Proceedings of the Standing Senate Committee on Legal and Constitutional Affairs

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The Standing Senate Committee on Legal and Constitutional Affairs met this day at 10:50 a.m. to give consideration to Bill C-15, An Act to amend the Controlled Drugs and Substances Act and to make related and consequential amendments to other Acts.

Senator Pierre Claude Nolin (*Vice-Chair*) in the chair.

[*Translation*]

The Vice-Chair: Dear colleagues, welcome to this meeting of the Standing Senate Committee on Legal and Constitutional Affairs. Today, the Committee is continuing its study of Bill C-15, An Act to amend the Controlled Drugs and Substances Act and to make related and consequential amendments to other Acts.

[*English*]

Thank you to the two witnesses who have agreed to be with us this morning. We have Dr. Gabor Maté as an individual, and from the Centre for Addiction and Mental Health, the Deputy Clinical Director, Addictions Program, Mr. Wayne Skinner.

Dr. Gabor Maté, as an individual: Thank you for inviting me. It is an honour to be present here, and I certainly appreciate the opportunity to present a perspective on addiction. I am a physician in Vancouver. For the last 11 years I have worked in the Downtown Eastside of Vancouver, which is well-known as possibly North America's most concentrated area of drug use. My clients have been people who have been at the extreme end of the addiction continuum — people with severe drug addictions, mental health issues and the attendant physical complications of HIV, hepatitis C, multiple diseases. My clients die in their early thirties, forties and fifties of complications of all these conditions or overdoses or suicide or violence and so on.

These are the people most afflicted by addiction, but also by what I consider to be the unenlightened social perspective of addictions. I know I have a short period of time only. I will briefly attempt to summarize for you my view of addiction, which is not only my personal view; it is also based on the available scientific evidence.

In North America, there are three views of addiction. The first view and most prevalent one and the one really that motivates the legal system is that addiction is a matter of choice. People seem to make a bad or immoral or dysfunctional choice. By inducing them to change their minds through punishments, sometimes rewards, we get them to behave the way we want them to, so it is a disease or disorder of choice. Indeed, a new book recently by a Harvard psychologist called it that — *Addiction: A Disorder of Choice*. Scientifically that is nonsense, and humanly it lacks insight. Nevertheless, the prevailing view is that people choose to be addicted.

What that question cannot possibly answer or that perspective cannot possibly cover is why would anyone choose to have HIV, live in the Downtown Eastside, lose their dignity, their teeth, their health, their families, their personal relationships, and subsist on the social periphery? Why would anybody choose that? The question of choice simply cannot be admitted here as a reasonable explanation.

The second explanation is more humane, that addiction is a disease, and certainly if you do brain scans on drug addicts, you can see that certain essential brain structures are impaired and the brain thickness does not grow the way it should; neither the white nor the grey matter of the brain survives the way it ought to. The longer the length of use, no matter what the drug is — particularly I am talking about the hard drugs like cocaine and crystal meth and heroin and the opiates and alcohol — you will find that there is shrinkage of brain matter over the lack of expected development of grey matter. It certainly is a disease. You can see that on functional brain scans and so on.

The disease perspective takes the onus, the stigma, off the drug addict and says that you have a disease; at least you are not morally flawed. There are two problems with that perspective, though. One is that it cannot answer why someone develops the disease or why some people are prone to it and others are not.

Now, the general medical view, which is lacking scientifically, is that a genetic predisposition decides who will be addicted and who will not. I will explain in a while why that is just not adequate.

The choice and disease models have in common the convenient removal of onus from society. If someone is born with the genes or if someone makes a bad choice, then as a society we are not responsible for how we treat children or for how we treat the First Nations peoples, and I mention that because 30 per cent of my clients in the Downtown Eastside are of First Nations origin, whereas First Nations make up only about 2 per cent or 3 per cent of the Canadian population.

Therefore, the choice and disease models do not suffice. They take society off the hook. We do not have to look at how we treat addicts, how we treat children, how we generally approach the issue of addiction as a society.

The third model is the only one that has any scientific validity, as far as I am concerned. It is a bio-psycho-social model of human development. ``Bio-psycho-social" means that

the biology of a human being, including the brain biology of a human being, is shaped by the environment into which that person is born, is conceived and lives their life. That is easy to demonstrate. For example, children whose mothers are depressed or stressed are more likely to have asthma. In other words, the mother's emotional state has a physiological effect on the child's lungs. That is not news; that is well-researched stuff. It is just an example of how people's biology is shaped by the emotional and psychological environment. At the end of life it is the same thing. A study in the *New England Journal of Medicine* a couple of years ago showed that when an elderly person is hospitalized, their spouse is more likely to fall ill within a short period of time. In other words, the physiological state of one partner is affected by the emotions they experience when the other person gets sick.

What I am pointing out here is that human beings are in a bio-psycho-social context, that their biology is very much related to the environment in which they live, whether that is the social or the emotional environment. For example, recently a study has shown that poverty actually has that effect on the genetic function of the brain. That whole science is called epigenetics: how the environment actually tells the genes what to do.

To come back to addiction, then, how do we understand it from a bio-psycho-social point of view? An American researcher called Dr. Vincent Felitti, a medical doctor and researcher from California, said dismissing addictions as bad habits or self-destructive behaviour comfortably hides their functionality in the life of the addict. In other words, he is saying that we need to look at the functionality of the addiction. What is the addiction actually doing for the addict? From the strictly medical point of view, it is totally clear: addicts are self-medicating. They are self-medicating depression, for example. You have all heard of the serotonin-enhancing antidepressants like Prozac and Paxil. Serotonin is a brain chemical essential for mood control, but cocaine also elevates serotonin levels so that the cocaine addict is actually often self-medicating depression.

