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**EVIDENCE**

## Tuesday, December 11, 2018

## Chair

**Mr. Bill Casey**

# Standing Committee on Health

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● (0845)

[*English*]

**The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)):** I call our meeting to order.

Welcome, everyone, to meeting 129 of the Standing Committee on Health.

I want to welcome all of our guests who are here at the table and who are with us by video conference. We have a number of people today to provide us with testimony and information.

That creates a problem for the chair. Each member of Parliament has a certain number of minutes to ask questions. I'm going to have to keep the time tight, so I would ask the members to direct your questions to one of the participants. That would be best. If you ask everybody for their opinion, we will always go over our time period.

Mr. Ouellette.

**Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.):** I would suggest, if possible, shortening people's time period equally among all the parties, so that we all get a chance to finish whole rounds and hear all the testimony and the various ideas from all the members.

**The Chair:** Your proposal is...?

**Mr. Robert-Falcon Ouellette:** It's to shorten the time, if need be, because if the testimony goes a little bit long—

**The Chair:** I will keep a closer check on the time. Usually I let people answer their questions no matter how long it takes, but today I'm going to have to limit it. I hate to interrupt anybody who is providing us with good information, but today I'll probably have to do so.

Let's start with our introductions.

From the Calgary Police Service we have Chief Constable Steve Barlow and Detective Collin Harris, the drug expert. By video conference from the City of Winnipeg we have His Worship Brian Bowman, mayor; the chief of police, Danny Smyth; and John Lane, chief of Winnipeg Fire Paramedic Service. From RJ Streetz Foundation, by video conference from Brandon, Manitoba, we have Kim Longstreet, president. Welcome.

From Sunnybrook Health Sciences Centre we have Dr. David Juurlink, head of the division of clinical pharmacology and toxicology. This is a repeat visit for you. Welcome back.

We're going to open with a 10-minute statement from the Calgary Police Service.

Calgary, you have the floor.

**Chief Steve Barlow (Chief Constable, Calgary Police Service):** Thank you, Mr. Chair.

I took over the helm of the chief of police in Calgary in October of this year. Prior to that, I oversaw our patrol operations division, which currently looks after the entire front line of the Calgary police.

I've been asked to speak to you today about the impacts of methamphetamines—commonly known as meth—from the municipal policing perspective. I won't go into great detail about the production of meth because I'm assuming that's been covered off by the RCMP. From the Calgary perspective, very few meth labs are found in our city. The vast majority of our meth is imported from British Columbia or from Mexico.

Over the last five years, meth seizures in Calgary have increased significantly, with 2018 predicted to be the highest yet. Currently, we're sitting at about 130% over our five-year average, with more than 1,769 incidents this year alone. Fentanyl has also seen a big increase since 2013. Calgary is currently 242% over the five-year average. Just last week, my officers seized approximately 10 kilograms of meth in Calgary—worth about $400,000—along with some cocaine and fentanyl.

This same trend has been seen across Alberta. Lethbridge police reported that they're currently sitting at 275% increase over their four-year meth seizure. The Alberta Law Enforcement Response Team reports that the quantity of meth seizure during their investigations went from 59 grams in 2013 to more than 27 kilograms in 2016. Adding to the glut of the supply, the price of meth has dropped significantly. In 2015, it was selling for about $100 per gram. We're now down to close to $50 per gram. Putting that into perspective, we're looking at about $5 a hit. This one dose can last up to 24 hours.

Meth is consumed by injecting or smoking and produces a very long high—up to 24 hours—usually followed by a binge of uncontrolled drug and alcohol use, which can last anywhere up to two weeks.

In Alberta, we're finding that needle debris is a common complaint in many places in our downtown core. A longer high, cheaper prices and increased availability gives meth a significant draw for individuals with substance use disorder. Fentanyl has received a lot of attention. We strongly believe fentanyl is a community health crisis, but meth is a crime and safety issue. Fentanyl affects individual families in a very tragic way, but meth impacts the perception and reality of safety in our community in Alberta.

Meth is fuelling much of the crime in our city. We're currently ranked number one in the country for stolen vehicles and have witnessed a number of recent unprovoked violent attacks on innocent bystanders. These are innocent people who happen to be in the public place when a meth-fuelled individual takes drastic actions to cause them life-threatening harm. This summer alone, I ended up witnessing, through my officers, a woman who stabbed three people within 20 minutes—all random. In another case, a senior sitting on a bench in our downtown core was stabbed multiple times.

Just recently, we had a woman standing on our CTrain platform and another young lady came up behind her and pushed her off the CTrain platform. She was not hit by the train, but is now paralyzed. This young lady—our suspect in this case—was high on meth at the time.

It is also a significant officer safety issue. Earlier this year, Honourable Chief Justice Wittmann released an independent report on a review of force in the CPS. In the review, Justice Wittmann found drug use and mental health concerns were identified as factors for 46% of subjects involved in our officer-involved shootings. The primary weapons used by subjects were vehicles, edged weapons and firearms.

Our auto theft team tells me that most of their arrests recently have been meth-addicted offenders—every single one of them. These offenders often drive impaired. It's different from alcohol impairment. They're very motivated and take immense risks with the safety of the public. They are determined to evade apprehension out of fear of not being able to get their next fix. Since October, we've had 139 vehicle events where a driver, typically in a stolen vehicle, flees police. We believe the majority of the drivers in these situations are under the influence of drugs and are constantly putting our public at risk.

● (0850)

We had four confirmed cases of impaired driving in 2016 involving meth. In 2017, that had jumped to 13. This year, we are waiting for toxicology, but we expect that to be well above 17. These figures do not include the people with whom we are involved in pursuits. This is just the regular public.

Meth is also driving our residential break and enters in Calgary. What I'm finding more alarming than anything is our nighttime break and enters, when families are home asleep. We are finding that these numbers are going through the roof. The major reason behind it is that these offenders are going into the homes and stealing the keys of the vehicles because they aren't able to steal the regular vehicles, since the newer vehicles are harder to steal.

They use the meth to keep themselves awake for their crime sprees. Offenders frequently report that they experience insomnia and remain awake for days at a time, while consuming meth. During these periods, the offenders are prolific in their activities and commit large volumes of crime, beyond what could otherwise be expected.

We've recognized the need to take immediate action in Calgary. We've started up an operation, which will be a long-standing operation, that will be dealing with our drug houses and all our social disorder and property crimes in the community. We're also working to educate our citizens on the current trends and pressing drug-related issues within our community, while working with our partners to find solutions to address the root cause of the addiction.

When I look at the tools on an officer's belt, there isn't a single one that will help people in the throes of an addiction. We can arrest the drug traffickers, who are preying on our vulnerable addicted population, but if the demand is there, another trafficker will take their place. My officers are worn out with the continual grind of arresting the same individuals for drug and property crimes in the morning and having them back on the street during the day.

What we need is an answer to the mental health and drug addiction plaguing our province and our country. We need to stop reacting to the specific substance of harm and deal with the strategies of obtaining treatment for all substances. We need to continue working with our partners in health and in the social sector to put forward the resources and evidence-based solutions to mental health and addiction. We need to find new ways to address the low-level criminal aspects in our justice system.

We are really good at processing cases involving physical harm to people, but I would rather be able to stop it before it gets to that level and another innocent person is harmed.

Thank you for your time.

● (0855)

**The Chair:** Thank you for your testimony. It's amazing.

Now, we're going to go to the city of Winnipeg. I believe Your Worship Mayor Bowman is going to make an opening statement for 10 minutes.

**Mr. Brian Bowman (Mayor, Office of the Mayor, City of Winnipeg):** Thanks very much, and good morning to everyone who is part of this parliamentary committee.

Thanks very much for the opportunity for us to join you here from the city of Winnipeg. You're going to hear some repetition of the presentation you just heard from the chief of police in Calgary.

Winnipeg is like any other big city right now in Canada. We're not immune to illicit drug use in our community. One of the most significant challenges that our police and our community are facing right now is not only the presence of opioids, but of course, the rising presence of meth in our community. Unfortunately, it is becoming increasingly prevalent here in the city of Winnipeg. According to our police, seizures of meth this year to date are in excess of 20 kilograms, which is nearly double that of 2017.

Meth, combined with other drug addictions, is incredibly stretching the limits of the resources in our community, especially those who are struggling to keep up with the demand on the front lines. You're going to hear later, if we have an opportunity during questions and answers, from Chief Danny Smyth of our Winnipeg Police Service and Chief John Lane, the chief of our Winnipeg Fire Paramedic Service, who can answer more specific questions, given that they and their teams are on the front lines in their respective capacities.

We're also hearing from other community groups. Groups like our Bear Clan or community foot patrols are reporting the nightly cleanup of needles in various locations across our community.

Conversations that I've had with families have been, for me, very educational and disturbing. I've heard about their experiences over many years dealing with loved ones they're trying to help, and sadly, those who have been lost due to addictions. I've talked with families from all walks of life. Meth doesn't distinguish between the area of the city in which you reside or your family's income. Addictions and mental health really know no bounds. We're seeing that here in the city of Winnipeg.

I've been in office now for just over four years. Over that time, much of the country has been talking about the opioid crisis, which we are seeing here in the city of Winnipeg, but another disturbing and challenging story is emerging that I would like this committee to really hear loud and clear. That, of course, is the rise of meth use.

Meth is not a new drug to the world, but as I've come to learn from those with lived experiences, meth is highly destructive to the individuals using it, as well as to our community, in significant ways. Meth doesn't have the same danger with overdose, but we've been told the drug is, of course, highly addictive, and with excessive and repeated use can cause users to behave in ways that are violent and unpredictable.

I've learned from presentations by stakeholders that there are many impacts related to the addictions that come from mental health issues. What we're experiencing in Winnipeg is more citizens being directly impacted—and even more indirectly impacted—as a result of the actions of violence associated with the drugs we're seeing right now on our streets.

There is a key connection, of course, between mental health and addictions, but also, with meth, there is the connection with homelessness. We certainly hear from those with lived experience that they will use meth to simply stay awake at night, so they don't freeze to death in the cold weather climates we experience across Canada and in the Prairies.

