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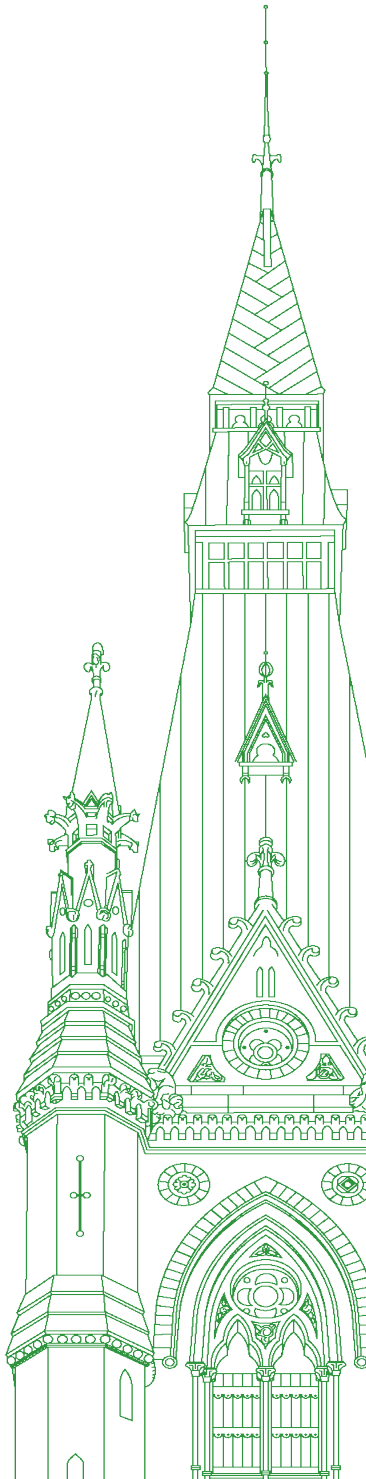

Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, December 3, 2024

● (1105)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 143 of the House of Commons Standing Committee on Health.

In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Pursuant to Standing Order 108(2) and the motion adopted on November 8, 2023, the committee is resuming its study of the opioid epidemic and toxic drug crisis in Canada.

I'd like to welcome our panel of witnesses. Here in person we have Dr. Erin Knight, associate professor in the departments of psychiatry and family medicine at the University of Manitoba. Online we have Lorraine Brett, assistant editor with The New Westminster Times, and Dr. Daniel Vigo, associate professor at the University of British Columbia.

I'd like to thank you all for taking the time to appear today. As I expect you've been informed, you will have up to five minutes for your opening statements.

We'll begin with you, Ms. Brett. Welcome to the committee. You have the floor.

Ms. Lorraine Brett (Assistant Editor, The New Westminster Times, As an Individual): Thank you very much for this opportunity.

My name is Lorraine Brett. I've lived in New Westminster, B.C., since 1994, where I raised three boys with my husband David. I'm here to address the devastating mental illness, overdose and homelessness crisis facing this country.

For the better part of 20 years, my now 40-year-old son Jordan lived on the streets of New Westminster and Vancouver's Downtown Eastside as a drug-addicted, homeless, mentally ill man. It was 20 years of living hell.

He survived 12 overdoses. He would be rushed to New Westminster's Royal Columbian Hospital, only to be discharged to the streets a short time later.

When addicts face death, there is often a moment of clarity. They want to stop the nightmare. I will never forget the agony of listening to my son outside of RCH emergency, saying through tears, “I don't want to die.”

To get into a recovery bed in B.C., you need to first go through detox, but detox typically has two to three weeks of waiting or more, and clients have to call every day, which is hard to do if you don't have a phone. Jordan overdosed and was revived twice while on that wait-list.

There is an illusion often fostered by misleading government PR campaigns that addiction care is available for those who want it when they want it. Well, this is not true.

I saw calamity erupt on the streets during COVID when the discreet access to safe supply rolled out to homeless addicts like a sick sideshow circus. The endless drug use saw human beings like my son devolve to the level of animals from excess use. Worst of all, COVID reduced the number of recovery beds, detox beds and shelter beds. It was such a horrifying catch-22 for the street-entrenched mentally ill, who are the most vulnerable and are helpless without anyone to champion their dignity and their intention to get off drugs.

Safe supply and the legalization of hard drugs creates an inferno. It's a deeper level of hell. It stalks, traps and incinerates lives.

Our son is doing much better. How could this be?

Here are some things that did not in any way help our son: slick government marketing campaigns about ending stigma, safe supply, decriminalization and social justice activists calling to dismantle systems of oppression.

Here's what worked: involuntary treatment in locked facilities, appropriate antipsychosis medications administered in a controlled environment, psychiatrists willing to use the B.C. Mental Health Act to commit those suffering from psychosis and addiction, and the availability of a bed in an appropriate facility.

In 2006, I helped found the New Westminster Homelessness Coalition Society. I spent five years there, helping to launch a pilot project for services that are still operating today, such as wraparound services for the hardest to house.

Many wonderful people are working on the front lines of this crisis, but I've spent enough time in this system to know the difference between an expensive, professional media relations campaign and actual results.

For example, in B.C., a new recovery and psych facility called Red Fish was opened on the Riverview lands. Those ribbons were cut and the government fuelled media fanfare and trumpeted great press. Unfortunately, the public is mostly unaware that Red Fish was just a replacement for the aging Burnaby mental health and addictions facility, where our son spent three months. No new beds were created.

Where are all the new beds? Thousands more are needed, not a few hundred sprinkled across the country, here and there.

Here's my request of all of you. Stop trying to change the channel by pointlessly boosting expensive anti-stigma campaigns and safe supply rhetoric. Stigma has nothing to do with the overdose crisis. It's just a cynical PR strategy to make the public think they're causing overdose deaths through the way they think and talk about addicts, and that is nonsense.

There is no such thing as safe supply. Stigma does not kill. Drugs do.

The myth is that if it were not for stigma, addicts would be rushing to access the care they need and safe drugs. That's a fabrication. There is not enough care available for those who already actively seek it.

Jordan was an innocent, happy kid a mom could be proud of. He was a football star, a standout, an all around athlete and a hard-working, focused student, and then it all went south.

● (1110)

Alcohol led to pot, which led to crack, which led to meth, which then got mixed with fentanyl. Jordan does not want to be a drug user. He works incredibly hard to stay off drugs. He has just celebrated a year clean.

Here are some concrete recommendations for you.

Prioritize those simultaneously suffering from addiction and psychosis. Dramatically expand the use of mental health laws to incarcerate and treat dual-diagnosis persons. Dramatically accelerate the opening of thousands of beds in secure facilities. It's an emergency. Take it on as an emergency. Find those facilities. Procure the land. Make the construction happen.

For those who are addicted and not psychotic, but who present with such psychotic symptoms as paranoia, remand them to care involuntarily. If the psychotic behaviour disappears, well, then, let them transfer into voluntary treatment facilities.

Now, for sure, expand tenfold the number of detox beds and expand tenfold the number of treatment beds in Canada.

Thank you very much for listening to me today.

The Chair: Thank you, Ms. Brett.

Next we have Dr. Erin Knight, who's with us here in the room. She's an associate professor in the departments of psychiatry and family medicine at the University of Manitoba.

Welcome to the committee, Dr. Knight. You have the floor.

Dr. Erin Knight (Associate Professor, Departments of Psychiatry and Family Medicine, University of Manitoba, As an Individual): Thanks very much.

As mentioned, I am an associate professor in the departments of psychiatry and family medicine. I am the medical lead of the provincial rapid access to addictions medicine clinics in Manitoba, and I hold several other leadership roles in addition to practising clinical addiction medicine and family medicine.

While I am speaking today as an individual, I am also the president of the Canadian Society of Addiction Medicine. Some of my comments are drawn from CSAM’s submitted brief.

I will note that any response to this complex crisis will need to be multi-faceted and responsive to the needs of all people who use drugs. However, my recommendations will focus on those with substance use disorder.

I will begin with a story that, although fictional, is a compilation of real events. Angela is a single mother. Her partner, Alex, was incarcerated for drug-related charges at a time when they were both using fentanyl. Alex went through severe opioid withdrawal and was denied treatment. Angela sought help and was started on buprenorphine and naloxone. She did well and was excited to move forward with her family. Sadly, Alex died of drug poisoning a few weeks after his release, due to a loss of opioid tolerance while in custody and his untreated opioid use disorder.

Angela has remained stable, but at our last visit told me that she needs to taper off her medication. She feels she can better support her kids while working than she can on social assistance. However, when she starts earning income, she’ll lose her medication coverage, and she can't afford to pay for it. Unfortunately, her chances of long-term success are low, and I am afraid that she will join the over 47,000 Canadians who have already died of drug poisoning since 2016, leaving her kids with both parents lost to the opioid epidemic.

My first recommendation is for the federal government to support national decriminalization of drugs for personal use. While the outcomes from the Oregon and Vancouver pilots have been poor and those pilots have already begun to be scaled back, accompanied by escalating calls for involuntary treatment, it's important that we not discount the idea of decriminalization based on flawed policies.

A key component to successful decriminalization, as evidenced in Portugal, is assessment and direction to treatment for people with problematic substance use. This element of dissuasion has been missing in North American efforts and must be combined with a scale-up of on-demand, evidence-based treatment prior to rollout.

Rather than jumping from decrim without any enticement for change all the way to implementation of involuntary treatment, we should focus on the middle ground, using well-constructed decrim policy to encourage voluntary or minimally coercive use of accessible, evidence-based treatment. Had Alex been offered treatment instead of incarceration, he might still be alive today to see his kids grow.

