketed there, doesn't get distributed there, but typically, because of the criminal organizations that are distributing these illicit drugs, they tend to go where the market is.

What we see with methamphetamine is that it seems to be directed toward poorer communities, which is perhaps why we see it more on the plains. Fentanyl is less of an issue in Saskatchewan, where 10% to 15% of our opioid-related deaths are due to fentanyl. The rest are due to prescription opioids, unlike in British Columbia or Alberta. Fentanyl is getting mopped up in those more western provinces when it's coming in from the coast. However, we see an increase in the marketing of methamphetamine.

● (1615)

Part of this is a marketing and distribution issue. To get to your core question, I think there's a role for telehealth, no question, but I think it needs to be targeted to community and resources that are on the ground.

The Chair: Thank you.

We have to go now to Ms. Gladu from Sarnia.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Thank you, Chair.

I'm going to start with Detective Sergeant John Pearce, because I want to thank him, first of all, for his outstanding service in the community, and also for the excellent input he provided recently at an opioid and methamphetamine round table we had, where we talked about the issues. As he's indicated, we don't currently have a detox...or any recovery for people who want to get off drugs. Because of that, there is an endless cycle, a revolving door, of arresting and releasing.

Could you describe for the group the insight you shared with me at that meeting?

Det Sgt John Pearce: Yes. Thank you.

The issues we're having were partially covered in the last question. We have this cycle. We come into contact with an individual, and if there is an allegation of a criminal nature and-or we don't necessarily have a medical issue, and the individual is potentially arrested for a criminal offence, typically they are taken to the police station. Police stations are not suitable for this type of individual. First off, if they have a drug addiction problem and they're high at the time, it's definitely not the right place to be. Or worse, if they're coming down off the high and they're detoxing, it's even more of a medical issue and-or a safety concern. Once they do present in a formal structure for court, whether it be for a bail hearing or simply an uncontested release, unfortunately, with the process in general, whether it be through the ministry of the attorney general's office or the justices of peace, we're finding the individuals back on the street, typically within hours of our arrest.

No matter what the central allegation is, we find that a lot of the time these people are, first off, homeless. They don't even have a place that they call a residence. We would call that “no fixed address”. The next thing is that they're potentially put back on the street again, into the same environment they just came from, where they had just been out potentially committing criminal offences, typically property crimes involving breaking and entering into homes or businesses and-or personal property being stolen or vandalized. They get put right back out on the street again, literally within hours. Typically, they're of no fixed address and are put back onto the street with some quasi-conditions. Within sometimes hours, sometimes days, we're having the same interaction with this individual again, where we have no other recourse. Now they're potentially breaching conditions they've been released under, and we put them back in front of the court system again, potentially for a very minor infraction. But, once again, they haven't reported that they need to go for medical help. They haven't suggested they need medical help. The furthest thing from their mind is the fact that they need to go to some form of detox; nor would they be suitable, potentially, for detox at the time.

From there, they also know that once their detox is complete, they have no other avenue to go to. Even if they go to detox and last out the seven days at the hospital, they're basically shuttled back out onto the street again, and promptly, because we don't have anywhere to send them right away. If we have a referral on a queue to send them to a treatment facility, sometimes that can be days or weeks away, so we're basically just putting them in a holding pattern. We hope they're on their honour system, and they're not going to reuse or reacquaint themselves with what we were trying to detox them from —or any substance for that matter—and hope that they can hold the line until we get them into a facility. The next thing you know, as soon as we open that door and let them out, whether voluntarily or not, they're back at it again. By the time a bed does become available for some sort of treatment, they're not interested; and we have to start over again anyway, because now they'd have to detox.

It's a vicious cycle. It just seems to be a revolving door to which there's no direct answer.

● (1620)

Ms. Marilyn Gladu: That's exactly what I wanted to hear, because it shows that, without recovery in place, you're not going to solve this issue.

I'd like to ask Dr. Peter Butt this as well. You mentioned that we need therapeutic supportive housing, and I'd like you to comment on this same thing. What are you missing in terms of recovery? How many beds would you need? How long is it to get treatment? What's the situation in the Prairies?

Dr. Peter Butt: It's very similar to what we've heard elsewhere, where there isn't adequate capacity with regard to accessing detox.