In 2018, a new concern of mine is certainly growing. As we look at—and are now dealing with—the legalization of cannabis, the concern is whether or not organized crime is increasingly shifting its energies to meth. I don't have any stats to back that concern. I just raise it as something we'll be watching for in the coming months and years, if and when those stats are available.

In terms of statistics, what I will say is that both of our chiefs can hopefully provide you with some additional and much more detailed information about what they're seeing with their teams. But I will talk briefly about what the City of Winnipeg's actions have been to date to help with illicit drugs.

● (0900)

First, the Winnipeg Police Service launched an illicit drug strategy some time ago that speaks to a three-pronged approach: education, enforcement and intervention.

The City of Winnipeg has made land available to our provincial government for the Bruce Oake memorial recovery centre. It's still in the public hearing process for rezoning so I can't get into too many details, but the story around this facility has been widely reported. In short, the city has sold land and a facility asset to the Province of Manitoba for $1, for the purpose of long-term addictions treatment to be made available in a greater capacity than what we have right now.

We've also been supporting the end homelessness strategy. This is a United Way Winnipeg multi-stakeholder strategy to help those Winnipeggers affected by homelessness. As well, we continue to advocate for the destigmatization of those who are affected by mental health and addictions in our communities so that they can get the treatment they so desperately need.

The last thing I'll mention is what we are currently working on. The primary responsibility of our council, the city, governments, of course, isn't health care, but when we see a crisis with meth, we have to do what we can to coordinate and leverage the resources of multiple stakeholders and multiple levels of government. Our council has unanimously called for a tri-government-level meth task force. We've been having very positive discussions with local members of Parliament, including one our MPs who I know is there this morning, Robert-Falcon Ouellette, as well as with the provincial government. These discussions are happening, and it's our hope that we'll be able to announce very soon the formal creation of a meth task force so that we can better coordinate and align all of our energies on the ground here in the city of Winnipeg, in the province and of course from our federal government partners.

Luckily, when faced with what seems like an impossible task, our community can rise to the challenge. In the early 2000s, our city was plagued with arson and auto theft, and we came together to knock both back. We know how to get things done by working together. That's why I wanted to appear before this parliamentary committee —to make the case for us to better coordinate our energies and our actions among all three levels of government.

I have three requests of Parliament that I'd like to submit to you. I think they could make the greatest impact with the responsibilities and the resources that are aligned with the federal government.

The first, of course, is to create a national strategy on illicit drugs, which would include meth and not just opioids. FCM, who has appeared before your committee.... I'm part of the big city mayors' caucus, and we've called for a national strategy on opioids. I would urge you to expand that national strategy to include meth, because it is growing in cities, and not just in Winnipeg. You've heard from Calgary, and I know others, where a national strategy is required. We'll be there to support those actions and the development and the implementation of such a national strategy if and when it gets developed.

Secondly, strengthen border protection. We're advised that the drugs are coming in from other countries, such as Mexico. Of course, greater border protection—as is the responsibility of the federal government—to combat the importation of illicit drugs would obviously help.

Most importantly, my third request is to provide greater focus and greater resources on mental health, addictions and homelessness. As long as the demand is there, these other efforts will not be as effective. Resources are required in cities like Winnipeg. Our resources are stretched, and of course we really do need the support of the federal government to help with mental health, addictions and homelessness.

That being said, these are my introductory remarks. Chief Smyth, Chief Lane and I are available to answer any other specific questions you might have today.

Thanks very much.

● (0905)

**The Chair:** Thank you.

Now we'll go to the RJ Streetz Foundation and Kim Longstreet, by video conference from Brandon.

You have 10 minutes. Welcome.

**Ms. Kim Longstreet (President, RJ Streetz Foundation):** Thank you for this opportunity to speak to the committee and to tell my story of loving someone who is addicted to meth.

Recently, my son wrote me a short note in which he expressed his love for me, his thankfulness for my ongoing support and his pledge to himself to once again try for sobriety.

He wrote the note on September 26 of this year, about four days prior to learning that his bed date was going to be October 18. By his math, he could continue to use meth for about another nine days. He would then attempt to detox himself so he could enter the program clean. On admission day, he was tested and immediately sent to detox. He went on to complete the 28-day program, returned to Brandon and immediately relapsed. This scenario has played out numerous times over the last six years.

The first 18 years of my son's life were normal by today's standards. I raised him mostly as a single parent. He was a model child, an athlete, a popular boy. He graduated from high school, went on to attend university and made it on to the men's basketball team. Everything he had ever wanted in his life was right there for the taking, but his dreams of playing basketball ended when using drugs became more important.

For 11 years now I've watched my son slowly succumb to the world of drugs, to marijuana, cocaine, ecstasy, crack and meth. Of all the drugs he has used, meth is the one that won't allow him to function in life. With the other drugs, he was still trying to get his education, play basketball and hold down a job. Meth took everything away except his need for the drug.

Meth is an ugly drug. It has been called the “evil” drug and having witnessed my son under the influence of it and also withdrawing from it, I can attest to the darkness in which it shrouds the substance user. The violence that comes with the drug is very real. Homemade weapons are a necessity for the paranoia that comes with using meth. I have been witness to the extreme behaviour that propels someone on meth to barricade their home from whatever evil it is that makes them do it.

My son tells me that he doesn't want to do bad things, but he has a genuine fear of the evil that manifests in his mind. This evil is the violence that service providers talk about. It's the “get them before they get me” psychosis that propels someone on meth to become violent.

It is impossible for anyone to understand the pain a mother feels when her child is hurting and she knows she can do nothing about it. We fix things. We're moms. We can do anything—but I can't fix this one.

Two years ago, after nine years of hoping things would turn around for my son, I gave in to the exhaustion that comes with loving a substance user. I took an eight-week leave from my job and used that time to grieve the loss of my son as I've always known him to be. I had a new normal and it was time to get on with it. After my eight-week hiatus from life, I made a decision to share my story with my community as a way to ring the alarm bell about the meth crisis upon us. I did this with my son's permission to share his story with mine.

In July of 2017, I shared my concern with my city's council. Since then, I have been advocating non-stop to raise awareness about meth and its impacts on a community. I see this advocacy as contributing to my community's willingness to address the meth issue we currently face.

The City of Brandon and our Brandon School Division sponsored five sessions last week called NEO, “Not Even Once: Brandon Fighting Addiction”, which featured well-known speaker and advocate Joe Roberts, the “Skid Row CEO” and founder of Push for Change. He presented to each of our three high schools and also gave an open evening session for service providers and other interested individuals.

Our Brandon Police Service has added two members to its crime support unit, a drug investigator focused on meth and a youth intelligence officer focused on youth who have been exploited, are missing or have run away due in part to meth.

We have a community mobilization unit. These are service providers who collaborate on services for citizens with risk factors that lead to emergent response from police, health and other agencies. A steady uptake in meth use has increased the need for resources beyond what is currently available.

In October, our Prairie Mountain Health opened a rapid access to addictions medicine clinic, which is open twice weekly for two hours. They also offer a needle exchange program, with 30,000 needles distributed in 2017.

● (0910)

Addictions Foundation of Manitoba has increased its crystal meth presentations in communities, some detoxing and longer stays have been added to their current programming, and they have improved their pathway planning.

The Canadian Mental Health Association is in the process of developing supportive recovery services for addiction and those in recovery to learn to live a productive life.

Our Brandon Friendship Centre has numerous options available to provide programs and services for aboriginal people, and it recently held a forum in the community about meth.

Brandon Bear Clan Patrol does twice-weekly patrols by volunteers with the purpose of providing a sense of safety, solidarity and belonging to both its members and to the community they serve. In 2017, the Bear Clan picked up 50 needles in our community. In 2018, to date, they have picked up more than 550 needles.

Westman Families of Addicts is a support group started in 2017 that currently supports 206 families in the Westman region who have been affected by meth.

Last week, the Government of Manitoba made two announcements that will assist in addressing the fallout from meth use in our province. A request for proposals for in-province residential treatment has been sent out by the government with a submission deadline for January 15, 2019. The intent is to provide service to 15 individuals per year with concurrent mental health and addictions disorders. Also, in the coming months, a tendered contract will be awarded to provide long-term withdrawal—detox—management beds. The number of detox beds has yet to be determined.

Very positive progress has been made so far, but based on my personal experience, we have a long way to go as a nation. I am in agreement with what previous witnesses have recommended as steps to take going forward.

If we trust what history has taught us about meth, we know that it periodically cycles in and out of the drug world. Knowing this, I think it's imperative that we make illicit drug use a topic for our school system to integrate as part of their curriculum.

Dr. Gabor Maté references the fact that we have lost our human connection. He also said something that is important for all of us to remember as we move forward. There is no war on drugs, because you can't war against inanimate objects. There is only a war on drug addicts, which means we are warring against the most abused and vulnerable segments of society.

After 11 years of coping with my son's substance use disorder, I can honestly say that I wish it were over, one way or the other. Every time I hear a siren or the phone rings at odd hours, I wonder if this is the call. To some, this will make me sound like a terrible parent, but sometimes I do imagine that it is the call from which my son will finally have peace from the war that our society appears to be losing.

Thank you.

● (0915)

**The Chair:** Thank you very much for that. I just can't imagine what you're going through and what you've been through with this.

Now we will go to Sunnybrook Health Sciences Centre.

Dr. Juurlink.

**Dr. David Juurlink (Head, Division of Clinical Pharmacology and Toxicology, Sunnybrook Health Sciences Centre):** Good morning. Thanks for the opportunity to speak here today. You'll hear a bit of overlap. I guess that won't surprise you.

You all know that this is a stimulant. What you might not appreciate is that, chemically, it's almost indistinguishable from the prescription drug Adderall. I assure you that you all know someone who has that medicine, those capsules, in their cabinet at home.

