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NIKI SHARMA, MLA, CHAIR

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Health

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LEGISLATIVE ASSEMBLY
of BRITISH COLUMBIA

MINUTES

Select Standing Committee on Health

Monday, May 16, 2022
8:00 a.m.
Birch Committee Room (Room 339)
Parliament Buildings, Victoria, B.C.

Present: Niki Sharma, MLA (Chair); Shirley Bond, MLA (Deputy Chair); Pam Alexis, MLA; Susie Chant, MLA; Dan Davies, MLA; Sonia Furstenau, MLA; Trevor Halford, MLA; Ronna-Rae Leonard, MLA; Doug Routley, MLA; Mike Starchuk, MLA

1. The Chair called the Committee to order at 8:01 a.m.
2. Opening remarks by Niki Sharma, MLA, Chair, Select Standing Committee on Health.
3. Pursuant to its terms of reference, the Committee continued its examination of the urgent and ongoing illicit drug toxicity and overdose crisis.
4. The following witnesses appeared before the Committee and answered questions:

   Office of the Chief Coroner
   - Lisa Lapointe, Chief Coroner
   - Michael Egilson, Chair, Death Review Panel
5. The Committee adjourned to the call of the Chair at 9:31 a.m.

Niki Sharma, MLA
Chair

Artour Sogomonian
Clerk to the Committee

MONDAY, MAY 16, 2022

The committee met at 8:01 a.m.

[N. Sharma in the chair.]

N. Sharma (Chair): Welcome.

We're all coming to you from the traditional territory of the Lək̓ʷəŋin̓əŋ-speaking people, the Songhees and Esquimalt First Nations. I wanted to start with that.

Good morning, all committee members, and to our guests here today.

Today we have the office of the chief coroner, Lisa Lapointe, and Michael Egilson, the chair of the death review panel.

I just want to welcome you on behalf of the committee here today.

We will have about 30 minutes for your presentation, and then we'll have the rest of the time for questions and answers.

I don't know if committee members want to quickly say who they are and introduce themselves.

I'm Niki Sharma, MLA for Vancouver-Hastings.

We'll start with Mike, over there. Go ahead.

M. Starchuk: Mike Starchuk, Surrey-Cloverdale.

D. Routley: Doug Routley, Nanaimo–North Cowichan.

R. Leonard: Ronna-Rae Leonard, Courtenay-Comox.

P. Alexis: Good morning. Pam Alexis, MLA for Abbotsford-Mission.

S. Bond (Deputy Chair): I'm Shirley Bond. I'm the MLA for Prince George–Valemount.

D. Davies: Good morning. Dan Davies, the MLA for Peace River North.

T. Halford: I'm Trevor Halford, Surrey–White Rock.

N. Sharma (Chair): Over to you.

Briefings on Drug Toxicity and Overdoses

OFFICE OF THE CHIEF CORONER

L. Lapointe: Thank you very much for the invitation to present this morning. This is a subject that, as you know, we have spent the last several years focused on, pretty much to the exclusion of almost anything else in our work, because of the tragic number of deaths that we've seen.

We've got a fairly detailed presentation. Lots of information. We thought we'd give you a context of this crisis as it progressed, from the perspective of the B.C. Coroners Service. Then Michael will talk about the death review panel and the recommendations that panel members have made.

You have the presentation. I'm just going to go through it, page by page, quite quickly, and I'll highlight the things that I really want to draw your attention to.

We know that illicit drug toxicity is the leading cause of unnatural death in B.C. That accounts for more deaths than homicides, suicides, motor vehicle incidents, drownings and fire deaths combined. A tragic number of people are dying — six or seven people now every day — as a result of drug toxicity. From 2014, when we first really started to see fentanyl become more prevalent, to date — well, to 2021 actually, more now — deaths due to illicit drug toxicity have increased more than 600 percent.

When we talk about illicit drugs, what we include in that category are all controlled and illegal drugs. So all drugs that are under the Controlled Drugs and Substances Act and drugs like heroin, cocaine, methamphetamine. We also include medications that are prescribed to an individual and then either sold or stolen by somebody else, and combinations.

These are only accidental or undetermined deaths. These do not include deaths where people take their own lives as a result of prescription drugs or another drug. Those are very, very rare. We don't include accidental deaths to an individual's own prescribed medications. That's important, and I'll talk a little bit more about that in a minute.

You can see the graph there on page 2. You can see that up till about 2013, the number of deaths…. Well, in 1998, there was a — some of you may recall — quite toxic batch of heroin that came into Vancouver. There was a significant number of deaths that year. That was the advent of the safe consumption site in the Downtown Eastside. Then the deaths sort of went back to about average. It's a terrible thing to say when you're talking about unexpected death. We saw about 200 deaths a year.

[8:05 a.m.]

Then the advent of fentanyl. We first detected illicit fentanyl in postmortem toxicology tests in 2013, where we saw three men who believed they had taken something else. The toxicologist, to his credit, noted fentanyl — very surprising. It wasn't something that had been prescribed to them. Since that time, we have seen fentanyl infiltrate the illicit drug market to an unimaginable extent, and I've got some other slides around that.

You can see the trajectory of this crisis has gone up and up and up. A slight decline in 2019. We attribute that to the widespread use of naloxone, which turned overdoses around but, of course, doesn't prevent the toxic drug event. People were still accessing illicit drugs. They were still suffering the effects of the illicit drugs. But we had naloxone to reverse those effects. If you were to look at a similar slide from the B.C. Ambulance Service, you would see that in 2019, their numbers did not go down. Their trajectory has

always continued up and up and up in terms of responses to drug poisonings. You can see where we are now. 2021 was an all-time high, and so far this year, we're much on the same path as last year.

On the next slide, page 3 there, you can see what I mentioned: the role of illicit fentanyl. Where we saw it in 4 percent of drug toxicity deaths in 2012, by 2021, it was detected in 86 percent of illicit drug deaths. This was initially, as per our informant in the law enforcement community, coming primarily out of labs in China, so actually still manufactured in a somewhat legitimate way — not licit here in Canada to sell but being manufactured somewhat carefully.

Now it's being manufactured quite freely in our province. Really, as we know about illicit drugs, there are no quality controls. There's no guarantee. If you ever see what you might hear of as a drug lab, you get the sense that "lab" connotes something that is somewhat scientific and clean and tidy and organized.

Drug labs are not. They're somebody's basement, somebody's kitchen. There are little mini-blenders, and there are all sorts of different cups and mixtures. There is no quality control, so it's not surprising to me that what we see now is basically a virtual grab-bag. Every time somebody buys something on the illicit market, anything could be involved.

So Dr. Perry Kendall, our provincial health officer, in 2016, declared a public health emergency. That was based on the numbers that he saw increasing in 2015. I think you've heard from Dr. Henry on this. The goal was to gather more information, as much information as possible, to have a timely response to the crisis.

In aid of that, we established a drug death investigation team. That was…. In retrospect, thank goodness, I'm very grateful that we did that. We have been able to gather quite detailed information about the people who are dying. We only see the deaths, of course. We don't have access to the records of living people, so we can't report on the people who have suffered adverse toxic drug events and survived, although we know what percentage of those who died have. But we can gather information about those who have died, and it has been fairly consistent — and Michael will talk about that — throughout the history of this crisis.