Keep in mind that detox is not treatment; detox is simply the first step. Locally, people have to keep phoning until there's a detox bed available, so they need access to a telephone, and they need to have the persistence and the perseverance to keep on calling until a bed becomes available. For somebody who's struggling with a substance use disorder, if they're craving or they're in withdrawal, they're only going to be doing that for a certain period of time before they go back out and self-medicate, if you will. They'll continue to use to avoid withdrawal.

I think that we set people up by not having a system of care that's evidence based and has continuity from outreach and engagement through various harm reduction strategies when they're prepared, when they want to move on to detox and have a transition there. The gap between detox and different treatment models is variable. In some instances, if people have stable housing, they might be able to go to a day program, and they don't have to go into residential treatment. But by and large with the folks we're talking about today, the psychosocial instability is such that residential treatment is usually preferred. Until their minds are more settled, it's very hard for them to engage in counselling, in the psycho-educational groups, and the intensity of just being present, not to mention some challenges with perhaps literacy skills and the pedagogy of how these things are taught within treatment centres, the ideology.

A host of things may not speak to a person. If the treatment centre is modelled on alcohol, that's not going to resonate with people who are smoking or injecting. They don't see the commonality to it. We need to be very mindful of this and be culturally appropriate, gender appropriate and so on. That sometimes is where supportive housing between detox and treatment can be helpful to help them to further stabilize so that they can engage when they go to a treatment centre. Following treatment, what's a 28-day period for brain rehab? Nowhere near long enough, and some treatment centres will go three months or six months.

I think it has to be client specific, particularly if there's a concurrent mental health problem, trauma or just layers of other issues that need to be addressed until people can get stable enough to get back out into the community and function on a day-by-day basis. This takes time, and that's not how we have provided services. As I mentioned, it's episodic acute care, nowhere near what we need.

In the DSM-5, the psychiatric manual, three months of non-use is early remission. Twelve months of non-use is sustained remission. We don't stop cancer treatment before they even get into early remission, and yet that's all we offer people with addiction. We're not offering them enough, long enough, appropriately client-centred treatment in order to achieve the success we could achieve if we did, and we blame these individuals because they're not able to get better. We don't provide them with a coherent, evidence-based system of care.

The Chair: Okay, we have to move on now to Dr. Eyolfson.

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

Thank you, all, for coming. That was all very interesting testimony.

This is directed to two of our witnesses, Dr. de Villa and Dr. Thomas. You both talked about harm reduction, particularly for injected drugs, and the use of safe consumption sites as part of health reduction, by no means as a long-term strategy, but as a short-term strategy.

Would either of you be able to give us an estimate on the yearly budget? How much does it cost at a harm reduction site, just the component that is for the safe injection site? Is there any estimate as to what that component of it costs in a year?

● (1625)

Dr. Eileen de Villa: It all depends on the model you've got. There are many different varieties of supervised consumption service that are available, and it depends on the nature of the staffing.

At Toronto Public Health, ours is a nurse-led model. We do have peer workers, as well, as part of the service. It's not just a supervised consumption service. It does also offer a variety of other services. We have a methadone clinic, for example, and we offer supplies for safer use. We also make referrals to necessary health care services.

Because of the nature of the staff we have and the nature of the contract we have with our staff, we tend to be a more expensive model than other community-based models doing similar things.

Also, it all depends on how many booths you have. Right now, we're able to accommodate six people at any one given time for supervised consumption service, per se.

Mr. Doug Eyolfson: Okay, thank you.

The reason I'm asking this is that one of the things that safe consumption sites will prevent, of course, is the transmission of blood-borne illnesses. You prevent HIV transmission and hepatitis C transmission.

From what I understand—and I haven't practised medicine in three years now—a single case of HIV can cost close to a million dollars in treatment over the life of the patient and a single case of hepatitis C might cost about a third of a million dollars per year. Do these sound right to you, as well, these figures? I see you're nodding.

Would you not agree that, given just these cost savings, these centres are a cost-effective public health initiative and not a complete waste of money, as some detractors say?

Dr. Eileen de Villa: I would characterize them as life-saving, cost-effective and very beneficial in terms of actually establishing that relationship that you've heard the other experts around the video conference speak about as necessary to address the challenges. Harm reduction workers are a crucial part of the response, and they actually provide access to the populations, to the clients, in a way in which you and I would not be able to get access.

