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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1530)

[*English*]

The Clerk of the Committee (Mr. Alexandre Jacques): Good afternoon to all members of the committee. Since the chair and vice-chairs of the committee are not in attendance, I will inform members that I have received an email stating that Mr. Casey is designating Mr. Eyolfson as his replacement as acting chair of the committee. This information was shared with committee members by email earlier this afternoon. I would simply ask for the consent of the committee to proceed in this matter.

Some hon. members: Agreed.

The Acting Chair (Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.)): Thank you for unanimous consent. I declare this meeting in session.

Welcome everyone. Pursuant to Standing Order 108(2) on the motion adopted Monday, April 16, 2018, the committee is resuming its study of the impacts of methamphetamine abuse in Canada. After our witnesses' testimony, and questions, we will go in camera and discuss the committee report.

Today we have with us, from Victoria, by teleconference, Ms. Lisa Lapointe, Chief Coroner of British Columbia; from Oregon, Katrina Hedberg, State Health Officer of the Oregon Health Authority; and from Vancouver, Dr. Susan Burgess, Clinical Associate Professor, University of British Columbia, from the Vancouver Coastal Health.

You each have 10 minutes to give testimony. In the interest of time, if we're running short I'll give you a one-minute warning when we're at the end of the 10 minutes and we'll go on to each speaker in turn. Then we'll go to our questions.

We'll start now with Ms. Lapointe, for 10 minutes.

Ms. Lisa Lapointe (Chief Coroner, Office of the Chief Coroner, British Columbia Coroners Service): Hello. Thank you.

I did prepare a slide presentation. Unfortunately, there wasn't time to translate it. Some of you may have it. I'm not going to refer to it greatly because numbers are not very interesting when a person is talking. I'm just going to basically tell you the story of what we're experiencing here in B.C. from the coroner service's perspective.

As you know, B.C. is in the midst of an overdose crisis. We lost 1,500 members of our community last year to overdoses, and we are reporting another 1,500 this year, although that number will increase slightly as more reports come in.

In B.C., we track all illicit overdoses. That is because the vast majority of overdoses are mixed-drug overdoses. It's very rare to find an individual who has died with just one substance on board. Fentanyl, as you know, is involved in 85% of all deaths in British Columbia now. That is predominantly what we're seeing with almost all overdoses. For many years, however, we have tracked other substances as well. I think that's really important.

There has been a lot of focus on opioids and the opioid crisis. In B.C., the only reason we recognized that people were dying at an increased rate of opioid poisoning was that we track all illicit overdoses, and we could see that opioids were starting to have a significant growth pattern. That's really important.

In B.C., more people have died of overdosing in each of the last two years than all motor vehicle accidents, suicides, homicides and prescription drug overdoses combined. Prescription drug overdoses are a very small number of the overdoses in British Columbia. We see fewer than 100 per year. We do not see a pattern in this province related to prescribing. As you know, methamphetamines are an illicit substance. They are primarily purchased on the illicit market. The illicit market is unpredictable and unmanageable.

People talk about drug labs. I don't know if any of you have ever seen a picture of a drug lab. They don't look like any laboratory you've ever seen. They are dirty kitchens and dirty rec rooms. There are cross-contaminated substances. There is no quality control. There is no ability, when purchasing substances in the illicit market, to guarantee dose, quality or even what is in a substance. That's what we think we're seeing now with the increase in methamphetamine deaths.

We have seen an increase in methamphetamine deaths over the last several years. In 2010, this province saw 23 deaths where methamphetamine was detected in post-mortem toxicology testing. In 2017—and we still have 20% of our reports outstanding—we saw 283 methamphetamine-detected deaths.

The reason I report it as “methamphetamine-detected” is that, as I mentioned, most overdoses are mixed-drug overdoses. For example, of 2,042 overdose cases that we have concluded in this province in the last couple of years, illicit fentanyl was detected in 80%. That's not prescribed fentanyl. That's illicit fentanyl purchased on the street. The next most common substance we see is cocaine. Fifty percent of deaths also had cocaine on board. The third most common is methamphetamines/amphetamines. Thirty-one percent of the overdose deaths we investigated had methamphetamine on board.

It's hard to know whether that significant increase, from 11% of the deaths involving methamphetamine in 2010 to 30% in 2017, is because there is more meth being used or because methamphetamine is now contaminated with fentanyl. Virtually every substance in this province is contaminated with fentanyl. We have certainly seen many reports where folks thought they were purchasing methamphetamine/amphetamines, and in fact their may have been some meth—we often find that mix—but there is very likely also fentanyl on board.

That, we believe, is driving the increase in methamphetamine deaths, but it's hard to know. When we arrive at the scene the individual is deceased. These are illicit substances, so they don't leave a record of what they've purchased.

● (1535)

In B.C. the majority of those who die—86%—die indoors and alone, so we don't have anybody to ask what they thought they were buying. Occasionally somebody dies in the company of their friends, and they'll say, “We bought cocaine. We thought we bought ecstasy, and in fact it was contaminated with fentanyl.”

We think it very likely that what people thinks is methamphetamine is methamphetamine, but also contaminated with fentanyl, and that's really driving the increase.

It's great to see the focus on specific substances. It's great to see the focus on opioids, great to see the focus on fentanyl and good to see the focus on methamphetamines. Really, though, what we're seeing is people dying of problematic substance use, and without looking at all the numbers in a broader context, it's really hard to see trends and patterns. We've been very fortunate that we had a database that allowed us to view trends and patterns over time so that we can see, of the number of people who die of illicit substances, what percentage involved opioids and what percentage involved methamphetamine. That's really important.

I remember about two-and-a-half years ago being at a meeting in Ottawa with a number of folks, including CIHI, Health Canada and Statistics Canada, at which there was a strong focus on opioids. I remember mentioning at that time that the prairie provinces were seeing methamphetamine and that maybe we should do a broader review. There was a lot of resistance, a lot of wanting to focus on one thing at a time.

If there's anything I would urge the committee to consider, it is taking a broader perspective. This is a problematic substance use issue. If we have robust infrastructure, robust reporting, robust analysis, then whatever the next substance is that comes to the fore, whether it's MDMA or—who knows what else might be the drug of choice, since it's largely dependent on the source, what's coming into the community and how cheap or expensive it is and how easy it is to get in—then we will be ready to respond to it.

Because I am the chief coroner for B.C., I heartily endorse the Canadian coroner and medical examiner database that is run by Statistics Canada. All coroner and medical examiner offices in the provinces and territories can report into it. Not all services have a robust data collection system, so if there's any opportunity to enhance data collection in the provinces and territories, I think taking it would certainly be beneficial.

Then, of course, the issues surrounding problematic substance use are not confined to one particular substance. We see pain, we see stigmatization, we see marginalization, we see the lack of evidence-based recovery systems and treatment systems and we see criminalization. All of those things serve to work together. If they do not increase the numbers of those dying, they certainly don't work effectively to prevent deaths.

Something else that is, as you may have heard, focused on very much here in B.C. is meaningful measures to address substance use, meaningful measures to reduce harms and meaningful measures to support folks to a full recovery.