In 2017, we had our first death review panel into the toxic drug crisis. The Coroners Act allows me, as chief coroner, to direct a panel and invite people who have subject-matter expertise. As coroners, we don't have expertise in every type of death we investigate, but we invite people with subject-matter expertise to come. We review the evidence with them. We do a literature review and then ask them to help us with some recommendations to prevent similar deaths.

The one thing that became very, very clear to us and we didn't know — maybe you do know, but we sure didn't — is that the treatment and recovery…. There is no evidence basis for that in this province. That's quite shocking to people. Any of you could open a treatment and recovery centre. You may have some background in treatment for substance use; you may have not. You may have struggled with substance use yourself, or a family member may have, and you think you have expertise.

[8:10 a.m.]

Provided that you meet the building codes for the area you live in — you're building in the right area for the type of facility you're building — there is no regulation around treatment that you utilize. It can be yoga and herbal tea. It can be psychoanalysts. It can be group therapy.

Because there are no reporting requirements, we actually don't know what's effective. It's a huge gap in our knowledge, where there are many, many services across the province ostensibly providing treatment and recovery services. We actually don't know if any of them are effective. We, in fact, are a bit concerned that some of them are adding to the crisis, because if people are abstinent for a period of time, their tolerance is reduced, and you are more at risk of dying.

For several years, many of them were abstinence-based. They were testing people for drugs regularly. If you tested positive for any substance, you were out of the program. Some of them are still like that. There are faith-based programs. They're all different programs, and I have no doubt that they are meaning to do good work. They are thinking that they're doing the best work, but because there are no reporting requirements, we have no idea. We have no idea how many people have been to them. We don't know how many people finished the program, how many survived six months, 12 months, how many still don't use substances. So it was a big gap.

Sorry I've gone on about that a bit, but it's something that I find quite astounding, and when I talk to the ministry, there is currently no legislative framework for that type of reporting. There is no legislation that requires private treatment or recovery centres to adhere to any type of treatment model. I know Michael will talk about that as well.

The second recommendation was to expand access to evidence-based addiction care across the continuum, including access to opioid agonist therapies and injectable opioid agonist therapies. Those were, at that time, very limited. They are a little bit more available now across the province but still not widely available for people who are experiencing problematic substance use.

And then the need to improve safer drug use through the creation of accessible provincial drug-checking services…. Again, currently in some of the major centres, there are those drug-checking services. Victoria has one. Vancouver does too. But not all towns have those.

You can see on slide 5 — and I really do want to point this out to you — the graph that shows the types of deaths and the trajectory of those deaths over the past ten years. Prescription drugs is the very bottom line.

There's a bit of a narrative that came out of the United

States and Ontario that the crisis was the result of the irresponsible prescribing of physicians. We did not see that in B.C. We have been monitoring prescription deaths in B.C. for decades, and we always had around 150 people die each year from their own prescribed medications — accidental, where they just took too much or took it in combination with something else or took it in combination with something in alcohol, and a synergistic effect led to their death. But we have not seen large numbers of people dying as a result of prescribed opioids.

In fact, what we saw was quite frightening. When the opioid crisis, as it was called at the time, was starting to be talked about in the United States and in eastern Canada, the College of Physicians and Surgeons here was quite nervous and produced some guidelines around opioid prescribing that were quite restrictive. We know that people were, in fact, being driven to the illicit drug market because they could no longer get their prescribed opioids, which was a very frightening prospect, given the fact that the illicit market was becoming more and more unpredictable.

I'm going to go over, quickly, the key findings. These have not changed throughout the course of this crisis. Still men outnumber women, about 80 percent to 20 percent, although we are starting to see the percentage of women dying creeping up slowly. The age group of those who die — I'm on page 6 now, of slide 11 — has primarily been, for men, between the ages of 30 and 59.

We have seen some youth. Fortunately, youth are unrepresented in this data. I'm very, very thankful about that. Youth represent 1 to 1½ percent of all deaths as a result of illicit drugs. It may be the protective factor of youth. Well, they don't use as many of these substances, and they tend to be using together. So if somebody gets in trouble, they can help.

[8:15 a.m.]

As you will see from the next slide, most people are dying at home, and many people who die are using alone. Of course, if they suffer a toxic event related to their drug use, there's nobody there to call 911 and offer assistance.

I know you know this. Contrary to the former belief that people who died of substances or toxic drugs were sort of Downtown Eastside, back alley with a needle in their arm, that is, in fact, not what we've seen. We know now that, in fact, most people smoke their drugs. Needle injecting is not as popular, and most people are at home. If not in their own home, they're in a friend's home or in a relative's home. Only 15 percent of people die outside provincewide.

Of course, you know it's everywhere in our province. Every community has been touched by substance use — remote communities, urban communities, all socioeconomic levels, all occupations. Nobody is immune in the current drug market if they're using substances.

Slide 13 shows what we always see, which is that people are dying of mixed drug overdoses. It's very rare that we would find one substance in a person postmortem. Illicit fentanyl is involved in 85 percent of the deaths, but cocaine is involved in almost half, 46 percent; methamphetamines, 41 percent. We see alcohol…. You'll see this slide is 2019 to 2021 — benzodiazepines in almost 12 percent. That number is changing, and I'll talk about that a little bit later.

It's very difficult for us to know what people are seeking. So the drug-checking services do a very good job of asking people: "What did you think you purchased?" Then they tell them what's in the drug that they purchased.

I recently saw a presentation from somebody from the B.C. Centre for Disease Control. I can't give you percentages. Much of the time, people were seeking fentanyl. Fentanyl is now often a drug of choice, and that was what they were getting, combined with other things. But sometimes people were seeking cocaine or methamphetamine, and the substance…. They bought, purchased, fentanyl. If you are opioid-naïve, which means that you're not a regular opioid user, it doesn't take very much fentanyl to cause your death. We're now seeing more extreme levels of fentanyl as well.

So the rates of death are on No. 14 there. We included this just to show the impact across the province. Again, it's not a Downtown Eastside Vancouver issue, although Vancouver has led this crisis in terms of number of people dying every month. Vancouver, Surrey and Victoria…. Victoria has been third pretty much the entire time. Kamloops took that position a couple of months ago.

But we are experiencing deaths across the province. You can see that in 2012 the rate of death for illicit drug toxicity was 5.9 provincewide, now 47.2. What we are doing isn't helping, and more and more people are dying.

The next slide, 15. I believe Réka Gustafson talked to you about this when she was here. Really, what it shows is that in terms of number of deaths in British Columbia, illicit drug toxicity is fifth. In terms of potential years of life lost, illicit drug toxicity comes in second. And the average age of a person dying of toxic illicit drugs is 44, so that accounts for the number of years of life lost.

On slide No. 16, you can see that for those 19 to 39…. Drug toxicity is the leading cause of death for that age group in our province by a wide margin. It's third for those under 19. So even though those under 19, in terms of the general population, don't comprise a large percentage of those dying, in terms of their population, illicit drug toxicity is the third leading cause of death — so certainly very concerning — and the second cause of death for those 40 to 59. It's having a huge impact on our province.

I know Dr. Wieman was here and talked about the impact on First Nations, so I won't go into that, except that we do want to note, of course, that First Nations communities have been disproportionately impacted by this crisis. Particularly, First Nations women have been…. Many more First Nations women…. Almost 50 percent of First Nations people who die are women, which is very dif-

ferent from the general population of people dying from toxic drugs.