My second recommendation is for the federal government to establish a task force to develop and enact a national action plan for addressing substance-related harms. There is far too much variability in access to evidence-based care across regions, including between provinces and between urban and rural or remote locations. This is particularly evident in areas where jurisdictional issues between federally and provincially funded services lead to gaps in care, including incarcerated populations and indigenous communities.

Going back to our story, had Alex been incarcerated in Alberta instead of Manitoba, he would likely have been offered treatment because of differences in the provincial correctional policies.

The third and more straightforward recommendation calls for universal coverage of medications to treat opioid use disorder, which will not only save the lives of people like Angela, but also support them to work, with fewer barriers. Specifically, buprenorphine products and methadone, which are the first-line treatments for opioid use disorder, should be prioritized for immediate inclusion on a national pharmacare formulary, with further consideration of alternative agents. Additionally, injectable naltrexone should be prioritized for Health Canada approval and included on the pharmacare formulary once available.

In conclusion, an effective response to the opioid epidemic and toxic drug crisis will be multi-faceted by necessity and must include expanded support for people with substance use disorder as one component. In developing this urgent response, we also need to deliberately combat stigma and divisiveness, recognizing that people who use drugs are our family, our friends and our community members, and they deserve care.

Thank you for your attention. I'm happy to take questions.

● (1115)

The Chair: Thank you, Dr. Knight.

Finally, Dr. Daniel Vigo from the University of British Columbia is coming to us via video conference.

Welcome to the committee, Dr. Vigo. You have the floor.

Dr. Daniel Vigo (Associate Professor, University of British Columbia, As an Individual): Thank you, Mr. Chair.

The situation in which we find ourselves in Canada and B.C. has been described by Ms. Brett and the previous speaker. The question is why. How can we move forward in improving those outcomes?

In 2013 the chief of police and the Vancouver mayor called a press conference declaring a mental health crisis. There were about 300 people with severe mental illness, polysubstance use disorders and acquired brain injury who were displaying some of the situations that have now overwhelmed our communities. The chief of police and the mayor asked the health system to please take care of it: “We are unable to do it. We are police officers.”

Why is it that in the past 10 years in Vancouver, we went from 300 to 10 times that, and to 100 times that for those at risk of suffering those severe illnesses?

There were three main causes for that. The first one was the 2012 closure of Riverview Hospital without a replacement. The replacement should have been sufficient community services and sufficient inpatient beds to provide treatment, mostly voluntary treatment but at times involuntary treatment, as needed.

The second reason was the technological revolution that happened. As with every technological revolution, it took society by surprise. That technological revolution was the backyard production of cheap synthetic opiates at scale, with precursors that are impossible to stop and cheap to obtain. They allow anyone with entrepreneurial instincts and no ethical boundaries to transform $1,000 into $1,000,000 by creating the tragedy we're seeing.

It has happened in many areas of human experience that technological revolutions have had an impact like this. Moore's Law for microchips predicted that every two years the potency of the computational power of chips would double. Well, morphine in the hands of these entrepreneurs has led to a hundred times more powerful fentanyl and to ten thousand times more powerful carfentanil. When that happens, nature is transformed by these molecules. Our brains are transformed. The ability of these drugs to produce addiction while at the same time damaging the brain and preventing people from recovering and engaging voluntarily in treatment has been overwhelming.

The third cause for this situation was that, as was highlighted by the previous speakers, a group of patients was particularly vulnerable—patients with severe mental illness who were exposed systematically to these synthetic drugs. By the way, it's not only opiates; it's also the synthetic stimulants, the crystal meths of the world and the new combinations of every drug that now contaminates the illicit drug supply. For people with severe mental illness, the systematic exposure to these drugs generates acquired brain injury. That acquired brain injury has generated a new clinical triad that is now the norm in our cities. We were unprepared for it, because it didn't exist to the scale, severity and complexity that we're seeing.

I'm a psychiatrist in an assertive community treatment team. We are interdisciplinary teams who treat these patients in the community—finding them where they are; finding the homeless housing; finding them an adequate inpatient bed when they need it, and ED visits just for the time they need it; giving them involuntary care when they are unable to seek it out themselves; and pulling them out of involuntary care the minute they are able to regain their ability to engage and the mental impairment is treated by the adequate combination of psychiatric medication and ACT.

● (1120)

These three things have created a blind spot in most of our societies, in most of our communities.

How do we fix this? Since June of this year, I've been the chief scientific adviser for psychiatry, toxic drugs and concurrent disorders, and, based on a decision to develop and implement evidence-based policy, we have access to all the provincial data. We know the number of beds, FTEs, psychiatrists, GPs, nurses and social workers that are needed, and our recommendations have to do with many of the things that have been said by the two speakers before. There's a thread of agreement in our three testimonies that I would like to highlight.

We need streamlined access to life-saving pharmaceuticals, including the ones that were mentioned right before me, like depot naltrexone and naloxone, but we also need to simplify the use of clozapine, which is a life-saving drug for these patients, and there's a lot of red tape around its use.

The Chair: Dr. Vigo, can I ask you to wind up? You'll have lots of opportunity to expand on your thoughts in the question and answer period. If you could just bring it to a conclusion, that would be appreciated. Thank you.

Dr. Daniel Vigo: The conclusion is that, in order to improve outcomes for this crisis, we need to expand community services and inpatient services that are able to provide both voluntary and involuntary services as needed, and we need to transform the existing services so that they are able to provide treatment for severe mental illness, substance use disorders and acquired brain injury.

The Chair: Thank you, Dr. Vigo.

We will now begin with rounds of questions, starting with the Conservatives and Ms. Goodridge for six minutes.

● (1125)

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you.

I'm going to start with you, Dr. Vigo.

Police buy-in was a key aspect of the government's justification for launching the decriminalization pilot that made hard drugs legal in British Columbia. Last week, both the BC Association of Chiefs of Police and the Canadian Association of Chiefs of Police pulled their support. They cited a continued high rate of overdose deaths, public drug use and drug-related crimes since the pilot started.

Have you or will you advise the government to end the failed experiment?

Dr. Daniel Vigo: The recommendations that I have provided are aligned with what we are doing now in B.C., which is that the use of drugs, the use of drugs itself, should never be criminalized; however, in our societies, we have rules and regulations that should be respected by every citizen, and, in that context, the current situation is that drugs are not criminalized but the rest of the rules that regulate our interactions are enforced.

Mrs. Laila Goodridge: You will not give a recommendation to roll back this irresponsible pilot project.

Dr. Daniel Vigo: Coming back to my expertise, which is psychiatry, mental health and public health, what I can say is that drug users should not be criminalized and that the laws that regulate the public space—

Mrs. Laila Goodridge: All right, thank you. I have very limited time. I'm going to switch courses.

Dr. Daniel Vigo: You have limited time, but I am a witness—

Mrs. Laila Goodridge: I gave you the same amount of time as it took me to ask the question, which is the procedure here in this committee.

To Ms. Brett, thank you so much for coming here and sharing your son's journey and your experience as a mother. Do you think that the NDP and Liberals have normalized drug use in this country?

Ms. Lorraine Brett: Yes, I do.

Mrs. Laila Goodridge: We had a mother from Ottawa come and testify at this committee that the government is acting like a drug lord. Do you agree?

Ms. Lorraine Brett: In essence, it's true. I saw her testimony. Yes, it's coming from the top down. The federal government has arranged laws to support safe supply, which has been delivered to clients who divert, and young children are dying as a result. It's drug trafficking.

Mrs. Laila Goodridge: In your opinion, do you think that this dangerous pilot project that was inflicted on British Columbia should continue?

Ms. Lorraine Brett: Absolutely not, and the moment that one child was impacted in any negative way, this should have been stopped. A lot of the folks who came to this panel used the words “dignity” and “respect”, but I claim that there is a moral and ethical obligation on the part of the government to respect human life and that of innocents. The children who find themselves intersecting with diverted drugs.... It's the beginning of the end. It must come to an end.

Mrs. Laila Goodridge: I really appreciate this. I think this is the scary part: The government keeps hearing evidence it doesn't like, so it decides that it is not actually evidence and that it's going to continue on its path because, clearly, “We just haven't done it properly.”

Dr. Knight, I found it really interesting that you said the outcomes are poor in Oregon and British Columbia, but you think that we should continue trying to do what has been a failed experiment. Then, further in your statement, you actually stated that Alberta, which is doing a dramatically different recovery-oriented system of care changes...that the Alberta model would potentially be a better outcome for the person you fabricated in your story. How can both things be true? I'm very confused.

Dr. Erin Knight: I think that, intentionally or unintentionally, you've taken my comments out of context. The thing that I compared between Alberta and Manitoba is a difference in provincial correctional policy related to opioid agonist therapy. I did not speak specifically about Alberta's model of care.

Mrs. Laila Goodridge: Okay. Thanks.

You support Alberta's use of opiate agonist therapies. I'm sure you're aware that Alberta has a very innovative program—the virtual opioid dependency program—that allows 24-7 access to opiate agonist therapies. Is that something that you think we should be rolling out across the country?

● (1130)

Dr. Erin Knight: I think there are elements of the VODP that are very successful, and there are also elements that don't reach at-risk populations. It is one thing, as part of a multi-faceted expansion of service, that we could look at. I do have concerns that it is entirely virtual, and there is some need to see people in person and to develop relationships with people.

Mrs. Laila Goodridge: Really quickly, you mentioned one thing that I think is a failure of Health Canada, the lack of listing injectable naltrexone. I have advocated to the Minister of Health and the Minister of Mental Health and Addictions on this particular issue, and it's fallen on deaf ears.

You now have a platform. Why do you think this is important?

