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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0850)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call the meeting to order. We have quorum.

Welcome to our guests.

This morning we have our ongoing study on the opioid crisis. From British Columbia we have Dr. Evan Wood.

I understand it's 5:45 a.m. there, approximately, so thank you for being with us.

From Méta d'Âme, we have Mr. Guy-Pierre Lévesque, the director and founder of the community centre.

From Recovery Ottawa we have Dr. Ujjainwalla. Thank you very much for coming and making a presentation.

I understand, Mr. Lévesque, that you have to leave a little early, so we'll ask you to start off with your presentation. You have 10 minutes.

Mr. Guy-Pierre Lévesque (Director and Founder, Méta d'Âme): As I was presented, my name is Mr. Guy-Pierre Lévesque. I am the founder of the organization Méta d'Âme, which is a peer-led organization. At our facility we are all peers, people who did or are still using opioids.

We initiated a program, starting in 2013, called PROFAN.

[*Translation*]

We call it *Aller plus loin*, or going further. The program focuses on prevention, reducing overdoses, peer training and access to naloxone.

Méta d'Âme is a users' association based on the principles of empowerment. We work to improve the quality of life those who use opioids—such as heroin, morphine and other drugs—through our day centre and our 22 housing units, with community support provided by peers, of course.

PROFAN is a response to a recommendation made by United Nations Commission on Narcotic Drugs in 2011. According to this recommendation, the continuum of care offered to opioid users must include greater access to naloxone and be rounded out with training and education programs. That was resolution 55/7. It referred to

[*English*]

promoting measures to prevent drug overdose, in particular opioid overdose.

[*Translation*]

PROFAN is a French acronym for prevention, reduction, overdose, training, access and naloxone. So it is really a prevention program.

It is designed to empower users to recognize the signs and symptoms and to differentiate among overdoses of various drugs. Unfortunately, there is an epidemic of opioid overdoses, but there are also stimulant overdoses. We train people to recognize these things.

We also train users to do cardiopulmonary resuscitation or CPR. We also teach them how to react to an overdose so they can call 911. For users, there are several things preventing them from doing this. We train them to react the right way. Reducing the number of overdose deaths is of course our ultimate objective.

As to the community, the objectives are as follows: develop a strategy for one or more physicians to become partners in the initiative and to prescribe naloxone to participants who have completed the training; demonstrate the feasibility and accessibility of the overdose prevention and naloxone access project as part of peer training, which is the unique characteristic of this program; document and evaluate the steps taken in the pilot project and establish a data gathering system, which has already been done; give the community tools to deal with overdoses, that is, first responders, ambulance attendants, police officers, and any other person who can respond to an emergency.

The program consists of two training sessions: a shorter one lasting two and a half hours and a longer one lasting five and half hours. The shorter training does not include CPR. The workshops are divided up as follows. The first one pertains to overdose prevention and education. The second workshop shows how to respond in the event of an overdose, that is, what are the signs and symptoms of an overdose of opioids or other drugs, CPR techniques, and administering naloxone.

All the trainers are peers. We called upon members of our association who are users and took the time to train them properly so they can give the training themselves. They are people who use or have used opioids or other drugs, as well as staff who work for agencies whose services are used by persons who use or have used opioids or other drugs. At the community level, this creates a safety net that is very close to the street, which is an asset.

I would like to highlight an important aspect. Depending on the resources, the staff working in the field may or may not be users or former users of opioids or other drugs. Why? Because drug users are often part of community groups. They work in certain areas and become part of work teams. They are users but they are part of a community group and are employees of that group.

The participants who are trained receive a certificate that enables them to respond to overdoses and to use naloxone appropriately in opioid overdose cases.

In conclusion, PROFAN is a community response to the problem. Peers began developing PROFAN in 2013. Why? Because at the various conferences I have attended, whether in Canada or in Europe, I heard that overdoses are on the rise. This helped me understand that a phenomenon was developing. In the organization's action plan, I included the objective of creating a training program. That is what I have just presented.

The partners who joined the initiative in 2014 were the Centre de recherche et d'aide pour narcomanes, or CRAN, the Douglas Institute, Montreal's public health department, and Quebec's ministry of health and social services.

From the start, peers, community organizations, and network pharmacists have been part of PROFAN. We got all these stakeholders to sit down around a table to evaluate the project and to establish a plan for its first year. We are now planning our third year of operations.

Since the program was established 18 months go, 378 people have been trained and 21 lives have been saved. We are seeing changes in the behaviour of the users who have been trained, but this must still be proven empirically. The researcher, Michel Perreault, who is affiliated with the Douglas Institute, is currently evaluating these changes, so our project is being evaluated.

We are also trying to understand how to retain people who have taken the training, how far peers can go in the training, and their ability to do it.

We found that when peers train people, they saw themselves as lifeguards and felt much more responsible in the community. That is where their behaviour starts to change, and that is very important. These people feel they are playing an important role and it means a lot to them. We had thought that this program would be disparate but it has turned out to be very specific and there is a high level of participation.

We recommend that programs similar to PROFAN be created for drug users wherever possible. Training must also be given to everyone who is in substitution treatment programs and who frequently relapses. These people are the most likely to overdose. They should be trained while they are receiving methadone, for example. These people often associate with other users and they will be able to save someone.

For those receiving pain treatment, it should be recommended that they keep a naloxone kit with them. There are a lot of accidents and non-prescribed drugs that are taken. They can be taken from their mother's or father's medicine cabinet. In our opinion, people with such prescriptions should be given a short awareness training before they receive their kit. That might save lives. If they are trained to prevent overdoses, they will recognize when there is a problem. Drugs that are kept at home must be locked up. Of course, a kit should be on hand should an adolescent, for instance, take pain medication that was prescribed for their father or mother. This has to be done.

Peer outreach workers must be able to train drug users right in the field, giving them brief and specific training. For example, we have outreach workers in downtown Montreal. They come into contact with many opioid users, both sellers or users. These people should be given brief training in the field along with a permit to get naloxone.

There is a legislative void in Quebec because no rules have yet been established surrounding naloxone management. In Montreal, we use a collective prescription for the time being.

● (0855)

That only covers the Montreal area, the users and their entourage. They could be parents, roommates, friends or even community workers who work for an organization such as ours or Cactus. All kinds of non-governmental agencies can play a role.

That is essentially what we do. We drafted the documentation in 2013 and, in 2014, we joined CRAN, as I mentioned before. There was a spike in overdoses in Montreal in spring of 2014, and we were of course encouraged to launch our project.

The use of fentanyl and other contraband drugs made in labs is not as much of a problem right now in Montreal. There was, however, a seizure at a fentanyl lab in the north of Montreal a year and a half ago. Fortunately, we have not yet seen an increase in overdoses, although there are still too many. In our opinion, this problem will eventually spread across the Quebec, so we have to be ready.

Thank you.

● (0900)

[*English*]

The Chair: Thank you very much.

Now we'll go to Dr. Evan Wood, professor of medicine at UBC.

Good morning, Dr. Wood. If you'd like to make your 10-minute presentation, we'd be pleased to hear it.

Dr. Evan Wood (Professor of Medicine, University of British Columbia, Interim Director, British Columbia Centre for Excellence in HIV/AIDS, British Columbia Centre on Substance Use): Good morning. Thank you for the opportunity to speak.

My name is Evan Wood. I'm a professor of medicine at the University of British Columbia, where I hold a tier 1 Canada research chair. I'm also an addiction medicine physician and medical director for addiction services at Vancouver Coastal Health.

As you are aware, the costs of substance use in Canada are substantial, estimated to be over $40 billion annually. This is, of course, before the opioid crisis emerged. I think you'll be very familiar with some of the interventions required to address the opioid crisis, but I thought I would take a moment to share with you some of the structural reasons this problem has emerged and some of the structural barriers to fully and effectively addressing it.

The first issue I think Canada can really pursue, to the betterment of public health and public safety and exploring this challenge, is the fact that we have not traditionally, in Canada, as in other jurisdictions, trained health care providers in addiction care. I'll just ask you to imagine a scenario of somebody having an acute medical condition like a heart attack. They would be taken into an acute care environment. They would be seen by a medical team with expertise in cardiology. The cardiovascular team would then look to guidelines and standards to diagnose the condition and to effectively treat it. Unfortunately, in Canada, because we haven't traditionally trained health care providers in addiction medicine, we have health care providers who don't know what to do and routinely do things that actually put patients at risk. With respect to the origins of the opioid epidemic in Canada, when it comes to prescription opioids like OxyContin, clearly there has been the exploitation of a knowledge gap, leading to unsafe prescribing. Of course, the failure to employ evidence-based treatments for alcohol and drug addiction suffers from this concern as well.