[8:20 a.m.]

Then the new challenges that we're seeing. Fentanyl, again, continues to be the really predominant reason for this crisis. Cocaine is up there, methamphetamine, but we are starting to see benzodiazepines creep up quite alarmingly.

Etizolam is a benzodiazepine analog, and I think you heard from Dr. Henry and Cheyenne Johnson and others about this. It does not respond to naloxone, so it's further complicating efforts to reverse overdoses. We would like to see one day where we don't get to the overdose stage, where somebody is suffering a toxic event. We have had naloxone to reverse those, and that's getting more and more difficult because benzodiazepines do not respond to naloxone.

I will let Michael talk now about the death review panel findings. I know he'll talk about the decriminalization, and there are a couple of things that I want to add about that when he comes to that. But Michael chaired our death review panel. We invite people with subject-matter expertise to come to the panel, and then Michael facilitates. He can talk you through that process.

M. Egilson: I, too, would really like to thank you for the opportunity to present today and your interest in this really important topic. I'm going to start off just giving you a brief overview of what a death review panel is and what the purpose of that work is.

Under section 49 of the Coroners Act, it gives the chief coroner the discretion to convene a death review panel to look at the facts and circumstances around deaths in order to provide advice with respect to public health and safety and the prevention of similar deaths. People appointed to the panel are appointed at the discretion of the chief coroner, and in this particular panel, it had a multisectoral group of experts in public health, health services, substance use and addictions, medicine, mental health, First Nations health, education, poverty reduction, oversight and regulation, policing and research.

The point is really to get a lot of different perspectives, of expertise, who engage in a particular topic. What the Coroners Service is able to do is bring our findings around deaths and have people help us understand what that might mean from a number of perspectives in providing advice and recommendations to the chief coroner.

The actual process happens…. The chief coroner appoints a chair, in this case myself. Myself and my team would conduct a literature review. We would pull together findings from deaths. In this particular case, this was over 6,000 deaths that were reviewed. We present those in person to a panel, and based on input from the panel, we would identify some advice and some recommendations in terms of, again, public health and safety and the prevention of death.

As panel chair, I would draft a report. There would be an iterative process back and forth with the panel until it was clearly established that the advice recommendations in the report reflect the entire panel, based on a consensus model. At that point, the report would be finalized, presented to the chief coroner, where recipients of the recommendations would be notified, and those would also be publicly released.

In this particular panel, the findings we noted…. We looked from the previous panel, which went to July 31, 2017. This panel reviewed 6,007 deaths which occurred between August of 2017 and July of 2021. Since the crisis was declared, over 9,000 people have died. Just to give some perspective of that, that's more people than would fit in Save-On-Foods Memorial arena in Victoria here. That's more people than the population of Revelstoke or Hope, or Cumberland here on the Island.

Some of the major findings that came out of that are clearly that drug toxicity deaths continue to increase. We're currently looking at two times as many deaths as when the emergency was declared in 2016. We note that the drug supply is becoming increasingly toxic. As Lisa had mentioned, smoking is becoming a more common method of consumption.

[8:25 a.m.]

That certainly has implications if you're looking at places like overdose prevention sites and safe supervision sites that would be accommodated. The fact that Indigenous people are disproportionately affected also has implications — I'll get into this in a little bit — about providing services that are culturally appropriate.

There are also issues, many of these communities are rural and remote, in how services are delivered. There is certainly a strong co-occurrence of substance use and mental health disorders. Most of the decedents had had contact with health care professionals recently, and I will get into that a little later, because that provides us some opportunities to intervene. Individuals living in poverty with housing instability were particularly vulnerable.

As Lisa mentioned, multiple substances were detected in the majority of the deaths. Very few of the decedents had engaged in substance use disorder treatment services. As in some of the information Lisa had shown, the deaths are occurring across the province in urban and rural and remote communities. That, again, has implications for service delivery models — and community challenges.

The panel discussions focused on three key areas regarding advice and recommendations. I'll go into those in more detail in a moment. Those focus on a safer drug supply, a coordinated, goal-driven provincial strategy and a comprehensive continuum of substance use care.

The next two slides I'm not going to spend a lot of time on, but they really illustrate that the people who died were disproportionately impacted by mental health and substance use disorders, compared to the general population. The coroner's findings showed, over the period of review

that we looked at, that 62 percent of the deceased were experiencing mental health disorders.

Reading through *Hansard*, I note that Cheyenne Johnson testified before the committee and noted: "There's an outdated narrative that substance use and mental health services need to be combined." I think, really, that she and I would agree that services need to be evidence-based and — as Lisa had referred to earlier — on the importance of getting a good evidence base about how to provide services, where to provide services, and what may be effective to ensure better outcomes.

Again, we note, on the next slide, that people who died as a result of drug toxicity were connected to health services. Some 72 percent of the deceased had accessed health services within three months of their death, and 87 percent within one year of their death. And 30 percent of the people who had died had had a previous non-fatal drug event that was attended by paramedics, prior to their death. The reason I'm specifically pointing this out is that contact with the health care system does provide an opportunity to assess, screen, refer, engage and support people.

The next slide is on decriminalization. I just want to be clear that, though important, decriminalization of personal possession of drugs is not going to end the crisis. Why it's important, though, is for a number of reasons. It moves drug use and drug use problems from the criminal realm to the public health and health care realm where it belongs.

That shift begins to remove stigma of drug use, which increases the likelihood that people will access services and supports. It also signals and moves that these problems are a health condition, not deviant behaviour. People don't, then, need to fear having their drugs confiscated, which can further endanger their health and safety by hiding their behaviour or needing to put their health and safety at further risk in order to obtain drugs.

You may have read about, and I think some people have discussed before you, the issue of what is an appropriate amount of drugs considered for personal use. I would say that that's a difficult question, and it's somewhat dependent upon availability.

[8:30 a.m.]

If you have a substance use disorder and you live in an area that's, say, remote or rural, which is where many Indigenous communities are, you may have less access. I liken that to if I live an hour away from a liquor store and I'm going for a beer, I'm likely going to load up. If I live next door to a liquor store, I'm probably going to buy a much smaller amount because I actually have access.

I think when we're considering this issue of what an appropriate amount is, there are a number of variables that actually need to be taken into consideration to ensure that there is fairness and equity for everyone.

Three recommendations. Moving on to recommendation 1, which came out of the panel report…. There was a recognition, I think by all, that the first priority needs to be to keep people alive and that the primary driver of this crisis is the toxic drug supply. That needs to be replaced by a safer supply.

There was a consensus during the panel that we're not going to prescribe our way out of this crisis, both because of the scale and the different needs that people have. Again, I understand that Dr. Gustafson, who presented testimony to the committee, had identified a number of safer supply models.

People use drugs for different reasons, and their life circumstances differ. One-size-fits-all certainly is not going to work. Also appreciating that not everyone has a substance use disorder, nor are they willing to engage in opiate agonist therapies or, necessarily, treatment.

In 2017, I had the opportunity, on another panel, to hear Dr. Scott MacDonald of the Crosstown Clinic in Vancouver. He's a renowned expert on opiate agonist therapies. He provided a statement that has really stuck with me for a long time. That is that if we don't offer people something that they perceive is better than what they currently have, why would we expect them to participate? I think what he was getting at is: if we make barriers or access or treatment too difficult for people, they're not likely to engage in that.