In summary, we see an increase in methamphetamine deaths. We have seen an increase, in the last seven years, of 200%. They compose 31% of all illicit drug deaths in B.C. Methamphetamine is on board, but more importantly, in 80% of all illicit deaths fentanyl is on board. We can't say whether, but for fentanyl, the methamphetamine deaths would still be occurring; we don't know. We think it's very likely that fentanyl is driving all of these deaths.

Thank you.

● (1540)

The Acting Chair (Mr. Doug Eyolfson): All right, thank you. You had more than 30 seconds left, so thank you very much.

Next we'll go to Ms. Hedberg.

You have 10 minutes.

Dr. Katrina Hedberg (State Health Officer, Oregon Health Authority): Thank you for the opportunity to talk to you all. I very much appreciate coming after my colleague in British Columbia, because many of the points she brought up are things I wanted to talk about as well.

To start off, one of the really important things to understand is the importance of data. We've been tracking overdose deaths for quite a while. In Oregon we started to see an increase specifically in methamphetamine deaths from the mid-1990s up until 2000. At that time most of our methamphetamine was “cooked”—that's the expression—made locally from Sudafed or pseudoephedrine. At that time there were a number of laws put into place, including that you needed to have identification for purchasing Sudafed, and then it became prescription only. We thus saw a decrease in the local production of methamphetamine, which was good news, and we started to see less use.

At the same time, though, the methamphetamine then began being imported from elsewhere, and while that helped with the meth lab issues around environmental contamination and injuries, our meth use then started to increase again.

I'm an epidemiologist by training and so I like to categorize things and count, but I would also agree with my colleague that many of these deaths involve multi-substance use. If you take apart methamphetamine and then only look at opioids, or if you look at the contamination, or even alcohol.... Many people are polysubstance users and may have chronic medical conditions on top of that. It's therefore a bit hard to say how much of this problem is specific to one drug or specific to another. Again, I would echo the concern about doing a multi-substance use approach.

One thing we've seen in Oregon that I think is a little different from what has been seen in Canada is that we have had in the United States a problem specifically related to prescription opioid overdose. We started to see it in the late 1990s and up through 2000. We were really seeing a lot of opioids being prescribed for pain. People would take them and would die of overdoses from prescription opioids or would use prescription opioids in conjunction with illicit opioids.

Of course, there has been a huge effort in the United States to tamp down on prescribing of opioids for chronic pain, and so we started to see a decline in prescription opioid overdose deaths. At the same time, we are very concerned about heroin deaths and then fentanyl, as another opioid.

In Oregon, for better or worse, we have not yet seen the same problems with fentanyl overdose that other parts of the country have seen. Nonetheless, we've had a very sharp increase in fentanyl deaths from 2016 to now. Again, the incidence is still much lower than that from prescription opioids.

A minute ago I said I don't like to categorize, and I'm categorizing here. It's important to understand that these are polysubstances. There are multiple drugs on board, and because of that we have to see where the interventions can occur.

Looking, then, at what's happening within the health care system, no one is prescribing methamphetamine per se, but they are prescribing stimulant drugs such as Ritalin or Adderall. for ADHD—attention deficit disorder—just as an example. We're saying that we don't want those to be prescribed. At the same time, we're very concerned about illicit use. We need to work within the health care system to look at what's being prescribed.

Many of these patients are chronic pain patients, and so, if we're taking away opioids or other drugs, we want to be sure that people have access to non-pharmaceutical therapies. That's another thing we've been working very hard on within our health care system: to look at what other things might address a person's chronic pain.

We need to support people with medication-assisted treatment and get them into care. Of course, specifically for opioids, naloxone is a rescue drug. We still need to get people into care, even if they're rescued from an overdose. That's a sort of ”death prevention”, if you will, and we really want the upstream substance use prevention to happen as well.

Then getting the data to inform policies is really important.

We in Oregon are quite happy, if you will, that we've started to see progress in prescription opioid overdose deaths. Specifically, we've seen prescribing of opioids decline, and that's by 28% over the last couple of years.

That is going, then, in the right direction: we're working with health care systems. The challenge with some of these other drugs is that while you can look at what's happening in the health care system, you really need to look at what's happening with illicit substances as well.

● (1545)

One of the things we did in Oregon was to pull together a group of stakeholders to help advise us around the prescription opioid overdose and then to broaden that to look at all illicit substances. We called it our opioid initiative, and that included many of the health care partners from the health care system, the prescribers themselves. It also included substance use disorder treatment folks, as well as law enforcement.

It is important to make sure that law enforcement is on board both in terms of the immediate response and when we're talking about the criminal justice system. At least here in the United States, it's important that people who are on treatment for substance use disorder continue that, that if they're in and out of jail or prison, there isn't a sudden stop. We know that one of the riskiest times is when people who are in prison for drug-related causes, or even if it's for something else but they are addicted—and they may get off it while in prison—get discharged or released from prison. They're back into the same environment they left and at an extremely high risk of overdose.

One of the things my colleague from British Columbia did not mention is that many of these people who are using drugs, and who might be injection drug users, are at risk for a number of other adverse health outcomes. We look at overdose, but among people who inject drugs, Oregon has one of the highest rates of death from hepatitis C anywhere in the United States. We see HIV infection related to that. Hospital stays for heart, bone, blood, soft tissue and skin infections are all much higher among injection drug users.

The altered mental status that happens increases the risk of injury. We're of course concerned about pregnant women who use this and what the effects might be on their unborn babies. Recently there have been studies to show that opioids and many of these drugs increase the risk of suicide. We call this a “syndemic”, a number of these various epidemics that are combined. Really, we can't do HIV prevention without considering how many people are injection drug users, and of those, how many are using opioids or methamphetamine and so on.

The challenge for this, of course, is to look at what we would consider the upstream factors: Why are people using these drugs? I mentioned physical pain, but we know a number of these people also have adverse childhood experiences. They're experiencing social problems as well. They have unemployment. They might have problems with housing. We need to look at those upstream factors where we can be more supportive in terms of the community and how these folks can have a number of issues dealt with before they start using drugs. Again, if they have been using drugs, they need not only to be in recovery specifically from substance use disorder but making sure that they have access to housing and employment and those kinds of things so that they aren't necessarily tempted to be using drugs again.

As just very few examples of some of the activities we're doing, we've developed some specific provider training related to a psychosocial approach to pain. That is again broader than just the physical, but understanding that some of the psychological input, how people react to pain, is just as important.

I mentioned the prescribing guidelines. We've done those for opioids. We're considering doing them now for tapering off opioids. That's an important thing. Again, that's done in a compassionate manner.

Another example is harm reduction, things such as needle exchange. I know in British Columbia there are both needle exchanges and supervised injection sites. That's something that's a little controversial in the United States. It's the idea that you want people off drugs, but if people are going to use them, really this harm reduction and death prevention is extremely important.

I mentioned naloxone distribution. One of the other things we're doing is looking at who shows up in an emergency department with an overdose, and can we do a fast track to treatment? Can we have peer support to get those folks into treatment? It's a teachable moment.

● (1550)

The Acting Chair (Mr. Doug Eyolfson): I'm sorry to interrupt. You have one minute left.