In addition to the lack of training for health care providers, the overall lack of investments in this area has meant that there aren't standards and guidelines for the treatment of addiction. In British Columbia the long-standing approach to treatment of opioid addiction has been the use of methadone maintenance therapy. That approach has been disconnected from recovery-oriented systems of care and has overlooked a much safer medication in the form of buprenorphine or naloxone.

In British Columbia, within Vancouver Coastal Health, we have recently developed a guideline for the treatment of opioid addiction, using an evidence-based medicine approach to look at what treatment should be first-line, second-line, or third-line as best ways to help people recover from opioid addiction. This is something we're looking to pursue nationally through the Canadian research initiative in substance misuse, which I'm happy to talk about.

Another structural barrier I want to flag for you is that in Canada we have increasingly lumped together the concepts of mental health and addiction. While we have large mental health challenges in this country, and I certainly support approaches to strengthen a system of care for people struggling with mental illness, when we look at addiction through the lens of mental health it results in a number of concerns. The first is that funding for mental health and substance use, when it's directed in that way, overwhelmingly goes towards other mental health conditions besides substance use.

Addiction really is one of Canada's most seriously neglected diseases, and I strongly encourage you to think about funding and support that's aimed at addressing substance use being clearly earmarked for that. Otherwise, it regularly goes into this sort of mental-health-and-substance-use black hole, and addiction is overlooked. There are tangible ways of focusing energy here, which I can talk about shortly, but certainly focusing on mental health and substance use has unintended consequences.

● (0905)

Of course there are individuals who struggle with both mental health and substance use, but your average person who becomes addicted, whether it be to tobacco or alcohol or opioids, shouldn't be thought of as a mentally ill person. The interventions they commonly receive are more tailored toward people with serious mental illness and can actually worsen an overdose crisis. For example, there are the benzodiazepine medications that people with anxiety traditionally have been prescribed. Individuals with addiction regularly are prescribed these medications, again due to a lack of physician training. These medications themselves are associated with increased risk of fatal overdose.

I anticipate that you saw the report released earlier this week on the need for prescription monitoring programs. British Columbia actually has one of the nation's leading monitoring programs to look at prescriptions being provided by physicians. It enables us to look at the patient in front of us, see what prescriptions have been filled, and address such issues as people getting multiple prescriptions and selling medications on the street. Even in British Columbia, however, it's a reactive approach. There is the ability to establish monitoring programs where colleges of physicians and surgeons could actually look for unsafe prescribing and routinely address that concern. It's certainly something that needs to be done in Canada.

A point that I think needs to be made is that we continue to overwhelmingly treat substance use and addiction as a criminal justice issue. Ultimately that worsens public health and safety. Of course we need to support law enforcement due to the intersection between drug use and crime, but we really need to look at solutions that are evidence-based, that support addiction treatment, and that can support people in their recovery rather than take an approach that reinforces stigma and ultimately worsens community health and safety.

I'll leave a couple of take-away points with you. Then I'll be happy to take any questions.

The first point is with regard to the training of health care providers. The college of physicians and surgeons and the college of family physicians are currently pursuing these strategies. I certainly encourage you to support this. A point I didn't make earlier, which I think I'll leave with you, is that addiction is much too common a disease to be left with specialist physicians. We should really be looking to family practitioners being adequately trained in the prevention and treatment of addiction.

My next point is with regard to a focus on addiction as a disease that's both preventable and treatable, and not getting lost in this muddy mix of mental health and addiction. I would use as an example something that could be done by the Canadian Institutes of Health Research, for instance, in terms of dedicated resources toward substance use. In the United States there is a dedicated institute focused on drug use, and that's the National Institute on Drug Abuse. CIHR has no such institute. It means that Canada is kind of punching in the dark when it comes to approaches to substance use. Certainly through the Canadian research initiative on substance misuse, which is CIHR funded, there are positive things happening, but certainly we could do much more with focused intervention.

As I alluded earlier, prescription monitoring programs provide a huge opportunity to reduce unsafe prescribing and to ensure that the issues that emerged with oxycontin don't happen again. We obviously need strategies for the safe treatment of pain. We are increasingly learning that in the context of chronic pain, opioids can be very dangerous for conditions that could be addressed with non-opioid medications.

I think I'll leave it there. I'll just reinforce the point that we improve community safety and public health by treating this as a health issue. That certainly requires dedicated focus and energy, and that obviously is the point of your meeting today, so I'll stop there and thank you for the work you do.

● (0910)

The Chair: Thank you for the work you do and for your contribution today.

We'll be asking questions shortly, but first we'll hear from Dr. Mark Ujjainwalla from Recovery Ottawa.

You have 10 minutes for your opening statement, please.

Dr. Mark Ujjainwalla (Medical Director, Recovery Ottawa): Thank you very much for having me here and for taking the time to be interested in this most important issue.

I'm a physician and an addiction medicine specialist. I'm ASAM-certified as of 1988. I've been in the addiction world for over 30 years, in the assessment, intervention, and treatment of addiction.

I developed the Ontario Medical Association physician health program in 1995. I've spent most of my career helping professionals and sending them primarily to the United States for treatment, primarily physicians and people who had a lot to lose. That was in the eighties and nineties. I can tell you that in the eighties and nineties we had the gold standard treatment for addiction, certainly in North America, and that's because we hooked into the United States.

In Ontario—and I can only speak for Ontario—in the seventies, eighties, and nineties, we could send people to the United States for comprehensive treatment at the Betty Ford Center at Hazelden or at the Talbott Center. It didn't really matter. They went there, OHIP paid for that, and when they came back, they had aftercare. We had an amazing program that helped many Canadians.

In the nineties, the government decided that they were going to stop this practice. They were going to take the money and develop treatment centres here in Ontario. Unfortunately, that didn't happen. In fact, in my observation, the only thing that happened was that they started closing psychiatric facilities and throwing those types of patients under the bus, unfortunately. They did not develop comprehensive treatment programs as they promised. That was the start of the downfall, of our crisis.

I agree wholeheartedly with many of the comments that Dr. Wood made. The problem we face here is that the real issue with addiction is not opiates. The real issue is the inability of the present health care system to treat the disease of addiction. An addiction is a biopsychosocial illness that affects 10% of society, probably more if you include families, and it is the most underfunded medical illness in our society.

The problem also is that it's a highly preventable and very highly treatable illness. It's very unfortunate that people don't see that. When it affects your family or you, you can feel the pain and suffering, and you watch the tragedy unfold in front of you.

Dr. Wood commented about cardiology and on what would happen if you had chest pain. I submit to you that if one of you were going blind in here right now and I asked you if you would rather that I give you a white cane or take you to the eye institute to see a retinal surgeon, I'm guessing you would go to the retinal surgeon.

The problem we face is the lack of knowledge and understanding on the part of everybody—society, physicians, people in general, and the government especially—in terms of understanding what this disease is and how to treat it.

I've run the addiction curriculum at the medical school here in Ottawa for the last 25 years. We've been decreased from 25 hours of curriculum time to three hours. Seemingly, people don't want to take this seriously, but at the same time, they want to talk about and sensationalize fentanyl and all of these other drugs. It doesn't matter what you die from; if you die from a Glock or from a rocket launcher, you're still dying from a gun. It doesn't really matter. The problem is that we have an issue here that's poorly understood, and I think it's people like you, who are taking the time to listen to this, who could maybe change this. That would be my hope.

I started an opiate withdrawal management centre here in Ottawa. We are self-funded. There's no government funding whatsoever for this. We started with no patients and now we have a thousand patients on Suboxone and methadone, in Vanier. We have seven doctors. My observation is that these people desperately want help. They're victimized, they're marginalized, and they're diminished. They're the people who really are the lost souls of the world and who we desperately need to help.

● (0915)

I got a card the other day, and I'll share it with you. It's a thank you card from one of my patients. They told me: I just wanted you to know how much my life has changed because of you and your staff. I will be forever grateful for your services. Thank you so much for helping me become who I am today.

I think that's what keeps me going, despite the fact that there is no funding and no treatment.

Some of you live in Ottawa. I sent somebody to a psychiatrist, and this is the message I got back from the psychiatrist the other day, after waiting six months: Dear physician, due to the high number of referrals received, there is currently a two-year wait to be seen. We are unable to accept your referral. Why don't you call the Royal Ottawa hospital?

I called the Royal Ottawa hospital, which is our CAMH here in Ottawa. Number one, if you don't have an OHIP card, you can't go in there. You can go to jail without an OHIP card, I can tell you that, but you can't go into a hospital without an OHIP card. They will not see you. It doesn't matter if you have a needle coming out of your neck, they won't see you. It's a one- to three-month wait to see a doctor for an assessment, and after that it's upwards of nine months before you can even get into any type of program. You're looking at a year, and these people are desperate. They are injecting drugs. It's a $600- to $1,000-a-day habit, and they don't have a job. Of course, they have to get money every day. They have to prostitute, sell drugs, or steal. The crime is unconscionable, and we are all part of that.