Recommendation 2 is around developing immediate action plans. It also speaks to urgency. Time is not a luxury we have in acting. Given the high death rate, plans of action are required that identify management and governance structures that identify clear goals, targets and deliverable time frames for reducing toxic drug events and deaths. Planning and reporting needs to be transparent and publicly accessible. The public health response to COVID-19 shows that this is possible and that it can be done quickly.

The third recommendation, around establishing an evidence-based continuum of care, is really consistent with the 2017 recommendation. There's a clear understanding that a safer drug supply on its own isn't going to end the crisis. An evidence-based continuum of services is required, from prevention, health promotion, early intervention, harm reduction, treatment and support. The treatment system needs to be regulated, evidence-based and accessible. It needs the same level of treatment expectation that one would expect for any chronic disease condition.

It's important to connect primary care, especially given the number of deceased accessing health care…. We need to support primary care in screening, assessing and referral of people with substance issues. However, there's a catch-22 in that we also need evidence-based services and supports to refer to. Perhaps most importantly, we need to involve people with lived and living experience in the planning, design and implementation of services to ensure that those services and supports meet their needs.

Finally, from the panel, from 2017 now…. We've certainly noticed that not a lot has changed since the 2017 panel in terms of who is dying, where they're dying and

under what circumstances. The drugs clearly have gotten more toxic and less predictable.

[8:35 a.m.]

Since 2017, the focus on emergency response and availability of naloxone was very important. However, the toxicity of illicit drugs has increased, and our response measures aren't keeping up. We continue to need an evidence-based, regulated treatment system. We are in an urgent provincial health emergency, and our response needs to be commensurate with the size of the problem.

We've seen what can happen when we match our response to the magnitude of the problem with COVID-19, and that level of response is necessary to address this devastating crisis.

L. Lapointe: Thanks, Michael.

I know there will be time for questions. I just wanted to seize on a couple of things that Michael mentioned. The fact that the majority of people who died had had contact with our health care system within three months of their death — I think that's really, really important.

There's this, maybe, perception that people who use drugs are not like us, and they're hidden in back alleys and back rooms and we really don't know who they are. And how could we help? But in fact, we do know who they are, because they are seeking medical help. They're in emergency rooms. They're in doctors' offices.

We hear from families over and over and over where their loved one is looking for support and looking for help — whether it's safe supply or opioid agonist treatment or some type of treatment and recovery. We know families are spending tens of thousands of dollars to send loved ones to places where we don't know whether the treatment is effective.

It's, frankly, been quite frustrating for Michael and I and people in our Coroners Service — and I'm sure many of you — where we know who the people are. We know what the need is, and we just can't seem to build a system as quickly as the number of deaths keep increasing.

It seemed like maybe that wasn't a possible task. Then we saw with COVID that it was very, very possible. We were able to stand up in our province — amazing, getting so many people double-vaxxed, boosted, across the province on very short notice. We know it is possible. We're not advocates, but certainly, we speak to so many families, and as you all know, there is so much heartbreak — people who have lost loved ones.

I went to the August 31 Overdose Awareness Day. It's an annual day. I went to the Moms Stop the Harm event last year. A mom came up to me. You could just see on her face the pain that she was experiencing. Her son had died last year.

I felt so responsible, because we know that in 2014-2015, maybe we didn't know a lot about what was going on. We felt like we couldn't really prevent those deaths. But by 2020-2021, we knew what was happening, and we knew what was happening everywhere in our province. We knew where the big gaps were. People are still losing their loved ones at an absolutely devastating rate.

It's hard to imagine any other crisis in this province that was taking the lives of six or seven people every day, with an average age of 44, that we wouldn't be collectively — as you are now, and we're so grateful for that — coming together to say: "We need to do something very, very quickly." As Michael pointed out, it needs to be on a scale commensurate with the size of the problem, because we are losing so many people.

Then one final comment with respect to decriminalization. It's a challenging topic. There are different points of view as to what would be an acceptable amount for personal use. We know that people who use substances feel that the amounts need to be much higher. We know that the law enforcement community is quite concerned and want to have the amounts much lower.

Having worked in this crisis over the last seven years, we are moving towards — I hope — decriminalization, recognizing that this is a health condition. Punishing people and stigmatizing people for what is, essentially.… They are using their drugs to deal with pain, mostly. Sometimes it's just young men, often, who are just doing it because they think it's a fun thing to do. It's a rite of passage. And they die. We see that a lot too.

Personal use is personal use. I don't, frankly.… I don't have an ideology around this except to keep people alive. I don't understand what the difference is if they're carrying one gram or two grams or three grams or four grams or five grams. If it's for their personal use, then…. Particularly if they've had those drugs checked.

[8:40 a.m.]

We know that police often will seize drugs, and that is very problematic because sometimes, as Michael pointed out, people who are living in poverty are more vulnerable or have tangential housing. Now where do they get the money to buy more drugs because their drugs are taken away? It adds to the social chaos that we all see in some of our communities and that people are so frustrated with.

Safe supply certainly would help with that. Decriminalization would help with that. And there is always…. Offensive trafficking has not gone away. Somebody can be arrested if there are the elements of trafficking, if they have two grams or four grams or eight grams. But if it's for their personal use, as Michael pointed out, having a limit that's too small is going to hurt people, particularly people in remote communities. Particularly, as many of our Indigenous community members live in more remote communities, if they're getting a supply for two or three people, they can easily be arrested.

We do hear from some of our bigger cities that they have de facto decriminalization. But that is very discretionary and, in fact, makes me nervous, because it's very dependent on the individual police officer, on the individual day,

and lots of room for unconscious bias in some of the arrest and criminalization rates that we've seen.

I just wanted to make that comment. Thank you, and we're happy to entertain any questions that you may have.

N. Sharma (Chair): Okay. I just want to start by thanking you on behalf of the committee for that presentation and for all the work that you've been doing on this very urgent matter for British Columbians. I'm going to try to coordinate the questions over here.

T. Halford: Thank you so much for your time and your presentation. Like MLA Sharma said, your work…. I can't imagine how tough that work is. On that note, I fit in that age demographic that you're talking about. I've gone to — I counted last night, before I knew I was going to see you — three or four funeral services.

Now, it's probably your job after a death has occurred to talk to the family and explain what happens. That's correct? How often is it, when you have those conversations, that they say: "I didn't know" or "I just thought it was kind of a one-time thing"? Based on some of the graphs, is that a fairly routine conversation you're having when we're talking about the numbers that we are today — "I didn't know" or "I just thought it was a once-in-a-blue-moon kind of thing, and then here we are"?

Then the other thing. The individuals that I knew and grew up with would probably never access safer supply. They wouldn't, for a number of reasons, and those are their reasons. But I would guess that they never attempted to or never would have considered it.

When I look at some things and I look at…. I've heard from other people that have used testing kits. I don't know exactly what it is. It's like a little strip that you can use, and it tests for fentanyl, things like that. Are those things…? I guess it's a two-part question. One is just the amount of conversations you're having with family, and if that's a problem…. Just no idea of what's being used. The second is: have we ever looked at using — I know people buy them off Amazon — those strips or the testing kits that actually test for fentanyl before they're using?

L. Lapointe: Thanks for your questions. The majority of people do know that their loved one has been experiencing problematic substance use or just using substances on a casual basis. Not all — there are families who don't know.