People use this drug for a variety of reasons. Some use it intermittently, socially, to disinhibit or facilitate interactions with others or to increase sexual drive, especially in the community of men who have sex with men. Some people use it to be functional—long-haul truckers and construction workers—and some people use it because they're dependent on it and will do whatever is needed to procure it. As you've heard already, it's incredibly cheap and its effects are incredibly long lasting.

As I think you heard the mayor say, it particularly effects the homeless population. They use it to keep moving, to stay awake and protect their meagre belongings, and sometimes, to change the mental state that accompanies exposure to and discomfort from the elements.

We see the harms of the acute use of meth in a variety of different ways. It can cause anxiety and frank psychosis, and this is a common reason for coming to hospital. First responders see this all the time. It's one of the main ways that meth can cause people to die. They engage in high-risk sexual activity. They can have seizures, strokes and heart attacks in their twenties. With chronic use, they can have heart problems, dental problems, skin problems and neuropsychiatric problems including depression. Even for those who do manage to stop, the depression can be long lasting and crushing.

People can die from this stuff through a whole host of mechanisms, including the suicidality that comes with the effects of this drug on the brain over the long term, and of course the mixing of it with other drugs. Sometimes that's not within the person's control.

What could be done to make this better? Right now, when patients are brought to hospital after meth use, there's a lot of tinkering and turfing, and then they're sent back out. I think we could be a lot more proactive and less reactive with how we handle people with meth addiction.

Unlike with opioids, we don't have a lot of good drug options. With opioids we have two very effective drugs for people who stick to them, drugs that are shown to reduce death. We don't have that same sort of chemical treatment with meth addiction. What I think we'd have to do—and you've already heard this—is engage people who use meth in treatment and improve access to supports, including qualified addiction care. Many people who use meth don't know about or have access to the path to treatment.

We could better treat their underlying psychiatric disorders and untreated mental health problems that often help these patients find meth in the first place. I think that would go a long way towards reducing the burden on law enforcement and the criminal justice system for patients who use meth.

We could improve access to their associated health problems, whether it's HIV from sharing needles, hepatitis C or the PTSD that so many of them have in the first place.

We could actually help them get better access to low-income housing, or shelters that don't require them to arrive late and leave early in the morning. I think that alone would go a long way to decreasing the demand for meth in a particularly reliable customer base.

To the extent that there is domestic production—there is some—we could make the main ingredient in Sudafed, pseudoephedrine, a prescription-only drug. It's not going to solve the problem, but you'll have fewer lab explosions if you do that.

I want to spend the last few moments of my time talking about something that I know is not popular. It's the issue of decriminalizing drug use. I know many of you will have views on this, and perhaps they're immutable. I'm not talking, of course, about the property crime or the physical or sexual assaults that accompany drug use. Those require punishment, as do the people who deal the drugs. I'm talking about the simple possession and use of drugs.

The mayor made a comment about reducing stigma. Part of the stigma comes from the fact that this is an illegal behaviour. Drugs have been around for a very long time, and people have used drugs for as long as there have been drugs, so drug use is here to stay. If you have had a few drinks on occasion, maybe one or two more than you intended to have, you are a person who has used drugs. You just happen to use a socially acceptable drug that's legal to use.

I think that in political circles as well as in social ones, there's a tendency to oversimplify the decriminalization discussion and sort of assume that people who don't forbid drug use therefore must condone it. That's simply not true. Whatever your view is on this issue, I think we should be able to agree that it would be better if fewer people had drug-related problems, and it would be better if fewer people died.

● (0920)

It's worth asking what criminalizing the simple use of drugs accomplishes. The threat of going to jail or of a criminal record causes people to hide their drug use. This is why so many people, especially with opiates but also with methamphetamine, die alone at home, in alleys, or in Tim Hortons' washrooms. It promotes stigma, as I mentioned earlier, as does the word “addict”, and I would discourage the use of that word. These are often people who've endured hardships that maybe you and I have been lucky to avoid. Maybe they have an untreated mental illness. Maybe they've had exposure to drugs or alcohol in the womb, and maybe, as children, they endured physical, emotional or sexual abuse. Maybe we can't expect them to be quite as resilient as those of us who grew up without those forces in our lives.

When someone who uses drugs and is a criminal as a result of using it is discovered, they're arrested and jailed. In jail it's often easy to get drugs. Sometimes it's easier than it is in the community. It is easy to share needles and transmit disease. People will sometimes die in prison or shortly after release. Even after the arrest, they have a permanent criminal record and all that goes with it. They have all the things that exacerbate drug problems: unemployment, social exclusion, trauma and family separation. Those things get worse after jail, not better.

I think the main argument, if I understand it correctly, for criminalizing drug use is that it deters the use of drugs, and there's very little evidence that claim is true. According to the Global Commission on Drug Policy, it does not do what you might think it does. In truth, we have very little to show for the vast societal resources consumed by our current policies aside from overburdened police departments, courts and prisons. I'd ask you to consider that tough drug laws don't result in fewer drug-related problems and deaths. They do the exact opposite.

There's a medical maxim. It's sort of simple on its face. If what you're doing is not working, stop doing it. As MPs, you might want to reflect on that in the context of drug criminalization. Portugal, as you know, did this in 2001. They were faced with a huge threat from heroin. In 2001 they decided to approach this as a health problem as opposed to a criminal one. They decriminalized the possession of small amounts of drugs for personal use. Today in Portugal, if you're found with drugs, you're offered help; you're not put in jail. Today in Portugal, you can tell someone you use drugs without fearing going to jail or a criminal record.

In the wake of that change, drug deaths fell, maybe not exclusively due to the change, but they fell nevertheless. New cases of HIV plummeted, and drug use didn't increase. In fact, it even fell in some segments of the population. In Portugal—and here's a statistic I hope stays with you—six people per million died from drug overdoses last year. In Canada, that number is in the order of 110. It's one of the highest drug-related death rates in the world.

I think it's time to acknowledge that our approach to drug use isn't working. It's really been a failure. As I said before, drug use is a health issue, and when we treat it as a criminal one, we promote fear, isolation and harm. We don't arrest people for drinking alcohol or smoking cigarettes. When people come to me with a problem with those drugs, we offer them help to the extent that we have it. We help them moderate their use or help them quit. When it comes to other drugs, we expend untold resources on measures that are plainly ineffective and even counterproductive, like imprisonment and interdiction.

I realize that the idea of decriminalizing drug use will be unpopular in some circles, particularly in political ones, but the alternative is staying a course that has quite clearly failed. One day in the future, Canada will eventually change its laws regarding drug use. I don't know when that will be. It might be decades hence. I think that, not long thereafter, we'll look back and ask what took us so long to start approaching this as a health problem. How many people died because for so many years we used the wrong approach?

I'll end my comments there.

Thank you.

● (0925)

**The Chair:** Thank you very much to all of you for your comments. They all come from a different perspective, and they help us start to understand some of the challenges we're facing.

I think we have everybody except Ms. Longstreet. We're still trying to connect. We lost the connection.

We'll go to questions now, starting with Dr. Eyolfson.

You have seven minutes, and I'll give you a flag as you approach your seven minutes.

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

Thank you, all, for coming. This is very valuable testimony. I'm so grateful everyone could come, in particular our guests from the Prairies. Thank you for coming here. It's cold and snowy here, so you'd feel at home, had you made it here.

Mayor Bowman, Chief Smyth, Chief Lane, thank you for your perspectives. As you know, I spent 20 years as an emergency physician in Winnipeg. I'm familiar with a lot of these problems. Interestingly enough, when I left the practice of emergency medicine three years ago, I had never seen an acute methamphetamine intoxication. It was around—I knew what it was, people gave a history of it—but certainly from the Winnipeg perspective, talking to my colleagues now, this problem has exploded in the last three years from something I'd never seen to a daily occurrence.

Mayor Bowman, I was pleased to be able to meet with you when you met with the Manitoba caucus regarding the task force we discussed on methamphetamine and illicit drugs. One of the issues that has come up—and this was talked about in our meetings discussing opioids, and was brought up by a witness in one of our recent meetings on this—is the issue of harm reduction. We had very clear testimony that harm reduction and safe consumption sites would be beneficial to this for a number of reasons. That testimony will be available in the briefs.

We do know that, to date, the provincial government of Manitoba has been very resistant to safe consumption sites. They even had a draft report of their mental health and addictions strategy that initially said to increase capacity for harm reduction services, including a safe injection site in Winnipeg. This was removed in the final draft to the public.

Mayor Bowman, has there been any recent dialogue with the provincial government on this topic? Are they starting to have a different view, or are they still keeping this line that this is something that is not a suitable fit for Winnipeg?

[*Technical difficulty—Editor*]

**The Chair:** Okay. We're going to fix that.

**Mr. Doug Eyolfson:** What I'll do is I'll make good use of my time.

Mr. Barlow, thank you so much for coming. I just wanted to expand on harm reduction. You talked about your harm reduction program you have in Calgary. We do know that there is a lot of political opposition often to these, there's often community opposition to these, and there are a lot of fears that there will be increased crime or problems with safety.

According to a recent story in the Calgary Herald, “The Calgary Police Service has been tracking incidents within a 500-metre radius of the facility since before it opened and says there has been no noticeable increase in calls connected to that area.” Does that sound like a fair evaluation of the situation there?

**Chief Steve Barlow:** Actually, I wouldn't say it's a fair evaluation. What our issue is now is that people have stopped calling. What we have done is actually put more members down in that area.

The community has significant concerns with the one area of our safe consumption site, and it's to do with the population that has now migrated into that area. Crime rates have increased somewhat, but what we're finding is the homelessness and what comes with the homelessness, and the use of the drugs in that area with the spent needles. Some of them are going into these facilities, using the facilities, but also coming out with the spent needles.

The biggest issue we have is that our drug dealers have now, of course, learned where their clients have moved to. That's one of the biggest issues we're dealing with right now, having to work with our drug dealers and arrest our way out of that part of the issue, the dealing, not the people who are consuming but the dealers.

● (0930)

**Mr. Doug Eyolfson:** Thank you.

This might be very difficult to quantify, given that there are so many variables. Does it appear to have caused any increase in general, or is it just the same amount that's going on but appears to be just concentrating because people are coming there? That may be impossible to answer, I understand, given the number of variables.