Dr. Erin Knight: It's important to expand the availability of evidence-based treatment options. Right now we have accessible our first-line treatment options. We have, also, in certain areas—

Mrs. Laila Goodridge: Yes, particularly naltrexone, because this is something that is not available currently.

Dr. Erin Knight: It's something that is not available currently, and we, as addiction physicians, have been advocating for its availability for many years. There are some barriers that have been put in place through Health Canada, and we are asking for the support of the federal government in reducing those barriers so that we can have this option for treatment.

The Chair: Thank you, Dr. Knight.

Thank you, Ms. Goodridge.

Next is Dr. Powlowski, please, for six minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I'm pleased to see you all here, but my questions are for Dr. Vigo. I think some of them were your remarks. I'm not sure if they're only your remarks, but I understand you're the chief scientific adviser for psychiatry and toxic drugs in B.C. and, certainly, within the popular press the message came out that British Columbia was contemplating more involuntary treatment of patients. I wonder whether you could explain your ideas about involuntary treatment. My understanding is, and this is for a population of...you already talked about the triad, people who have substance abuse disorder, mental health issues and acquired brain injury altogether. Certainly, my understanding is that, under present psychiatric law, there is the ability to involuntarily admit and treat people who require long-term antipsychotics. Is that what you were contemplating using more in B.C.?

The other component of that is I think there was something about clarifying the issue of being able to use OAT, like sublocade, for people who were also receiving long-term antipsychotics. Maybe you could just clarify for us the whole issue of involuntary treatment, who should get it and whether that should be expanded.

Dr. Daniel Vigo: For any physician, the need to provide involuntary treatment is something we encounter with relative frequency, not only in the areas of mental health—

The Chair: Dr. Vigo, we're having trouble hearing you. Is it possible that you moved your mic since your last intervention?

Dr. Daniel Vigo: Can you hear me now?

The Chair: I think that's better. Can you raise the mic up between your nose and upper lip, please?

Thank you.

Dr. Daniel Vigo: Thank you very much.

We encounter people we need to provide involuntary care to in several situations. I was an ED physician for a couple of years, and if we had someone who had suffered a concussion with loss of consciousness, and we were assessing them and saw that they were confused and said, “No, I'm going to go home and sleep it off,” we could not allow that to happen. That can happen through a different act than the Mental Health Act, but it is the same type of situation.

If we stay closer to home and you have a patient with a manic episode who tells you they want to go get on a plane to Vegas and so on, and you see they are in an episode of psychosis and agitation, again, you cannot let them go as they will. You need to treat them, because there is treatment for that.

Very similarly, we know that in this clinical triad, the effect of synthetic opioids on the brain decreases the volume of the brain. The more the brain is damaged, the higher the risk of overdose, so there's a vicious circle there that eventually leads you near cognitive disorder, not unlike the one we see due to vascular disease or other forms of dementia.

The Mental Health Act that we have in B.C. allows us, and even requires us, to treat people when they have a state of mental impairment meeting certain stringent criteria. That state of mental impairment is something we find very frequently with people who are acutely affected by the combination of a severe mental illness with either a substance-use disorder or a neurocognitive disorder that is the product of acquired brain injury.

Does that mean we want to expand the use of involuntary care? No. We want to increase the options for voluntary care, which have not been sufficiently expanded so far, and as we expand options for voluntary care, we will be able to use involuntary care more precisely for the people who really need it.

In order to do that, we need to create some services that don't exist. Among them, again under the Mental Health Act, we are able to create things called “approved homes”. Approved homes are secure houses in the community where people at the most severe end of the spectrum, who require services under the Mental Health Act for long periods of time, can be housed in a safe, humane environment with one-on-one rehabilitation.

Similarly to what was said by Professor Knight, we are also creating units in correctional centres—on remand in Surrey, for example, where our patients frequently wind up because of their disturbed behaviour due to this clinical triad. Because of the Mental Health Act, they cannot receive involuntary care while they are being incarcerated, so what happens is they are put in seclusion until a bed frees up in a forensic hospital. We have now created a mental health unit in corrections where they can receive treatment the moment they need it. It will take a few months to create it, but it has been decided.

These are the types of things we're trying to do. We're trying to allow for the treatment of people who absolutely need involuntary care and create services that can provide both voluntary and involuntary care as needed, so that the overall use of the Mental Health Act will decrease, but the number of folks who need it and don't receive care will also decrease because they will receive it the moment they need it.

You pointed out the important thing about the use of buprenorphine and other psychopharmacology under the Mental Health Act. There's no restriction under the Mental Health Act of B.C. as to what a psychiatrist needs to decide is the appropriate combination of pharmacology for a person who needs it. We need to provide holistic psychiatric care, and that very frequently includes, in these types of patients, a depot antipsychotic or clonazepam and depot buprenorphine, because of the repercussions that psychosis has on behaviour if it's treated only with antipsychotics.

● (1135)

The Chair: Thank you, Dr. Vigo.

Thank you, Dr. Powlowski.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you, Mr. Chair.

Thank you to the witnesses.

This crisis is complex. Most of the committee's witnesses talked to us about multiple solutions.

Dr. Knight, you started by saying we need multi-faceted responses. Can you talk to us about the role stigma plays in the addiction process and in treatment? There's a social aspect to it, but there's also a mental health aspect. Ms. Brett didn't talk about the mental health aspect.

[*English*]

Dr. Erin Knight: I think stigma does play a role in accessibility to treatment and people's willingness to address treatment. I think it plays a role in the way that we talk about substance use in the community. It also plays a role within our health care setting.

The reality is that addiction medicine is a relatively new specialty, and incorporating substance use disorder treatment within the health care setting is relatively new. Even among health care providers, nurses, doctors and other providers within both the hospital settings and the communities, there's a need for increased education and increased competency to work with people who use drugs.

As we build that competency and continue to work on the issues of stigma through appropriate use of language and through appropriate and person-centred approaches to people who use drugs, we can increase their comfort level with seeking care when they're ready to do that.

● (1140)

[*Translation*]

Mr. Luc Thériault: Dr. Vigo, your experience—

[*English*]

Ms. Lorraine Brett: I'm sorry to interrupt.

Is there any chance that someone could assist me? My translation is not working.

[*Translation*]

Mr. Luc Thériault: She has to choose the right channel.

[*English*]

The Chair: Do you see on the bottom of your screen where you have three options of English, French or floor audio? It's like a little globe.

If you set that to English, then that's what you'll hear in your headset.

[*Translation*]

I'm speaking French right now. Can you hear the English interpretation?

Yes? Okay.

[*English*]

Dr. Daniel Vigo: I also don't have that option, or I don't see it.

The Chair: On the bottom of your screen, do you see a globe, Dr. Vigo?

Dr. Daniel Vigo: I do. Thank you very much.

The Chair: Okay.

[*Translation*]

Mr. Thériault, you have three and a half minutes left.

Mr. Luc Thériault: Thank you, Mr. Chair.

Dr. Vigo, in your experience, how does stigma hinder the healing process when the patient internalizes the other's gaze? Does internalizing that stigma interfere with the healing process?

[*English*]

The Chair: Dr. Vigo.

[*Translation*]

Dr. Daniel Vigo: Thank you.

[*English*]

I think the issue of stigma is important. As you pointed out, there is self-stigma; there's structural stigma and there's stigma in societies.

I believe we are all tending to a more inclusive approach that seeks to make sure that stigma doesn't play a role in preventing people from getting care, so it's an important part of that.

I also think that, as was said before by other witnesses, the urgent issue is the effect of toxic drugs on brains, so most of our attention and funding should be directed to expanding available services.

[*Translation*]

Mr. Luc Thériault: Doesn't stigma lead to a loss of self-esteem? If a person doesn't have a positive self-image, that could actually slow the healing or treatment process.

[*English*]

Dr. Daniel Vigo: For sure that is a key piece of the treatment and recovery journey of people who are struggling with addiction and mental health issues. That is why it is so important that the treatment of people affected by this is holistic—

● (1145)

[*Translation*]

Mr. Luc Thériault: Thank you.

[*English*]

Dr. Daniel Vigo: —and includes the provision not only of psychopharmacology but also of psychotherapy.

[*Translation*]

Mr. Luc Thériault: Stigma is therefore not just a political tool in the hands of those who want more liberalization to fight the toxic drug crisis.

[*English*]

Dr. Daniel Vigo: Stigma is a concept and a societal phenomenon. Whether it's used for one thing or another, it's the responsibility of whoever uses it, but it is, in fact, something that, as you outlined, can hinder people in getting care for themselves. It's something that, in certain quarters, can exclude people from care. Certainly, every health system that I know of is trying to make sure (a) that health systems do not stigmatize people who use drugs or have mental illness and (b) that people who have the self-stigma that you indicate can recover through psychotherapy and various forms of interventions that allow for overcoming that.

The Chair: Thank you, Dr. Vigo.

[*Translation*]

Thank you, Mr. Thériault.

[*English*]

Next is Mr. Johns, please, for six minutes.

Mr. Gord Johns (Courtenay—Alberni, NDP): Thank you Mr. Chair.

I want to thank the witnesses for their important testimony, especially Ms. Brett for having the courage to share her lived experience as a mother with a child who is struggling with substance use disorder.

I'm going to start with Dr. Knight.

Dr. Knight, can you talk about what the risks and potential harms of involuntary treatment are?

Dr. Erin Knight: It's somewhat challenging to talk about the evidence base for involuntary treatment, because the research and the evidence are very poor on all sides. There are some studies that show that involuntary treatment is helpful. There are some that show that it's harmful, and there are some that show that it doesn't really change anything.