Then I said, okay, I will call our detox centre here in Ottawa, which is heavily funded. Guess what? It's not a medical detox. If you call there and ask what to do if you're in withdrawal from benzos, alcohol, or opiates, they'll tell you there's no doctor or nurse there and you have to go to the hospital. But when you call the hospital, they tell you that they can't help you.

You can't go to the Royal. There is no emergency department in our psychiatric hospital, so you go to the emergency department at the General hospital, our teaching hospital, and ask where the department of addiction is. You're told there isn't one. When you ask them what you should do, they tell you to wait, which you do for 13 to 20 hours while you are in serious withdrawal. Then you see a first-year medical student or a resident who, as Dr. Wood says, has no training in addiction whatsoever.

This is a case I had here, where someone went to the hospital by ambulance. They were unconscious. I can't really read this—it's all scribbled, as doctors will do—but it says the patient was found unconscious at a bus station. They woke him up and the diagnosis was “intoxication”. The disposition was to follow up with his GP, which he doesn't have, for a refill on his pills. And that's it. That's at a teaching hospital in our country. That is poor. I do a lot of teaching at the university, and I am a Royal College examiner. If that's what you did on an exam, you would fail. You can't let people who are dying leave a hospital. It's ridiculous. But that's what we do all the time—constantly, all day long.

The smokescreen answer of the government appears to be, “Let's put up injection sites; that will solve our problem. Oh, and give them a pamphlet, by the way.” Here is the pamphlet they give you. I had several media sit with me for four hours. I said, “Let's go through this pamphlet. We'll call everybody and see whether we can get help.” After four hours, they went, “Oh my God, there's no help.”

Nobody will help you. You can't be at any treatment centre on methadone or Suboxone. There is no medically assisted treatment. There are no physicians involved. There is nothing. You have to fill out forms with a thing called OAARS, a 12-page report. How does that help you? You're dying of a disease, and you are filling out reports. Imagine if you had crushing chest pain and they told you to fill out a 12-page report first and then go stand over there for 13 hours. It wouldn't happen.

I feel ashamed, as a physician and as an addiction physician in this province, that this is what it has come to. You can tell by my voice and by my enthusiasm. I have a thousand patients right now: a thousand. I deal with it every day. We try to help these people as best we can. We are integrating with the CAS, the parole boards, and the jails.

It's a bureaucratic nightmare. This is a health problem that's highly treatable, and we are doing nothing about it except say let's talk about care fentanyl, this fentanyl, that fentanyl. It's like a group of people who don't know what they are talking about, or sensationalists followed by the media, rather than saying we have a treatable illness that's called “addiction” and we should take the time to go back to the 1980s and see what we were doing back then, when we didn't have this problem. We had a lot. We still had 10% to 20% of the people with the issues, but we were treating them.

● (0920)

Now, though, if they can't get a psychiatrist, they can't get an addiction doctor, they can't get treatment, what do we expect these people to do? Of course they're going to go around in the market area. Every person you've seen in the news lately has been one of our patients. The girl who got stabbed the other day didn't get stabbed because of fentanyl. She got stabbed because she cheated a guy on cocaine for $15. The guy came back, he was so high, and he stabbed and killed her right in front of the shelter. Another guy got shot the other day. It was another drug-related thing. He was also our patient.

These people need help. They're desperate. They're living in a war zone here. You can just go downtown and look. You can come with me; I'll show it to you. It's right here in Canada's capital, and it's shameful. We as a group should take this opportunity to say that we're all going to leave here and do something meaningful about this. We're not going to let these people die.

Thank you.

The Chair: To all of you, thank you very, very much for your passion. We're certainly getting the message.

We'll start the questions now with Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you very much to all three of you for your excellent testimony and for presenting your recommendations and thoughts to us.

I just want to step back a bit and review where we're at. Certainly the government and this committee are highly concerned about the number of overdoses and deaths, particularly from opioids. We've heard from many witnesses that this is a public health crisis, not a criminal justice issue. I've heard you echo that.

The Minister of Health has laid out a comprehensive federal strategy: better information for Canadians about the risk of opioids; supporting better prescribing practices; reducing easy access to unnecessary opioids; supporting better treatment options for patients and a better evidence base around this; allowing naloxone to be used, and bringing naloxone nasal spray in from the U.S.; and making some of the drugs that are used to produce fentanyl, some of the chemicals, illegal.

There will be a summit in November to deal with the opioid crisis, which I think the Minister of Health is convening. We're trying to figure out what recommendations we could add to that discussion from witnesses such as you.

From Dr. Wood I heard pretty clearly about training primary health care providers in addiction care and treatment strategies, establishing guidelines and practice standards so that there's a methodology to it, directed funding to addictions versus mental health and addictions, and the online prescription database.

I'm trying to figure out, Dr. Ujjainwalla, what the advice is; I heard about the gap. Is it that we don't have a proper diagnostic category for this? For the person who was left at the emergency department, there was no diagnosis. Do we need a DRG group—

Dr. Mark Ujjainwalla: It was “intoxication”. It's as Dr. Wood and I are saying. You wouldn't want me being a retinal surgeon right now, because I have no training for it.

● (0925)

Mr. John Oliver: Exactly.

Dr. Mark Ujjainwalla: You'll die if you put me in charge. If you want your appendix out right now, I'm not the guy to do it. But if you want to get recovery, if you want to get your son, who's addicted to fentanyl, off and back to normal, then okay, I'm your guy.

Where are all the addiction physicians? Where are Dr. Wood and I on all these committees that are trying to explain to hospital boards and the LHIN and all these people that give them money?

You're talking about naloxone, just as an example. There's no limit —

Mr. John Oliver: I get the gap, but what's required here? If there was a diagnosis that said “addiction” or—

Dr. Mark Ujjainwalla: It wouldn't matter.

Mr. John Oliver: It wouldn't change? How do we get a focus on —

Dr. Mark Ujjainwalla: It's action: action. You need to develop a comprehensive treatment program for the treatment of addiction.

Just go on the Internet and google “Hazelden Betty Ford”. It's the gold standard of treatment.

You know, when people ask me, “In 15 seconds, tell me how you'd solve this problem”, it's ridiculous. One needs time to explain to you guys what this means. If you go on that website, I can show you what it—

Mr. John Oliver: So it's about federal leadership to say there needs to be....

Dr. Wood, would you add anything to this conversation around some specific recommendations we could make as a committee to Parliament around initiating these kinds of practices?

Dr. Evan Wood: I think there is a lot of consensus in the room. Through the college of family physicians federally, really ensure that part of the curriculum includes the prevention and treatment of addiction.

I don't want to bash specialists—I'm a specialist myself—but this disease is so common. It's not something rare like rheumatoid arthritis or something that's relatively uncommon. As you've heard, this is 10% of the population. So we need a primary-care-based strategy to train physicians. In the example that was given with the emergency room, they're saying it's intoxication, but they know exactly what's going on. It's just that the health care system is a deer in the headlights; it does not know what to do. So it's about training health care providers and developing evidence-based guidelines and standards.

Just to give you an example, at St. Paul's Hospital in Vancouver, between January and August there were 2,700 non-fatal overdoses that presented to the emergency room. The literature clearly shows that people who have had a non-fatal overdose are at a heightened risk of a subsequent fatal overdose. So there's a very captive audience. You want to do something about it. There is no system. It's not a broken system: there is no system in place.

I don't want to make it seem so daunting that no one knows what to do. There should be standards in the emergency room and evidence-based pathways and referrals to programs, because I tell you, the Canadian taxpayer is hemorrhaging money to send ambulances, to send police, to treat the infections, to treat the lung disease or the liver disease—all the things that go along with untreated addiction. So there's money to be saved, but what's required is to train health care practitioners and establish guidelines.

Mr. John Oliver: Thank you very much.

I have one other line of questioning I want to get in before my time runs out.

We haven't heard any advice or comment around pharma: the introduction of OxyContin, the introduction of opioids, the initial encouragement to prescribe these or the recommendation to physicians to prescribe. Do any of you have any comment about the role of pharma in this, and do you have any advice there?

Dr. Evan Wood: I'm happy to speak to that.

It has been well documented, and there are lawsuits for hundreds of millions of dollars in the United States because of the shenanigans of the makers of OxyContin. As I alluded to, there was a void in physician knowledge. This promotion of pain as a fifth vital sign and implying that OxyContin was safe and non-addictive was clearly not true. The influence in the pharmaceutical industry on physicians had a hugely negative impact. So there's regulatory opportunity there, too.

Dr. Mark Ujjainwalla: If I could add to that, I think one of the reasons I can't give you a specific recommendation is that it's so broken. Where do we start? As I said, you could go on the Hazelden Betty Ford website, present that to the federal government, and say this is what we had in the seventies, eighties, and nineties. We need to open those doors up.