Dr. Katrina Hedberg: Okay. Thank you.

I mentioned the naloxone or the detox, making sure that it's not just addressing their overdose problem but linking that to housing and employment, and so on.

One of the things that's a challenge for us here in Oregon is that while we have some urban centres such as Portland and what we call the I-5 corridor or the Willamette Valley, parts of the state are extremely rural. Some of the folks living in those parts of the state have a lot of difficulty accessing treatment facilities, but even accessing alternative treatments for their pain. Acupuncture, for example, or massage is very hard to come by in some of the more rural parts of the state.

I would agree again that what we know is best, if you have data on reporting not only what's happening with death but overdoses. We wish we had better toxicology screening so we could understand the combination, and then really using that data to help drive immediate programs, the overdose prevention, but to address some of the upstream factors that are causing people to use the drugs in the first place.

Thank you.

The Acting Chair (Mr. Doug Eyolfson): Thank you very much.

Now we will go on to Dr. Burgess for 10 minutes.

Dr. Susan Burgess (Clinical Associate Professor, University of British Columbia, Vancouver Coastal Health): Thank you very much.

I did not prepare an opening statement. I did, however, send a description of our current situation, and I thank the previous speakers for really defining many of the important issues.

I am going to speak as a front-line provider in the inner city of Vancouver, where, essentially, methamphetamines and fentanyl have destabilized all of my patients. We are really left with very little to offer. I'll try to explain that. Certainly all of our patients are multi-drug users. We test routinely when people do present or when we go out to them. They don't even know what they're using most of the time, but rarely do we see cocaine. You have to be very sophisticated in getting cocaine from your dealer nowadays. Everything is crystal, and if you think you're getting crystal, as was described, there is usually fentanyl, and if you think you're getting fentanyl, there is usually crystal.

Multi-drug use is a problem. We have a saturated community. I follow patients with HIV, hepatitis C, COPD and cancer who are all using these substances with a background of trauma and poverty. They're pretty good at surviving, but now, with the introduction of methamphetamine, unfortunately, that is not the case.

While we run around and give people needles and they have safe places to inject, and we work very hard to give them housing and we take their medications to them, increasingly, with the effects of crystal meth, this is becoming more difficult.

People are developing psychiatric effects from this medication that make it really difficult for them, even with the supports we provide, to be successful in treatment of their HIV or their hepatitis C, for which there are very simple treatments now. We can take people their meds every day, and increasingly we're not able to get them into their mouths. It's the same with all the other medical conditions they have. Their condition is exacerbated by the mental illness effects of crystal that we are seeing. This may be in combination with fentanyl. I don't know what the biochemical cause is, other than it's only with the appearance of crystal meth that we're really seeing this in such great depth.

Yesterday I was trying to certify a long-term AIDS patient who did well. He can no longer find words, he is incontinent in his room, and so forth. Unfortunately, when we find people like this with their paranoia, their violence and their hallucinations, which are really increasing, what we have to offer them is limited. It's limited somewhat by the way we approach these symptoms in our patients. They are psychiatrically impaired; however, it is described as a drug-use problem. It is drug-induced psychosis.

This term, unfortunately, in many cases really means that the patient doesn't receive the psychiatric support they need. They go into the emergency department, they sleep it off, they come out, and they're immediately back to where they were. We are looking at a real epidemic here. We call it the elephant in the room. We are constantly dealing with violence and people who are no longer able to engage in care.

I work on the street and I also do palliation, and more and more of my patients are really palliative in terms of the concomitant medical illnesses they are carrying. They are not able to talk to me. They're not able to engage with their support team. They are at risk of overdose. They try to modify things. They take a bit of crystal so that they don't go down with fentanyl. They will frame their drug use by saying, “Dr. Burgess, aren't you glad I don't use cocaine anymore? I just use crystal twice a day.” Unfortunately, those people are becoming more and more psychiatrically impaired.

● (1555)

I'm going to make my remarks short because I'm working at the bottom end of this. What I would like to see is rapid treatment of people when they are psychiatrically so unwell. Without that, everything else falls apart—absolutely everything.

We have a system where psychiatrists are really in charge of a lot of the treatments for psychosis. Depending on their assessment of a situation, they are more or less helpful. In the Downtown Eastside, the inner city area where I work, we have tried to increase the availability of psychiatric services. It's an up and down thing. It's in the middle of being fixed, I hope. The psychiatric issue here is an emergency and we need to be able to help people with this so they can re-engage with the rest of their lives. They are becoming more homeless are kicked out because they're violent. They can't really understand a lot of what's happening around them. They are open to more trauma: running into traffic and not taking their medications.

My population is, as I said, particularly HIV heavy. I'm seeing people who have been stable, with support on HIV and hepatitis C medications, falling off. I have more AIDS patients in the inner city than I had at the height of the epidemic in 1994, 1995 and 1996. From the street, it's a serious illness, this use of crystal meth, but people love it, and people love fentanyl.

While we have now developed an inner city pain program that's specific to the needs of our patients—and that's not including opioid use—as well as mobile ACT teams, assertive mental health teams, we still have a large group of people who are now permanently psychotic. Even if the patients actually appear fairly stable, in conversation, they'll say they're hearing voices and so forth. There's the mild form as well as the very extreme form of people who are totally dehumanized. I would like to see more availability of injectable anti-psychotics for these patients, otherwise I'm accompanying them to either an overdose death or a death from their chronic illnesses, like HIV and hepatitis C. It's really quite an emergency for us and for our population in the inner city.

Thank you.

● (1600)

The Acting Chair (Mr. Doug Eyolfson): Thank you very much.

Thank you all for your testimony. Thank you for the hard work you do in the communities.

We're going to start with our seven rounds of questions.

We'll start with Mr. Ayoub.

[*Translation*]

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

I'd like to begin by thanking the witnesses for their presentations, which I found rather troubling.

I took notes as I was listening. Oftentimes, during meetings like today's, witnesses tell us about real cases. We hear from people who have been able to come out the other side and find another solution to their problem.

Dr. Burgess, I scribbled a few notes while you were speaking. Is there any hope? Your comments gave me the impression that there wasn't much hope in your situation. Am I wrong?

[*English*]

Dr. Susan Burgess: That's how it feels at the moment; that's what I'm observing. I will be writing a paper that I'm basically going to call “The End of AIDS”. It's in the paper. We've conquered HIV, but really, in my community now, it's more the end of life.

I went out into the epidemic a number of years ago and my treatment numbers were better than those within clinics. Patients were able to present to clinics, and we looked after them where they were and treated them. That's really gone now. That's very, very difficult.

[*Translation*]

Mr. Ramez Ayoub: You mentioned your community, but patients addicted to many drugs are stigmatized. We are talking about methamphetamines today, but there are many others. Mental health and homelessness have been raised. Is there a common thread, some aspect that is common to all those affected, regardless of which walk of life they're from?

[*English*]

Dr. Susan Burgess: I think we understand that there are reasons why people choose substances. Often if we look at people's childhoods, we can find the answers. When we look at the inner city, we often say there is a reason why people are here even if we don't know exactly what it is. There are specific vulnerabilities that lead people to our community and to the really intense drug use that's openly available there for people.