Mr. Doug Eyolfson: Okay, good. Thank you.

I'll address Dr. de Villa again. You were talking about crack, that it is still an issue there. One of the things this reminded me of, as I've been watching the history of methamphetamine and this recent history, is that it sounds parallel with what happened with crack in the 1980s. Cocaine was a very expensive drug in the 1970s before crack was invented, and in the 1980s, crack was invented. I think it first surfaced in New York in 1980, and that's when it started to flood the streets and become a drug of those with low incomes and those living on the street.

You said actually that there's more cocaine around in your centre. What are the trends over the years? Would you say the use of crack is levelling off? Is it going up? Is it going down?

Dr. Eileen de Villa: I think it depends on particular populations. We have seen a little bit of an increase. I think I addressed that in my remarks, but in respect of methamphetamine use, there have been particular subpopulations where its use has been more prevalent relative to the general population.

As I mentioned in my remarks, in the general population, methamphetamine isn't reported to be particularly widely used, and it's not the most prevalent drug that is used here. However, there are particular subpopulations where we are seeing quite a bit of use.

● (1630)

Mr. Doug Eyolfson: I'd like to go back and get input from you and Sergeant Pearce. Getting back to harm reduction and particularly needle exchange programs, which were the very first of the harm reduction modalities—I think they started in San Francisco in the 1980s—there are detractors who claim that needle exchange programs facilitate or encourage drug use. Is that true?

Dr. Eileen de Villa: I would suggest to you that needle exchange programs are also, as I mentioned with harm reduction, a critical, life-saving component as part of a response to drug use in our community. They are not encouraging drug use. I think they encourage safer drug use. They allow for the healthier choice for drug use to be more amenable.

Mr. Doug Eyolfson: Thank you.

Sergeant Pearce, you are in law enforcement. We've been getting push-back from staff having Corrections Canada starting to introduce needle exchange programs in prisons. We've been receiving literature saying we're here to keep the public safe; we are not here to facilitate drug use by inmates.

What would you say to the staff in Corrections who are pushing back on this, given what we know about needle exchange programs?

Det Sgt John Pearce: It's a very awkward situation. My opinion is somewhat biased. I support what they're saying, because ultimately you're not incarcerating to promote or facilitate that type of drug use.... In theory, they're being incarcerated to pay their debt to society and—

Mr. Doug Eyolfson: I don't want to cut you off, but all the medical experts have agreed, this does not facilitate or encourage drug use. It's clear on that.

Det Sgt John Pearce: Right, but that's what I'm saying. If you're having needle issues while they're incarcerated, how is it coming to be? Is it their job or responsibility to get involved in that because now we have another health and safety issue as well?

Mr. Doug Eyolfson: But you already have a subset—

The Chair: No, time is up.

Mr. Donnelly, welcome. You have seven minutes.

Mr. Fin Donnelly (Port Moody—Coquitlam, NDP): Thank you, Mr. Chair.

Thank you to all our witnesses for being here.

I want to return to my colleagues' earlier line of questions to Dr. Butt, talking about the need for therapeutic housing.

I'm wondering, Dr. Butt, if you could give us an idea of the state of the current supply of this housing.

Dr. Peter Butt: It's inadequate. Typically it relies on faith-based or community-based organizations to fill that need. It comes from people in recovery or from a particular religious or philosophical point of view who see this as an important service to the community and that indeed these individuals are worth investing in.

I think the recovery community is probably one of the stronger proponents, but it's hard for them to raise funding to provide these services. That's where working with developers, people who have housing stock who can be convinced that this is a good investment... if you're providing support to people who are transitioning into recovery or support for people in need, they're less likely to damage the property. They have income support from social services. There's a way of making this more of a wraparound approach using existing resources in the community if people can be brought together at the same table. I appreciate that Health doesn't want to buy houses, but they can provide programming to some of these residences.

We're seeing this very successfully with people who have HIV, with people struggling with mental health and addiction problems. There are mental health group homes in many communities, but we don't see a lot of addiction group homes that are effectively recovery homes. We tend to leave that to the community-based organizations rather than having them facilitated through our health care system.

Mr. Fin Donnelly: You mentioned municipalities, municipal services, developers.