It's already been said by some of our other witnesses today that the use of involuntary treatment already exists through our mental health acts and can exist for people who have such severe disorders, both mental health disorders and substance use disorders, that they require care because of the lack of capacity to make decisions for themselves.

However, whenever we remove somebody's autonomy, we have to do so very carefully. Autonomy is a core component of medical care and of medical ethics, so we need to be deliberate about ensuring that, if we remove somebody's autonomy, it is because they require it. Additionally, we need to be cautious that we are not expanding involuntary treatment to the detriment of voluntary treatment for people who want to access service.

Mr. Gord Johns: Can you speak about involuntary treatment in terms of whether it is culturally safe for indigenous people and patients? As well, are there maybe concerns that involuntary treatment of indigenous patients could compound intergenerational trauma arising from residential schools and colonization?

Dr. Erin Knight: That's a great question. I would say that, in my experience.... To sort of clarify my experience, I will tell you that I trained in a family medicine program specific to serving indigenous populations, and my family practice specifically serves urban indigenous populations in Winnipeg. One of the things that I see in my patients is that even voluntary admission to hospital is sometimes perpetuating intergenerational trauma for a variety of reasons. Any institution where people have less power over their decisions has the risk of re-perpetuating trauma. That would only be escalated in the context of involuntary treatment.

I have had patients express to me their concerns about being involuntarily admitted under the Mental Health Act and how that has perpetuated trauma. At the same time, sometimes it's necessary. It is important that when we look at involuntary treatment to any degree, including that sort of course of involuntary assessment that should be part of a decriminalization policy, we do so in a way that is informed by people who use drugs, by people who are indigenous and by minority groups that may be at higher risk of harms related to those policies.

● (1150)

Mr. Gord Johns: I think there are going to be a lot more questions from that.

Now, in 2023, the Canadian Society of Addiction Medicine published the results of a systemic review of involuntary treatment, which concluded that more research is needed to inform policy in this area.

Again, Dr. Knight, can you speak about how more research can be conducted ethically on the effectiveness of involuntary treatment, given the risks?

Dr. Erin Knight: I don't think we have time to really talk about the ethics involved and the process involved in developing a research study. Certainly, anything that is research from a health lens, particularly with vulnerable populations, which include people who use drugs and people with substance-use disorders, has high levels of scrutiny for acceptability.

One of the issues that we pointed out in that paper that you reference is that there is such poor description of what was included in involuntary treatment studies that we can't even pull reasonable learnings from most of the studies, because they don't tell us what they did other than putting people in a place where they didn't want to be. Anything that looks at involuntary treatment and attempts to study involuntary treatment in a more robust, evidence-based and scientific way needs to look at the implementation of evidence-based treatment as part of that involuntary treatment, so that we can see whether or not outcomes are favourable.

The Chair: Thank you, Mr. Johns.

Next we have Mr. Moore, please, for five minutes.

Hon. Rob Moore (Fundy Royal, CPC): Thank you, Mr. Chair.

Thank you to all the witnesses who have appeared.

Ms. Brett, thank you for your personal testimony here today and for sharing the story of your son Jordan. I'm very happy to hear about his one year of sobriety. You certainly have added value to the meeting we're having here today.

Unfortunately, we now have data from a number of years to go back on. We see that the current approach is simply a proven failure. It's not working. In 2016 Canada had about seven overdose deaths per day. That is a terrible stat, except when you compare it with the stat now. We're exceeding 21 per day, more than a tripling of the number of deaths.

When we look at what actions have taken place, one action that this government brought in was Bill C-5. It eliminated mandatory jail time for serious criminals who were producing and importing drugs like fentanyl, meth, cocaine and so on, the most serious drugs—schedule I drugs—in Canada. It allows these individuals to import those drugs, export those drugs, or produce those drugs, such as running a meth lab out of their own home, but then, if they are caught by the police, charged and sentenced, to serve their sentence from the comfort of their own home. I think that sends a terrible message to Canadians, because it allows for the revictimization of the most vulnerable.

I want to get your thoughts on that. In your opinion, should those who are bringing deadly drugs like fentanyl and meth into Canadian communities face more serious consequences?

Ms. Lorraine Brett: Absolutely. It's shocking how vulnerable homeless, mentally ill and addicted people are. My son was a constant victim of violence. He was never safe. The great irony of bafflegab and buzzwords like “harm reduction” is that while he was out on the street, decades' worth of living outside, he was predated on by other addicts and by dealers. He had a knife held to his throat for a two-dollar drug debt. He was routinely threatened. Someone in my presence said to my son, “You know, we'd break your legs for that.” I mean, what...?

We need to support police. We need to give them all the tools we can. Bill C-5 should be repealed. We need drug dealers and drug creators to face the stiffest penalties. Our children are dying, and they're dying under horrific circumstances, being predated upon.

● (1155)

Hon. Rob Moore: Thank you for that.

You said something that I took note of. You said, “Stigma does not kill. Drugs do.” There's certainly no doubt that drugs are taking the lives of so many. It is an epidemic. That's why we're having these meetings. We're looking for solutions.

You've been very critical of the buzzwords. You're saying that we need to focus on things that actually work, on actual results. Can you expand a bit on your statement that it's not the stigma but the drugs that are taking innocent lives?

Ms. Lorraine Brett: Sure.

My son attempted and actually was in treatment 26 times. He entered 26 different treatment facilities. In almost every case, he was kicked out. He had an undiagnosed mental illness. This was some of the evidence. He also attended about 5,000 AA and NA meetings while he was drunk, while he was high and while he was sober. He has always had an intention to not use drugs, yet we claim that the stigma is so overwhelming that these people need the succour of drug injection sites and safety.

This is a man who knew his mind when it came to drug use. He did not want to be and does not wish to be a user. Safe supply is an expensive PR campaign to promote a false narrative that these are individuals who want and need to sustain their drug use. He wanted off.

He has arrived at that moment. He is a year clean. This is evidence that the combination of involuntary care and clozapine does miracles.

The Chair: Thank you, Ms. Brett.

Thank you, Mr. Moore.

Dr. Hanley, you have five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you to all the witnesses.

Dr. Knight, I'll start with you.

You mentioned that you trained in B.C. Now you work in Manitoba. You pointed out differing approaches in different jurisdictions, for example, the availability of treatment while incarcerated in Alberta versus Manitoba.

When you look at these differing approaches across the provinces and, as you mentioned in your testimony, the need or the recommendation to constitute or perhaps reconstitute the expert panel, can you connect those two?

Are you referring to reconstituting the expert panel we had in 2021, or is it some other vision that you have of how we can get some national leadership to help guide best practices from one jurisdiction to another?

Dr. Erin Knight: This is a recommendation that I highlighted in our Canadian Society of Addiction Medicine brief about expanding and re-establishing a task force to work on mental health and substance use health, specifically around addressing some of the expert advice and developing a framework that establishes expectations around the availability of evidence-based care.

You can look at it through a provincial lens. The people who live near my rapid access to addiction medicine clinics in Winnipeg have vastly different access to evidence-based treatment than people who live in Red Sucker Lake, Manitoba, or in any of our fly-in, remote communities that have very little access to care.

The same thing is true if you look across different provinces and different jurisdictions. There needs to be some expectation of availability of service for all Canadians, regardless of where they live.

● (1200)

Mr. Brendan Hanley: Thank you very much.

Dr. Vigo, you started to describe the difference between criminalizing the act of taking drugs versus criminalizing or making other services illegal. I was quite interested in this. I'm not sure you had time to finish your thoughts earlier.

Can you comment on the current climate in B.C. and where we find the right political environment in order to ensure access to treatment and services for those struggling with addiction?

In other words, how do we get that balance right of what should be in the criminal envelope and what shouldn't be?

Dr. Daniel Vigo: Thank you very much, MP Hanley.

I think it is really important to strike a balance there. I think the most accurate depiction of that is a curve developed by the Health Officers Council here in B.C., which was later taken up by, for example, the Canadian Drug Policy Coalition and others. When you criminalize substances, you have a high degree of harms, at both the personal level and the community level, that stem from all sorts of epiphenomena of the black markets and of all of those things, like people getting caught in the criminal system when they are using drugs or have an addiction, etc.

On the other hand, when you completely forgo any regulations and you unleash for-profit criminals to prey on people with an addiction, you have all sorts of high societal harms.

The sweet spot is somewhere in between, which is called a public health regulation approach, where you don't criminalize an illness. Addiction, mental disorders and acquired brain injury are, of course, illnesses that should be treated, but at the same time the societies and the communities in which we live require the laws to be respected by everyone.

There isn't a contradiction between making care available as needed and demanding and enforcing respect for those rules of interaction between individuals. I believe that this is exactly the sweet spot we need to continue aspiring to, where people using drugs are not criminalized, but other actions that are defined as criminal by our Criminal Code are enforced and receive the societal approach that we reserve for them.

Does that answer the question?

Mr. Brendan Hanley: Thank you, yes.

The Chair: Thank you, Dr. Hanley.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Dr. Knight, you talked about the B.C. experience and said that decriminalization wasn't enough.

What didn't work? What should have been done before drugs were decriminalized?

[*English*]

Dr. Erin Knight: There are two main components that were missing from Vancouver's attempt at decriminalization. One is the scale-up of on-demand treatment. We heard there's this myth that people who want treatment have access to treatment. In reality there are often significant wait-lists, significant barriers for people who actively want substance use treatment to get into treatment. One thing is significant scale-up of the availability of evidence-based treatment prior to the rollout of decriminalization.