Oftentimes their loved one…. It tends to be that if your loved one is experiencing problematic substance use, it becomes a whole-family challenge. There's so much shame still attached to substance use that because of the stigma, people will go through a recovery or a treatment or stop using or say they've stopped using and then hide their drug use because they don't want their family to know that they're back using again. As you know, that's extremely problematic.

Many families aren't aware, but most families are, because it is generally something that families struggle with. They are aware. But there are a lot of hidden people. We find people who come home late, and they use downstairs or in the bathroom, and their wife or spouse or parents didn't know. The stigma is a huge problem around that.

[8:45 a.m.]

In terms of testing, you raised that question with me before, and I've been asking. Nobody seems to be aware of any legitimate home testing for illicit substances. There are some drug-checking services, and they're excellent — you send them your drugs; they will give a printout to the individual — plus they're compiling data around what they're seeing in the community.

It's certainly something that the B.C. Centre for Disease Control could look into. I don't know if that came up at the death review panel at all. I'll get Michael to comment on that. If that was a legitimate technology, it would certainly be helpful, because as you point out, not everybody is going to use substances at an overdose prevention site or a supervised consumption site because they don't want people to know that they're using drugs or those aren't in their suburban or rural neighbourhood.

So how do we access safe supply or drug testing for those people, who really still are keeping their drug use very hidden? That's part of the reason for the decrim, because the more that drug use is hidden, the less opportunity there is to help people either manage their supply safely or not use, if that's their desire.

Michael, I don't know if you talked about that — the home checking of drugs.

M. Egilson: I talked about, really, where good drug checking is available. It's really not that prevalent in communities. In larger areas…. It's not as widely available as it could be. I agree, Lisa, that there doesn't seem to be a lot of good information on the Amazon testing trips.

I did want to quickly pick up on a point you made, which I think is really important, when you said that the people you were referring to that had died aren't the kind of people who would access a safer supply. I think that's a really key discussion that was at the panel — about the need to go beyond just medicalized safer supply models — because there are all kinds of people who use drugs for all kinds of different reasons. They're not all going to go and get on an opiate agonist treatment therapy. Not everybody wishes to actually stop using drugs.

It's important to actually be able to look at some of these models where we can actually ensure that people can have a safer supply under different conditions. The needs of the population certainly aren't going to be uniform.

S. Chant: Thank you for your presentation. This hard, hard work and hard on the heart.

Are there other provinces that have a model in place that appears to be stemming the tide? Let's stick with

provinces, and then we can go global if you have some ideas there too.

L. Lapointe: No. I'll say no, and then again defer to Michael, the committee's chair. But no. In fact, B.C is leading, in terms of the Canadian response. Our province is taking on more novel responses than any other province. Arguably, it's because the extent of the crisis is bigger here in B.C.

There again, our data is more timely. Based on some criteria that we've developed, we release drug-toxicity data monthly, many based on preliminary findings. Those are always…. The numbers never go down. They only ever go up when we get postmortem toxicology results. Other provinces will wait until they coroner or medical examiner concludes their investigation, so they can be up to a year behind.

We're not always sure that data is equivalent, but if you look at the national data, B.C. still has the most challenging drug toxicity problem per capita.

And no, there is no other province. I don't know whether you talked about that.

M. Egilson: I don't have anything further to add to that, Lisa.

R. Leonard: Thank you for your presentation.

I actually have a number of questions. You'll stop me, Madam Chair.

[8:50 a.m.]

Early on you said that there was no evidence-based treatment. I just want to challenge that a little bit, because my understanding is that we have a public system and a private system and that our public system…. The funding that goes out is either direct-serviced through ministries that have their offices go through accreditation processes…. The hiring is related to expertise. Then, also, if it is being funded, there is accreditation or certification that's required.

I know that our recovery centres…. We've raised the standards. I'm just wanting to give the public a bit of reassurance that it's not all out there. I do know that there are a lot of private systems out there, and people go shopping. Often, people who do seek treatment go to many different kinds of treatment. They succeed, and then they fail. Then they try something else until they get it right, or don't.

I just wanted to challenge that a little bit and see what your read is on the system that we do have in place publicly that does have some checks and balances in it.

L. Lapointe: It's a difficult subject. After the first death review panel report, some health and safety regulations were brought in, in terms of…. People who now work in publicly funded treatment and recovery centres must have a minimum of 20 hours of training in occupational first aid — something somewhat related, not from any, necessarily, accredited university. There's no list of places that they need to take that, but demonstrate some understanding of health and safety matters.

When we say there's no regulation, what we mean is that…. I've had this conversation with the ministry, and I have no doubt that everybody has the best of intentions, and this is a huge subject. For decades, this was a law enforcement matter. Treatment and recovery for people who used drugs was not a priority.

In that void, private treatment and recovery centres stepped in, many of them not-for-profit. Many of them are for-profit — and all intent on doing good work. But what we don't have, still to this day, for the publicly funded or the privately funded, is any reporting in terms of how many people enter any of those facilities, what their ages are, how they do. Do they stay for the treatment?

We don't have a definition for success. Is success that they last through the course of treatment, whatever that may be at that particular centre? Do they survive six months without using substances? Do they survive 12 months without using substances? All of those are just big gaps in data that we just don't know, from public or private.

Again, I've had this conversation with the Ministry of Mental Health and Addictions, who I know are very, very focused on doing as much as they can as quickly as they can. When we say we're funding beds, and I say, "What is a bed?" there really is, at this point, not a definition for that. I said: "Is it a bed for a person for year? Is it a bed that two or three people might occupy in a year? What happens to those two or three people?"

That's no fault of any of the people involved, who are all meaning to do good work. It's just that there is no legislative framework for that reporting. So we actually just don't know. When we're providing this funding for beds, we don't know what's happening. We just don't know what the results are. They certainly are accredited people.

B.C. Centre on Substance Use did a strategic planning session, and I was in a session with a number of treatment and recovery providers. One of them was frustrated that somebody had been criticizing the abstinence-based, faith-based providers. She said: "Anything is better than nothing. Nobody should be criticizing anybody, because anything is better than nothing." I said to her: "With all due respect, we don't know that. We just don't know that anything is better than nothing." In fact, some of these programs may be doing harm, and we don't know. We don't know which are effective and which are doing harm.

It's certainly not a fault of anybody here. It's a system that was a law enforcement system. We're now trying to shift to a medical model, and there are lots of different pieces that need to be established to really understand how that works.

I don't know if that answers your question.

[8:55 a.m.]

S. Furstenau: Thanks so much for the presentation. Two things.

One is just on data. In terms of where people are dying — and I don't know if it's broken down to this level — is there any way of knowing, for example, how many people might be dying in some of these residential treatment centres? Is that captured? Also, in live-in sites, industrial camps — whether those numbers are captured.

Secondly, to the treatment and recovery centres, I really appreciate the way in which you're bringing to light the lack of regulation and oversight and outcomes and measurements of what's happening in these. From your point of view, what are the barriers that are preventing, since this recommendation was back from the 2017 panel's report…? This was a significant recommendation. What are the barriers that are preventing that regulation of the system, moving forward, and then, do you have a sense of how much provincial money is currently going into these centres?

Interjections.

S. Furstenau: I'm just trying to fit them all in at once, Chair.

L. Lapointe: Maybe I will take the question about the barriers for funding, and then, Michael, you can talk about the places where people are dying, whether we have data on that.