Nobody's happy living there. Nobody really likes being there, but the way out is not clear. To someone who is in tears and saying, “Look, I can't do this anymore”, I am not able to say, “Then come with me now, we have this beautiful and wonderful supportive treatment path out of here”, because it doesn't exist. I can give people clean needles all through the day. I can give you hydromorphone. I can give you injectable this, that or the other thing. I can give you free opioids. I can't give you a way out.

[*Translation*]

Mr. Ramez Ayoub: I don't want to put words in your mouth, but are you saying that all we're doing is delaying the inevitable?

● (1605)

[*English*]

Dr. Susan Burgess: Yes, I think we focus on the addiction piece of any individual, but they're people. There's a complexity to each individual that needs to be addressed and respected. I don't think anybody who works in this community has any sense of stigma for these people. Really, it's heartbreaking.

[*Translation*]

Mr. Ramez Ayoub: Sorry to cut you off, but I'm running low on time.

You work in the field, so I'd like to know what solutions you'd like to see in place. I'm referring above all to federal measures, but also, provincial ones eventually. What would you like to see? What isn't being done that should be?

[*English*]

Dr. Susan Burgess: Personally, I think we need to be looking at how we treat children in our country. I think that absolutely has to be a priority, to support all children so that they are not as traumatized as all of my patients have been. Of course, there's a lot of the colonial approach that has led to many of my patients being in this circumstance, which hopefully we are addressing and leaving behind. But, really, we have to start at the beginning.

[*Translation*]

Mr. Ramez Ayoub: You're talking about a long-term approach, but in the short term, is there anything we can do to save people's lives, either through research or treatment?

That question is for all three witnesses, not just Ms. Burgess.

[*English*]

Dr. Susan Burgess: If I could just stop you, there is no real treatment for crystal meth addiction other than contingency programs. People have to actually want to stop crystal to engage in that process. I think we do a great job in harm reduction; however, we don't do a good enough job in really good treatment and support for people. We do nothing that's really great. People should be able to go to a spa, not only people with money, but my folks. I would like an increase in psychiatric response to the effects of crystal meth immediately.

[*Translation*]

Mr. Ramez Ayoub: Ms. Lapointe, is there something you'd like to add?

[*English*]

Ms. Lisa Lapointe: The B.C. Centre on Substance Use has proposed what they're calling a “heroin compassion club”. It could be modified for other substances. This approach makes people afraid because I think their first reaction is, you're going to give illicit drugs to people. What it does is provide a safe place for people to get drugs that are uncontaminated—

The Acting Chair (Mr. Doug Eyolfson): I'm sorry, but I'm going to have to ask you to wrap this up really quickly. Thanks.

Ms. Lisa Lapointe: They would pay a modest fee. They would live. They would be provided with support and services, and they could see a way out to make their lives better, because to continue to force people to buy drugs off the street just leads to disease, disaster and death.

The Acting Chair (Mr. Doug Eyolfson): Thank you very much.

We'll go on now to Mr. Webber for seven minutes.

Mr. Len Webber (Calgary Confederation, CPC): Thank you also to you three out there, and especially to Ms. Hedberg in Oregon, for taking the time here today. I'm looking behind you at the scene outside and I'm quite jealous of how it's looking there. We've been going through quite the snowstorm here and it's been brutal, so we're mad at you for having such nice weather.

Dr. Lapointe, you talked about analysis on the streets. We heard testimony from Deputy Commissioner Barnum of the Ontario Provincial Police. He talked about the bad batches of methamphetamine out on the streets. He said there was an urgent requirement to analyze these drugs, and he recommended that Health Canada increase its capacity to conduct timely drug analysis.

Can the coroner's office expedite any type of analysis of individuals who come in? Of course, if they've passed away, you're able to do an analysis of what killed them. Can you get a timely analysis of the type of drug? Right now Health Canada takes 45 to 60 days to analyze a drug and then to report that to the police. By then, of course, there are many deaths.

● (1610)

Ms. Lisa Lapointe: Yes, absolutely. In B.C. we have an expedited toxicology policy, whereby the provincial toxicology centre will turn around toxicology results for us in 48 hours. It's the only service of its kind in Canada. We've worked with the lab for a number of years to get that in place. Once somebody's died, it tells us the substances in their system. I think what the police officer is talking about is that when they see a number of deaths, they want to be able to isolate the source by having tested at Health Canada. We don't have the capacity to do that. We can only do the post-mortem testing, which is valuable, and we do share that.

In B.C. there is the Drug Overdose and Alert Partnership, whereby the Crown, police, public health, health officers, the coroner's service and the provincial toxicology lab meet on a monthly basis to talk about all the things they're finding and share information. It's been fantastic in getting interventions. My colleague from Oregon recommended something similar.

Mr. Len Webber: Thank you for sharing that information. It's certainly good to know. I think that is one big problem we have here, the fact that drug analysis is taking too long. We can prevent some deaths, I think, if we expedite that process.

Ms. Hedberg in Oregon, you talked about tapering prescription opioids by having doctors prescribe less for people with chronic pain. What's the alternative? These people need a drug. They need an opioid to relieve their pain. We've heard a lot of testimony here, and as you likely know we just recently legalized recreational marijuana, along with our medicinal marijuana. Are a lot of people converting to marijuana in the States as well and finding it to be a nice and easy replacement for opioids?

Dr. Katrina Hedberg: Thanks for the question. There were actually a couple in there.

One of them is that when we're talking about chronic pain in the United States, we also know—and we have an entirely different health care system than you do—that the amount of opioids being prescribed for pain in the United States is much, much higher than in Europe, for example. So it isn't that opioids are the only answer to chronic pain. In fact, we have to offer other things. It's true for acute pain too. If people come into an emergency department with a broken leg or sprained ankle, certainly things like ice or ibuprofen.... There are a number of other medications that could be used—not prescribing opioids.

A lot of what we're talking about is a change in expectation between a quick response, which is a pill, and something that might take longer. Certainly, physical therapy for chronic pain, for example, takes a lot longer. The idea is that there isn't one size that fits all. We have to look at a variety of things.

In Oregon, of course, we had one of the first medical marijuana programs, along with California, and we recently legalized the retail sale of cannabis or marijuana. It turns out that a lot of people who are buying retail, as you mentioned, aren't doing it just because of the psychoactive effects that they're interested in, but also for pain. They might be buying a salve to use for arthritis, etc.

The problem is, how do we get data on how much people are replacing, if you will? Are you using cannabis instead of opioids? How much? Anecdotally, we know that people say they are trying to taper off opioids and are replacing the treatment with cannabis, but that's just anecdotal.

In my mind, that's clearly an area where we need a lot more data and science. Unfortunately, in the United States, it's very hard to get that because, as you know, cannabis is a schedule I substance at the federal level. In terms of who is using what and what are the long-term effects, we really aren't even allowed to do research protocols related to people in chronic pain if you give some an opioid and others cannabis. That's an area where we really need a lot more data.

Mr. Len Webber: I see.