The other aspect is an element of dissuasion built into the decriminalization policy. That's what was done in Portugal, where, when somebody has substance use disorder, they are required to go in front of a dissuasion panel that looks at their particular situation and their particular type of substance use and makes recommendations for what type of intervention they are going to get. That was lacking from the rollout in Vancouver, where there wasn't that element of encouraging people to access treatment and trying to direct people with problematic substance use to treatment.

● (1205)

[*Translation*]

Mr. Luc Thériault: Has safe supply saved lives or not?

Do you have any data on that?

[*English*]

Dr. Erin Knight: The question around safe supply is complex. When I talk about safe supply, I want to be clear that there are lots of different definitions that have floated around in terms of that. I'm going to define “safe supply” in your question as prescribed safer supply, which is a prescription for a pharmaceutical opioid typically, although it can be other medications to decrease somebody's reliance on the illicit toxic drug supply.

We know from some of the research and evidence that there are individual benefits from safer supply. We also know that there are significant concerns from the community and from some providers and prescribers around the potential public health harms. The reality is that I don't think we're at a place where we have a strong enough evidence base to say that safer supply is good or bad. It is something that probably does need more evaluation and more research before we talk about whether it's going to be a key component to this.

The Chair: Thank you.

We have Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: Thank you.

Dr. Vigo, can you speak about the assertive community treatment teams? I understand that they provide wraparound care and treatment for people living in a community who have complex mental health or concurrent mental health and substance use disorders, who might benefit from a supportive approach to care beyond that of standard services. Is this a model you've looked at?

Dr. Daniel Vigo: Well, it's the only evidence-based community treatment for people with the most severe forms of mental and substance use disorders. It has been studied for decades. The continuum of care of assertive community treatment teams and their variation, flexible assertive community treatment teams, has proven to reduce unnecessary in-patient treatment, to reduce ED visits, and to improve the interactions between patients and their families, as well as their housing situation. They are, for sure, an evidence-based approach to this problem.

In fact, I am a psychiatrist in one of those teams in B.C., and I'm the medical lead for the provincial assertive community treatment and advanced practice initiative. We have evaluated this, and we have proven that it reduces by half the days of inpatient treatment compared to the year before admission, and then continues to reduce these up to two-thirds, meaning that we only have one-third of the days of in-patient treatment in five years. The same thing happens with ED visits. The reason for that is that you have a wraparound team that seeks out the patient where they're at and makes a decision in the moment. Do they need to be admitted? Do they need to be discharged? Do they need to be under the Mental Health Act or extended leave, or can they be decertified?

Yes, it is an evidence-based and also cost beneficial approach. We have proven that for every dollar invested in five years, we get $2.20 back. The government saves money through this. There are 34 of those teams in B.C. They are being expanded, and we need to do more; however, that is certainly one of the evidence-based tools we need to rely on.

Mr. Gord Johns: Do you consider the community treatment teams a best practice that other jurisdictions should also implement?

● (1210)

Dr. Daniel Vigo: Absolutely. It is the only practice, basically, for keeping these patients in the community without unnecessary certification, without unnecessary inpatient treatment.

The Chair: Thank you, Mr. Johns.

Next is Mr. Doherty, please, for five minutes.

Mr. Todd Doherty (Cariboo—Prince George, CPC): Thank you, Mr. Chair.

Thank you to our witnesses for being here.

Dr. Vigo, in your answer to our colleague, Gord Johns, you stated some statistics and some facts. Are you able to table that information with our committee, please?

Dr. Daniel Vigo: Yes.

Mr. Todd Doherty: Thank you.

Ms. Brett, in your opinion, does Canada prioritize recovery for those with substance use issues?

Ms. Lorraine Brett: No, not at all. My son has gone through hell, as have I and my family. He's essentially been victimized by the lack of appropriate care. We've pounded on every door, yet, in the end, his behaviour became.... I mean, he turned into an animal. I found him bent over, eyes closed, unaware that he had his eyes closed when speaking to me.

There was just never any supportive help, not what we needed when we needed it. It's chaos. It's malevolence to leave people to die on the street. It's a form of evil. It's inhumanity. It's man's inhumanity to man, and we need to do everything we can to change this. We are in an emergency. There is no doubt. We must act as if this is a crisis of immense, horrific proportions.

Mr. Todd Doherty: You said in your opening statement that you've been in New West since 1994. I'm sure that over the course of those years, you've seen changes to our community and to the New West community due to the drug crisis.

Ms. Lorraine Brett: Yes. There was chaos on the streets. It was reported by everyone. There have been violent acts. We had a taxi-jacking, which resulted in multiple car crashes. In Vancouver, of course, we had someone who cut off the hand of an innocent bystander. The chaos has just continued to mount, and deaths continue to mount. We cannot, in good conscience, any one of us, continue with the status quo. It cannot remain thus.

Mr. Todd Doherty: Would mandatory treatment have helped your son get clean? Has it helped get him clean? He's a year sober.

Ms. Lorraine Brett: Yes, he is a year sober. He has been under the Mental Health Act, involuntarily. This is the end of year four. It's been a process.

He did use occasionally in that window, prior to this last year, but there has been such an amazing focus of care. Limitation of movement and locked facilities were the ticket to begin with and continue to be so, where needed and when needed. He is a miracle of the benefits of mental health care, the best psychotic drugs, like clozapine, and great therapeutic services provided by the psychiatrists there.

We couldn't be happier. This is a godsend. It's a miracle. We need more, and we need it now.

Mr. Todd Doherty: Ms. Brett, if you could speak directly right now to Prime Minister Trudeau, Minister of Health Mark Holland and the Minister of Mental Health and Addictions, Ya'ara Saks, what message would you give them?

Ms. Lorraine Brett: Oh, dear God, do not prevent the opportunity for our children to have this care. They need it so desperately. They're dying every day, every minute. We need the floodgates to open. We need help. We can't live this way.

● (1215)

Mr. Todd Doherty: I truly appreciate your heartfelt testimony.

As you probably have heard, my brother is on the street as well, and has been since the early 1990s. He started on the streets in Surrey and in New Westminster, and so very likely was probably in the same circles as your son, so my heart goes out to you. I wish you and your family nothing but the best.

Thank you for your testimony.

The Chair: Thank you, Mr. Doherty.

Next is Ms. Sidhu, please, for five minutes.

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

Thank you to all the witnesses.

My first question is for Dr. Knight.

Dr. Knight, you talked about fewer resources and the difficulties of providing addiction medication to those who are living in rural and remote areas. You also recommended universal coverage for first-line medications for substance use disorders, including naloxone.

What needs to be done so they can have access to the medication, especially in remote areas and rural areas?

Dr. Erin Knight: It's a very complex situation, and it really depends on the degree of rurality and remoteness we're talking about.

There are a large number of "fly-in only" communities in my province, and often, almost exclusively, they are communities that don't have pharmacies and don't have the ability to dispense medications within the communities. That is a major barrier to the use of medications that have to be witnessed and dispensed by either a pharmacist or a health care provider.

The advent of long-acting injectable buprenorphine has enhanced the ability to provide treatment for opioid use disorder in those communities, because it doesn't require daily use of medication. That is another area where the availability of long-acting injectable naltrexone, which I mentioned, would be useful in terms of providing another treatment option for people who either don't want to or can't go to the pharmacy regularly for medication options.

Ms. Sonia Sidhu: Thank you.

My next question is for Dr. Vigo.

Dr. Vigo, can you speak about the difference between a mental disorder and psychosis? Also, can you explain holistic psychiatric care?

Dr. Daniel Vigo: Psychosis is a syndrome that affects cognition. It entails, for example, delusions and hallucinations, and is very frequent in certain mental disorders, such as schizophrenia or bipolar disorder type 1, so it is a syndrome as part of a disease.

What is holistic psychiatry? Was that the second question?

Ms. Sonia Sidhu: Yes...holistic psychiatric care.

Dr. Daniel Vigo: That refers to the B.C. Mental Health Act, which indicates that when someone requires detention under section 22 of the Mental Health Act, then that person can receive treatment under section 31. That treatment needs to be psychiatric treatment.

Now, for a while there has been a lot of confusion and back-and-forth as to what psychiatric treatment means and what can be provided under section 31 of the Mental Health Act.

What I was indicating is that once someone meets criteria for the Mental Health Act, meaning they have a mental impairment that results in their inability to take care of themselves—with physical and mental deterioration, risk to self and others—and there is a treatment that could help them, but the person is unable to comply or engage with it, then you can provide the treatment as a psychiatrist under section 31. That treatment needs to be psychiatric treatment, meaning that you cannot, for example, say that this person has a psychotic syndrome because they have a brain tumour, so you're going to indicate brain surgery under section 31. No, you need to provide things that are under the specialty of psychiatry, which means any psychopharmacological approach, including, for example, a combination of antipsychotic medication and buprenorphine.

The distinction here is on buprenorphine or any other psychopharmacological approach that is within psychiatry and its subspecialty, such as addiction psychiatry. The distinction is important, because many of our patients with severe mental illness and substance use disorder do require a combination of these two, and other medications and other psychotherapeutic approaches. That is what I call holistic psychiatric treatment—something that can be provided voluntarily 99% of the time and involuntarily when needed, and can address the person as a whole.

Does that make sense?

● (1220)

Ms. Sonia Sidhu: Thank you.

The Chair: That's your time. Thank you, Ms. Sidhu.

Next is Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Chair, and thank you to the witnesses.

Dr. Knight, I have a couple of questions for you, if I might. You talked about evidence-based treatment with respect to opioid use disorder, substance use disorder, etc. Can you tell us exactly where the so-called safe supply fits in that? What is the evidence?

If you have some evidence, I think it important that you table that with the committee.