To Dr. Wood's point about the 2,700 people who came in with non-fatal overdoses, what a unique time to put them on Suboxone. Why would you not just put that guy on suboxone, send him to my clinic, and then get treatment? It's simple: bang, bang, bang, done. Instead, they don't know what they're doing. They're irritated by these people. They spend, as he said, lots of the resources and they dump them back on the street. They get picked up by the police and are back in jail. That's the issue.

Really the message is that you have to open the doors again. You can't have a two-year waiting time for a psychiatrist. It's ridiculous. You can't have no treatment centres. It's ridiculous. You can't have no non-medical detox. It's ridiculous. This is 2016.

● (0930)

The Chair: Time's up.

Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Mr. Chair.

I truly want to thank the witnesses here today, because one of the things I think we've been lacking in this study is, really, the front line.

I want to start off with you, Dr. Ujjainwalla. I think you're actually the first medical professional we've had in front of the committee here who actually works every day with opioid-dependent individuals. I think you're the first one to appear at our committee, so thank you for your insight. I want to thank you as well for your passion. I think everybody around the table sees how committed you are and how discouraged you are that all levels of government are not really taking the bull by the horns to deal with this. I do want to thank you for your work, and I have a few questions for you.

I see you as actually doing it. Nobody else who has come here is on the ground actually treating people. I wonder if you could elaborate on the kind of appropriate care that you would provide an opioid-dependent individual in contrast to what has been brought up a lot here, these supervised or safe injection sites. You made a comment just now about dumping them back on the street, so they're in and are just dumped back, dumped back, and dumped back. Could you give us some advice on appropriate care? You're giving them care today. You're helping people today. Could you elaborate on that?

Dr. Mark Ujjainwalla: It's similar to Mr. Oliver's question about what you would present to the provincial-federal governments on how you treat the disease of addiction. As physicians, we're evidence-based, so what we're saying is that we have to utilize resources or processes that help people. As a doctor of 30 years, I'm trained to help people. I'm trained to treat treatable illnesses.

Let's say you have a palliative care patient and they're going to die. My father died in a palliative care unit, so I know what that's like. He wasn't coming back, so yes, he had lots of opiates. That was fine, because he had bone pain and he was going to die. But when you have a 26-year-old who two years ago was on the McGill soccer team and now is homeless and injecting heroin and smoking crack, and two years ago lived in Westmount, that's a different story. This is a person we can help.

How do you help them? You have to deal with it from a medical detox point of view, depending on whether it's alcohol, benzodiazepines, opiates, or amphetamines; it doesn't really matter. You have to develop a comprehensive plan to say we're going to deal with each of these issues, and you have to do that properly. Unfortunately, you can't do that in 10 minutes. It requires hospitalization, often, to be able to take the time to investigate it, to understand the biopsychosocial element of this woman to treat her withdrawal properly.

For us in the opiate world, Suboxone and methadone have been godsends. Think about it; if you're stealing up to $1,000 a day to get your fentanyl patch, think about the crime. You're 26 years old, and you have to get $800 today. It's eight o'clock in the morning, and you're in horrible withdrawal. The withdrawal of opiates is like the Norwalk virus and a panic attack at the same time. It's just horrible. They'll do anything. So we have to deal with that withdrawal, and Suboxone and methadone work very well for that.

It's not the treatment; it's the transitioning away from that horrible existence that you've developed of acquiring pharmaceuticals or heroin to a place where you're now stable enough to deal with your life. And then, that's the next part of it. If you go into an actual treatment centre, whether it's Bellwood, Homewood, or any of these places, then they start dealing with life. It is the thinking process that's the problem. We get focused on the behaviour, i.e., using the drug. They're using that to deal with all their problems. They like to use that because it makes them feel normal. The problem is that the consequences of using are the issue. What we need to do, then, is look at the person's physical problems, the person's emotional problems, the person's psychological problems, career, money, family, and all that stuff.

Again, for 25 years I sent professionals, physicians, and lots of politicians to treatment in the U.S. They stayed down there for three months, and when they came back, they were really in an excellent position and maintained sobriety. If I could try to help you guys understand what a comprehensive treatment program looks like, then you could explain that to the rest of the world.

● (0935)

Mr. Colin Carrie: I can see a holistic approach working. We've had a lot of witnesses say these safe injection sites are the solution. I see that as kind of giving up on people, just throwing them back into what they've been doing day in and day out. I'm wondering if you could share the success of the recovery centre you have. Do you do safe injections at your...?

Dr. Mark Ujjainwalla: First off, I'm sure you've heard a lot about this injection site thing. The word “safe” is a marketing thing. If I had a needle right now full of fentanyl, would anybody volunteer to let me stick it in their neck? I doubt it, because it's not a safe thing to put a needle full of fentanyl into your neck

On the word “supervise”, the idea I think came out of their issue—Dr. Wood, I'm sure, can speak to this—in the upper east side of Vancouver. Fair enough, it's a public health HIV and hepatitis C issue. It's not really an addiction issue, in my opinion. It's almost like a government smokescreen to say that if we do this, then we don't have to do a comprehensive program that would cost billions versus maybe half a million for the injection site.

My experience is this. If I had an opportunity to get better, why wouldn't I take it? This is one of the analogies I use. Let's say I'm a lifeguard and somebody is drowning. I finally get them out. I do CPR. They're alive again. Then I just throw them back in the water. Why would I do that? I've got them here now, so let's treat them, because it's a treatable illness.

The problem, I think, is that the door is closed everywhere. It's like this has become a quote-unquote treatment option when instead it's just an idea that homeless people could go to this place and I guess somebody would wake them up if they stopped breathing. The thing is that we have in Ottawa alone probably 3,000 to 4,000 people injecting at home every day, and they inject five to eight times a day. That's about 30,000 injections a day. You don't see everybody dying from it.

My main point with the treatment aspect is that if you're this woman who is homeless, who is hepatitis C positive, who hasn't eaten, who is just ravaged with illness, addiction, depression, and who has to wake every morning to turn a trick to get money, do you really think she wants to wake up in the morning? That is no life. That is a living hell. I have some pictures I could show you. If I showed you their faces, then you'd see that it is a living hell. They don't want to do this. If I gave them an option, if there were another door....

But there isn't another door. That's the problem. That's my whole point of telling you all this stuff. There isn't another door.

I opened that door because I saw a need. We had a thousand people within three years. We have had seven physicians within three years working flat-out, all day long, trying to keep people out of withdrawal. Our problem is that we don't have the next step. We don't have any funding for any kind of psychological help or any kind of treatment programs. There are just roadblocks and barriers everywhere.

It almost seems like there's this conspiracy not to treat addiction, but to say, listen, this is the answer; you can come into our little basement thing, inject, we'll give you a pamphlet, and bye-bye. That will be the answer for the treatment of addiction. I don't think, as Canadians, we believe that. I know a lot of really wonderful people who are supportive of a foundation I'm going to try to start, to privatize this, to develop our own centres. If the government's not going to do it, I think we're going to have to do it. I just can't stand here and watch these people die every day, and suffer.

● (0940)

The Chair: Your time is up.

Ms. Kwan.

Ms. Jenny Kwan (Vancouver East, NDP): Thank you very much, Mr. Chair.

I thank all the witnesses for their presentations.

This question is for you, Dr. Wood. In the 1990s, in my community of the Downtown Eastside, where we had an epidemic of overdoses, at that time the medical health officer declared a medical health emergency in our neighbourhood. The truth of the matter is that people die from overdoses. We had a community rally, and a thousand crosses were planted in the local neighbourhood park to mark and honour each person who died. I get it that we need to have treatment.

Coming out of that effort, a table was initiated with all levels of government—I see Dr. Hedy Fry here today at committee—and we worked together between all levels of government to come up with the four pillars approach: harm reduction, treatment, prevention, and enforcement. Coming out of the harm reduction pillar was the supervised injection facility, which was evidence-based. Since that time, the facility has demonstrated that there were no fatal overdose deaths at that site, hence the opportunities for people to get onto treatment and an alternate course down the road.

Has the supervised injection facility in Vancouver been an effective program? Can you tell us, Dr. Wood? As I understand it, there is also a place called Onsite, upstairs from the supervised injection facility. I wonder if you can elaborate on that, and then talk about the critical link that is required following Onsite and what's missing.

Dr. Evan Wood: My biggest philosophical comment would be how counterproductive it can be to pit public health interventions against medical treatments and recovery interventions, because they don't need to be viewed in opposition or as isolated interventions.

I'm very sympathetic to my colleague's frustration with the sort of attention being given to public health interventions when the treatment system has yet to be developed. We need a comprehensive approach. In the absence of that, as I alluded to, we are hemorrhaging health care dollars. Each and every case of HIV infection on average costs the health care system about $500,000. Consider the amount of money that gets spent looking after somebody who has had a hypoxic brain injury and who will, because of that brain injury, have to be institutionalized for the rest of their life and cared for at the expense of the taxpayer. Chronic hepatis C infection is prevalent. Upwards of 70% of people who inject drugs have it. The pills to treat hepatis C are about $1,000 per pill. It's not just an issue of people dying and the fact that government should be responding. These are huge health care costs.