I have one minute and I have a quick question for Dr. Burgess, who of course works in the inner city in Vancouver. I was down there recently to see East Hastings and also had the privilege of meeting Dr. Gabor Maté and speaking with him for about an hour. He talked a bit about the decriminalization not only of marijuana but of all psychoactive substances.

Could I have your thoughts on that, Dr. Burgess?

Dr. Susan Burgess: I'm not sure. I think I can speak to some of the reality down there, in that we have people in our Crosstown program who are getting scheduled heroin three times a day. I've inherited quite a few of these people who were ejected from that program.

Even with injectable heroin—and we have injectable Dilaudid in our clinic—our patients still love fentanyl. They still use it in addition, and I think that has to be recognized. We can throw a lot of things at people, but for people who have been opioid stable for a very long time, once they taste fentanyl again, it's like the first time, and because people don't develop tolerance very quickly, it continues to be very enjoyable and very much a problem.

I don't know as yet. We'll see whether there's much that can replace that, other than the community itself [*Inaudible—Editor*]

● (1615)

The Acting Chair (Mr. Doug Eyolfson): All right. Thank you very much.

We're going to Mr. Rankin for seven minutes.

Mr. Murray Rankin (Victoria, NDP): I'd like to begin by thanking all the witnesses and in particular to salute my constituent, Coroner Lapointe. It's lovely to have you here, Coroner Lapointe.

I'd like to say for the record that I express my condolences to you and your colleagues on the loss of a truly great Canadian, Barbara McLintock, who of course worked with you for so long.

If I may, I will start with you, Ms. Lapointe. In a February 2019 article, a news piece on Global News, you're quoted as follows:

> Families and communities across the province are losing friends, neighbours and loved ones to illicit overdoses at an alarming rate. The illicit drug supply is unpredictable and unmanageable, and fentanyl is now implicated in 86 per cent of overdose deaths. The almost 1,500 deaths in B.C. in 2018 due to illicit drug overdoses far outweigh the numbers of people dying from motor vehicle incidents, homicides and suicides combined.

Could you please explain to this committee what you meant when you said that the illicit drug supply is “unpredictable and unmanageable”?

Ms. Lisa Lapointe: As I alluded to earlier, illicit drugs are manufactured in clandestine labs. Fentanyl primarily comes over from China, we believe. As you know, very small doses are needed compared with the amount people would have taken when they were using heroine. We believe that, for some reason, fentanyl is now being included in cocaine. Methamphetamine has fentanyl, and fentanyl has methamphetamine, as Dr. Burgess mentioned. Fentanyl has cocaine, and cocaine has fentanyl. There is no quality control where these things are being manufactured, so that's what I meant by “unpredictable”. People think they are buying cocaine, and it may be infiltrated with fentanyl. They think they are buying fentanyl, and it may have something else. There is just no control.

Mr. Murray Rankin: You also were quoted this month in an article from the Canadian Press as follows:

> Substance use disorder is a health issue, and forcing those attempting to manage their health issue to buy unpredictable and often toxic substances from unscrupulous profit-motivated traffickers is unacceptable.

In your view, what steps could the federal government take to ensure that people with substance use disorder aren't forced to buy unpredictable and toxic substances from the illicit market?

Ms. Lisa Lapointe: It would laudable for the federal government to take a very health-focused approach, recognizing that problematic substance use is a disease. People come to problematic substance use for a number of reasons: childhood traumas, as Dr. Burgess mentioned, which we see a great deal of; the effects of colonization, which we also certainly see; other traumas that they've experienced through their life; or because it's what their friends were doing. Whatever the reason, they are now in a place where they are experiencing problematic substance use. They need the substance that they're used to.

Some people say we should just lock them up and force their treatment. That doesn't work. It hasn't worked for several hundred years.

Dr. Evan Wood of the B.C. Centre on Substance Use recently proposed a model where those who are using problematic substances would have the opportunity to buy them “guaranteed safe”. They would pay for them.

It's a little bit frightening, because people are afraid to introduce substances. There are substances everywhere, and they are contaminated, so people are dying at a huge rate. We're seeing four people per day die here in this province. If they could at least access safe substances—substances they're already using— then they could stabilize. They wouldn't have to buy on an infiltrated market. They wouldn't have to steal. They wouldn't have to prostitute themselves.

● (1620)

Mr. Murray Rankin: And the 1,500 people in British Columbia who are going to die this year from the opioid crisis might not die.

Ms. Lisa Lapointe: Yes, even if we save 10%, that's 150 people.

Mr. Murray Rankin: We heard testimony in this committee by Ms. Suzy McDonald, assistant deputy minister, opioid response team, Department of Health. Among other things, she made similar points about the increasing contamination of opioid with fentanyl. You talked about that and the people dying increasingly as a result of the poisoning of the drug supply with fentanyl.

Do you think that the continued criminalization of substance use is an impediment to addressing our illicit drug supply problem?

Ms. Lisa Lapointe: Without a doubt. People who are suffering are criminalized and it doesn't help them. It fills the jails. It fills the courts. It gives the police way more work than they want, and at the end of the day it doesn't help them.

Mr. Murray Rankin: Thank you for your testimony.

I would like to turn to Dr. Susan Burgess.

You were quoted in November on CBC as follows:

> We're still at a loss with how to deal with [methampthetamine] in our clinics. Every day, we have to certify someone who is just totally violent, out of control and very, very impaired from this drug. There is no dedicated treatment for methamphetamine addiction. Unlike heroin or other opioids, there aren't effective forms of substitution therapy, such as methadone or suboxone, to treat it. [Methamphetamine] was for us the clinical crisis that was most difficult to deal with. We used to say: give me a heroin addict anytime. That's easy, we've got something to do. But we've got nothing for cocaine or crystal meth in the same category other than treating the psychosis.

In your view, how could the federal government better support frontline health care providers with respect to methamphetamine use?

Dr. Susan Burgess: I'm not quite sure. However, I do think we can respond better to the psychiatric issues in a better way with more psychiatric medication. That's the problem for us having to stabilize anyone who is a methamphetamine user. All of us have tried other stimulants, Ritalin and so forth, and it makes absolutely no difference in our community. That is not the easy answer.

We have to deal with the results of that use and, unfortunately, because of the strength of opioids, people will often use it to counteract the depressant effects of an opioid to keep themselves a little safer. However, it gives you wonderful energy. You have increased libido. If you happen to be schizophrenic and you use crystal meth, all of a sudden you feel like a king. What a wonderful feeling for someone who may have been institutionalized and has difficulty making it through a day.

It's very complicated, but we do have to address those very tragic psychiatric side effects.

The Acting Chair (Mr. Doug Eyolfson): Ms. Sidhu, for seven minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Chair, and thank you all for being here. It's very disturbing testimony, and thank you for working hard in that field.

Last night, I was listening to CBC News. It was reported that 10 babies had died with syphilis. In seven of the cases involving infants, the mother was using a substance like meth or injecting drugs. Can you comment on that?

Ms. Lisa Lapointe: Certainly, one of the outcomes we see from substance use is folks living very marginalized lives. When they are in the throws of addiction or problematic substance use, they have marginal housing, they have no income and they have very little resources, so the infants of women who are pregnant are, of course, at risk.