**Det Collin Harris (Drug Expert, Calgary Police Service):** Thank you for your question.

I am also a returning witness to the Standing Committee on Health. I appeared before to speak about prescription drug misuse and opioids. I've been with the service for 30 years, and I have seen a tremendous increase in methamphetamines over the last number of years.

As you mentioned, the number of instances isn't necessarily so much increasing, but I believe the daily use of individuals has increased dramatically. I deal with a lot of non-profits and a lot of service industries down in that area, and many of their clients, specifically youth—I can attest to that—have stated that last year their daily use may have been that 30% of them were using on a daily basis. Now, over 50% or 60% of them are using on a daily basis. That daily use causes other incidents to occur that are not necessarily reported to us.

**Mr. Doug Eyolfson:** Thank you very much.

We don't have video, but do we have audio with Winnipeg?

Mayor Bowman, can you hear me?

**Mr. Brian Bowman:** Yes. Thank you.

**Mr. Doug Eyolfson:** We can hear you now, so if you can just answer the question.

Thank you.

**Mr. Brian Bowman:** With regard to harm reduction, what I'll say is that, obviously, I take my cue from health care professionals and front-line service providers. The approach that I have taken is that we shouldn't be ruling any options out if they're going to help save lives and reduce the broader harm to our community.

Of course, I'll let the provincial government speak for itself, but my understanding in speaking with front-line service providers is that there are differences between the different substances, opioids versus meth.

Perhaps I could ask our chief of police and our fire paramedic chief if they might be able to add some context and some thoughts on harm reduction.

**Mr. Doug Eyolfson:** Please go ahead.

**Mr. John Lane (Chief, Winnipeg Fire Paramedic Service):** The major concern with meth use in terms of harm reduction is the unpredictability of the intoxication. It's quite different from opioids. The unpredictability of the time course of the intoxication really complicates the aspect of the effects of safe consumption sites as far as methamphetamines go.

Really, the expertise here, I think, lies more within the public health service. Those are the experts that I would look to for expert advice on the use of safe consumption sites.

**Mr. Doug Eyolfson:** Thank you very much.

**The Chair:** You time is up. We have to move on to Mr. Webber.

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

I will focus my questions on my fine fellow Calgarians.

Detective Harris, thank you for coming back again.

Chief Barlow, thanks for being here.

I'm going to talk a bit about your dealings with dealers. A couple of months ago your fine people in Calgary arrested two suspects, and you found 66 kilograms of cocaine and 30 kilograms of methamphetamine worth $8 million street value. There was $41,000 of cash. They had a taser. You arrested these individuals. Apparently, it was one of the largest drug seizures in CPS history. You took them in for processing.

Are these the individuals who you were talking about earlier, Chief, with regard to their being in and out of the system within days and back out on the street?

● (0935)

**Chief Steve Barlow:** Some of these individuals would be in and out. I wouldn't be able to answer that specifically on that case alone. I may lean over to Collin here in a moment.

The ones that we're dealing with are the everyday ones. These are the stolen cars, the break and enters, the stolen property, the breaking into everything they can downtown. They're the ones who are in and out. It's a revolving door. It's unfortunate, and I'm not blaming our justice system. It's just the way it works right now. When we get into some of these bigger busts, some of those people, I guarantee, would spend some more time in jail. As I said, Collin may be able to answer that one a little more specifically.

The unfortunate piece is that a lot of our users are stuck in this ever-turning style of criminal behaviour because that's the low they've gotten to as users, and they continue to come into contact with our system. These people are not being arrested for possession. These people are being arrested for other crimes that relate to their addiction problem.

**Mr. Len Webber:** Detective Harris, do you have anything to say on that?

**Det Collin Harris:** In all of our larger scale operations, individuals who are importing these large amounts, depending upon their criminal history, typically may spend a brief period of time... until they're able to post bail. If they're able to post bail, then they're able to get released on conditions and they're back in our communities, maybe not as quickly as some of the smaller scale individuals who get arrested, however they are back.

We've all seen the drug world to be very profitable for those individuals. At times their activities continue.

**Mr. Len Webber:** Dr. Juurlink has talked about decriminalization, and of course, it's brought up a lot by our colleague here, Don Davies.

I just want to know your thoughts, Chief and Detective, about decriminalization. Do you think it would provide more resources for treatment and less responsibility for police to continually arrest those same individuals who have small amounts of drugs on them?

**Chief Steve Barlow:** As I mentioned before, sir, we will not arrest our way out of this problem. That is absolutely 100%. That's not what we're dealing with. I'm going to say, anecdotally, that probably 75% to 80% of the charges that we are laying with these people are property crimes. A lot of the higher end ones are the attacks against people, the random attacks. Those are the ones that are very concerning to me, not that I'm not concerned about people's property, but the randomness of this is the issue.

We will need to continue working with our partners in health and social services to support each other when it comes to working our way through this problem. Personally, if we were to get into the decriminalization at this level, I don't think it would make a difference on the street-level crime that we're dealing with. But of course, I will say that I don't have facts to back that. That's strictly what my officers are faced with every day.

I do want to give Collin a chance.

**Mr. Len Webber:** Certainly.

**Det Collin Harris:** I certainly believe it's a topic of discussion and one that merits some discussion and some more study. I agree with Chief Barlow that we're not targeting those individuals who have a substance abuse disorder. We don't focus our investigations on those individuals. They're just ultimately the individuals we tend to spend a great deal of our time on. We need more resources, and I think that's the biggest thing, going forward, dealing with all our external partners. Our addiction services are overwhelmed.

Typically, when we've utilized informants or witnesses to assist in our investigations, those people would look to us for money or charge considerations, and one of the biggest things we've noticed in the last number of years is that people are coming to us asking for help to get assistance and services.

That's a huge, telling factor in that these individuals want and need help, and I think we need to stop providing barriers to treatments and get more treatments. I totally agree, and we've said it numerous times. We're not going to arrest our way out of this. Society needs to change.

● (0940)

**Mr. Len Webber:** We had a representative here from the nurses' union last time. She talked about how concerned they are about violence in hospitals and emergency rooms, and justifiably so. They talked about these RAAM facilities—rapid-access facilities—where you can bring in meth users who are aggressive. Do we have something like that in Calgary?

**Det Collin Harris:** No, not to my knowledge.

**Mr. Len Webber:** Do you find the supervised consumption site in downtown Calgary to be beneficial?

**Det Collin Harris:** We certainly have seen it to be beneficial. They are getting a great number of individuals attending, which is fantastic. It's good that individuals are utilizing the facilities.

However, as we mentioned before, it does bring in those individuals who wish to ply their trade. They know there are customers who are looking. As I mentioned before, we're not looking to arrest those users. I've had front-line members walk individuals to the site, to assist them in getting there safely. It's the individuals plying their trade who really score in the area.

We've also noticed that methamphetamine has increased in use at the safe consumption sites. Initially, it was opioids, but they're now seeing it trending towards more methamphetamine. I've also seen a lot more methamphetamine through injection use throughout the city.

**The Chair:** Okay.

Mr. Davies, you have seven minutes.

**Mr. Don Davies (Vancouver Kingsway, NDP):** Thank you, Mr. Chair. Thank you to all the witnesses for being here.

Mayor Bowman, you were quoted in a September article from the CBC saying that your city "desperately" needs more long-term addiction treatment facilities to combat the current meth crisis and, I would imagine, drugs generally. In your view, Mayor, how many treatment beds would be needed to adequately address demand across Winnipeg?

**Mr. Brian Bowman:** Front-line health care providers would probably be better equipped to provide you with the specific number. Let me just say that we need a lot more. I agree with the witnesses from Calgary. We cannot arrest our way out of this crisis—and it is a crisis. We absolutely, desperately, need more long-term treatment for addictions, as well as mental health.

Sadly, the families and parents I have spoken with are very similar to the witness you heard from Brandon. It is absolutely heartbreaking to hear what we heard this morning. Sadly, it's not uncommon, from what we've heard from parents. I think parliamentarians, and all politicians—municipal, provincial and federal—need to act in a way in which we realize that these could be our own kids, because it could be and it can be. No one is immune to this. My wife and I have two boys. They are eight and 10. Like many parents, I am very concerned about the risks for them. These drugs have no bounds.

The short answer is that we need a heck of a lot more than we have right now. The consistent message I hear from those with lived experiences, as well as people who are using or have family members who are using meth, is about the inadequacy of the long-term treatment options.

We're willing to do what we can, but we can't do it alone as municipalities. Yet our front-line service providers—

● (0945)

**Mr. Don Davies:** I'll stop you there, Mayor. I have other questions. Thank you for that.

Dr. Juurlink, I want to talk about drug policy generally. You have previously called on the federal government to declare a national public health emergency to address the opioid crisis. We've all seen the numbers: 4,000 Canadians died last year. The numbers have been going up each of the last three or four years. Eleven people are dying a day.

Can you explain to the committee why you make that call?

**Dr. David Juurlink:** It is an emergency. It was 4,000 deaths, and it's only in the last couple of years that Canada has actually tallied the deaths from opioids. Those 4,000 were from opioids alone. Opioids and other drugs usually, but....

I don't think there's merit in declaring an emergency simply for the sake of declaring one. The reason to declare an emergency is that it allows you to do things that you can't otherwise do under an existing structure. To the extent that the declaration of an emergency would allow federal or provincial governments to deploy measures that we know work, I think that would be a beneficial intervention.

**Mr. Don Davies:** I've actually asked that for the last two years from this government. The repeated answer you get from the federal health minister is that the declaration under the Emergencies Act would do nothing and give the government no tools that they're not presently employing. I've suggested that's not correct. One measure that would be taken is under section 8 of the Emergencies Act. It allows the government to designate emergency clinics or shelters. This would allow the government to designate the overdose prevention sites—not supervised injection sites—that are currently popping up in cities like Vancouver, which that are operating illegally, as medical clinics under the Emergencies Act, thereby making them legal and qualifying for federal funding.