So I have spoken with the ministry about this at length. When we say there's no legislative framework, there is not a piece a legislation that brings in all of the treatment and recovery centres — publicly funded, not-for-profit and private — under a piece of legislation that says that anybody who is receiving treatment….

Let me take a step back. I've used this example before, and I don't mean it to be disrespectful. If I take my cat to the vet, I know my vet is trained, I know that the treatment is regulated by a college, and if I have a complaint or a concern, I know where to take it.

Depending on where I take my vulnerable 19-year-old for substance use…. In fact, anywhere in the province, there is no evidence-based treatment where we have…. It's because we have not been doing this for years and years in any meaningful way, where we can say that we know that over the past three years or five years of ten years, this type of treatment has been most effective because 5,000 people have gone through this treatment, and of those 5,000, 70 percent are still alive and 60 percent are no longer using. We just don't have that data.

Again, it's because we were focused on the law enforcement. We were focused on funding the police and the courts and the jails, and we weren't focused on funding treatment and recovery as a really meaningful area — any of us. It just wasn't all on our radar, and this crisis has really elevated it in terms of public health and safety.

That's what I'm talking about. There just isn't currently a piece of legislation that brings all of that in and says that anybody who's offering these services must have these accreditations. It would be fantastic if it was linked to our PHNs because then we would have that data, and then agencies like mine or the B.C. Centre on Substance Use or the B.C. Centre for Disease Control would be able to link the data linkages to the PHN numbers, and we would be able to draw that data. Right now we just can't. So that is the gap.

Michael, I'll let you talk about places of death and work camps.

M. Egilson: To get as specific as things like work camps and that, I would have to go back, and we would have to look specifically at our data. There have been instances where people have died at treatment centres, but certainly, that's not primarily where people are dying.

L. Lapointe: And in treatment centres. Yeah. We did, actually, hold an inquest into a death in a treatment centre.

What was the fellow's name?

M. Egilson: Brandon Jansen.

L. Lapointe: Brandon Jansen. That was a public inquest because we had seen a number of deaths in treatment facilities. One of the challenges that came up was that many of them were abstinence-based, so they weren't allowing some of the treatments that we know are effective. That's changing, and certainly, any publicly funded treatment now must permit people using OATs.

I do know, with the last grants for treatment and recovery, there is a requirement for evaluation. That went out with the last series of grants from the ministry.

[9:00 a.m.]

D. Routley: It seems very work-related in so many ways, with the age of men who are dying, the sectors that they're coming from.

In a personal experience, our family has lost two people, and our kids have lost two friends. Three out of four of those were men who were injured at work and prescribed. At least two of those were people who used drugs recreationally but were healthy and didn't experience any obvious harm in their lives because of their lifestyle. But it was the work-related injuries that caused them to turn to opiates. Then the fourth one was a young woman who was recreationally using, but it was almost certainly related to trauma that she was using in the first place.

Since it's so closely related to work and in these workplaces, you have drug-testing programs often, and workers need to hide their use, especially if they're using cannabis or whatever they might use. They don't want to be detected. Workplace safety, then, is implicated. Is the workplace

safe? And is the demand on the worker to return to work before they're healthy…? That sort of thing.

Have you any recommendations, or are you working with employers to shift the way they deal with the issue of drug use on the job, measuring impairment versus the presence of residual drugs in somebody's system? Is there any work being done to bridge that?

L. Lapointe: Yeah. We certainly know that a significant number of those who were employed were employed in trades and the transportation industry. We know that many people turn to substances to manage pain, all sorts of pain, as you pointed out. Sometimes it's trauma-related. Sometimes it's physical pain, emotional pain. That's why it can't be a judgment that people who use drugs are not good people. They're good people. We know them. You know them. I know them. My children have also experienced the loss of friends who have died using substances.

One of the challenges is, of course, the college did come down very hard on prescribers, back in 2012, 2013, really tightening up opioid prescribing. Even with the new safer supply initiative…. This was something that came up.

Certainly, I have talked to people — not from the death review panel, which is confidential — that we invited and outside of the panel. They're very concerned about the fact that the College of Physicians and Surgeons sent a letter to those who are prescribing safe supply, saying: "You're doing something that's not…. We don't have the evidence for this yet. Be careful."

They took that as a…. There was a lot of fear when that letter came out. We've talked to the college about that, and they did put something in their newsletter that was much more conciliatory, sort of recognizing that this is a new field and: "Just make sure that you're following the guidelines."

In terms of employers, we have not…. We're in a bit of a funny position as the B.C. Coroners Service in that we do the investigations and collect the data and report it. We can make recommendations. We haven't made specific recommendations to employers. I know there are a number of employers that are really working hard to get drug services in for people.

I think it was the Steelworkers union, their last contract. They had a provision in the contract that if you tested positive for a drug like you mentioned, they were out. Of course, all that does is further stigmatize and doesn't help anybody. Now they're jobless and also using substances. So that was a contract negotiation piece where they were very clear that people who tested positive for drugs get support, and it would not be an offence or a punishment associated with that.

The Ministry of Labour was represented on the death review panel as was WorkSafeBC. They didn't specifically…. I don't know. Again, it's challenging. We can't speak specifically about the day and the conversations because those are in confidence.

But I don't know, Michael, if you could talk about the themes of any of that.

[9:05 a.m.]

M. Egilson: Certainly, you're right that that is…. About 35 percent of the people who died were employed, and the biggest areas of employment were trades, machine operators — those kinds of things.

My understanding is that…. Sorry, I'm not going to get the name right. One of the construction associations…. Certainly it's on their radar, and it's something that they've been working on with others. Specifically what that looks like, I don't know. You're right that there are challenges in terms of ensuring the health and safety of the workers themselves, but there are also WorkSafe concerns. I know that it's something that has become, I think, a bigger concern to WorkSafe, which is also looking at some of those issues.

P. Alexis: Thank you so much for all of the work that you do. It's extremely difficult work — no easy solutions. I just want to go back, if I could, to treatment options. In my limited experience, I have seen people recover through various means. I've always said that you need all of it, because not everyone responds in the same way. When we talk about legislation of treatment options, it's going to scare a few folks because it means that that option may be eliminated. I want you to just talk about that part, if you could.

Also, if you could talk about the training aspect of the counsellors that are involved…. I'm sorry. There are kind of two questions, but they may go into the other when we talk about legislation. Many of the counsellors that I know have lived through the experience and can provide, perhaps, the best guidance for those seeking treatment. Can you talk to me a little bit about that?

M. Egilson: I think if we look at the issue of regulation, if we look at people with, say…. I'll take another chronic disease: asthma. If you were to go in, the provider would be required to have certain credentials. The treatment would be an evidence-based treatment. Also, what we would find is that we would need to tailor that treatment to an individual. Particular drugs, particular diets and particular regimes would vary. That's part of what the expertise would bring.

What we would also be doing all along there is evaluating that. The asthma treatments that we were providing in the 1950s probably aren't the same things as we're doing now, as we get better drugs, as we understand more about respirology and a number of things. So the equivalent of looking at regulating substance use treatment…. You're right. There are people, through all walks of life, providing different levels of intervention. Some of that may be helpful; some of it may not be. But we really don't know.