In terms of addressing those costs, Insite has been shown to reduce overdoses as well as syringe sharing and other high-risk behaviour, so of course I support it. I think everybody should, because we already have programs across Canada that, just as an example, in an effort to mitigate these harms and costs, give out clean needles to people. A program like Insite is actually what I would call a more conservative approach, in that it allows the health care system to ensure that a needle doesn't end up in a park, that young people don't see a person injecting, that an intervention is delivered in an environment where a person can be encouraged into treatment, such as it is.

Unfortunately—and I know this is a huge source of frustration among my addiction medicine colleagues—you see injection sites in the news, and it is implied that the taxpayer is investing a great deal here. I'll just share with you that Vancouver Coastal Health, of which I'm the medical director for addiction services, spends hundreds of millions of dollars every year on mental health. They spend an almost insignificant amount, less than one-sixth of that, on addiction, and a miniscule amount of that, a really inconsequential amount, on supervised injecting, which then saves the taxpayer a huge amount of money. Among the things it is able to do is that it has a detox program upstairs called Onsite, which can take in individuals, help them through detox, and transition them into treatment. They're very effective in doing so.

To people who want to pit one of these things against another, it really is nonsensical. We need a comprehensive approach. We need an addiction system of care that can meet people where they're at, and these low-threshold programs are very effective. We need a door to addiction treatment and recovery, but that door, as the literature from Europe would suggest, means meeting people where they're at. To be honest, these interventions are associated with reduced rates of injecting in the community, so I certainly support a public health approach, and it has been effective in Vancouver.

If there has been any mistake made, it has been the lack of emphasis on addiction treatment going back to the 1990s. That's something that we're trying to dig ourselves out of now in terms of some of the interventions I talked about. These include training health care providers and developing standards and guidelines, but from an evidence-based medicine perspective, the supervised injecting facility has certainly been effective. We need a more comprehensive approach, obviously.

● (0945)

Ms. Jenny Kwan: Thank you.

To follow up on that, it's clear that supervised injection facilities and harm reduction approaches save lives. They address a whole range of other community impact issues as well.

You spoke about the issue of treatment. Onsite provides support for that, but then, coming out of Onsite—I know this to be a problem in my own community—people don't have better alternatives to go to. I often think that other, more long-term treatment options are not available, and hence we create quite a challenge within the system. People can get into a situation where there's a revolving door.

With that in mind, Dr. Wood, could you elaborate on what needs to be done in the next phase? In the meantime, we are faced with yet another crisis with fentanyl usage. Deaths are occurring in our communities, not just in my community, but throughout the country. Could you comment on Bill C-2 and whether or not that bill should be repealed?

Dr. Evan Wood: In terms of your first question, Onsite is located in the Downtown Eastside, so you're exactly right: it's a place where people in crisis, whose lives really are a living hell, see the opportunity for something else. They get a bed, but then what next? Obviously we want to get people out of the Downtown Eastside. Investments in recovery-oriented systems of care have not been there. Unless you have $20,000 to go into an expensive treatment program, the door just isn't there. Wait lists are long. It makes absolutely no sense.

I'm not a lawyer, and I don't want things to get politicized in terms of Bill C-2. I just think there's been a lot of misinformation. I've seen how, when these things become oppositional, people get entrenched in their thinking. They put their blinders on. They don't understand that by focusing on preventing public health interventions, it doesn't achieve the objective of another thing coming forward. I just haven't seen that. I strongly encourage everybody to try to get beyond historical partisan issues around this crisis and to focus on what's best. Clearly that will be an evidence-based approach.

It was alluded earlier that it will cost a lot of money. I would just reiterate the point that we're spending that money. We're spending it on emergency rooms, on HIV and hepatitis C wards, and on programs for people who've had hypoxic brain injuries. There's also a cost to productivity, and of course the cost to families who have lost a loved one. The money is being spent on downstream consequences.

If we can reduce those costs through public health programs that are proven effective, of course I support that, but we need a more comprehensive approach in addition to that, one that involves an effective treatment system. Training health care providers and establishing guidelines and best practices: it's a clear way to identify where those investments should be and then move forward.

The Chair: Mr. Ayoub.

[*Translation*]

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

I would like to thank the three witnesses for being here this morning.

I am not in the medical field but I can see that this is truly a warning sign. I am surrounded here by doctors, so the medical aspect could easily be discussed.

I will talk instead about the social aspect of the approach, despite the potential weaknesses. Human beings are not perfect. At least, that is what my 50 years of experience have led me to conclude.

Dr. Ujjainwalla, from what I know, drug dependence occurs in all social classes. It strikes all classes indiscriminately. Anyone can become drug dependant. Is that correct?

Is drug dependance more prevalent though in a particular class or among people who are less fortunate in life? I am thinking for instance of people who do not have a lot of support and who enter a cycle of dependency with no way out because there is no family support and social assistance is inadequate.

Have you seen that to some extent in all your years of practice?

● (0950)

[*English*]

Dr. Mark Ujjainwalla: Yes. I believe addiction, like any other disease we face in medicine, crosses all the borders. If you're diabetic, it doesn't really matter what your income is. In a general sense, addiction, encompassing substance abuse that includes alcohol and other drugs, affects everybody.

For 25 years, as I told you, I dealt with professionals only. Every quote-unquote person suffering from addiction was either an MP, an MPP, a physician, a lawyer, an accountant, a dentist, a pharmacist. That was one element, and I can tell you first-hand that I treated hundreds.

In terms of the people we see in the opiate and cocaine world, unfortunately, the amphetamine world, the consequences of the use of their drug, which they may start.... Believe it or not, I have two professional hockey players as patients who injured themselves playing hockey. They're just regular guys who broke their arm. They went from bad to worse. This happens to many people when they get dependent on the drug.

Mr. Ramez Ayoub: I only have seven minutes, so I need you—

Dr. Mark Ujjainwalla: Okay: my answer is yes.

Mr. Ramez Ayoub: I expected that answer.

The Chair: Mr. Lévesque, do you have a comment?

Mr. Guy-Pierre Lévesque: Yes, Mr. Chair, I have a comment, and I would like to make it before I have to go. I have to leave, and there might not be questions for me, so I'd like to comment on what's being said, if I can.

The Chair: Yes.

Mr. Guy-Pierre Lévesque: First, I want to say something. I came here with an approach to react to overdoses, but in our facility we have a drop-in centre with peers and community workers, and we also have apartments. We reach out to people who are homeless. We try to bring them to treatment and also into a program that runs over three years with a plan of action to change. That's one thing we do.

The other thing is this. When we're talking about safe injection sites, it would be a big approach for Canadians to talk about consumption rooms, so that way you don't have only people with needles in those places but also people who smoke crack and use other substances.

There is also a reaction to different things that bother society in downtown Vancouver, downtown Montreal, or here in Ottawa. Treatment is also a reaction. Naloxone is also a reaction. I think it's very important that we start educating our young as soon as possible, starting from the lower grades, with an approach of harm reduction, not with an approach of prohibition. It is the worst thing to do; it makes it tempting for people to use.

Also, I want to say that all users are not always in the streets. They also live in houses. I want to say also that people who use drugs get worse and worse in their condition if their conditions in life are bad. If you don't have proper work, a proper amount of income, you're not staying in an environmentally safe place, and you don't eat properly, you will go down very fast. It's very important to understand that. If you have the capacity to sustain yourself with a good quality of life, you might not end up downtown. You might have your addiction for many years before you seek treatment.

From my experience, not all users want to go into treatment. Some don't see themselves as sick people, so it's very important to consider that also when you implement programs in Canada.

Thank you.

● (0955)

The Chair: Thank you very much. Thank you for coming. I know you have to leave early, and we appreciate your contribution today.

Mr. Guy-Pierre Lévesque: Thank you.

The Chair: Mr. Ayoub, you still have three minutes and 24 seconds....

Yes, Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Mr. Chair, this is just a point of order.

Mr. Lévesque, are you leaving right now?

Mr. Guy-Pierre Lévesque: I can stay a few more minutes.

Mr. Len Webber: Okay.

I think I'm up next, am I not?

The Chair: You are.

Mr. Len Webber: I just have a couple of questions for Mr. Lévesque.

The Chair: Mr. Ayoub, carry on.

[*Translation*]

Mr. Ramez Ayoub: Thank you, Mr. Chair.

I will be brief. After 25 or 30 years of professional and practical experience, I can say that the same problem still exists today, 25 years later. It might even be worse since it is on the rise. The bandaid solutions that were used 10, 15 or 20 years ago no longer work. Yet it seems that more of the same thing is being done all the time to try to fix the problem.