Do you have any comments on that? Are there any other tools you think would be available?

**Dr. David Juurlink:** You know the ins and outs of the law better than I do. To the extent that it would permit those sites to be more available.... I know there's opposition to them. I know that there are sometimes valid concerns, but people don't die in these places. It's simply a fact. They might continue to use, but at one point down the road they might recover—especially if these facilities serve as sort of an access point into help. You can't rehabilitate somebody who's dead, so to the extent that the provisions within the law allow what you've just described to happen, I think that would be a good thing.

An even bigger issue that has come from everyone who's spoken today is that we need a massive societal investment in addiction care. Without that, this is not going to go away. People are going to die by the thousands.

**Mr. Don Davies:** You've also been quoted as saying, "The illicit drug supply has never been more dangerous because of the profusion of fentanyl-related compounds". We've heard evidence at this committee that sometimes fentanyl is discovered in meth and other drugs as well.

**Dr. David Juurlink:** That's right.

**Mr. Don Davies:** This is why so many people are dying. They're dying because the drugs they're using contain much more opioid than they thought.

Dr. Juurlink, in your view, could we prevent overdose deaths by providing substance users access to a regulated, safe supply in known dosages through our health care system, for instance?

**Dr. David Juurlink:** I think the answer is yes to that. I know that's particularly unpopular in some circles because it's perceived as promoting drug use, but the answer is yes. People know what they're using. There still might be people who make bad decisions and continue to use more and more and die as a result, but you are right when you say that a lot of the time people die because the stuff is so incredibly potent they don't know how much they're injecting. Are they injecting 300 micrograms of fentanyl, or 3,000? They don't know, and they are dead as a result of the uncertainty.

To the extent that this is a health problem and to the extent that providing someone with that health problem something that helps them not die as a result of their health problem, I think it would help people.

I appreciate that it's seen by some as distasteful, but given how incredibly toxic the drug supply is, it's one of the things we have to have on the table.

● (0950)

**The Chair:** Your time is up.

Mr. Ouellette, you have seven minutes.

**Mr. Robert-Falcon Ouellette:** I'd like to thank everyone very much for attending here today. It's a great honour to have all of you.

I'd like to ask Mayor Brian Bowman, or any of your chiefs there, how many homeless people do we actually have in Winnipeg?

**Mr. Brian Bowman:** We've had a couple of street censuses. I'd have to refer to the most recent one and get back to you, Robert. I'm not able to say off the top of my head. Of course, we have those who are facing chronic homelessness and then we have those who are not. It does vary depending on the time of year as well. I can get back to you on specific numbers.

**Mr. Robert-Falcon Ouellette:** I believe the actual number is 1,500.

**Mr. Brian Bowman:** Yes. It's absolutely over 1,000.

**Mr. Robert-Falcon Ouellette:** The Province of Manitoba and the federal government just put out a bilateral agreement—$4.2 million from the feds and from the province—to help fund more capacity. That's what the province is saying. They're talking about 130 people being treated in a year. Is that enough to treat the addiction in the city of Winnipeg, Brandon, and elsewhere—not only in indigenous communities, but across the province?

Is that the end for the Province of Manitoba? Have they done their bit? Have they done their heavy lifting?

**Mr. Brian Bowman:** It's a step in the right direction, but it's a step. I think more needs to be done by all three levels of government, to be honest, with respect to mental health, addictions and homelessness. There's the federal commitment, and we have seen some actions recently by the provincial government on quicker access. All of these are positive, but they really don't match the scale of the crisis.

**Mr. Robert-Falcon Ouellette:** When you say quicker access, are you talking about rapid access to addiction medicine?

**Mr. Brian Bowman:** Yes.

**Mr. Robert-Falcon Ouellette:** That's open 22 and a half hours a week in five different locations, so that's not a lot of access in my mind.

I'd like to talk to Ms. Longstreet. How long do you think a treatment should be? The province says it should be 10 days here for a recovery bed, seven to 10 days, and then they say perhaps management withdrawal and recovery for up to 30 days. Is that enough for someone who's addicted or on meth?

Dr. David Juurlink, maybe you'd also like to answer that question.

I'll go with Ms. Longstreet.

**Ms. Kim Longstreet:** Having had my son in and out of treatment, 28-day treatments and 21-day treatments, for the past six years, if you were to total up all of that time, you're going to come up with probably a year or so more of recovery needed. For me, no, 30 days is not enough. Eleven days of detoxing is definitely not enough. A program of 21 days is not enough. It is absolutely not enough.

I would like to touch on the fact that the request for proposals that recently went out by our provincial government is to help 15 people per year. That's a pebble in this ocean of meth crisis that we're facing. We need long-term treatment. I would say it takes a year before somebody is even prepared to integrate back into society.

**Mr. Robert-Falcon Ouellette:** Doctor.

**Dr. David Juurlink:** I guess I would echo those comments. The nature and duration of treatment that one needs is a function of what drugs they're using and what other supports they have in their lives. I don't know that you can put one answer on it, but the way you've described it is on the short side.

**Mr. Robert-Falcon Ouellette:** This next question is for Mr. Harris from the Calgary Police Service. You mentioned barriers. I was wondering if you could elaborate more on those barriers that you see in your work day to day that impede someone from obtaining addiction treatment, getting off the streets and getting well.

**Det Collin Harris:** Thank you for the question. It's a very good question.

I think it's one of those things where, as I mentioned before, our addiction services are overwhelmed. We have facilities that have individuals lining up at the start of the day in order to see whether or not they can get a bed. Numerous individuals are being turned away that morning, because there just isn't the availability. We need to have more flexibility to be able to take these individuals into different facilities.

We need to change the manner in which we provide stabilization and long-term care. We can't just bring them in for that 30-day period, as Ms. Longstreet presented, where we believe that the addiction is going to be completed in 30 days. That's just not going to happen. We're going to continue to have that revolving door of individuals receiving treatment going back out, and hopefully getting access to long-term care, but it's just not there at this point in time.

● (0955)

**Mr. Robert-Falcon Ouellette:** I have a few more minutes left.

In Winnipeg we know we have a lot of issues in the health care department, the emergency wards, people who are in addictions and security issues for staff who are being hurt. Is that same thing going on in Calgary as well?

**Det Collin Harris:** I believe it is.

**Mr. Robert-Falcon Ouellette:** Are officers also required to be on service and on call at that time when they're in the hospitals?

**Chief Steve Barlow:** Our officers will be called to the hospitals on a regular basis. We spend a lot of time at our safe consumption site in Calgary, which is attached to a hospital. They have their own security there, but we have been called in on the odd occasion to assist with some of these people.

**Mr. Robert-Falcon Ouellette:** My final question, for both chiefs of police, is this: Because you're occupied doing this work, what are you not doing that you should be doing? What are the other tasks that you have been mandated to do that you're not able to do?

**Chief Steve Barlow:** I'll quickly answer. When I get into violent crimes, sex crimes and child abuse areas, the numbers are going through the roof. I don't have the officers to put into those areas or promote them into those areas when I'm leaving them on the street based on the crime rates we have that are skyrocketing in Calgary.

**Mr. Robert-Falcon Ouellette:** Chief Smyth.

**Chief Danny Smyth (Chief of Police, Winnipeg Police Service):** In Winnipeg we see it in two ways. Certainly our call for service queue is backlogged as officers get tied up with the health care facilities, monitoring people who are awaiting treatment, and that prevents us from getting into the community and doing proactive work in the community.

Because we're focused on a backlog of calls for service, our resources get tied up quickly.

**The Chair:** The time's up.

We'll go to our five-minute round. These questions are a little shorter as time's a little shorter.

We're going to start with Mr. Lobb.

**Mr. Ben Lobb (Huron—Bruce, CPC):** Thank you very much.

My first question is for Mr. Barlow. I'm just not quite sure about this, but when you make an arrest or seizure and there's a considerable amount of money, what do you do with the proceeds of crime?

Does it vary by jurisdiction? Where does that money go?

**Chief Steve Barlow:** I'm going to throw that over to my expert.

**Det Collin Harris:** The proceeds of crime go back to the province, and the province decides where that money goes to. It doesn't necessarily come back to the jurisdiction that seizes it. It gets divvied up in the province.

**Mr. Ben Lobb:** Does anybody keep a tally? Say, for example, in your city in 2018 you're going to have $35 million in cash. I know it's probably way too high, but does anybody keep track of that?

**Det Collin Harris:** I believe the province does keep track of what is divvied up amongst the municipalities and the areas. However, I do not have that information for you at this time, sir.

**Mr. Ben Lobb:** I mean that....

**Chief Steve Barlow:** I'll follow up really briefly with this because we're short on time. For the proceeds of crime, one of the most difficult issues we have is actually proving that it is a proceed of crime. It's something that's very small on our scale when it comes to crime fighting in Alberta right now.

**Mr. Ben Lobb:** Yes, that's because most people usually have a million dollars in the frame of their house—a million dollars cash in small bills.

In our last meeting, I brought up the fact that maybe the tax collected on the sale of cannabis should be going back into rehabilitation and so forth, so that even people who are against the idea of legalization could say, “Well, at least the tax dollars are going to help those who need the help”, and they could also see that there should be a direct link between the proceeds of crime and the attempt to help people who are addicted by what these dollars have come up with.

Maybe that's something we could mention, because in the province—I don't care what province you're from—there's a black hole there and it never seems to circulate its way back through. Whether it's for beds or for extra police officers, I could see that being a good effort.

This is probably more of a hypothetical question. If meth is $5 for a shot—if you want to call it that—is a lot of this just economics? A king can of beer is probably $2. A gram of marijuana is probably between $7 and $8, depending on where you're buying it. I think at the cannabis store in Ontario it's $7 or $8 for a gram. Is this just pure economics 101 for an addict, the fact that I can get the biggest bang for my buck with meth? Is that the idea?

● (1000)

**Det Collin Harris:** I believe it is. It's one of those things. We have seen a dramatic drop in the price of methamphetamine in the last three years.