Dr. Erin Knight: There are some reasons I deliberately didn't talk about prescribed safer supply in my recommendations, and that is partly because I feel, in reading the evidence that exists to date, that we don't have a clear picture of the role of prescribed safer supply.

I do want to highlight that it really is an intervention that is trying to decrease people's reliance on the illicit toxic drug supply, and that there are other mechanisms to do that as well that could be considered, including what Dr. Vigo talked about in terms of the regulation of drug supply.

Mr. Stephen Ellis: This is your area of specialization, Dr. Knight. This is what you do. If I hear you correctly, realistically, the use of, as you call it, “prescribed safe supply”.... From some of the testimony we've heard, I'm not entirely sure how much prescribing is going on, simply because there doesn't always appear to be a significant doctor-patient therapeutic relationship that exists. That being said, what I heard you say just now is that the scientific evidence related to that is minimal.

Let us consider that what we're seeing with this so-called safe supply is an experiment with a terribly vulnerable population. Is that what you see it as?

Yes, I agree that perhaps the intent was to save lives, but there's no evidence, and of course you mentioned in one of your statements that it's important that we use the best evidence there is.

Dr. Erin Knight: I'd like to clarify that my position is not that there is no evidence for prescribed safer supply. My position is that there is conflicting evidence. We know that there are some benefits for people who access prescribed safer supply, and we know that there are some potential harms. What is not clear is where that balances out in terms of risks and harms. Any time we do any intervention, that's the question; is the balance of benefits higher than the balance of harms?

Mr. Stephen Ellis: I'll just interrupt you there, Dr. Knight.

When you look at this—again, you talked about the evidence—I think it important that the evidence you cite be tabled with the committee. Would you undertake to do that, please?

Dr. Erin Knight: Yes, I can send some evidence to the committee, absolutely.

Mr. Stephen Ellis: As we've heard, not just today but multiple times from many witnesses, this is an extremely vulnerable population. Would you agree with that?

Dr. Erin Knight: I would agree that lots of people with substance use disorders have aspects of vulnerability. There are lots of people who have substance use disorders who are highly functioning people in our society as well. I go back to the idea that, really, people—

Mr. Stephen Ellis: I'm sorry, Dr. Knight, I just have limited time.

Does it make sense, then, without their consent, to do experiments on vulnerable populations who may or may not be impaired by substance use...or on anybody?

Dr. Erin Knight: I said this earlier, in one of my comments. When we're doing scientific research, there are checks and balances in terms of the ethics and in terms of—

● (1225)

Mr. Stephen Ellis: Dr. Knight, there were no checks and balances with so-called “safe supply”.

Do you think that folks who were receiving so-called “safe supply” consented to it being an experiment?

Dr. Erin Knight: I can't speak to the individual conversations between the prescribers and the people who received safer supply, but it would be general medical practice to discuss the risks and benefits of any treatment with individuals.

Mr. Stephen Ellis: I think, Dr. Knight, we've established already that many folks who received so-called safe supply didn't even have a doctor-patient relationship with their prescriber, so how could you possibly think that they gave any consent to be part of an experiment?

Please. I mean, you're a scientist. I think this is basic science, is it not?

Dr. Erin Knight: This brings us back to the need for recommendations on a national level in terms of what the requirements are for a provision of—

Mr. Stephen Ellis: Dr. Knight, this is about a basic science experiment gone wrong.

The Chair: Thank you. That's your time, Dr. Ellis.

Mr. Stephen Ellis: Thank you, sir.

[*Translation*]

The Chair: Mrs. Brière, you have five minutes.

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you to all the witnesses for being with us today.

Dr. Knight, I want to give you an opportunity to tell us a bit more about Digital Front Door and the Rapid Access to Addictions Medicine Clinic.

[*English*]

Dr. Erin Knight: The Digital Front Door is something that we've rolled out in Manitoba relatively recently based on the experience out of Ottawa on increasing the accessibility of different avenues for getting connected with addiction medicine treatment, particularly for people who live in areas where they may not have physical access to an addiction clinic or who have other barriers to accessing service. It's really an alternative door, through either a computer or a smart phone, to be able to essentially get the same rapid access to addiction medicine services as if you physically walked through our door.

[*Translation*]

Mrs. Élisabeth Brière: What outcomes have you seen? Are you seeing any positive impacts so far?

[*English*]

Dr. Erin Knight: So far, it is still relatively new for us. We're still trying to figure out the right way to roll it out and access the people who most need the access to care.

We certainly have had positive experiences in terms of people being able to access care that they wouldn't otherwise have gotten. One way that we're using the Digital Front Door actually is to provide initial contact for people in those remote communities that I spoke about earlier, where otherwise people would have to physically get on a plane, fly to a community and then come in through our walk-in clinics. Making that first connection and being able to provide some of the education and some of the initial assessment to make a plan for that person before they have to leave their community and come into an urban centre has been really helpful.

[*Translation*]

Mrs. Élisabeth Brière: Could that be done elsewhere in the country?

[*English*]

Dr. Erin Knight: Yes, I think it is something that can be produced elsewhere. As I mentioned, we actually took it from The Royal here in Ottawa and adapted it to Manitoba, so it's already been taken from one place and replicated elsewhere.

I mentioned this when we were talking about the VODP as well: There are some inherent problems with virtual care alone, because lots of people who require access to care don't have computers, don't have smart phones, and aren't able to come in through those routes, so having the accessibility of low-barrier, in-person service is also really important. We can't do one without the other, but having a broad number of doors that people can get into makes sense.

[*Translation*]

Mrs. Élisabeth Brière: During this committee's study, which has been going on for several meetings, a number of witnesses have told us that the overdose crisis is due in large part to drug toxicity.

In contrast, Alberta's Minister of Mental Health and Addiction said that the crisis stems from an addiction problem, not an increasingly toxic drug supply. He also said that it always ends in one of two ways: pain, misery and death; or treatment.

What are your thoughts on that?

● (1230)

[*English*]

Dr. Erin Knight: I prefaced my statement today by saying that my recommendations were going to be specifically for impacting people who have a substance use disorder. The reason I prefaced with that is that while a lot of the people who are impacted by the opioid epidemic and toxic drug crisis have substance use disorders, not all of them do. There is a component whereby the toxic drug supply is sometimes killing people who don't have substance use disorders, because it is toxic and because they don't have access to a regulated supply like we do with alcohol or other regulated substances.

The reality is that our liquor stores are a place to access safe and regulated drugs, and our bars and restaurants are supervised consumption spaces.

The Chair: Thank you, Dr. Knight.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

If I understand correctly, the answer to the question I asked earlier is that safe supply has saved lives.

At one point, we had a witness who had a clinic and was caring for people. He told us that we should focus on drug substitutes that are long-acting agents.

I'd like to hear your thoughts on that.

Do such products exist? If so, is there a difference between having to take something daily and taking a substitute drug that's effective for, say, a month?

My questions are for Dr. Knight, but Dr. Vigo can add to the answer if he wishes.

[*English*]

Dr. Erin Knight: I believe your question is about the difference or the potential benefits around long-acting agents such as an injectable agent versus a daily dispensed medication. Is that correct? Okay.

There is evidence for daily use of OAT medications like buprenorphine and methadone. There is also evidence for long-acting agents like injectable buprenorphine, which is a monthly injectable formulation.

For some people, getting away from taking a medication every day and having that routine as part of their daily experience is beneficial in terms of being able to get away from that idea of continuously taking a medication. They still have access to that medication in their body physiologically, but it's not always front of mind. We have evidence for both, and I think it's important that we have accessibility of a variety of treatment options for people who want to access them, so that we can tailor treatment to the individual in front of us.

[*Translation*]

Mr. Luc Thériault: What does access depend on? Cost?

[*English*]

Dr. Erin Knight: The cost is very dependent on where people live and what the availability of drug coverage is, which is why one of our recommendations is broad coverage of these first-line medications for opioid agonist therapy.

In my province, buprenorphine, naloxone and methadone, as daily options, as well as the injectable buprenorphine, are covered if people are on social assistance or if they have coverage through treaty status. Otherwise, people have to pay for them, and they are relatively similar in terms of cost.

● (1235)

The Chair: Thank you, Dr. Knight.

Next is Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: Thank you, Mr. Chair.

Dr. Vigo talked about the closure of Riverview in British Columbia, and Ms. Brett, you highlighted that as well. We've lost beds, and we see provinces and territories scrambling to scale up to meet the crisis, but the federal government spent less than 1% responding to this crisis.

Ms. Brett, you talked about stigma not being an issue, but it is a stigma that the federal government has spent only 1% of what it spent responding to COVID-19 on this crisis.

How important is it that the federal government scale up detox beds and treatment beds, as you highlighted?

Ms. Lorraine Brett: I'm thrilled to be able to say over and over again to all of you in significant positions of power, and to the Prime Minister himself, that we absolutely need to shift our approach to crisis emergency management. In this case—and my son is a witness—there is evidence now that this involuntary care will work.

Dr. Vigo has articulated a way forward, but without more beds and without more effort to create spaces, we can't treat these people; we can't take them off the dangerous streets, and we can't save them.

Absolutely, we need the Prime Minister to move on this. We need the federal government to move now and quickly. Lives depend on it every single day. There's always someone else, and there are many who die. We need to act like every life matters.

Mr. Gord Johns: Thank you so much, Ms. Brett. The B.C. Liberals closed that facility.

We know, Dr. Vigo, that involuntary treatment is not an ideal approach but one that is seen as a last resort. What do you think can be done upstream to potentially avoid getting to the point where caregivers or medical professionals are pursuing involuntary options to keep people safe? Are there early prevention initiatives that are effective and need to be scaled up?