We hear about multidisciplinary and intervention teams as part of a preventative approach. What are we waiting for to have a Betty Ford Centre, as you mentioned, Dr. Ujjainwalla?

Over all this time, what has been the impact of your work with respect to government action? For my part, I have been here for barely a year. Actually, yesterday was my one-year anniversary and I am very happy to be here. Seeing all of this, though, I have to wonder what kind of world we live in.

I think I know part of the answer. I think it costs less to use bandaid solutions, to close one's eyes and say that the last five years went smoothly.

Mr. Lévesque, I think you are part of this bandaid approach. I do not mean to criticize your approach. It is extremely important because it can save lives in the short term. Yet it does not solve the problem.

Would it be wrong to say it is a vicious circle? You talked about water and a lifeguard. We might rescue someone, but we know they will swim again. Yet if the person does not know how to swim because they have not been taught, their problem has not been solved.

What should we do? There is the political aspect and the financial aspect. There are limits to everything, but what should we do? What must the government recommend in this regard? I will give you a minute or two to answer these questions.

[*English*]

Dr. Mark Ujjainwalla: Those are amazing comments. I'd throw it back to the politicians here. You tell me why it's not happening. It was good and now it's gone. So that's the question and it's a rhetorical one. I appreciate your comment.

If the will is there, if the people want to help these individuals, then you can do it. If you don't see it as a problem, and you don't live it or you don't understand it, then how are you going to develop a comprehensive treatment program like we are talking about? I think that's the job of this committee, to make Canadians aware of what the disease of addiction is and all the different components of that—the public health components and all the other things that Mr. Lévesque was talking about—so that we don't see it as a band-aid.

However, I agree with my colleague that we don't want to be fighting public health against addiction medicine, against specialists, against social workers. We need to work as a team. I find what has changed now is that we're not working as a team. It's so regionalized. There's so much bureaucracy in it. Everybody is worried about their jobs and stuff. People have ideas such as, “Okay, I'm a harm-reduction guy.” It's like the Leafs against the Habs, a harm-reduction guy against a treatment guy. That's ridiculous. What we need to do is work together and realize that there are different strata. Just as in all medicine, some people need to be in an ICU and some people can be treated as an outpatient.

Here is the problem and why I brought these things in. With what we presently have, if you want to see a psychiatrist, it's a two-year wait to see one. How's that going to work? You want to see an addiction doctor, and there isn't one. So how's that going to work? You can't get into the psychiatric hospital.

That's my point. If we open these doors again, as they used to be in the seventies and eighties, we can be proud of that system and we can develop it. It's not complicated. It's just the ability to say the political will is there and the will of Canadians is there to change this.

● (1000)

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

That completes our seven-minute session. Now we'll go to the five-minute session, with Mr. Webber, Dr. Eyolfson, Dr. Carrie, and Dr. Fry.

Mr. Webber, the floor is yours.

Mr. Len Webber: Thank you, Mr. Chair.

Thank you, Mr. Lévesque, for sticking around. I appreciate that. I just want to talk a bit about your facility and where you are at with PROFAN. How difficult is it for you to get the antidote of naloxone?

Mr. Guy-Pierre Lévesque: Actually, we have naloxone because we have what we call a collective prescription from Dr. Massé from the *département de santé publique de Montréal*. Under this condition, we were able to have this naloxone. It's vials and injections. It's a kit that has everything in it that you need. To get it, people have to take the training, actually, at this time. When the legislation is done, it might change.

Mr. Len Webber: So you go through this two-part training that you explain, and there's even a shorter-term training, and you can train dealers. Once they get this training...although I find it difficult to understand how you can train an addict, in a five-hour course, how to put naloxone in his system.

Mr. Guy-Pierre Lévesque: First, we know that people who are using are hustling for money, so we give out a compensation amount. Let's say, if it's short training, it's $25; and if it's for the whole day, it's $50. That way, we know the person can manage to get their drugs if they need them.

Mr. Len Webber: They get those drugs from you. You hand them out to the user.

Mr. Guy-Pierre Lévesque: We don't give out drugs.

Mr. Len Webber: The naloxone is what you're referring to.

Mr. Guy-Pierre Lévesque: The naloxone is in a community group of pharmacists.

Mr. Len Webber: Yes.

Mr. Guy-Pierre Lévesque: I think there are five of them, and it's designed so that people can come out of our facility with a card—we issue a competency card—and they go to the pharmacy and get the naloxone. That's how it's being done.

Mr. Len Webber: All right. Then cost-wise, who pays for that?

Mr. Guy-Pierre Lévesque: At this moment it's paid for through the *département de santé publique*, so it's the ministry. It was a trial for the first year; with the results, a second year; and now we're on the third year.

Mr. Len Webber: Are you a safe injection site as well?

Mr. Guy-Pierre Lévesque: No, we don't carry safe injection sites. People can use in our facility. It's there. We have supervision training and we're able to answer to those.

Mr. Len Webber: Do you have equipment there in order to test the drug to see if it's safe?

Mr. Guy-Pierre Lévesque: No, we can't test drugs right now, because we could be arrested for holding the drugs.

Mr. Len Webber: I'm going to quickly jump over to Dr. Wood,

Dr. Wood, of course you've been to Insite and Onsite. You've worked in British Columbia. I have a stat here that I want to put out. In 2015 there were over 263,000 visits to Insite. Of those 263,000 visits, 464 were referred to the Onsite treatment centre to get further help. That's only 7%. I find it quite surprising that it's so low. Can you comment on that at all?

Dr. Evan Wood: I'm happy to. First of all, the number of injections are not unique individuals. Insite isn't for everybody. The people who use it tend to be homeless, street-entrenched, and live within a couple of blocks. In the Downtown Eastside, it's estimated there there are only about 4,700 people who inject drugs. Onsite has 12 beds.

To answer your question, as I think you've heard, the door to a functioning addiction treatment centre is not there. Many people have successfully entered into recovery through Onsite, but it can be viewed as a sort of a crack in the door to a whole other reality that simply has not been invested in.

Insite has saved lives. It saves the health care system money. But we haven't realized the opportunity to address this concern comprehensively, because there hasn't been an investment in addiction treatment in accordance with the scale of the problem. The money has gone to the consequences of addiction.

● (1005)

Mr. Len Webber: Just quickly, do you have the equipment there at Onsite or Insite to test the drugs they bring in for safe injection?

Dr. Evan Wood: No, but I think it would help if we addressed regulatory issues there, because we've seen this shift toward fentanyl. The average patient of mine is not looking for fentanyl. Fentanyl is a market force. People with a background in economics can understand that it's cheaper, it can be imported, and it doesn't have to be grown with a poppy. It's a market force because of the long-standing illegality of these drugs. Organized crime is seeing an opportunity and exploiting it. The market could be influenced through drug testing.

The Chair: Time's up.

Dr. Eyolfson.

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

Thank you both for coming. Thanks in absentia to Mr. Lévesque. I appreciated all the comments very much.

Dr. Ujjainwalla, I practised emergency medicine for almost 20 years in Winnipeg, much of it at the major teaching hospital downtown. I could not agree with you more that during training we did not receive nearly enough training in addiction. The only addiction training I received in medical school was a two-hour instruction on what to do if one of your own colleagues was addicted. I knew what number to call if I found out one of my colleagues was addicted to drugs. That was pretty much all I learned about it in medical school. I learned more in residency, because I did a five-year emergency residency. Most of what I learned about treating addiction was due to the fortunate coincidence that some of our physicians were part-time emergency physicians and part-time addiction specialists. I learned most of my addiction medicine from them during shifts, just during conversations, which is not a well-structured way to learn a very important topic.

I agree that we don't have the proper facilities we need. Family doctors don't know what to do. They send them to us. People come to the hospital expecting to be admitted for their morphine or fentanyl addiction. We tell them that we have no place to admit them. We don't have a program to admit them. Internal medicine won't admit them. We can't keep them in our emergency department. We can give them a prescription for clonidine and give them a referral, which is going to take weeks to months. That's all we have.

I initially disagreed, Dr. Ujjainwalla, with what you had said about harm reduction, but maybe I misunderstood. I think we would both come to the agreement that it's not the only pillar of treatment. If you had nothing but safe consumption sites for drugs, then you're not addressing the problem. I think you and I would both agree with that. But we talked about it being a band-aid solution. As I said in an earlier meeting, when I'm in the emergency department and someone is bleeding, they need the band-aid. When someone comes in stabbed, yes, they shouldn't have been stabbed, and that should have been prevented, but they're stabbed and they're bleeding.

Would you not agree there's a role for it in saving lives, improving outcomes, but in addition more investment in addiction is needed?

Dr. Mark Ujjainwalla: Sorry, a role for what?

Mr. Doug Eyolfson: A role for centres such as harm reduction sites and supervised consumption sites, as one of the aspects, as a short-term treatment while you invest further in this.