It wasn't so long ago that meth was roughly the same price as a gram of heroin, being $250 probably about five years ago. It's one of the most dramatic drops that I have ever seen in a substance, and I've been a police officer for 30 years. The price for a gram of cocaine has remained practically the same throughout my entire career, but the price of meth has dramatically dropped.

It's that glut of product that's in the market, and it's also the fact that the highs associated with it are that much longer and that much more intense.

As you mentioned, yes, it is bang for the buck. They're getting a great deal of product for a very cheap amount. Those individuals who are disenfranchised and marginalized, as Dr. Juurlink mentioned, use that drug to stay awake. The only time that they're safe is when they're awake, and that leads to prolonged use.

**Mr. Ben Lobb:** For the drugs coming in from B.C., there's only so much you can do about that, obviously. For the meth coming in from Mexico, is it mission impossible to try to intercept every load of meth coming in to this country, or are there strategies that would help alleviate that?

**Chief Steve Barlow:** I think we can always strengthen our borders when it comes to the movement of drugs. It is always going to be a significant problem of ours, not just with meth, because it's something that either comes from the south or is going to come from the west when it comes to Alberta. We could use assistance that way, but it does end up leading back to what we've talked about earlier today, which is the people involved in this, the users. They're the ones who.... In my humble opinion, if we're going to spend significant dollars, that's where we need to spend them right now.

**The Chair:** Mr. Lobb, your time is up.

**Mr. Ben Lobb:** Thanks.

**The Chair:** We will go to Dr. Eyolfson next.

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

Mayor Bowman and also Chief Lane, we know that the first place you take people to deal with acute intoxication, when they're not manageable for regular rehabilitation facilities, is the emergency department, because there's nowhere else to go.

We've already had one emergency department close and turn into an urgent care. That was the Vic. They've announced that very shortly the Concordia will no longer be taking ambulances, in its conversion to an urgent care.

Are we expecting this will cause any problems, the fact that there are fewer places to take them and that acute management of these problems is going to be getting more crowded in fewer places?

**Mr. John Lane:** The acute management is accomplished quite well in the field through chemical sedation. A patient who is uncontrollably psychotic probably can be most effectively managed in the field through chemical sedation. That, of course, involves both law enforcement and paramedics.

In regard to those with subacute psychosis, the people who are worried or anxious about the effects of the drug they may have consumed, the recent introduction of olanzapine at the pre-hospital level may well help to alleviate their concerns, but that's a relatively smaller proportion of the people we see.

**Mr. Doug Eyolfson:** If I may, I'll cut you off there.

What I'm getting at is this. I'm assuming that even if someone is acutely sedated in the field, once they're managed there, they are taken to the emergency department. Are they not?

● (1005)

**Mr. John Lane:** That's correct.

**Mr. Doug Eyolfson:** Has there been any concern? First of all, have there been any changes in, let's say, wait times for paramedics unloading patients because of this, the closures they've had, or they're increasing, more of a load from that, because you have fewer places to take these people once they're managed in the field?

**Mr. John Lane:** No, that's what I was getting to. The fact that they're managed in the field, I think, allows them to be safely transported a farther distance.

The other aspect is that we've seen the opposite. Our patient transfer times from paramedics to hospital staff are decreasing.

**Mr. Doug Eyolfson:** Thank you very much.

Ms. Longstreet, thank you for coming and for sharing your story.

As I mentioned at the beginning, I practised emergency medicine for 20 years. I saw first-hand the effects of this tragedy of drug addiction. One of my greatest frustrations—and I'm sure you'll share this—is when people are brought in.... I don't mean when they're acutely intoxicated, but rather when there's a problem. They've been on a waiting list for months. They say he can't wait for months. If he goes out into the community, he's just going to keep using, a nd they don't know what to do. For my part, in the emergency department the frustration is that in our acute care hospital system, we have nothing. Maybe we'll make some calls, let someone in the system know there is someone and ask if we could get them bumped up. Sometimes they'll put their foot down and say they can't send them home. Then we have to say there's no place to put them, and nothing we can do for them here. It's frustrating on both ends.

Thank you again for your comment on the war on drugs. Many people have known the war on drugs was not a war on drugs; it was a war on drug addicts. It's been a war on our most vulnerable people. I think that as a society, we have to change that, so thank you for that message.

I believe that is my time.

**The Chair:** Thank you, and thank you for your message. I'm glad you said that to our guests.

Ms. Gladu, you have five minutes.

**Ms. Marilyn Gladu (Sarnia—Lambton, CPC):** Thank you, Chair, and thank you to the witnesses.

First, on the subject of decriminalization I took the point that decriminalizing the possession of drugs is not going to get around the problem of property theft that goes along with it and the violent activities happening with methamphetamines. I thought it would be worthwhile, though, to make a comment about Portugal and what they had in place before they went to decriminalization.

They had mandatory public education in the schools about the harms of drugs. They had truly universal health care in which mental health counselling and supports were paid for. It wasn't as though people couldn't get access to them. As to their treatment capacity, they had 170 treatment recovery facilities for 11 million people.

If we put that in the context of Canada, we would need 55,385 beds for our 36 million people, which works out—if it were evenly distributed, which we know it's not—to 164 beds per riding. That's the kind of gap we're talking about, in terms of treatment and recovery that we're missing.

One of my questions has to do with trying to get at the supply part of this. The drugs are coming in from Mexico and from B.C. Under a previous government there was a visa requirement for Mexicans, which was used basically to screen out the criminal element. Do you think it would be useful to put that back in place, or is it going to be ineffective?

I would direct that question to Chief Barlow and perhaps also the chief in Winnipeg.

**Chief Steve Barlow:** I don't see that reintroducing this would be the answer.

The reason I say so is that the criminal element changes as the environment changes, as with vehicles right now. I'll use them; they're an easy example. As our cars get newer and are safer and you can't steal them as easily, you can't stick a screwdriver into them. That's why the criminals are breaking into houses.

They change as the environment changes. I don't see bringing in a law about.... You mentioned people from Mexico. I don't see that as being the issue. I can't speak for Winnipeg or for eastern Canada. Realize that when we talk about meth coming from B.C., it's because of where we're situated. We have very few labs that we know of in Alberta.

It would be hard for me to say that the meth is coming from B.C. and making it straight across the country. I would say that their suppliers are also from that area.

But yes, coming from the south and from Mexico is common.

● (1010)

**Ms. Marilyn Gladu:** What about you, Chief Smyth?

**Chief Danny Smyth:** Our experience is similar to Calgary's. Most of our supply chain is coming from the west, from B.C. It's fair to say that in some of the investigations we've been involved in, it looks as though it's being smuggled up from Mexico into B.C. and then across the Prairies.

**Ms. Marilyn Gladu:** Do you have any recommendations about what ought to be happening in B.C. to cap the supply of meth?

**Chief Danny Smyth:** I'm not familiar with B.C. Certainly border security would come into play. These drugs would be smuggled in containers on transport trucks and ships.

This is certainly not my area of expertise, in the middle of the Prairies.

**Ms. Marilyn Gladu:** Chief Barlow, do you have any ideas?

**Chief Steve Barlow:** I'm similar in that way. If we are to tighten up our borders, these are.... The organized crime world is very sophisticated. I would have a serious concern with spending millions of dollars on our borders before spending millions of dollars on supporting the people who are addicted. I'm not saying I would ever say, “Cut my budget”, but I would say that supporting the users.... If we're able to work with them more, doing so is, in my humble opinion, what we need to be looking at spending our money on right now.

**Ms. Marilyn Gladu:** All right.

Dr. Juurlink, you have a comment.

**Dr. David Juurlink:** I'm nodding because I'm in complete agreement.

Like fentanyl, these drugs are not very difficult to synthesize. Even if you could somehow snap your fingers and make our borders impermeable, somebody would make it here. You would see more labs in Calgary than you currently have, because the market is there. It goes back to the whole issue of drug use just being an element of human behaviour.

I think the way to tackle this is not through trying to tackle the supply side. It's trying to tackle the demand side. If you can help the people who are currently using it, most of whom are wanting help, you're going to tackle the supply indirectly.

**Ms. Marilyn Gladu:** That's very good. Thank you.

**The Chair:** Your time is up.

Now, we go to Mr. Ayoub. I imagine that Mr. Ayoub might ask his questions in French, so if you need translation, it's right there for you, I hope.

Mr. Ayoub, you have five minutes.

[*Translation*]

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

I will continue along the same lines as Ms. Gladu, concerning the traffic in narcotics and methamphetamines. Basically, you are not giving us the impression that trafficking can be stopped. So the drugs will either be made in Canada or they will be imported.

You mentioned investing money in research and development in order to find a cure. What is your understanding of the research and development, Dr. Juurlink? Do you think that we should develop a substitute drug that could be given to patients to help them to get out of this vicious circle, as is done with opioids? Is that something you see in your practice and in your research?

[*English*]

**Dr. David Juurlink:** Thanks for your question.

The research could be funded that gets a magic bullet to help address methamphetamine addiction, but I think billions of dollars have already been spent in the U.S. to that end, in particular, to no avail. As I said earlier on, it's quite different from opioids, as your comment implied, so I don't think the answer to this crisis is going to be through finding some magical medication that helps people stop using. There are some drugs, like anti-depressants, Prozac and others that will help reduce cravings in some people, but there are not a lot of drugs.... I think it's unlikely we're going to find one that solves the problem that way.

[*Translation*]

**Mr. Ramez Ayoub:** You are telling us that there is no replacement solution for this drug. In your opinion, it will always be available and users will basically have no other choice than to be treated for addiction. No medical assistance is possible, other than treatment for addiction.

● (1015)

[*English*]

**Dr. David Juurlink:** I guess it depends on the context. Someone who is using meth to stay awake, like a long-haul trucker, for example, could use something that's safer in the form of Adderall, for example, the drug I mentioned to you earlier. That's not an ideal solution, but it's something that's inherently safer than the stuff that you're buying from a guy, because you don't know what's in it.