Dr. Daniel Vigo: For sure, we need to implement the scale-up of voluntary options that would allow us to use involuntary as a last resort, as you said. We also need, as Professor Knight indicated, broad access to available drugs, such as buprenorphine and others, and simplified ways of prescribing that.

That's another important thing. Some of the drugs we use to treat these very difficult disorders have all sorts adverse events and unintended effects. Buprenorphine has a very benign profile of side effects and there are immense benefits, at least for people who also have mental disorders, to the depot formulations.

I guess what I'm saying is that we should simplify the way physicians can prescribe buprenorphine and other alternatives, for sure, across the board.

Second, if we could make, as a result of these conversations, depot naltrexone available across Canada, that would be phenomenal. It's not there just because of a combination of bureaucracy and poor business decision-making that is fixable in the context of a health emergency.

The Chair: Thank you, Dr. Vigo.

Ms. Goodridge, you have five minutes, please.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

Dr. Vigo, I appreciate that you've also now shared your concerns about the fact that Health Canada's bureaucracy has stood in the way of access to an evidence-based drug, which is injectable naltrexone.

Can you describe why it is important that Health Canada finally act to make this drug available?

Dr. Daniel Vigo: We have a lot of safeguards that our institutions create to make sure we have thorough evaluation and assessment of the different options. In a public health emergency, we need to do a reassessment of those risk and benefit equations.

In the case of depot naltrexone, this is a molecule that would block opioid receptors. It would allow us to treat, for example, as we were discussing before, people who have not developed an opioid use disorder but are in the initial stages of that. They are being exposed systematically to overdoses, either by seeking them out or through the contamination of the supply. They would benefit from blocking those receptors, because, let's say, they are young and their brains are developing.

● (1240)

Mrs. Laila Goodridge: Thank you. I appreciate that.

Earlier at this committee, we had British Columbia's public health officer, Dr. Bonnie Henry, call for the legalization of hard drugs. She actually produced a report a bit later on that recommended that the government consider running, or have privately run, retail stores to sell drugs like heroin, cocaine and meth.

Do you believe that this is something British Columbia should embark on?

Dr. Daniel Vigo: The premier has been very clear that the current approach of the government is that there will be no expansion of those initiatives that make drugs available. The expansions are going to be for services that are within the context of treatment. Access to opioids in the form of agonists, partial agonists and antagonists will be through treatment centres and recovery-oriented practices.

Mrs. Laila Goodridge: We've also recently been seeing quite a number of drug busts of super labs. The most recent one was found in your province of British Columbia.

Are you seeing issues in regard to the increased availability of drugs as a result of the pilot project that made the possession of hard drugs like cocaine, meth and fentanyl legal?

Dr. Daniel Vigo: The question is whether I have seen an increase.... Can you repeat that question?

Mrs. Laila Goodridge: Have you seen an increase in the availability of drugs on the streets in British Columbia as a direct result of the pilot project that made it legal for people to have fentanyl and use fentanyl in British Columbia?

Dr. Daniel Vigo: The increasing availability of synthetic drugs is due to how easy it is to obtain those precursors. Those precursors came initially from China and now come from Mexico. They allow for the backyard production of those products at scale. That is the cause.

Of course, the responsibility falls upon the authorities to prevent the circulation of those precursors and to bust those labs, as you just said.

Mrs. Laila Goodridge: Do you think the federal government is doing enough to actually ban these precursors and find and dismantle these super labs?

Dr. Daniel Vigo: My area of expertise is mental health, public health and psychiatry. I think the enforcement area is a fundamental one, but it's outside of my area of expertise.

Mrs. Laila Goodridge: Okay, but you deal with people who have addictions, and I'm sure they share some of the information.

Do you think that the Government of Canada is doing enough to deal with the precursors that are coming into our country and allowing criminals to profit off the drug issue and make fentanyl?

Dr. Daniel Vigo: To be clear, everything that could be done to prevent those precursors from being in Canada and available to drug traffickers and producers should be done. No expense should be saved, and no effort should be avoided, because that is ultimately what would allow us to curb this crisis.

Mrs. Laila Goodridge: Dr. Knight, what are your thoughts? Do you think the government is doing enough to ban precursors in the country?

Dr. Erin Knight: The enforcement area is not my area of expertise, and I'm not going to comment on it.

The Chair: Thank you, Dr. Knight. Thank you, Ms. Goodridge.

Dr. Powlowski, go ahead, please, for five minutes.

Mr. Marcus Powlowski: We're trying to come up with recommendations out of this committee. With that in mind, I think certainly one thing we want to do is reduce the number of deaths due to overdose and try to help people get their lives back on track.

I would suggest that one thing I'm thinking of in coming up with recommendations is how we address the deteriorating situation we see in so many downtown cores, where you have increased numbers of homeless people and people with clear psychiatric problems and substance abuse problems.

Dr. Knight and Dr. Vigo, how much do you think we would benefit from having more ACT teams, with psychiatrists who could assess and, where appropriate, put people on long-term antipsychotics if necessary? Is part of the equation that we ought to be trying to gear up those services and to address the mental health issues we see on the street?

We'll go to Dr. Knight and then Dr. Vigo. Please make it quick, because I have a couple of other questions, too.

Dr. Erin Knight: Sure, I'll try to make it as quick as possible.

I think the ACT teams make a lot of sense. Dr. Vigo has talked about them. I saw great work from them when I was in Vancouver.

I do think it's important to also highlight that we're often talking about downstream, severe treatment. We do need to think about prevention and early intervention as well.

● (1245)

Dr. Daniel Vigo: My answer is a categorical yes. We need to expand ACT teams. We also need to expand long-term psychiatric rehabilitation beds, and we need to expand housing options for folks who require intensive services. We need that continuum of care: the ACT teams, the in-patient beds and the approved homes.

Mr. Marcus Powlowski: That's a perfect segue to where I want to go next.

How much of the answer is just more supportive housing? You mentioned the closure of Riverview as contributing to the number of people living on the streets. Should we also be contemplating reopening some long-term psychiatric institutions?

I know supportive housing is probably better, but when we have large numbers of people with similar kinds of problems, should we be thinking about opening more long-term psychiatric beds for people?

For example, in Thunder Bay, we closed down those long-term hospitals with the advent of long-acting antipsychotics.

Dr. Vigo, you mentioned it first. Then maybe we can quickly go to Dr. Knight.

Dr. Daniel Vigo: The answer is another categorical yes.

Yes, we need to open decentralized units with long-term psychiatric rehabilitation beds. We need to also have them in a continuum of care with housing.

This is not like rocket science. I mean, that's the same thing that happened in the U.K. In the U.K., they closed all the old psychiatric hospitals, and now they've reopened a whole bunch of decentralized units that exist throughout the country. They have created thousands of beds, which is what we need.

Mr. Marcus Powlowski: Dr. Knight, would you like to add, on the same issue?

Dr. Erin Knight: I don't have anything to add to Dr. Vigo's comments.

Mr. Marcus Powlowski: The last question is on involuntary treatment. Somebody has an underlying mental health disorder, and under the Canada Health Act they qualify for involuntary treatment. How about, though, when somebody has—and I don't know how often this happens—a pure substance use problem? They don't have underlying psychiatric problems, but they are using drugs in such a way that they are clearly either trying to harm themselves or indifferent to harming themselves.

Is there scope for that, and should we be using existing psychiatric legislation? I'm a long-time emergency doctor as well. When somebody is suicidal, you have a duty to bring them into the hospital to try to prevent them from harming themselves. Should we be using that existing psychiatric law on people who are abusing drugs and either actively trying to kill themselves or indifferent to their deaths?

Maybe I'll start with Dr. Knight.

Dr. Erin Knight: Thanks. This is an ongoing debate among health care providers, for sure. In my view, substance use disorder is a mental disorder. It's classified under the DSM-5. For somebody who does have severe disease and is incapable of making treatment decisions, I would argue that our mental health acts would cover that. They are not being applied in that way, so there needs to be conversation around that.

Again, in talking about involuntary treatment, we know that the only way to use involuntary treatment appropriately is if we have access to voluntary treatment for people who want treatment.

The Chair: Thank you, Dr. Knight.

Thank you, Dr. Powlowski.

Next up is Dr. Ellis, for five minutes.

Mr. Stephen Ellis: Thanks, Chair. These questions would be for Dr. Vigo, Dr. Knight and Ms. Brett, if we have a bit of time at the end.

My colleague talked a little about prevention. It's certainly something that's incredibly difficult and not talked about very much.

Dr. Knight, in a few minutes could you give us your thoughts on the prevention of substance use disorder and difficulties, which, realistically, we are not spending any money on at all in this country.

Dr. Erin Knight: Thank you for bringing it up. We are often focusing on the downstream effects in the people with very severe disease.

There are some evidence-based prevention tools out there in other jurisdictions that we can look at, and we've outlined some of them in the CSAM policy brief we submitted.

Really, a lot of it comes down to supporting the fundamental social determinants of health, access to safe housing, to activities and to education; and supporting the growth of people—young people, in particular—who are able to develop in a positive way and not rely on the use of substances early on in their lives, which lead them to develop substance use disorders later.

● (1250)

Mr. Stephen Ellis: Thank you very much for that, Dr. Knight.

Dr. Vigo, do you have any comments you might want to add to that?

Dr. Daniel Vigo: Absolutely.

We have evidence-based interventions that we could deploy at every school in Canada for a relatively inexpensive investment—developed here in Canada, by the way.

The preventative intervention is one example. It has shown that when you intervene early enough, in ways that can be delivered in one or two sessions in a school, that has effects many years afterwards and decreases the risk of substance use.