When we're talking about regulation…. Dr. Gustafson

used this term when she was here — about evidence-gathering. For some, we do have some evidence; for some, we don't. So we gather evidence, we evaluate, and we find out if certain things actually do work or if they don't, who they work for and how they work, so that we can start providing individualized services to people that are likely to improve their situation. Until we actually start getting that knowledge base, what we fall back on are anecdotal pieces where somebody said, "I found that really helpful," or: "That didn't…."

I can speak, from my own work, that lots of times I'm dealing with all kinds of data, and Lisa or somebody else may come to me and say: "What do we know about this?" I'll say: "Hmm, well, I've seen a bunch of this." Then I actually go back and look at the data. Sometimes my anecdotal understanding of what I think happened and what I actually look at doesn't line up.

[9:10 a.m.]

That's really the importance of continuing to build that evidence base and, where it doesn't exist, gather more information. Unless we have some standards and some regulation about how that all works, we can just be on this spinning wheel and not know whether or not anything's getting any better.

M. Starchuk: Thank you for your presentation. I spent a number of years working in my city, so-called trying to clean up the unregulated recovery houses that were going on in the city of Surrey — there would have been 150 to 200 of them that were unregulated — to a certain point.

Things have changed. Zoning bylaws have come into place, public hearings, numbers have been capped — all of those things that are there, working directly within the assisted living registry that's there. As you pointed out, it's a system that's not well handled to provide the data that's there. But funding has been increased to them so that they can do that. I know that they provide a list of prescribed services. That's there, but like you say: where's the code on the wall? There's no cookie-cutter to be able to find the treatment that's there.

In so many cases, housing is a big aspect for those people. They're not having to worry about where they're spending their evening. They've got a roof over top of their heads. In most cases, if they pass the test with ALR, there's food on the table as well. Then there are some services; we just don't know what those services are and whether or not they're providing that level of help, whether it's OAT or abstinence that they're working with.

My question's more around: when was it first discovered that the data's not being collected? What would the data look like that you'd be asking for? For me personally, being inside of so many of those places, it doesn't seem that hard for somebody to give the checkboxes — say, like, your personal health number, as you pointed out. Is it a matter of a funding model that goes into these places to assist them with providing the data so that you can look at it? What is the barrier to getting that data out of there?

I find it very interesting that they're in that business to take a look at people — the good places, not the ones, as you pointed out, that were there for the criminal system so that a judge goes: "I will release you if you have a place to go to." My horror story is that there was a building in Surrey that no longer existed, and the justice was actually releasing them to that address, and it never existed. We've gotten a lot better. I mean, make no mistake about it: we've gotten way better than what we were in 2012. So ten years later, it's better.

What needs to be collected? How does it need to be collected? What's the answer to allowing those operators to collect that data?

L. Lapointe: Maybe I'll start, and then I'll let you jump in, Michael.

Firstly, I do want to say that we are speaking a great deal right now about treatment and recovery. But I do want to note, as Michael pointed out, that not everybody is looking for treatment and recovery. Many people are using drugs that are not ready for treatment. They may never be, or they may be in a period of time. So safe supply is still the number one recommendation of the panel in terms of what will save the most lives in a very short time frame.

But for those people who are looking for treatment and recovery, what we would like to see — what would certainly help — would be, first of all, legislation that encompassed every facility, agency in this province that purports to provide treatment and recovery services. So nobody could operate in this province…. You couldn't allege to be providing veterinary services unless you are a registered veterinarian. And nobody in this province would be able to purport to provide those services without being registered with the province.

Then, the data we would like to see…. It was for all of them. You know, I certainly take your point, MLA Alexis. Different things are going to work for different people. What has been effective? For every single one of those treatment providers, how many people did they treat? What was the treatment? How many people were in treatment for…? What were the time frames — one month, three months, six months, a year; and then follow those people, which the B.C. Centre for Disease Control could do, post-treatment. Which ones were more successful in terms of what people were seeking in terms of their treatment and/or recovery?

[9:15 a.m.]

That's the kind of data that we would be looking for, because we just simply don't know right now how many people in this province have accessed treatment. We know that people then go out of province, then they go out of country. We can't get that data, because we wouldn't have that legislative framework. But at least in this province,

when people are seeking treatment and/or recovery services — where, by whom, and what are the results?

As Michael pointed out, evaluating — and having some means of knowing over time — what is most effective. Maybe it's different things for different age groups, or depending on how long you've been using substances. That would be such valuable information, but we don't know that.

S. Bond (Deputy Chair): I will just note that, for the Chair to consider, I think all of us have multiple questions. We're going to have to figure out how we come back or something at some point, because this work is pivotal to ensuring that we understand where we need to go from here.

I will stick to my one. I have a list, as others do. I just want to read one sentence out of the report, which captured my attention when I read it when it was first released. It says: "…time was not a luxury to be afforded. In short, desperate times required doing things differently and quickly in order to protect the health and well-being of British Columbians….This same approach is required to address the illicit drug toxicity crisis."

The comparison, and the reference throughout all of the work that you have done, has been to talk about the COVID response compared to the response that's provided here. I don't want us to lose sight of that.

I would very much be interested…. In the recommendations, it talks about things like more regular briefings. I mean, we basically sit and wait every month to find out how many people have died this month.

I think that it is incumbent upon us to think about…. You point out in the report that rules were changed, things were done, in order to get moving here. I think that we need to think about and hear from you, at some point in the next while, about: what does that look like? One thing I know for sure. We need to bring British Columbians along with us.

One of the things about the way COVID was managed was…. It was hard to avoid it. There was always information about what you need to be doing. Even now, we're still seeing tweets about vaccination clinics. That continues today.

I think we need to better understand: what does a more urgent, public-facing response look like? I guess the question that I have is this. I don't think for one minute that recommendations are made lightly. There was a recommendation made by you that talks about a 30/60/90-day plan, and it had a timeline assigned to it.

Now, I'm assuming that part of that was to prompt…. I'm not sure. In your mind, was that doable? Is it doable? I mean, I can't imagine that a panel of this stature creates a recommendation of that nature without believing that it is possible to be done.

Could you speak to that for me?

M. Egilson: Sure. That recommendation clearly is speaking to urgency. I know that was based on seeing how quickly action plans were able to come together for COVID.

The expectation isn't that you're going to have a problem solved in 30 days, but that you have an actual action plan that says: "Here's how we're going to approach this. Here are our goals. Here are our targets. Here are our time frames." So that we can actually evaluate…. If we look at….

To me, the COVID response really was a wonderful example of things needing to be done and being able to be done and being able to think outside the box and do things differently, if that was required.

What we saw was it pivoted all the time. So we had a plan. The delta variant came along. We pivoted that plan. Rates went up. We started restricting the public getting together. We loosened that off. Omicron came along. We had to pivot again.

[9:20 a.m.]

In thinking about 30/60/90-day plans, it's not about thinking that a problem that's gone on for a long time is all of a sudden going to go away. But what it is doing is it's then giving us targets, it's giving us actions, and it's allowing us to pivot.

What we are going to learn is that some of the stuff isn't going to work, and that's important, so we stop doing that. We learn some stuff is working well, so we do more of that. We get input from the people who are most impacted so that we have a sense of what we're doing. Is that actually going to meet the needs of those people?

I would come back…. I guess I really want to emphasize that the purpose…. Is it doable? Yes, absolutely, it's doable. It doesn't mean that everything is going to go away. What it means is that there's an urgency in planning and an urgency in actually setting goals and targets and measurables so that we actually have a sense of…. We're here now. Where are we in 90 days, where are we in six months, where are we in 60 days, and where do we need to go?