[*Translation*]

**Mr. Ramez Ayoub:** Thank you.

I have half my time left. I am going to go back to my colleagues in the Winnipeg and Calgary police services.

Let's not talk about the users, the consumers, of this drug. Let's talk about the dealers. In your opinion, are federal and provincial laws restrictive enough, specifically federal laws on trafficking? Are they strong enough to have an impact on the dealers themselves, and on organized crime?

Dr. Juurlink was talking about legalizing drugs. It has been done for marijuana, but, at the same time, to protect young people, the penalty for the dealers who sell the drug to young people has been increased to 14 years. For this drug, do you feel support from federal laws in terms of getting the criminals out of the market?

[*English*]

**Chief Steve Barlow:** This is very complicated when we get into the dealers' part of this and feeling supported. In my humble opinion, the laws of our land do support our being able to deal with the dealers, but the unknown factor here is that a lot of our serious dealers will use addicts to be their dealers. There's a really fine line between a true dealer, who is the money person and the person who is truly profiting.... They are the difficult ones to get to because of that middle person. You have the user at the bottom and then you have the middle person, who generally is a user, so we are balancing and having a difficult time trying to figure out, on the policing side, whether we are dealing with the true dealer. I think when we get to the true dealers, in what I see, we are being supported by the legislation.

I turn to Collin here because he's in our court system, on a regular basis all the time, so we would like to actually also hear from him.

**Det Collin Harris:** I agree with Chief Barlow in that we are supported to a certain extent. I believe it is often very difficult to obtain successful investigations into individuals who are importing at a wholesale level. A great deal of time and investigative ability and evidence is required in order to successfully prosecute those crimes.

The smaller crimes are a lot easier to do, and unfortunately, we aren't making our way to as many, as you would say, big fish as we would like. Those investigations cost millions upon millions of dollars to carry out and successful prosecution can be very difficult at times. When we do have successful prosecutions, we are getting supported to a certain extent. Some may say we are getting good sentences. Others may say they're not enough, but that's really not for us to decide.

**The Chair:** Time's up. Thanks very much.

You have three minutes, Mr. Davies, and the last question.

**Mr. Don Davies:** Dr. Juurlink, does the threat of punishment generally prevent people from using drugs?

**Dr. David Juurlink:** I don't think it does.

**Mr. Don Davies:** In your view, is there any substantial credible evidence to support the continuation of the criminalized approach to substance use?

**Dr. David Juurlink:** No, as I said in my comments, I think it's intensely counterproductive.

**Mr. Don Davies:** The current federal government has explicitly ruled out decriminalization and regulation of drugs. In your view, will it be possible to meaningfully address the current drug crisis if we're unwilling to consider decriminalization and regulation of supply?

● (1020)

**Dr. David Juurlink:** No. I think there's a lot of talk about harm reduction and I think you can't really have a serious conversation about harm reduction without at least broaching the concept of decriminalization and a regulated supply for the people who are using and are literally at risk of dying today from what they're using.

**Mr. Don Davies:** Yes, it's one of the puzzling things I hear in this debate. The government talks about being committed to harm reduction and they talk about supervised injection sites and opioid substitution projects, but isn't decriminalization and regulating the supply of drugs that people get in all quantities the ultimate harm reduction?

**Dr. David Juurlink:** Yes. I can see the argument being lobbed against that, but if you wanted to prevent people from dying from drug use, that would be the most effective way to do it, and guiding them, those who are ready, into treatment, provided treatment is there, whether they want treatment themselves or are referred by family, or from the emergency department or from the police.

**Mr. Don Davies:** I have a final question. You made a reference to alcohol being a drug, and now we have cannabis. We've legalized alcohol and cannabis. Is there any principled medical or sociological reason to treat other forms of drugs, whether it's methamphetamine or opioids, in a different legal structure from a policy point of view?

**Dr. David Juurlink:** Yes, different people will give you different answers to that. I have some fears about the carte blanche legalization of all drugs and it's because we as a society aren't very good at moderating.

For example, if someone wants to smoke a joint on his back deck once a month, there's not a lot of harm that's going to come from that, but if it becomes a daily phenomenon, then that person has a problem, and a lot of addiction, 40% or 50% of it, is genetic. We don't know what causes it, so if we introduce into society the legalization of all drugs I think we're going to have a problem on our hands.

**Mr. Don Davies:** Do you know how many people died from alcohol, directly and indirectly, last year?

**Dr. David Juurlink:** Five per cent to 6% of all the deaths in the world are alcohol-related.

**Mr. Don Davies:** Thank you.

**The Chair:** You had 12 seconds left. It's not like you.

On behalf of the committee, I want to thank you all. You're dealing with this on a first-hand basis in a very personal way, especially you, Ms. Longstreet, in your situation. We especially appreciate your testimony, but all of you are dealing with this on a day-to-day basis, either in law enforcement or health care or as a family involved, and I want to say thanks from all of us for your contribution here.

Not many Canadians are seeing what you're seeing and it's a great thing that you're able to come here and tell us about it. Hopefully we'll be able to prepare a report that will help you do your jobs and help your families. I just want to say, on behalf of the committee, thanks very much to all of you, and good luck with your work.

We're going to suspend the meeting.

Yes, Mr. Davies.

**Mr. Don Davies:** Thank you, Mr. Chair.

Mr. Chair, I'd like to move my motion again that was adjourned last meeting. I move that this committee call the Minister of Health to provide a briefing to the committee on the issue of forced sterilization of women, and also be present to answer questions from the committee.

I'd like to move that motion be lifted from the table and discussed.

**The Chair:** My understanding is that the motion, really, is whether we want to continue the debate, because it was adjourned the last time. The motion is still on the floor.

**Mr. Doug Eyolfson:** I have a point of order, Mr. Chair.

You said we were going to suspend for committee business, so are we suspended? Will people not on the committee leave the room and are we in camera?

**The Chair:** He had his hand up before I made the statement. He had the opportunity to speak.

Now you have the opportunity to speak.

**Mr. Doug Eyolfson:** All right. Thank you.

**The Chair:** There's no debate on this motion. This is just yes or no. We're going to vote on whether we're going to continue the debate or not.

Thanks very much, witnesses. I'm sorry for this little derailment here, but this happens from time to time in our business.

I'm going to call for a vote on Mr. Davies' motion to re-engage the debate. All in favour of the re-engagement of the debate?

**Some hon. members:** [*Inaudible—Editor*]

● (1025)

**The Chair:** The question is, are we going to restart the debate because it was adjourned before? It's not on the motion. It's just whether we're going to restart the debate.

All in favour of restarting the debate?

I'm going to have to say it's opposed, because nobody voted in favour.

**Mr. Don Davies:** Yes, we did.

**Mr. Ben Lobb:** We've now had two votes on this, and I'm not criticizing anybody on this. The first time it was a unanimous vote to continue on with Mr. Davies' motion. Now we've had a second vote, which is the opposite result.

I would say the first vote should count, and we should have our discussion with Mr. Davies in public and carry on with it. That's my opinion.

**The Chair:** I'm going to determine that there was confusion on the motion whether we were voting on Mr. Davies' motion or whether we were voting on reinstating the debate. There was confusion, so I'm going to call a whole brand new vote.

(Motion agreed to)

**The Chair:** We're going to start Mr. Davies' debate again.

Mr. Davies is first.

**Mr. Don Davies:** For my colleagues' benefit, the motion is this:

> That, pursuant to Standing Order 108(2), the Committee invite the Minister of Health to provide a briefing, at the earliest opportunity, on the forced sterilization of Indigenous women in Canada.

Frankly, I think it's broader than just indigenous women. It has primarily been indigenous women, but not exclusively.

When the minister appeared before committee, I had a chance to ask her one question on this. Her answer was this:

> I have to agree with all of your comments, Mr. Davies. It's an appalling situation. It's completely unacceptable to think that this is happening in this country. It's certainly a clear violation of human rights, and also, it's gender-based violence. Here we are, on December 6, of all days, talking about this—a very appropriate day to be talking about this. It's just simply not acceptable at all.
>
> Minister Philpott and I work in close collaboration. We are reaching out to provinces and territories in order to further this discussion, and not only provinces and territories, but medical associations that regulate these professions. We want to make sure we do all that we can to put an end to this.

She finished by saying:

> I've indicated I still can't believe that in 2018 we're having this conversation, and it's happening in this country. Let me be clear: This is absolutely unacceptable, and we will do all that we can to ensure that it no longer occurs.

Mr. Chair, I can only second the very powerful comments of the minister. This is a really appalling situation. I mean, we have women in this country who, as late as last year, have been sterilized against their will, without their knowledge, sometimes forcibly. We know that this constitutes torture under international law, and we know that the Supreme Court of Canada stated the obvious—that this is illegal—but we know it's going on. I think that we need to do all that we can, and as a health committee, it's our responsibility to delve into this as an emergency issue. I think it starts with the briefing.

I think the committee should probably conduct a study on this some time in the new year. However, at this point, I think that it's time for us, as a very collegial committee, to simply ask the minister to come back on this one issue to brief us on what's going on, how this happened, what steps are possible, whether charges are being contemplated, who is making these decisions to sterilize, and whether they are being held accountable. There are a lot of questions that I think we, as a health committee, should look into because these are medical procedures that are happening in health care facilities and primarily to a population—indigenous women—who are a core federal responsibility.

I think the least we can do is have a briefing on this. At this point, of course, we're going to be looking at the new year, so that gives us a lot of time to get the minister here. I would do that. I'll just give notice now that when we do go into committee business, if we don't get a briefing from the minister, I will be moving a motion that the chair send a letter to the chairs of the Standing Committee on Indigenous and Northern Affairs and the Standing Committee on the Status of Women, proposing a joint study on the forced sterilization of indigenous women and on government action to eliminate this practice, which I think everybody in this room would want to see happen. The reason for that is that this is an issue that crosses over three committees. It affects women, it affects indigenous women, and it affects health. All three committees have a slice of this issue. No one committee has it all. If it were just studied by the indigenous affairs committee, well, that doesn't take care of the women who are not indigenous. If it were just studied by the status of women committee, it would not have the health component, and if it were just studied by our committee, we wouldn't have the indigenous component. It's a thing where I think all three committees ought to have a role.