How do the senior agencies fit in there, the province, the feds, the health authorities? How is this instigated? You talked about communities where this wraparound service is happening, and happening effectively. Can the federal government play a role in instigating that or is this more the municipal agencies?

● (1635)

Dr. Peter Butt: I think that every level of government potentially has a role. The question is what role they would have depends upon what enablers they have at hand. For instance, in terms of tax models that would be more federal or provincial, I would think.

In terms of recognizing social impact from people who are making donations or philanthropic organizations that are getting heavily involved in this, if they're working with the health care sector and we're providing what's essentially an expansion of a health care need, does that social impact merit a higher level of a charitable tax credit than what they would get? Or is there a way of returning some of the money they've invested in achieving a health care end back to them, that can then be recycled into the organization that's providing that care?

If there's a million-dollar donation, yes, there are certain tax credits. Can some of that be recycled back once they achieve certain health care metrics with regard to people being stabilized and people avoiding the vertical transmission of HIV? If we're providing housing and services to women who are pregnant and HIV positive.... In chaos, they may very well transmit that to their fetus. We can prevent a lifetime of HIV care if we can provide stabilization to high-risk women and prevent that vertical transmission. Is there a way of recognizing that, in terms of some of the funding models, in order to keep that money recycling and supporting these very marginalized, vulnerable people and programs that are just grossly underfunded?

The other thing I mentioned—and I don't want to be in competition with the police—is recognizing that proceeds of crime related to trafficking and drugs perhaps could be a source of revenue as well, to address the demand side of this.

Mr. Fin Donnelly: Okay. Interesting.

Moving to addiction substance use disorder, can you describe the impact of criminalization on patients suffering from addiction substance use disorder?

Dr. Peter Butt: The challenge, of course, is that particularly with these more potent drugs we have, with methamphetamine and the more potent opioids but also even with alcohol, the disruption in people's lives is such that it's difficult for them to hold jobs. They don't have the income. They go in and out of withdrawal. The positive reinforcement of getting high diminishes over time as they develop tolerance. What takes over is the negative reinforcement, which is to avoid withdrawal. Typically, when I see them, they're sick and tired of being sick and tired. They're just trying to get through a day, trying to feel normal, typically by going out, getting the money, getting the drugs, using, and then the cycle continues 365 days of the year. It's not surprising that it will reach a point where they're going to commit property crimes, where there are going to be break and enters, where this sort of activity increases.

Once people transition, typically through the outreach and engagement that we see with people who can work in harm reduction programs and in detox and treatment, with stabilization that crime goes down. Statistically it diminishes very rapidly, because they're not inherently criminal by nature. It's circumstance. If we can treat, we can keep them from going back, in and out of the correctional system, in and out of police contact, and hopefully to a place where they're not only not drawing on community resources but perhaps potentially contributing to them.

Mr. Fin Donnelly: Would you agree that it's better to look at this as a health issue as opposed to a criminal issue, and it's even more cost effective to do it as a health issue?

Dr. Peter Butt: No question, there's absolutely no question at all. This is fundamentally a health issue. This doesn't mean that if they're committing crimes and are potentially a danger to public safety, there isn't a role for policing in this. Sometimes I've had patients whose lives were saved by a period of incarceration because the chaos was so severe. But having said that, if we could combine the two, then I think it would be much more effective. It would reduce correction and policing and justice cost, ultimately reduce health care cost, and improve the safety and well-being of our communities and our families. Families are terribly devastated by this.

● (1640)

The Chair: Okay, thanks very much.

That completes our seven-minute round. Now we'll go to our five-minute round. We're going to start with Dr. Kitchen. Welcome.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you, everyone, for being here today.

Dr. Butt, as full disclosure, my riding is the southeast corner of Saskatchewan, and my home town is Estevan. I also spent time at Royal University Hospital in Saskatoon.

I appreciate your comments and your presentation. You talked about the federal roles, particularly about issues such as taxation, charitable donations, philanthropy, mental health and proceeds of crime. You also mentioned education a little earlier, and I would like you to expand on that, what that education is. Are we talking about public health announcements, school-based education, media blitzes?

Dr. Peter Butt: Education involves all sectors of society, and one of the challenges we have is, yes, it is important to get that education to the public, particularly with youth, because with some of the potency of these drugs, particularly with illicit fentanyl, they try and they die. They don't have a substance abuse disorder. They're experimenting. They're adolescents. I didn't have a full brain when I was an adolescent. It goes with the state of life.