I hope that answers your question.

S. Bond (Deputy Chair): It does. Thank you.

N. Sharma (Chair): I have a question. I want to dig a little bit into your expertise about the examination you've had of the deaths. Particularly, there's a chart that you have that talks about the top drugs involved in illicit toxicity, and fentanyl seems to be the highest still.

I'm really curious — we were talking a lot about evidence and outcomes — about the experiments that we've done or the move that we've done into safer supply and the prescribed safe supply. The nurses have stepped in there. Is that working to save lives, and how does it? If fentanyl is still the leading cause and now we have a more toxic supply, how do you intervene and get somebody on a safer supply? What does that look like, and what's working in that area?

L. Lapointe: Those are great questions. I'll start and, Michael, please add.

We are seeing more extreme levels of fentanyl as well and, as I mentioned, we're now seeing etizolam, which is complicating responses to a toxic drug event.

We are monitoring to see whether safe supply is playing a role in the deaths. We know what's being prescribed, and we have access to PharmaNet, so we can see for any individual person what they've been prescribed. Then the B.C. Centre for Disease Control is also looking at it on a population level. They also have access to the PharmaNet database, so they can make linkages.

Neither the B.C. Coroners Service nor the B.C. Centre for Disease Control has seen any linkage between prescribed safe supply and increasing deaths. Those two are not linked, and we are monitoring that very, very carefully, because we know there's a lot of fear around that.

In terms of linking people to safe supply, we know people are looking for access to safe supply. There are lists of people who either go to their medical practitioner.... I have talked to the college, and they are very reluctant to engage this as a physician's area of responsibility — fair enough. But at the very least, people are used to going to a physician or a nurse practitioner first and saying: "Here's my problem. What do I do?"

That was one of the recommendations — to have that continuum of care so that when people go to their medical care provider and say, "I'm using drugs, and I'm afraid," or "My son or my husband or my wife is using drugs, and I'm afraid," then they know where to refer to.

We know what a standard assessment would look like — that currently doesn't exist either in our emergency rooms or with our health care providers — and then a list of options. Whether it's safe supply, whether it's opioid treatment, or whether it's residential treatment, it's knowing where they would go. We know from the data that a vast majority of those who died had contact with a health care provider, so they are in connection with health care.

So it's that key of raising the profile of substance use, making sure that there's an assessment that is evidence-based and that all practitioners in the province know it, and then having a list of options — depending on where a person is, what it looks like to keep them alive — with the number one goal being: how do we keep people alive?

I do just want to say that we are not being critical of what has been done in the past. As I pointed out, we have decades of the war on drugs, which ended up being very much a war on people who use drugs. There is a massive shift taking place, and it takes time to get all those new pieces into place.

[9:25 a.m.]

You can sense the panel's frustration. Or not frustration, but the panel's eagerness — Dr. Gustafson and Cheyenne Johnson and, certainly, people in my agency — to move as quickly as possible because we are just seeing so many deaths. And every day that we're delayed, we see more deaths. It's not the business of the coroner's service to find fault with anything that anybody is doing, but what we always look for are opportunities to prevent deaths and improve on public safety.

I hope that answers your question.

N. Sharma (Chair): Yeah, thank you. I'm just going to go to the second round here. We'll try to get through as many as we can.

S. Chant: Just really quick. The benzodiazepines — is there an agonist for that that could be made?

L. Lapointe: No. Not currently.

S. Chant: Okay. Thank you.

R. Leonard: Which one to choose here. Some of it has been discussed a little bit.

One of the things that.... I believe Dr. Henry said that during COVID, even the numbers in Portugal were going up in terms of overdose deaths, in spite of the safe supply there and the work on destigmatization, etc. Is it simply the drug supply that was available? Was it the lack of availability in terms of service provision because things were shutting down? I have a lot of questions around the impact of COVID on this, as opposed to the services that are being provided.

But at the same time, it's that.... We keep moving forward, and there's the question around the.... I know there is a real eagerness for the expansion of that multiplicity of drugs that are being consumed. The impossible job for physicians to take on prescribing for pain versus prescribing something kind of off book.... There's a real reluctance there. How do we get over that in the meantime, when we don't have that legislative capacity? Those are the two things in terms of COVID and the physicians' response.

L. Lapointe: I'm just going to mention a couple. There's a program here in Victoria, for example, that Michael and I visited recently — the SAFER initiative here in Victoria that is on Cook Street. It's managed by two registered nurses — Heather Hobbs and Corey Ranger, whom I would recommend you speak to as people who really have a very on-the-ground view of all of this.

They have a physician attached to their clinic who prescribes safe supply for about 140 people, I believe, that they have. Those people can come in to the clinic every day, get their safe supply, use it. It is still a bit of a barrier in that people have to come there and use it, but it's in their neighbourhood, and it's very convenient. That is very, very successful.

There's one physician attached — but has assessed and prescribed for 140 people. Now they see the registered nurses every day, and the physician comes in regularly, not every day, to assess if there are medical issues. So it's

a great opportunity to achieve a number of things. That's one model that has been very effective. That's a prescribed model.

Then there are models — I know that Cheyenne Johnson talked about this — where it would be a public health model, where once people met a certain criteria, they would be able to access safe supply. It doesn't necessarily…. I appreciate you're saying that there's…. We are in the midst of a crisis, and as Michael pointed out, it's about trying a number of things and seeing what works. It doesn't necessarily mean that everybody is provided safe supply.

There's a physician in Vancouver right now who is for, I think, $10…. She's providing safe supply, prescribed, and people are paying…. The same amount that they would pay for their illicit supply — she is providing them a safe supply, as a physician, for the same amount. But they know that it's safe. They know that what they're asking for is what they're getting, and then it's not infiltrated with something else, like etizolam, for example. That's another very successful model.

There are a number of models that can be looked at. I know Cheyenne talked about this, and certainly that's what the panel was recommending. Not everybody who uses drugs is the same — different walks of life, different reasons, different goals — but it's about meeting people where they are and doing whatever we can to eliminate unsafe supply.

[9:30 a.m.]

You've probably heard me say this publicly. All the current model does is provide huge profits to unscrupulous organized crime. They are making millions of dollars off of our loved ones, with no guarantee of safety. We know that. We see that by the number of people dying every day. We have to do something differently. We just have to do something differently.

We hear from the families in the heartbreak that we see across the province every day. Every day people are dying in every part of our province. It's a big ship to turn around, but we need all hands on deck, to use a bit of a nautical phrase, and just move as quickly as we can.

N. Sharma (Chair): Okay. That's our time. Clearly, we all have more questions for you, so we'll have to figure out how to process that at some point.

I just want to thank you so much for coming here and sharing with us your expertise and the journey that you've been on to try to figure out a way to get out of this crisis. And I know that you also hear a lot of really heartbreaking stories, and you carry that with you. I just want to thank you for all your work.

L. Lapointe: Thank you very much, MLA Sharma. We would be pleased to come back at your convenience. It's such important work for us.

Thank you, everybody.

N. Sharma (Chair): We just need a motion to adjourn. Okay. MLA Davies.

Motion approved.

The committee adjourned at 9:31 a.m.

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612 Government Street
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Telephone: 250-387-3681
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