This could be implemented, and it should be implemented, because, as everyone here has said, our best bang for the buck is in preventing the damage to those children's brains.

Mr. Stephen Ellis: Thanks very much, Dr. Vigo.

Ms. Brett, might I ask you a couple of questions?

Obviously, we're talking a bit about prevention now. One of the contentions we've heard is that nobody is born wishing to become addicted to drugs as they age. Would you echo those comments? If you could, give a comment with respect to what you think the benefit of treatment might be for younger children.

Ms. Lorraine Brett: Thank you.

Yes. You know, Jordan has never seen himself as an addict. He was a football star. He was an amazing athlete on many fronts. He was also using drugs quite early, at age 14—pot, alcohol. It was known to the school system that this was the case, and they placed him in a special after-school program, which he aged out of.

Now, when he looks back, he claims that was an effective way for him to manage the impulses he was feeling at that age. It's such a shame that there was no alternative and continuing program.

For him, with 26 treatment engagements and most failing, we were perplexed beyond belief, but the fact that those treatment centres existed was a reprieve from the street for him, in a way, and potentially saved his life. It helped him to accrue clean time.

We're really grateful for what existed at the time when he needed it, but he was undiagnosed with a severe mental illness in spite of engaging with mental health routinely. This is a crime in itself. I'm not saying it's a “crime” crime. It's just a sad reality of inefficient resources applied to him.

I'm not sure if I've answered your question.

Mr. Stephen Ellis: That's great, Ms. Brett. I appreciate that.

I have about a half a minute left.

What advice would you give to other parents and families who are going through what you have with your son Jordan? What advice would you give to the Canadians out there listening?

Ms. Lorraine Brett: Don't abandon your children. There is always hope. When it's the bleakest, when it's the darkest, go alongside them. Walk in their shoes.

Walk beside them, see what they see and know what they know. Bring them into whatever facility and support there can be, where there's dialogue, where there's a counsellor, where there's someone who can become a listening post and who can generate whatever resources are available. It's the only way.

We have to pound on the door of the services available to us and bring our kids with us. Don't leave them behind. Join them in their misery, because you need to be witness to it. You need to speak when they can't. In my case, Jordan was not able to describe in any real way, except to me, privately, the terror of what he was experiencing. He couldn't express it in public or in a counselling session of any kind.

We need to be there for them, and we can see them through to a better place, along with the aid of doctors like Daniel Vigo and the change in our B.C. government's intentions here, it seems, although I have no evidence that there are going to be new and effective beds made available for involuntary care. If that were to occur, there would be a significant change.

I just pray for that day. We need it. Our children are dying.

● (1255)

Mr. Stephen Ellis: Thank you.

The Chair: Thank you, Ms. Brett.

Thank you, Dr. Ellis.

Next is Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley: Dr. Knight, among the many misconceptions that are being promulgated by my Conservative colleagues are that this government or respected health care leaders like Dr. Bonnie Henry are pushing for “legalization of hard drugs”. What I'm hearing from many experts such as you is advocacy for a safe, regulated supply of drugs, such as we see with the post-prohibition approach to alcohol.

I wonder if you can help us distinguish between so-called “legalization” of hard drugs, which I've never seen in this country, versus access to a safe, regulated supply as an alternative to the rampant access to a toxic supply of drugs that is basically being supplied through organized crime networks?

Dr. Erin Knight: Maybe one of the easiest ways to talk about that is by giving an example, because we have access to a safe supply of alcohol through regulation. There are communities in Canada where alcohol is not allowed, and often in those communities an unsafe supply of alcohol becomes what people are using, in terms of homebrew and in terms of superjuice, things that have much higher risks of harms related to them because they're part of an unregulated supply of a generally regulated substance.

Dr. Bonnie Henry was talking about regulation, and Dr. Vigo has talked about this as well: that curve, where the lowest amount of harm is from a regulated public health approach to the supply of addictive substances.

Mr. Brendan Hanley: Very briefly, because I have a couple more questions for Dr. Vigo, what would that actually look like in practice? Could you give me an example of how that would be applied?

Dr. Erin Knight: It's hard to be brief about this. The complexities of it are why I didn't actually address it in my notes. If we were to look at creating a regulated supply of addictive substances more broadly, we would need to look at it with a strong lens of prevention as well, in terms of ensuring we're not having too loose regulations that increase the risk of early use and increase availability.

However, being able to supplant the illicit toxic drug supply with a regulated and more predictable supply would likely decrease harms related to the existing toxic drug supply.

Mr. Brendan Hanley: Thank you.

Dr. Vigo, I have a couple of questions for you while I have the remaining time.

One is that you mentioned the role of clozapine, and I think you implied that it is underused or perhaps is not as available as it should be. This was also reflected in Ms. Brett's comments about how this helped her son.

I wonder if you could talk briefly on that drug and what we need to do to elevate access to it.

Dr. Daniel Vigo: In our organizations, our institutions, our practices are usually that the risk-benefit analysis in the use of certain drugs leads to very stringent prescription protocols. Clozapine is one of those drugs that requires, for example, weekly venipuncture blood tests in order to check the white blood cells, because there's a very infrequent side effect, which is neutropenia, the decrease of white blood cells. If that goes undetected, some people can die.

Now, of these folks we're talking about, no one's going to die of neutropenia. No one's going to die of an undetected infection because of neutropenia. They're going to die of an overdose. For this subpopulation, the risk-benefit equation needs to change.

We are restricting accessibility by demanding those venipunctures that they cannot comply with, simply, so what we did here is that we developed a protocol by which we forgo the venipuncture and we do the dips, the point-of-care testing that can be done very easily by the ACT teams as needed.

Therefore, we can expand the availability of clozapine, but that needs a willing bureaucracy, and I say bureaucracy in a positive sense, not in a negative sense. I mean in the old sense of the way we organize our rules and our administration. A willing bureaucracy can accept this adjusted risk-benefit equation. The College of Physicians and Surgeons of BC has accepted this, and it is now approved and being rolled out.

● (1300)

The Chair: Thank you, Dr. Vigo and Dr. Hanley.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

Dr. Vogel and Dr. Knight, here's what Ms. Brière-Charest of the Association pour la santé publique du Québec told us last week:

> ...existing solutions are no longer an adequate response to the scale of the needs and cannot attenuate the crisis. We need to do more to prevent premature, avoidable deaths, expand access to voluntary treatment, enhance prevention, ensure a regulated supply and reduce the burden on the judicial system.

Do you agree with that?

[*English*]

Dr. Daniel Vigo: Those were a number of different statements. I agree with most of them.

I would say, though, that for some substances, the proper level of availability could be none. Carfentanil is 10,000 times more powerful than morphine. It has no use anywhere in any regulatory framework that I can foresee. Nitazenes and fentanyl are drugs that it would be very difficult to find a suitable availability for that is outside the medical system for the purposes of treatment, surgery, etc.

That's the only one of those statements that I would qualify in the sense that, for sure, we need to find a sweet spot of regulation, and, for some substances, that may be none.

Dr. Erin Knight: Essentially, I agree with those statements.

I do agree with Dr. Vigo's qualification of finding the right regulation for a regulated supply of substances. I absolutely agree with increased access and prevention and reducing the legal burden associated with substance use.

The Chair: Mr. Johns will have the last round of questions for this panel. It's two and a half minutes.

Mr. Gord Johns: Dr. Vigo, what can the federal government do to support provinces and territories that are trying to scale up mental health and substance use supports?

Do you think the government should set a target for spending on mental health and substance use health that reflects the disease burden?

We know many OECD countries spend significantly more than Canada on their health care budgets—double, in fact.

Maybe you could speak to that.

Dr. Daniel Vigo: I definitely think that in a country such as Canada, where the funding for health care is public funding and it's a combination of meeting federal regulations and targets and provincial decision-making, the federal government could help by—

[*Translation*]

Mr. Luc Thériault: Excuse me, Mr. Chair, but there's no interpretation.

[*English*]

The Chair: Just a minute, Dr. Vigo, I think we have a problem with translation.

[*Translation*]

Mr. Luc Thériault: It's working now. Thank you.

[*English*]

The Chair: We're back. Please continue, sir.

Dr. Daniel Vigo: I was saying that for sure the federal government would have a role in developing incentives for provinces to prioritize evidence-based interventions that expand treatment. There will be innovations that need to be developed, in the same way that in the U.K. there were innovations to suddenly scale up thousands of beds.

Where the capital funding and operating funds will come from will require important changes in the way we do things.

The other thing, with the utmost respect, is bureaucracies. We sometimes find that to create 20 beds with one secure room, we have a timeline of nine months. That cannot happen. We need to streamline our expectations with building permits, community consultations and things like that, so that we can actually expand the number of those beds.

● (1305)

Mr. Gord Johns: I have one last, quick question.

What can be done to reduce the risk of relapse following involuntary treatment?

What wraparound supports are necessary after treatment?

Dr. Daniel Vigo: That is an interesting thing, because it's only if the involuntary treatment is inappropriate that someone would have an increased risk of overdose or death afterwards. Involuntary care, under section 31, for someone who has a substance use disorder or an opioid use disorder, would never withhold opioid agonist therapy. On the contrary, it would provide it in the form of, for example, depot buprenorphine, which would ensure that the person does not have an overdose that would kill them.

The Chair: Thank you, Dr. Vigo and Mr. Johns.

Thanks to all of our witnesses.

Ms. Brett, your testimony was extremely personal and powerful. We wish you and Jordan every success on your journey to recovery.

To Dr. Vigo and Dr. Knight, your presentations showed great patience, professionalism and expertise, and we are grateful for that.

Thank you all for being with us.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: We're adjourned. Thank you.