Dr. Mark Ujjainwalla: It's such a small, minuscule part of what we do; I agree with my colleague. For example, in Ottawa probably only 20 to 40 homeless people would come from the shelter on Nelson Street over there. That's about it. I deal with people all across Ottawa. Nobody's going to get on a bus in February from Orleans and drive down there to inject.

● (1010)

Mr. Doug Eyolfson: I agree with you on that. That's what I'm saying; I agree that it's a small part of it a huge problem.

Dr. Mark Ujjainwalla: To your point, I was an emergency physician in a small community for 10 years, and we had no specialists. When somebody had a fractured femur, I'd put an IV in, splint them, and then I'd call the orthopedic guy in North Bay. The difference here is that you guys aren't calling Dr. Wood and Dr. Ujjainwalla. It would be so easy to implement a program where emergency doctors would call the addiction guy, they'd put them on suboxone, they'd send them to my clinic the next day, and then we'd get them into treatment with some counsellors whom the government pays for. That's it. It would happen so fast. What we're missing is that piece. The emergency doctors aren't doing that. They're missing a unique opportunity. They see them as drug seekers.

Mr. Doug Eyolfson: Well, I can say, at least from our experience in Manitoba, that we want to do that.

Dr. Mark Ujjainwalla: Okay.

Mr. Doug Eyolfson: In Manitoba we don't have anything like that. I do not have anyone I can call who can see them in the next few days and put them on suboxone.

Dr. Mark Ujjainwalla: Are you sure?

Mr. Doug Eyolfson: I am positive. I spent the last eight years in a hospital that everyone comes to.

Dr. Mark Ujjainwalla: Well, we need to develop that.

Mr. Doug Eyolfson: I agree completely. What I can do is put them on things like...well, suboxone is fairly new. We've been using clonidine with reasonable effect. We call these people, and they say, “Yes, put them on our list; we'll get back to them”, and it might be a week. There isn't someone like you, who I can send them to right away. I would love to have that. We want that. We've been advocating for it. I'm glad you're here today to tell us how badly we need that.

Dr. Mark Ujjainwalla: To your point, if you google “suboxone New York” or “suboxone California”, you're not going to believe what you see. There are thousands of physicians who do this. To the point of developing these guys, it wouldn't be hard. The buy-in on suboxone just hasn't been here in Canada for some reason, unlike Chicago, where every emergency guy is doing it.

Actually, it would be pretty simple to do, and it would save all the emergency guys dealing with all that: you want to put them on suboxone, you send them to me the next day, and it's good to go. It would be really easy to do.

Mr. Doug Eyolfson: I would love to be able to do that.

The Chair: Time's up.

Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Mr. Chair.

I want to ask an opinion question. Please don't take this as one being pitted against another.

Dr. Wood, we've looked at the stats for the Insite website itself, and it does seem to be a positive slant. We have the stats from 2007. There have been about 3.5 million visits since it opened its doors, with about 18,000 registrants over that time period. How do you define success and how do you define good value for dollars and resources? I think everybody's in agreement that you need to have a comprehensive approach, but on the website they're saying out of those number of visits, 1,200 have gone to transitional housing. It really doesn't say how many people have actually been managed properly through treatment. There's nothing there. So 1,200 out of 18,000, that's 6.6%, if they're calling going into housing as the success measurement. Is that how they're measuring success, and is that any indication of how many people are actually being treated properly?

Also, Dr. Ujjainwalla, perhaps you could give us an opinion. There is a cost for Insite. The police association said 100 police officers get diverted down there. If we multiply approximately $100,000 per officer, that's $10 million. That doesn't include the fire, the paramedics, and things like that. If you were given the resources, those millions of dollars going into treatment, and 18,000 registrants, how would you define a success rate with those numbers?

Dr. Mark Ujjainwalla: Sorry, are you asking me or Dr. Wood?

Mr. Colin Carrie: I'll ask both of you, so you can start if you want.

Dr. Mark Ujjainwalla: The thing is that the end points are different. From an infectious disease and public health standpoint, that's why these things are getting started. We support a safe injection site in Ottawa. I do, and I'm involved. I started a hepatitis C clinic in Ottawa, so I'm all into public health.

I think everybody is getting confused with what you're saying about success, about what the end point of success is and how you define success. For these people, success might be having their own bed to sleep in and having a meal.

That's the problem. You have to define it properly. Again, in medicine, we take a lot of time to define what success is and what the gold standard treatment is, based on evidence. If the success of your daughter is that the best she can do is get off the street and have a clean bed and that's what you want.... I tell my patients that it's like they're on the C team for hockey, but then there's a B team, there's an A team, and there's a AAA team. They all have different expectations. Do you want to be a guy who has a job and a family and pays taxes and enjoys your life? Or do you want to be the guy who has to go and steal and assault people and rob pharmacies in order to use? I don't know which team you want to be on. Also, do you even know what the teams look like?

It's very hard to write out on paper that “this is a success and we save lives”. My position always is that you think you're saving a life, but the people are so unhappy and miserable and they're living in hell. Why do you say that we're saving their lives and therefore we should put this money into it? It should be more about what's important: should you change the whole system so that people have the opportunity to have housing, education, and treatment for their illness?

I agree that this argument.... I've listened to a lot of police. I've been involved with the police chiefs of Ontario. They're frustrated. Of course they are. Think about it. For these injection sites, when you go in, they're not giving you the drugs. You have to bring in your own drugs, so in Ottawa, let's say, you have to go and do all your criminal activity downtown in the market. You have to prostitute, steal, or sell drugs. You get your drugs, you walk over there, and then you inject. You're finally asleep and you feel good, and somebody wakes you up and asks if you're dead yet. You wake up and you have to leave, and then you have to go and get more. You need to get $300 more, so you have to do more crime. It's not really changing anything.

To me, the point is that you're enabling or encouraging a negative existence and at the same time saying, hey, they didn't die today, so that's a good statistic for this funding. I just think everybody's missing the point on it. If that's all you have, if you live in a war-torn zone and it's the best you can do, okay, great, but I think we'd all agree that on every other aspect, whether it's education, or other areas or portfolios that you all have.... In the military, for example, we want the best. We want the best in our military. We want the best in our education. Everybody wants to send their kid to private school.

Why is it different in this area? This is about people's lives. They're sick. They have a treatable illness. If you can treat it, why don't you? If you can't treat it and they're palliative and they're going to die, okay, that's fine, they die, but to Dr. Wood's point, for these hepatitis C guys, I have these guys, and it's almost $100,000 a month for the treatment of hepatitis C. Are you kidding me? They're homeless.

Hey, we didn't really talk about jails yet, but it's $120,000 a year to put one of these guys in jail. That's expensive treatment. Trust me, they look better when they come out of jail, simply because they haven't been exposed to drugs, they've been eating, and they have a safe place to live. That could be an end point, but that's an expensive way to treat somebody.

I don't know if that answers your question.

● (1015)

Mr. Colin Carrie: You have good ideas. I think it is a struggle for all of us.

The Chair: Your time is up.

Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): I was hoping I could hear Dr. Wood answer his part of the question.

I just wanted to focus on something here. I'm not a member of this committee, but I saw that you're studying the opioid crisis, so I want to go back to the issue. I think I am in full agreement with Dr. Wood that we need to look at this from a public health point of view and then, of course, see what happens when people are in treatment. How do you support them, how do you rehabilitate and house them, and how do you provide all of those kinds of support systems that need to be there to back them up once they've been treated?

I just want to quickly say, because I don't want to use up all my time, that Jenny Kwan and I were ministers who were in charge of the Vancouver agreement, out of which came the safe injection site, and this came out of an evidence base that had happened in Europe that dealt with some of the issues. We were dealing with people who were dying. What are we dealing with now if a thousand people in British Columbia die from an overdose this year? If that happened because of bacteria, a virus, or tainted meat, we would be rushing around trying to stop it.

I want to talk about all of those elements. What do you do immediately to stop those deaths? I think you can't measure deaths on a level unless you think that people who die because of substance abuse are not worth it, that it's okay for them to die. We're talking about deaths. We're talking about stopping deaths. We're talking about preventing disease. That's a public health piece.

I would like Dr. Wood to tell me what he thinks we should be doing immediately, right now. I reiterate the question that Bill C-2 has stopped people from accessing this immediate treatment of stopping overdose deaths, which is what we intended to do, and we were very successful. People's lives were saved.

What other things, Dr. Wood, do we need to do on an immediate basis? You talked about the long term and the medium base, which is the training of doctors and looking at clinical guidelines. What are the immediate things we need to do—now—to stop real people from dying? What can we do now?

● (1020)

Dr. Evan Wood: I'll try to answer that as well as the earlier question in terms of success and where we should be investing. First, these programs are not clinical trials, so we have to look at data on deaths and things like that.