I'll conclude just by saying that this is a call that has been officially made by Action Canada for Sexual Health & Rights and Amnesty International, who have asked this Parliament, this committee, and members of Parliament to conduct that joint study.

Finally, under international law on the issue of coerced and forced sterilizations, they asked governments to investigate, to pursue charges and to seek redress for the victims.

● (1030)

I think we know now that not a single person has been charged in Canada—not that I'm aware of anyway.

I think it behooves us to investigate this thoroughly, and we can start by getting the briefing. I hope my colleagues will support my call for a briefing from the health minister. When we go into committee business, I will move my motion formally to have the joint committee study.

Thank you.

**The Chair:** Our next speaker is Dr. Eyolfson, but you said that we know this is happening against women's wills and that it was forced upon them. I don't know that. It may be true, but to have a briefing by the minister under those assumptions.... I think we need to hear more than that before we hear from her. That's for myself. You're saying that we know that, and maybe others do, but I personally don't know it.

**Mr. Don Davies:** May I just say, Mr. Chair, that I think the issue has been described as forced or compelled sterilization, so I think that's the whole premise of this. There are women coming forward. In fact, I believe there's a class action being filed by some 60 indigenous women who claim that they have gone into the hospital for various surgeries and come out having had tubal ligations and other procedures that they weren't prepared for and didn't authorize. I think that's the premise of the study.

**The Chair:** Dr. Eyolfson.

**Mr. Doug Eyolfson:** Thank you, Mr. Chair, and thank you, Don, for bringing that up. It is an important issue, and I think I can speak for all of us here when I say that we are horrified by this.

The minister has appeared in front of the committee. We know her feelings on it. We also know that this is being worked on by three different committees because it's also being worked on by Indigenous Services and by Status of Women.

What I'm asking for is a friendly amendment to this. As the minister has appeared, and since we know her feelings on this, we amend that instead we have the officials from Health Canada appear, to get their take on it. I think many of the questions we would have would be more of a technical nature, which the minister would refer to the officials anyway. I don't know the value of having the minister here when we've already asked her about this, but we could get some very useful information from Health Canada and other related government officials.

Would you be prepared to accept that friendly amendment?

**Mr. Don Davies:** Thank you, Dr. Eyolfson.

I do think that as the head of the ministry and the person responsible to the Canadian public, the Minister of Health ought to be here to answer questions, but in the spirit of co-operation, I'm happy to accept the amendment and accept a briefing from the department officials if that's the will of the majority.

**The Chair:** I was really quite surprised at the minister's reaction. She was so adamant about it. There was no hesitation on her opinion. I remember that she used the words, “appalling” and “unacceptable”. I was quite surprised that she came back so quickly on that. She's obviously concerned about this.

We now have an amended proposal to hear from officials on the forced sterilization of women.

Mr. Ayoub.

● (1035)

[*Translation*]

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

[*English*]

I just want to make a quick comment in English if I may. I'll try.

Don, usually I'm very much in favour of all the amendments you're asking for, but for the joint committee, I'm not in favour of that. It's very complicated. I think that we are our own committee, and if we want to do a study on that, we have all the power to do that on our own. It's going to be quicker to answer that. I'm in favour also of the amendment for the officials to come before us. That's it.

**Mr. Don Davies:** Mr. Chair, could I just respond to something that I might clarify?

I'm happy not to proceed on the motion for a joint study given the willingness to have a briefing from the department officials. Maybe we can see how that goes. I'm happy not to move that motion at this point if that's helpful.

**Mr. John Oliver (Oakville, Lib.):** I wanted also to add, in joining with everybody around the table, that we find this practice to be horrible. I think the minister has spoken quite strongly about it in the House.

I also want to advise the committee that both the Minister of Health and the Minister of Indigenous Services have written to all the provinces and territories and to the related medical associations asking them to cease and desist the practice. Those letters are being sent.

I think it also would be worthwhile to get those responses back from the provinces and territories, and from the associations. I think that would be an important part of a committee deliberation. Otherwise, if there's an agreement to cease and desist the practice, it really has become a bit of a moot point.

That's the only other thing I would add to the conversation.

**The Chair:** Mr. Ouellette.

**Mr. Robert-Falcon Ouellette:** I have a number of questions, Don.

I was just wondering if you know what the scope is of the status of women study they're doing right now.

**Mr. Don Davies:** My understanding is that they're just hearing from department officials, like we are. My other information is that the indigenous affairs committee voted down that attempt. I think the only other thing going on right now is the status of women committee is going to be hearing from officials of that department.

**The Chair:** Mr. Ouellette.

**Mr. Robert-Falcon Ouellette:** Are we meeting with the same officials and asking similar questions? If they're meeting with the officials from the health department and we're meeting with officials from the health department, I could conceivably see that we'd be meeting with similar people who are going to say similar things. The point, for me, is that....

I have no issue with Parliament actually looking into the subject, pushing the provinces and asking the RCMP. I actually also think there's a public security issue related to this. I'm just concerned that our time might be better used on something other than meeting with officials. If someone's already done it or is doing something very similar, why would we repeat the same type of work? Would we conceivably find anything different? Might there be different answers that come out of the bureaucracy?

**The Chair:** I just want to interject here. We were talking about it here at the head table. Status of women is hearing from indigenous services, not from health. This will be different.

**Mr. Robert-Falcon Ouellette:** Okay. That clears up something very important for me.

**The Chair:** Mr. Lobb.

**Mr. Ben Lobb:** In addition to everything that everybody else has mentioned, I'd also wonder, when something like this happens, who paid for it. Is it Health Canada that's paid for this? Is it the indigenous department that's paid for it? Is it the province? I see in Saskatchewan there were 60-plus sterilizations performed. Is it the province that pays for this? Not that the cost matters, I'm just trying to say there should be some responsibility attached to doing that. Did somebody knowingly sign off on something like this? I think this is atrocious, and I think it would be nice if the department could come and tell us, “Yes, we can confirm that Health Canada wasn't involved. We didn't know,” or if it's unfortunately the other way around, “Yes, we do know it was signed off, approved, etc.”

Not that this is going to cure any problem—

● (1040)

**The Chair:** I'm sure you'll ask that question when they come.

**Mr. Ben Lobb:** Okay, hopefully they can answer it.

**The Chair:** Dr. Eyolfson.

**Mr. Doug Eyolfson:** At this point, could I have the amended motion read back so that we're in agreement as to what it is?

**The Chair:** It's that, pursuant to Standing Order 108(2), the committee invite department of health officials to provide a briefing, at the earliest opportunity, on the forced sterilization of indigenous women in Canada.

Mr. Davies, you're next.

**Mr. Don Davies:** I want to raise a couple of things. I'm pleased to see the cease and desist letters. It would be nice if we could get copies. I don't know, Mr. Oliver, if you, as parliamentary secretary, can get copies for the committee of that.

I just want to say that I'm concerned that it's not enough to make the situation moot. We know there are allegations that forced sterilizations were occurring as recently as last year. It's illegal, says the Supreme Court of Canada. Telling a province to cease and desist is not sufficient. They were doing them when it was illegal to do it. I think we need to inquire into the scope of this, how often it is happening, how broadly it is happening and who is making these decisions. Is it provincial officials or is the federal department making these decisions and authorizing or signing off on them? Is there federal policy involved? What about accountability?

An order to cease and desist would remind provinces of the law and to quit breaking it, but I think there's much more that needs to be done.

**The Chair:** I'm going to let you say that.

**Ms. Karin Phillips (Committee Researcher):** One thing that I think would be worth distributing to the committee or at least having translated, then distributed is the Boyer and Bartlett report, which was the external investigation into what happened in Saskatoon. It's a very good report. It's very objective. It also explains some of the things that.... I would have it distributed doing this study. It's worth a read. It will answer at least some questions going into the study.

**The Chair:** Mr. Ouellette is next.

**Mr. Robert-Falcon Ouellette:** In the health branch under the rearrangements with Crown relations, Indigenous Services and Indigenous and Northern Affairs, I believe Health Canada had a component: FNIHB, the first nations and Inuit health branch, which was transferred into Indigenous Services.

How does that play? I suspect they would have a lot of the answers.

If we're calling officials from the health department do we also want to have at least an official from FNIHB there who can answer questions as well?

**The Chair:** Ms. Sidhu.

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

Status of Women have heard from the indigenous population. If we could share that report that would be beneficial for us too.

**The Chair:** Mr. Davies.

**Mr. Don Davies:** I was just wondering if the motion should be amended again to take out the word "indigenous" so it just says "women" so we are as broad as possible. We would study the forcing of women, because I think it's not necessarily just indigenous women.

Could we vote on it?

If we get that report we could read it over the break and pick this up in February.

If I don't get a chance, I would like to wish everyone a very merry Christmas and happy new year.

**The Clerk of the Committee (Ms. Marie-Hélène Sauvé):** I have a quick question. When we're talking about reports from the status of women committee, were you just talking about the Evidence from that specific meeting?

They just heard from these officials yesterday. If there is going to be a report, it's not going to be any time soon.

It's just the Evidence I could get.

● (1045)

**Mr. Don Davies:** Yes, just the Evidence

Then the report that the analyst, Karin, suggested.

**The Chair:** All right. Let's proceed to a vote on the motion as amended. It isn't restricted to just indigenous women and includes the officials.

(Motion as amended agreed to)

**The Chair:** We will set that up.

Does that complete that business?

We have some committee business to talk about. It involves what we are going to do, where and how we're going to travel.

We're suppose to go in camera. It's 10:45. Can we proceed?

Do I have unanimous consent to proceed for a few more minutes with committee business?

**Mr. Doug Eyolfson:** I have a point of order. Can we go in camera for committee business, please?

**The Chair:** We are going in camera.

We'll just take a second and go in camera. If everybody could pack up and leave, we'll do this as quickly as we can.

[*Proceedings continue in camera*]

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