The point is, we need to be able to provide them with education, but we also need to encourage them to get engaged with other prosocial activities so they are not bored, they have recreational, cultural, artistic, sports and other pursuits. Part of it is also providing other activities to youth. The education is important, as well as the education of the teachers, or whoever is doing this. There might be an interface between the schools and the public health sector, but the education there is important.

There is also that wider level of education. The Canadian Centre on Substance Use and Addiction has done work on infographics and so on for parents to have this conversation with their children so they are better equipped to discuss this around the dinner table.

There is also education with regard to health care professionals, because we have stigma entrenched within the health care system. More can be done there. We are seeing within Corrections sometimes this dynamic tension between correctional staff and therapy staff. More education would be helpful there. People have their roles, but we need to be able to think about ways of breaking down the friction between those roles to have synergy rather than a sense of conflict.

There is also education of health care providers. Some of these individuals are treated very poorly within hospitals, particularly if they have a concurrent mental health and addiction problem. They might go into a mental health facility, and if they slip and use, they are kicked out. If their depression gets worse, if their psychosis gets worse, they get treated. This is not rational health care service. We need to be thinking much more rationally, using the evidence and applying it in improving our systems of care.

That is a fairly broad answer to your question on education.

Mr. Robert Kitchen: I appreciate it. I like your comments about education not only for youth and adolescents, but also for our primary health care practitioners, which is also part of the whole equation. We shouldn't just be focusing on one part of it. A number of areas need to be educated in the whole area.

Dr. Peter Butt: I couldn't agree with you more. In primary care, it's important to have health care providers who are meeting population health needs. At a primary care level, just as if you had an extensive older adult community, a geriatric community, you'd want services appropriate to that community.

Also, if you're providing services to a community that's heavily impacted by mental health and addiction issues, you'd want addiction counsellors as part of your primary care system, so it's a multidisciplinary approach.

● (1645)

Mr. Robert Kitchen: Detective Pearce, I appreciate your comments, but one thing you said that really caught my attention was when you were talking about how it is easy to manufacture the drug, and one of the things was, it was more attractive because of Hollywood. My concept of that is this has become glamorized by Hollywood to be an everyday, simple little thing and people see that all the time. I wonder if you could quickly expand on that.

Det Sgt John Pearce: Yes, that's what I was alluding to. Several television series and movies have glamorized it. Take even the word "methamphetamine", to the point where we talk about "crystal" methamphetamine; as we talked about earlier, the people watching are possibly comparing it with other drugs—recreational drugs like cocaine, or even marijuana, for that matter, and stuff like that. They don't realize what's involved with this type of drug, the compounds that go into it, and the highly addictive "one-time use" type of attraction that will happen as a result of experimenting with it recreationally.

The big thing is that the market itself is making the product look more attractive to appeal to more people and to attract different types of socio-economic age groups. They're making it look that much more appealing and less dangerous, so to speak.

Mr. Robert Kitchen: [*Inaudible—Editor*] It's not a recreation.

The Chair: Time's up. Sorry.

Mr. Robert-Falcon Ouellette.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Thank you very much, everyone, for coming today. I have a number of questions, and I'd like to start with the gentleman from the University of Saskatchewan.

Mr. Butt, I'm wondering if you have any ideas surrounding the loss of economic productivity, more as it's related to the cost of providing health services to people using meth. I'm wondering if you have any information on the costs related to someone using opioids, or on the cannabis-related or alcohol-related costs, with regard to the health care system.

Dr. Peter Butt: I am not an economist, but I can tell you that most of the cost with regard to substance use disorders is the loss of productivity and the economic impact. When we look at the demographic in Saskatchewan, at least, it's older rather than younger now with regard to methamphetamine. It's the slightly older twenties and thirties as opposed to the teens and twenties. You're dealing with people in their twenties and thirties who are losing their most productive years. As well, unfortunately, their children are being lost to care, because they are unable to look after them.

With regard to the health care costs, I think we're seeing significant costs because of our inadequacy in addressing the health care needs of individuals. People are in and out of detox, in and out of treatment centres, in and out of emergency departments and in and out of acute-care wards in the hospital. They're not getting effective treatment long enough, and that actually leads to an escalation in costs. It's not efficient at all.