To give people context, when Insite opened, it was in the midst of a public health emergency, as was mentioned, and we had the highest rate of HIV infection in the developed world. Because of the comprehensive approach, which included Insite, we have seen a greater than 90% reduction in new HIV infections. Insite is a public health program. It's not a housing program. It's not a treatment program. So having those types of expectations makes no sense.

Because people are dying, and British Columbia is on track to have over a thousand people die this year, young people in the prime of their lives, we need public health interventions and we need them now. We need the things that were mentioned like take-home naloxone, absolutely, and public health strategies to address overdose, including supervised consumption. I think the band-aid point is a good one in that when people are bleeding, you need band-aids. But you also need more comprehensive approaches to prevent bleeding in the first place.

We don't want to have a system that just pulls people out of the river without going upstream to figure out why they're in the river in the first place. These are just structural issues. We need a national approach to the treatment of opioid addiction, and the Canadian research initiative funded by the federal government through CIHR intends to do that.

The other is training health care providers. To use the example of Winnipeg and the emergency room, at Vancouver Coastal Health, which has been dealing with this for a long time, there still have not been the dedicated resources so that emergency room physicians can just pick up the phone and say, “I'm sending someone over to be initiated on Suboxone”, or “I've started it tonight, and they're going to have an appointment tomorrow morning.”

I'll go back to my point about mental health and substance use. We need strategies focused on substance use and on shifting money to mental health and substance use or it just will not trickle down to the needed substance use interventions. Focus on guidelines, focus on practitioners, and don't divide these types of interventions as in opposition.

Hon. Hedy Fry: Thanks.

Do I have a minute?

The Chair: You do, and 10 seconds.

Hon. Hedy Fry: Thanks very much.

I just want to quickly ask one question. You've talked about the immediate things we need to do, which is what I'm concerned about right now. I agree with you on the long term and the comprehensive. There is a big question that I want to ask you. What is the role of heroin as a treatment in opioid addiction? Is there a role for people to go on heroin or heroin substitutes?

Dr. Evan Wood: Really, what we need, as we have for other diseases, is a stepped care model. Some people who are opioid-addicted actually don't need Suboxone. They don't need a medication. By going to a peer support meeting or going into a recovery program, they will go into long-term recovery. They don't need an intensive medical approach.

For other people, Suboxone would be effective. If that's unsuccessful, by the current Vancouver Coastal guidelines we would look to methadone. There are other new emerging therapies using long-acting oral morphine as an agonist therapy that can extinguish illicit drug use.

For some people—again, it's almost an inconsequential fraction of the population in terms of population size—in terms of costs, it can be extremely costly. These are individuals with huge histories of trauma, oftentimes fetal alcohol syndrome, other sorts of diseases of the brain that result in compulsive behaviour, or hypoxic brain injuries. For those people, the science would suggest that for very tightly controlled programs where people get diacetylmorphine —“Heroin” is actually the trade name of a drug that was once marketed by Bayer Pharmaceuticals—there is a role. It's not like we're talking about heroin programs rolling out across the country in suburban areas, but for a sliver of the population it can add a great deal of public health and public safety in terms of being able to successfully engage people in a program. For many others, a huge group, no medication might be required.

As my colleague has alluded to, those programs don't exist, so it's really a comprehensive approach and an evidence-based medicine approach. There's a Cochrane Collaboration meta-analysis looking at the trials of diacetylmorphine prescription in demonstrating the benefits. I'd refer to that.

● (1025)

The Chair: Thanks very much.

Ms. Kwan, you have three minutes.

Ms. Jenny Kwan: Thank you very much, Mr. Chair.

Thank you again to the witnesses.

I want to go back to the crisis we're faced with today. I know that the Vancouver medical health officer, Patricia Daly, has publicly stated that their application for an additional supervised injection facility has been hampered by delays as a result of Bill C-2. The onerous requirements in trying to move forward in upcoming facilities to save lives has been severely hampered. She has articulated that on the public record. I know that the health authority in Vancouver is attempting in the interim to get five additional supervised injection facilities up and operating in the midst of this crisis.

Dr. Evan Wood, do you know anything about that process and whether or not additional sites would be effective in saving lives?

Dr. Evan Wood: Yes, for sure. I mean, there are long wait times to use Insite. There are scientific papers showing that's among the reasons why people will go and inject in the alleys.

Just to describe it for people, it is a horrible life, as my colleague has alluded to. People are using water from puddles, or people are defecating in those same alleys and drawing up water into used syringes and injecting street drugs into their arms. People will often do that because they're in severe withdrawal, they're at risk of a negative interaction with a street predator if they're standing in a lineup, and they can't get into a health program, so they'll go and they'll inject on the street.

We need to scale up these programs, but as I've said and as you're hearing, the funding for these things is actually relatively small in comparison to the huge money that's going into the downstream consequences of addiction. That money would be much better spent on effective treatment programs so that we can do the public health side of things and also the recovery-oriented system of care that does not exist and really needs to be developed.

In terms of the legislation itself, it's my understanding that the federal government is working with Vancouver Coastal Health within the existing legislation, but that public health officials like Dr. Patty Daly, who are involved in that, feel that the legislation is onerous and really is not supporting any sort of positive outcome in terms of what it may have originally been intended to do.

Ms. Jenny Kwan: Thank you.

You mentioned investment into addictions and the need for a comprehensive approach. I absolutely agree. I think harm reduction is one pillar. I hate to think that if my daughter or son were addicted they would die injecting; I would want them to survive that experience and be able to move forward to the next phase, hopefully to detox treatment, and then, hopefully, to a successful life. I keep thinking about that because my constituents lose lives; they are somebody's son or somebody's daughter, and it's very real.

With that in mind and in terms of the other pillars, we now know what the issues are with harm reduction and the need to move forward. With the other pillars, I get the point about the need for additional treatment dollars. I think you mentioned, Dr. Wood, that we have $40 billion that would otherwise be spent because of addictions. If we were to invest that money into addiction prevention, treatment, and harm reduction services, what would that look like? In your dream world, what would that look like? What kind of investment do we actually need for a comprehensive approach across this country to deal with this issue in a comprehensive way?

Dr. Evan Wood: From a prevention perspective, unfortunately the science doesn't point a clear path forward in terms of discussing with youth in high schools. Those types of interventions have traditionally been shown to be ineffective. But from a prevention perspective, certainly a national approach to prevent the unsafe prescribing of opioids is clearly needed, and something that this committee can push for in terms of a monitoring system to ensure that prescriptions are safe.

In terms of treatment, we need accessible treatment. We are just spending so much money in terms of downstream consequences of addiction, so absolutely we need that, and we need public health approaches too, as was alluded to by Mr. Lévesque. For many people —and some I've described as very traumatized, or with hypoxic brain injuries or fetal alcohol syndrome—even if the door to treatment were open, they may not be motivated to go there.

We have prisons, and I agree that prisons are oftentimes a chance for people to turn their lives around, but in far too many cases, at great taxpayer expense, people come out of prison only to relapse and go immediately back to substance use because there's no treatment in prison. So we need a comprehensive approach.

I think we've focused way too much energy on treating this as a criminal justice issue, and we've spent lots of money there. I would argue that the war on drugs approach has led to ever more potent drugs like fentanyl, and it needs to be looked at as part of the problem.

● (1030)

The Chair: Dr. Ujjainwalla.

Dr. Mark Ujjainwalla: Perhaps I could add to that, Ms. Kwan.

I'm thinking outside the box. We've been approached by a group in Sweden and also a group in Kentucky. They have built facilities where the people are diverted from jail; instead of going to jail they go to these facilities. In those facilities they're very quickly encouraged to work. The state owns these things. They own companies like painting companies, catering companies, and whatnot. Then the individuals are given a sense of self-esteem and order. They have high productivity.

The guys from Sweden came and showed me that program, and it looks amazing. The same thing is happening in Kentucky. They have 2,000 beds in Lexington, where they have the same approach happening, and it's working really well. I think looking outside the box of Canada could be of use to us.

Ms. Jenny Kwan: Can I just ask—

The Chair: No, your time is up. You went way over.

To the witnesses, I just want to say on behalf of the committee how much we appreciate your testimony. For those of us who have not been exposed to this, this has been profound testimony. We really very much appreciate this, and we appreciate what you do.

Dr. Ujjainwalla, you've offered the committee a visit to your Recovery Ottawa.

Dr. Mark Ujjainwalla: Absolutely.

The Chair: I've asked the clerk to check to see if we can do that. I'm not even sure we can do it. We'll discuss it as a committee. If we have the time to do it, and if the committee chooses to do it, I think it would be helpful to us to see that. That's just my thought.

I want to thank you both very much for what you do. Thank you for testifying today and providing us with this information. It was very moving and very profound. Thanks very much.

We don't have anything on the schedule for committee business.

The meeting is adjourned.