They're not accessing health care. They're living chaotic lives trying to get their next fix, for lack of a better word. From my chair, that's certainly one of the impacts you would see. For infants born into that environment, there is no prenatal care or very little.

● (1625)

Ms. Sonia Sidhu: After they are born, the baby experiences withdrawal. How do you cope with that? Can the doctor from Oregon Health Authority comment on that?

Dr. Katrina Hedberg: I was going to comment on the first point. You had brought up the issue that I had talked about earlier, which is the “syndemic”. We don't compartmentalize many of these things, but we have to look at them as a whole.

In Oregon, we've seen sharp increases in syphilis in general. Much of that is among men who have sex with men, but many of them also have sex with women. We're starting to see an overlap of those congenital syphilis cases. When we talk to those folks, many of them are also using opioids, meth or other drugs as well. Again, it's very difficult to say the issue is syphilis because the issue is not only syphilis. It's also these other drugs and disinhibited behaviours that people have. That's in general.

When you're talking about the infants, you're absolutely right, infants born addicted to drugs is a real problem. The neonatal abstinence syndrome that we're seeing takes a huge amount of health care dollars. These babies need to be monitored very closely for withdrawal, and even after that, they have a lifetime of problems, so it is part of a larger issue.

We can't just focus on individuals. We really need to think about the larger context that is causing them to both use drugs in the first place and/or have this disinhibited, if you will, sexual behaviour that's leading to this increase in syphilis.

Ms. Sonia Sidhu: Dr. Burgess.

Dr. Susan Burgess: Maybe I'll just describe some of the response to pregnancy in drug-using women in Vancouver.

We have, in the inner city, a specialized group of nurses, doctors and outreach workers to track and bring prenatal care to our drug-using ladies, and to offer them treatment at B.C. Women's Hospital on a specialized ward called FIR where they can be and are stabilized. They often go back and forth, but they're always known and tracked, and the ward is where they can deliver their children as safely as possible, with rooming in and support for the baby in the withdrawal phase as well.

It's a long-recognized problem for us in our community and there is a lot of effort being made to support women who are pregnant and who happen to be using substances. That said, a number of my patients, particularly those who are HIV-positive and for whom intensity is absolutely essential to prevent transmission to the infant, we can still have them deliver on the sidewalk. However, usually we're there.

It's an intense process and we try to keep people unpregnant as much as possible, but there is a specialized service for them that seems to be quite effective.

Ms. Sonia Sidhu: You said you have a mobile ACT team, mental health teams, and you need psychiatric help. What kind of psychiatric help do you need and how can other jurisdictions help you? Can you elaborate a little bit on that?

Dr. Susan Burgess: Yes, I think some of it is attitudinal. If we categorize people's psychiatric illnesses as schizophrenia, you're born with it, or you have bipolar illness, etc., when you put the element of drug use and these particular substances together with that, the effects are actually exactly the same on the brain and the behaviours. Therefore, the treatment needs to be the same.

Some of our psychiatric colleagues do not share that urgency, unfortunately, and our systems are really not robust enough to keep people safe. A lot of these people, when they become very impaired, such as the patient I'm going to be tracking as soon as I leave here, actually need to be certified and be admitted to the hospital for a long time, to be stabilized and have a constant psychiatric team and treatment around them. They can't just sleep it off and go back to the same circumstance, because they've actually had chronic or permanent impairment of their brain. It's not just as case of, WI used this drug and I have this effect and behaviour". People are now permanently psychotic. They are permanently dementing. They are losing their ability to speak. They have movement disorders. They are hoarding. They are fixated on their little bicycle parts, etc.

When they are in this state, which is now becoming permanent, it is very difficult for them to accept any sort of health care, let alone addiction care, because they have been permanently damaged. They are psychiatrically unwell and I need more of what we need.

● (1630)

Ms. Sonia Sidhu: This is called rehabilitation, so how long—

The Acting Chair (Mr. Doug Eyolfson): I'm afraid your time is up. Thank you.

Next, we're going to go into our five-minute rounds of questions.

We're going to start with Mr. Lobb for five minutes.

Mr. Ben Lobb (Huron—Bruce, CPC): I'd like to first ask Katrina Hedberg from the Oregon Health Authority something.

We've had a few discussions during this study on injection sites, border security, policing and trafficking, etc. I just wanted to get your opinion.

I understand you're with the health authority, but in terms of the penalties and so forth for people—I'm not talking about the person who's caught with one or two grams and is using, but the people who are middle level and trying to sell it—would any stiffer penalties work for them if they're caught with 20 grams? Or is it the case that you get one and the next one's up and running a few minutes later?

Dr. Katrina Hedberg: I'm not sure I'm the right person to answer your question because you're right, I am with the health authority.

What I would say with regard to the idea of not criminalizing the end-users is that substance use disorder is certainly a chronic disease and, as we've talked about, needs treatment.

I really do think that one of the things we're trying to focus on is the upstream. Who are those people who are both importing and dealing, if you will, with these drugs and getting it to the end-user? That said, we do work closely with our high-intensity drug trafficking partners—they're federal, as well as local law enforcement—to try to help identify how the drugs are getting into the state. But when it comes to whether stiffer sentences would make a difference, I can't answer that because that's outside my area of expertise.

Mr. Ben Lobb: Again, I know you're not in the legal business or the policing business, but for the end-user who is addicted and in a terrible spiral, is decriminalization or legalization something you discuss with your colleagues?

Dr. Katrina Hedberg: The Oregon legislature is meeting right now and there's a bill that has been put forth by our governor that is specifically related to opioids. One of the primary points in this bill is to treat substance use disorder as a chronic disease. This means that even if people get in and get rescued with naloxone, and even if they're in rehab or substance use disorder treatment for awhile—people do relapse—rather than saying, "You're off the bandwagon, you now need to start at square one," we're saying it's much like blood pressure or diabetes or even smoking. People who want to stop smoking need to do so several times.

I think viewing the end-user, if you will, as somebody who has a chronic physical disease.... This is not a moral failing, but how do you get them into treatment? Even if something happens with that—like I said, they fall off the bandwagon or start using—it may take them several tries before they get there. That's the piece we're focusing on with the end-user, to really decriminalize the behaviour and treat it as a medical condition.

Mr. Ben Lobb: I'm from a rural area and methamphetamine abuse has certainly been present in the rural areas of southwestern Ontario for many years. I don't want to use the word "epidemic", but it maybe 20 years ago, cocaine and marijuana and other things might have been the drugs of choice for users. Certainly now, I think everybody ends up, after awhile, with crystal meth. It is unlike any other in that it will, as a police officer once told me, steal your soul. Unlike others, you can't come back from it.

I know we're doing our best to figure out what to do for the country and I don't want to say it's impossible, but it's almost a dire situation, I would say.

I don't know if anybody else wants to add anything.

● (1635)

Ms. Lisa Lapointe: I might just add one thing.

Certainly, we have heard police officers here in B.C. say, "We can't arrest ourselves out of this situation." Our public health folks here in B.C. certainly have the same perspective: As my Oregon colleague mentioned, substance use disorder is a chronic, relapsing disease and a medical approach will make a difference.