For instance, with IV drug use, we often have people being admitted to hospital with abscesses of joints or bone infections that require six weeks of IV antibiotic therapy. If we are not able to provide a stable environment for them to complete six weeks of IV antibiotic therapy in a very structured environment in a hospital ward.... These are individuals who might have been previously hunting and gathering on the streets. We need better behavioural management to keep them there for six weeks and address some of their root issues. If they are not able to be retained there, they leave, they come back, and the infection is worse. They're not able to complete the antibiotic therapy. They leave and come back. So it might take 12 or 24 weeks to complete six weeks of antibiotic therapy, simply because we are not providing the behavioural management and support they require.

This is why it's difficult to answer your question. So much of the cost is due to our inefficiency.

Mr. Robert-Falcon Ouellette: I'm wondering if you could also discuss your harm reduction sites that are funded by the Saskatchewan Ministry of Health and the Saskatchewan Health Authority. From what I understand, you provide clean needles and inhalation supplies. What does that include? Was it easy to set up?

● (1650)

Dr. Peter Butt: The needle exchange programs have been going on for some time. Really, needle “exchange” is a bit of misnomer, I think, because it's needle distribution and needle recovery, and includes counselling and support, vaccinations and access to all the other services that are there. It's outreach and engagement with a community that is otherwise very marginalized and out of care's way. If we are not putting ourselves in their environment, care isn't accessible.

Mr. Robert-Falcon Ouellette: Do you see a lot of needles being spread around Saskatoon or Regina? In Winnipeg, for instance, a lot of needles are finding themselves in school parks and back alleys, and in vast quantities. We have to pay or get volunteer groups like Bear Clan to go around and clean up a lot of these needles.

Dr. Peter Butt: Right.

Mr. Robert-Falcon Ouellette: They're sometimes getting pricked, and these are volunteers doing this work. Is it the same situation in Saskatoon and Regina?

Dr. Peter Butt: It's less so. When that does happen, it hits the media very, very quickly. We have drop boxes, like recycled mailboxes, in high disposal areas. If you have a particular park, an alley or some place where you're finding needles, particularly in the spring when the snow melts, then that's where you need to have these disposal boxes. Also, of course, the needle programs strongly encourage people to bring them back.

Mr. Robert-Falcon Ouellette: Also—sorry to the other witnesses—you also mentioned you have neighbourhoods that are blacklisted as too dangerous, and they create health care deserts. I was wondering if you could explain what you mean by places that don't have enough health care.

Dr. Peter Butt: This is an extreme frustration. We have areas in the city, homes and addresses, where home care will not go. They say it's for occupational health and safety reasons, and these addresses get on a list that never gets revised. Essentially the inner city becomes blocked for home care services, because people won't go there to provide those services, and then they wonder why they go to the hospital in order to get basic care. It's a travesty. It's criminal, I think; yet, there are other people who have the outreach and the harm reduction skills who can go and work with the population. We need to partner people, and if they don't have the confidence or the skill set to provide services in different neighbourhoods, then get people who can. These people need the care.

The Chair: Thank you very much. That's amazing information.

Now we're going to go to Ms. Gladu for five minutes.

Ms. Marilyn Gladu: Thank you, Chair.

I'm going to start with the doctors on the call.

We heard testimony the other day that said only 4% of people who try methamphetamine get addicted to it, which I think is in conflict with what I heard today, which is more in line with what I experience in Sarnia. For all four of you, starting with Dr. de Villa, how addictive is meth, and is it really something you could use multiple times and not worry about getting addicted to?

Dr. Eileen de Villa: I think this question of addiction and addictive tendency is one that has a fair amount of individuality to it. What I was trying to address in my comments is that there are many reasons that people engage in drug use. I think really getting to the heart of it and getting to prevention requires really looking at the underlying factors and how we then prevent them.

I can't let the opportunity go by without saying that I want to address something you said earlier in respect of the cycle of arresting and releasing. I think we heard some good rationale from other colleagues around the video conference that criminalization does create problems, and in fact, causes more. One method—you're right—is detox. Providing detox might be a treatment option, one option that would certainly help arrest or stop that cycle from continuing, but not criminalizing drug use would also be a very, very effective method of stopping that cycle.