From my chair—having been in this type of work for the last 25 years—it's almost impossible to remove the traffickers because it so profitable. You take one off, and because it's so profitable, one, two, three or four more will pop up.

If we can focus on the users, if we can focus on the poor folks who are experiencing this chaotic existence, if we can support them where they are and provide evidence-based treatment when they need it.... Some folks are asking for it and it's just not there. It's certainly not there in any way that they can afford or access. If we can focus on the users instead of the suppliers, it just seems to me that we can be much more effective. We know who they are for the most part. They're in our communities. We're already spending lots of money putting them through courts and jail. If we just repurpose that money, it strikes me that it would, in the long run, be a much better solution.

The Acting Chair (Mr. Doug Eyolfson): All right. thank you very much.

Now we'll go on to Mr. Falcon-Ouellette for five minutes.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Thank you very much, everyone, for coming. I really appreciate it.

Dr. Burgess, you mentioned that people had been ejected from an HIV program. Could you explain why they were ejected from that program?

Dr. Susan Burgess: It wasn't an HIV program. Nobody gets ejected from that, luckily. It's from the Crosstown Clinic, from early on, when they were doing NAOMI and SALOME studies of injectable heroin and hydromorphone to try to stabilize patients.

Various behaviours led to their being ejected; usually it was for trying to steal the substance that was being provided to them freely or for behaving violently. The majority of those people also happen to be HIV-positive, so given my role, those are people I inherited.

Mr. Robert-Falcon Ouellette: That obviously causes some major issues in health care treatment, if they're ejected from one health care program—

Dr. Susan Burgess: Yes, if you so-called "fail" injected heroine—free heroine—that makes you pretty complicated for me to look after and to try to get HIV meds into you every day.

I don't have the same experience of a lot of our potential programs being effective for everyone. I have patients now who were given a whole lot of hydromorphone from some prescriber, and who have just gone on opioid substitution and are now way more interested in going to the free hydromorphone provision site.

At the individual level, everything has an effect that we can't always predict. I have experience with people who are very committed drug users and have very difficult health issues that need to be supported lifelong or until death, and others who are very committed drug users and are thrilled that we may be providing no opioid replacement, but really their drugs of choice. We should, perhaps, but there are effects on stabilizing.

Mr. Robert-Falcon Ouellette: In Manitoba we often have issues concerning safe injection sites or safe consumption sites. Does it make the community safer to use safe injection sites or providing things like this for other citizens—citizens who don't use drugs, but who end up...? Obviously someone in the streets might cause issues.

Dr. Susan Burgess: We know clearly from research that safe injection sites save lives. People can overdose there and be resuscitated. They can also receive health care at a certain level there and possibly, when they're ready, get some help in trajecting out of drug use life.

However, other people, because they're so damaged, actually require something like drug court for them to get a time out to rebuild their health and to engage in some low-level treatment instead of ongoing drug use. That's particularly the case for and will benefit people with HIV, hep C and other chronic illnesses that can't be managed just by provision of the drug of choice. They actually need to be kind of removed from the setting.

The experience of the individuals I see is complicated. We definitely need to offer all sorts of options for people, but they have to be connected to a benefit in their health needs as well—not just their addiction. Their addiction prevents them from actually living in a more healthy way. How do we connect the treatment of them as an addict or provision of substances with something more, which is robust?

● (1640)

Mr. Robert-Falcon Ouellette: That's a question I have for you. What would be the ideal treatment plan for someone who presents obvious polysubstance abuse issues and who might have trauma? If you're dealing with them on the front lines and they're causing chaos not only within the health care system, but also in the streets, how would you go about it? What would be the ideal treatment plan that you could see, or that you would recommend to the government at the provincial, federal and municipal levels?

The Acting Chair (Mr. Doug Eyolfson): I'm sorry. Please make that response very brief.

Dr. Susan Burgess: Thanks for that question.

I think the individual needs options for care, of which we don't have enough.

Mr. Robert-Falcon Ouellette: What kind of options?

Dr. Susan Burgess: Going off to a wonderful treatment place that is culturally appropriate might be an option.

The Acting Chair (Mr. Doug Eyolfson): Thank you very much.

We're going to go on to Mr. Lukiwski for five minutes.

Mr. Tom Lukiwski (Moose Jaw—Lake Centre—Lanigan, CPC): Thank you very much. I've always been told you never start a presentation or an intervention with an apology, but I do apologize to my colleagues around the table, because I'm subbing in for someone else on this committee, so if I ask any questions that are somewhat redundant and you've covered this ground before, I do apologize for that.

There's a saying, ladies, in politics, that all politics is local. In my case, local means my home riding. As Mr. Lobb indicated with his riding in Ontario, mine is primarily a rural riding. The community of Moose Jaw is the largest city in the riding, with a population of about 38,000 people. I think by anyone's definition, it would not be considered a cosmopolitan centre at the scale of Montreal or Toronto. Nonetheless, according to our mayor, there is a serious meth problem in Moose Jaw.

I'll address my primary question to Dr. Burgess, since you have collected a lot of data. Whether it's meth or a combination of meth and fentanyl, I'm not really sure which, but do you see any commonality in the demographics of drug problems and drug usage across Canada, whether it be age, income, gender or ethnicity? Are there some determinants that we can get some data on to try to make some conclusions that would, we hope, assist the government in finding solutions for this widespread epidemic? I really do think it is an epidemic.

What can we do to try to collect more information than we currently have? I have not heard anyone yet in discussions talk about drug-use problems in small towns with populations of under 5,000 people, for example. What do we need to do to collect the data to assist us and any future government in trying to address this most serious problem?

Dr. Susan Burgess: Thank you for that. I think my colleagues on the panel here are well aware of our need for more data collection in real time, so that we will know exactly what's happening and what the appropriate, if possible, response is to that local condition. I have experience only with Vancouver, as well as the Northwest Territories. One of the issues that may be relevant for us across Canada is what I saw when large numbers of people with mental illnesses were released from large psychiatric hospitals into the community—but not to a lovely community. What were they released into? They were released into the inner city in Vancouver.

These vulnerable people were released into SROs. They were released into drug use. They were introduced to drug use, which, as I described, actually has some psychometric effects on the patients that they enjoyed. Within a month of being released, they were using injection drugs. Within three months, they were HIV-positive.

That was a policy decision. That was not something that those patients sought. How we care for people with vulnerabilities, whether they are psychiatric, trauma or culturally destroyed backgrounds, is really important. I think we need to think about those policies, and their potential effects on vulnerable people, before we make them willy-nilly.

The latest is, “Let's close all the institutions.” Very good point, but what do we replace them with? Currently, in Vancouver, what do we replace our psychiatric care with? It changes monthly. If I'm on the psychiatric ward in St. Paul's Hospital, the psychiatrist will say, “I actually don't know where I'm sending this vulnerable patient now.” They need psychiatric housing. It's changed so much. We need a robust system everywhere, but we need to be careful, and think thoroughly about what our policies are going to do to these vulnerable people.

● (1645)

Mr. Tom Lukiwski: How much time is left?

The Acting Chair (Mr. Doug Eyolfson): You have 30 seconds.

Mr. Tom Lukiwski: I'll cede the rest of my 30 seconds to the next intervenor.

The Acting Chair (Mr. Doug Eyolfson): Thank you very much.

We're now going to go to Mr. Baylis, for five minutes.

Mr. Frank Baylis (Pierrefonds—Dollard, Lib.): Thank you for being here, everybody. I would like to understand the differences in the gateway to opioid use between Canada and the United States. Ms. Hedberg, you said that a lot of people are on prescription drugs, and that leads them into a list of drugs. Do you know the numbers, or the percentages?

Dr. Katrina Hedberg: I don't know the exact numbers or percentages. What we do know in the United States.... There was an article by a couple of economists from Princeton, who were looking at the causes of death and saw that it was particularly white middle-aged men in America who had an increase in opioid overdose deaths. As we were hearing from the previous speakers, it is much higher in rural parts of the United States than it is in urban parts, believe it or not.

Again, I think local data are really important. With white middle-aged Americans, they were talking about the epidemic of despair. It isn't just physical pain. For people who have had jobs in the construction business, forestry, agriculture or whatever, when those jobs move away or people lose them, they're left with economic despair, as well as physical pain.

Mr. Frank Baylis: If I understand, the prescription rate of narcotics is much higher in the United States than it is in the rest of the world. Is that correct?

Dr. Katrina Hedberg: Yes, that's my understanding, and when people are faced with that physical pain and start thinking about—

Mr. Frank Baylis: I understand that. Thank you.

Ms. Burgess, in Canada, our doctors are monitored much more for their prescription of opioids, to the point where they're not even going to prescribe them when they should be prescribing them, because they're afraid of being labelled as a prescriber of these drugs. What I'm trying to understand is whether the type of patients seen in the United States, as Ms. Hedberg mentioned, is the same as the type of patients we see in Canada. Do we still have this type of, as she mentioned, white, middle-class people who are sliding into drug use illicitly, or are they homeless people? Does that cadre of people exist in Canada as well?

Dr. Susan Burgess: It does. As in the United States, a number of years ago there was a huge push, usually, as we know now, from pharmaceutical companies promoting the treatment of pain by physicians as the next vital sign, and particularly OxyContin or oxycodone—which is a very nasty drug, because if you take one, very often you'll just say it feels great.

Mr. Frank Baylis: In that sense, though, if you have 100 patients, how many are going to meet the same criteria Ms. Hedberg mentioned?

Dr. Susan Burgess: Within the community practice I am in, very few will; it's not prescription driven. However, certainly as a prescriber, all of us have college-mandated limits currently. I do palliative care, so I deal with a lot of opioids appropriately, I think. There is this situation now where we do need to find more appropriate and effective ways to deal with chronic pain.

● (1650)

Mr. Frank Baylis: Treat the pain; bar them from prescribing opioids.

Dr. Susan Burgess: Particularly chronic pain.

Mr. Frank Baylis: Pain that lasts more than six months, chronic pain, is what I'm driving at here, because in the United States they've had great success—and correct me, here Ms. Hedberg, if I'm wrong—by moving towards these alternative pain management devices or products, and in Canada we're very far behind on them.

We're not going to solve this for everybody everywhere, but I'd like to know your thoughts. If one of the actions the federal government could take along with the provincial governments is a strong investment in alternative pain management technologies or methodologies and... I understand it won't address all of them, but it's something that's been very successful in the United States. Would this be something you'd encourage the government to look at?

Dr. Susan Burgess: Absolutely. We've actually set up that program for our inner city patients now, because access to alternative supports for chronic pain in our country requires us to pay. Not every province provides that free.

Mr. Frank Baylis: Because it's not covered under provincial regs.

Dr. Susan Burgess: Exactly, and even if you're poor, you still have to pay $10 or whatever, and that could be a discouraging process.

Mr. Frank Baylis: Because it's not covered; it's a private pay.... If governments were to take on that, at least they'd start to carve off and could see the same successes that we saw in the United States, if the governments were to say they'd cover the cost of alternative pain management treatments.

Dr. Susan Burgess: If we're saying that's what we should be offering, then we should be paying for it.

Mr. Frank Baylis: I'm asking you if that's a good idea.

Dr. Susan Burgess: Yes, it is. That's what we're doing. We've got a little program going that's free to our patients right now with physio, OT, counselling etc., but that's just a small pause. That should be available to all of us.

Mr. Frank Baylis: Are you using any of the—

The Acting Chair (Mr. Doug Eyolfson): I'm sorry but your time is up.

We're going to go on to our last member for questions.

Mr. Rankin, you have three minutes.

Mr. Murray Rankin: This first question is for Ms. Lapointe. According to a recent article in the The Georgia Straight, the overdose prevention society site on East Hastings Street is apparently the only location in British Columbia, and only one of two in all of North America, the other being in Lethbridge, Alberta, that permits clients to smoke drugs in supervised settings. That's because all of those supervised injection facilities like InSite can get around Canada's Controlled Drugs and Substances Act with a federal exemption from the law. They can't avoid a provincial law that forbids smoking inside a workplace. In your view, should access to supervised inhalation services be expanded across Canada?

Ms. Lisa Lapointe: That's a good question and, of course, you want to take into account the folks who are working there and their health.

I haven't given this thought. I think I would want to think about this a little bit. Certainly low barrier treatment is what we need. The more barriers you put up for folks who are already struggling, the more challenging it will be to bring them into safe places. If it could be designed to protect the health of the workers there so they weren't exposed to the smoke, then yes, absolutely.

Mr. Murray Rankin: Dr. Burgess, I want to talk to you about the Vancouver Native Health Society for a moment, and the barriers or challenges faced by indigenous people who live in the Downtown Eastside, for example, in accessing health and substance use services. There are a whole bunch of them, which you probably know way better than we do. What role could the federal and provincial governments play in addressing these challenges?

Dr. Susan Burgess: One thing I've observed happily in our community is the flowering of first nations indigenous culture apart from health authorities. It has a place, and we support that within our clinics and so forth, but the actual community itself is finding its own power and voice. That has been, in my view, the most powerful path to healing for the majority of my indigenous patients. When they have access to someone who has the lived experience they've had.... For example, when they have to fill out sixties scoop forms, that is highly traumatizing, so who should be with them? Various people are with them, but who better to be with them than someone from their own culture? Recognizing, honouring, and supporting that approach within our health system is really amazing. It's the only thing that's making a difference, quite frankly.

● (1655)

Mr. Murray Rankin: Thank you very much.

Do I have time for one more?

The Acting Chair (Mr. Doug Eyolfson): No, I'm afraid not.

I would like to thank all the witnesses for coming.

If I might add a personal observation, I appreciate first-hand many of the challenges you have. I spent 20 years as an emergency physician, much of it in the inner city of Winnipeg. I've seen much of what you've seen and I share your frustration at how difficult these problems are to deal with. I would like to thank you for all of the work you do and for coming today.

At this point, we're going to suspend for a couple of minutes while we go in camera for a discussion of a report. Thank you.

[*Proceedings continue in camera*]