Ms. Marilyn Gladu: Dr. Thomas, could you comment on how addictive you think meth is? The statistic that I quoted said 4% of the people who tried it would get addicted. Does that sound right to you?

Dr. Réjean Thomas: It's a very high addiction. It looks to me like heroin at the moment, and we don't have methadone; that's the problem. We don't have easy ways to stop it. They come, they start, they try, they do everything, but it's very highly addictive.

● (1655)

Ms. Marilyn Gladu: Dr. Butt.

Dr. Peter Butt: I have a couple of comments. If you look at the general population, it's estimated that 10% of people who use methamphetamine will develop a substance use disorder immediately, just with one use. Typically, it's 10% within a lifetime with most substances, but the reinforcing effects of the methamphetamine are very, very strong. If you look at dopamine release in the brain with sex, it would be 10 times that with regards to what people get from methamphetamine, so it's 10 times orgasm and very reinforcing.

I'm not suggesting that this is what's going on, but it's analogous to that when you look at how intense the release of dopamine is in the brain with exposure. We also have to look at the risk factors. My colleague is absolutely right, because some of these might be genetic, some of these are epigenetic, adverse childhood experiences, trauma in childhood, exposure to the substance and then the pattern of exposure as well.

There are other people who get exposed to methamphetamine who I've had as patients who hate it. They've tried it once or twice, and they dislike it; they don't like the way it makes them feel. There are definitely individual characteristics that speak to some people and repel others.

Ms. Marilyn Gladu: Detective Sergeant Pearce.

Det Sgt John Pearce: I think the stat of 10% is what we've been using as a guideline for that. This is one of the few drugs that you try once and get hooked on for life. I think that's one of the issues we have. It's similar to an opioid. Once you're on it, not only are you addicted to the drug, but you find it that much harder to get off that drug no matter what treatment you choose to take or what path you choose to take to try to get off the drug.

Accessibility, too, is a big thing that's different about these different types of drugs: what you can get access to and what's readily available. When you go to each community—we talked about the plains—you're going to come across different types of drugs, some that aren't available and some that are readily available in other communities. I think that's a big one that plays on some of those numbers, too, because you're going to find that the numbers for the different types of drugs are going to vary across the country as well.

I would agree. That number I heard was 10%.

The Chair: Thanks very much.

We will move on to Mr. Ayoub.

[*Translation*]

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

My questions are for Dr. Thomas in particular.

Dr. Thomas, you have a long practice of the profession in Montreal. Can you give us a picture of the situation? You have a clinic specializing in treatments related to sexual health, particularly AIDS. You have been known for this in recent years.

What is the overall situation in Montreal regarding substance abuse? We are talking about methamphetamines, cocaine or other substances to which individuals are highly dependent. It is difficult for them to stop using them. Since you are in the field, what can you tell us about the service offer?

There is also the issue of prevention. It's very wide. I only have five minutes and I really want to give you time to answer.

Dr. Réjean Thomas: Thank you.

The situation has changed a lot. In the 1980s and 1990s, it was certainly cocaine, at parties for example, on occasion. We were in no way seeing the addiction we've been seeing in the last three or five years.

After that, there were opioids. In Quebec, we have had needle exchange centres since the early 1990s. We did not see that this increased or encouraged drug use. On the contrary, we have seen a significant decrease in HIV and hepatitis C among people who used the services of these centres.

Then there was a decrease in the number of people using injection drugs in general. People switched to other drugs. For the past five or six years, this has been particularly the case with crystal meth. In my office, it's catastrophic. In my practice, in the gay community in downtown Montreal, this drug is the most damaging, along with the STI epidemic and HIV, diseases that have been mentioned.

We receive testimonials from people who have used crystal meth. They often tell us that, even if they want to stop, it has been so good sexually that they are dependent on it. Some people will rather tell us about their creativity, which is stimulated when they consume it. They wonder how they will ever be able to stop and whether they will be able to do so.

There are resources in hospitals at the emergency hospital centre. Then there are the resources for detoxification. However, there is little expertise for this clientele, which corresponds to a particular group, the one I see in downtown Montreal.

● (1700)

Mr. Ramez Ayoub: Do you have the impression that there is a certain cohesion in the offer of services in Montreal, but also in the rest of Canada?

Across Canada, is there an exchange of best practices? Are you being informed? Do you have to do it yourself? I suppose you do. Is there any leadership in this exchange of best practices across Canada?

Dr. Réjean Thomas: I find that, in Montreal, it is completely insufficient. Crystal meth is not a drug like any other. It destroys people very quickly. Even if cocaine is used more, the consequences are not at all the same.

There is little expertise and few resources. That's one of the problems. In Montreal, a community group gives lectures here and there.

There was talk about education earlier. If there are educational campaigns on cannabis, there may well be campaigns on crystal meth as well. Education campaigns aimed at the general public are also important, and the federal government certainly has a role to play.

This is not well known. There is little expertise, and few doctors are interested. Those who work in the mental health field do not know those who work in addiction. Then you end up with a particular group of gay men. These are all double and triple expertise.

Mr. Ramez Ayoub: I have barely 30 seconds left.

Do your resources come mainly from the provincial government?

Dr. Réjean Thomas: Yes, but—

Mr. Ramez Ayoub: There are resources that come from the federal government and that go to the provincial government, particularly in Quebec. However, you don't have a direct link with the federal government, right?

Dr. Réjean Thomas: No.

Mr. Ramez Ayoub: Right.

Thank you, that answers my questions.

[*English*]

The Chair: Okay, thanks very much.

Now for our very final question we have Mr. Donnelly for three minutes.

Mr. Fin Donnelly: Thank you, Mr. Chair.

Dr. de Villa, you recently presented a report to the City of Toronto's board of health entitled "A Public Health Approach to Drug Policy". One of the recommendations in the report is that, "The Board of Health call on the federal government to decriminalize the possession of all drugs for personal use, and scale up prevention, harm reduction and treatment services."

Could you explain why you made that recommendation and tell the committee a little bit more about that recommendation?

Dr. Eileen de Villa: I think we've tried to allude to this already, myself and others around the video conference. I feel, and I think the evidence demonstrates, that there are significant harms associated with prohibition and that there is a good rationale for looking at drugs and drug use through a health lens rather than through the lens of criminal justice. We've heard that it creates all kinds of problems, cyclical problems, arrest-and-release cycles within the criminal justice arena. I think, in fact, what we're talking about is a multifactorial health issue. We would have greater success in creating a relationship and establishing effective roots through to prevention and treatment if we were to actually adopt a health approach to it.

I can say that there are other jurisdictions around the world that have taken this approach and have demonstrated great success. Portugal is one of them. They had significant issues with injection drug use in their population. In 2001, they decriminalized the personal use of all drugs, and 16, 17 years later they have significantly reduced the challenges they face with respect to drugs and drug use in their society. It's not perfect, but they're certainly going in a better direction than we are.

● (1705)

Mr. Fin Donnelly: That was going to be my second question, so that's great, you've already addressed that one.

Have you had any preliminary reactions from the board of health in terms of how they're taking your report and what next steps look like?

Dr. Eileen de Villa: The board of health did approve that report and they did make the call to the federal government.

Mr. Fin Donnelly: Has there been a response yet? I'm sure it's too early, but are we anticipating a response?

Dr. Eileen de Villa: I look forward to receiving that response.

Mr. Fin Donnelly: Perhaps this report will be part of instigating a response.

Dr. Eileen de Villa: I hope so.

Mr. Fin Donnelly: Do you have any final recommendations for the committee in the 30 seconds I have left?

Dr. Eileen de Villa: I think that, again, you need a fulsome response. I would treat this as a health issue rather than a criminal issue. I think we've done a great deal of harm and I think we've burdened our health care system. I can't speak enough to the determinants of health: supportive housing, prevention, upstream interventions. That's not to say that safer consumption services and harm reduction services aren't important. They are further downstream. They're important, they're life-saving, but we need to shift our focus higher upstream, to be more preventative.

Mr. Fin Donnelly: Okay, thanks very much.

The Chair: All right, that winds up our meeting.

I want to say thanks very much, on behalf of the committee, to the witnesses. I know this is not an easy format to operate in, but you've handled it really well. You all have chosen very challenging vocations. We thank you for doing it. The things you have to deal with every day are amazing.

I want to thank you all for your participation in sharing your information and experience with us.

I want to thank the technicians, because this has worked quite well. This is the first time we've ever done a video conference from four different locations.

Thank you, members of the committee, for your questions and your input.

I now adjourn the meeting.