People self-medicate ADHD, attention deficit hyperactive disorder, something I have been diagnosed with, and for a while I was prescribed stimulant medications for that, Dexedrine or Ritalin, which elevates the level of a brain chemical called dopamine, and dopamine is essential for motivation, incentive and attention. When the ADHD person gets a stimulant, they calm down, strange as it seems, but that is how we treat it. Crystal meth, cocaine, nicotine and caffeine are all stimulants. People who use many of these drugs are very often self-medicating their hyperactivity; they are using it to calm themselves down.

People self-medicate post-traumatic stress disorder. The opiates are powerful stress relievers. A lot of people with addiction actually suffer from PTSD or its various variations. People self-medicate anxiety, social anxiety, social phobias and so on. On one level, it is a desperate and not skilful but nevertheless highly enticing form of self-medication.

To go deeper into the brain biology of addiction, which you must do if you look at the classes of drugs that are used, such as the opiates — heroin, opium and morphine — and

their various artificial analogs like Percocet and Percodan, these medications have been used in Chinese medicine for 3,000 years for pain relief. The opiates are powerful pain relievers of not only physical but also emotional pain. The same structure in the brain that interprets the emotional significance of physical pain also responds to the emotional significance of psychological pain. If you hurt people emotionally and do a brain scan, the same part of the brain will light up as would light up if you had stuck them with a knife. That is why the English language talks about a painful remark or a hurtful experience.

The question in addiction often is not just why the addiction but why the pain. You need to look at the literature and the research on who is addicted. In the Downtown Eastside of Vancouver, I have never met a single addicted woman client of mine in over 11 years who was not sexually abused as a child — not one. Many of the men were sexually abused as well. If they were not sexually abused, they were physically abused or abandoned and neglected.

The research literature is clear. A large study of 17,000 adults in California showed that if a male child had six adverse childhood experiences — meaning a rancorous divorce, a parent being addicted, a parent being jailed, violence in the family, a child being abused — he had a 4,600 per cent greater risk of using injection-delivered substances as an adult than a male child with no such experiences. In other words, there was a 46-fold increase due to early childhood trauma.

I do not have time to tell you all the details of it, and this is not controversial — I am just telling you the brain science as it is right now, although it is not yet taught in medical schools for the most part. The human brain develops in correspondence with the environment and not according to a strict genetic program. Which circuits in the brain develop and which do not depends on the environment. A child who does not see light for five years will be blind, because the child's brain needs light for the development of the light circuitry.

For the development of the circuitry of internal pain relief, for the development of the circuitry of incentive and motivation — that is, for the development of those brain circuits where the body's own opiates or the endorphins function, and for the development of those circuits where incentive and motivation are located, which involve the chemical dopamine — you also need the right environment. That environment must be a non-stressed, emotionally present, consistently available parenting caregiver. You can do this with animals. They will have diminished dopamine receptors in their brains, and they will be more likely to use alcohol and cocaine when they become adults. I am talking about laboratory animals. You can separate infant monkeys from their mothers and measure their brain dopamine levels. Within two days, it is diminished. In other words, it is a bio-psycho-social model, and the human brain is shaped according to the environment. For example, there is a class of monkeys that are more prone to be genetically predisposed to be alcoholics because they have a gene that protects them from the sedative effects of alcohol. That means that when they drink, they can get rip-roaring drunk and not fall down or fall asleep. In those monkeys that are brought up by their

mothers, that gene is turned off. In those monkeys separated from their mothers, that gene is turned on. They are the ones at risk.

A study in the United States just three months ago showed that amongst children who might have a predisposition genetically towards addictions, if they are brought up in nurturing families, that gene is inactive. It is those children brought up in dysfunctional families or under circumstances of trauma and dysfunction who go on to develop addiction.

That is the biology of it in a nutshell. That means that the drug treatment programs in our country are aimed at the most abused segment of our population. It also means that the legal system is aimed at the most abused section of our population, invariably people who have been traumatized in childhood, who suffer from mental health conditions that they self-medicate with their drugs and who then, because of the illegality of the drugs that they depend on, commit crimes and become a problem for the legal system.

I will read to you briefly from my book on addiction, *In the Realm of Hungry Ghosts: Close Encounters with Addiction*. I will read you a paragraph and then come to a close:

Detective-Sergeant Paul Gillespie, head of Toronto's sex crimes unit, rescued children from the purveyors of Internet pornography. As the *Globe and Mail* reported on his retirement from police work, six years at that job had not inured him to the horrors he had witnessed:

Paul Gillespie still can't get used to the sounds of crying and pain in the graphic videos of children being raped and molested that he has seen all too often on the Web. ``It's beyond horrible to listen to the soundtracks of these movies," said Canada's best-known child-porn cop . . . But it is the silent images of desolate children that tear the most at his heart. ``They're not screaming, just accepting," he said of the infants captured in these pictures. ``They have dead eyes. You can tell that their spirit is broken. That is their life."

There are two points to be made here. One is that people's eyes go dead when the suffering they are forced to endure is too much to bear. The ``eyes going dead" is an expression of emotional shutdown, which is the brain's response to overwhelming trauma. These people shut down emotionally early. They become careless sometimes. They become disconnected from their feelings, and they also stop developing, because to develop emotionally you need to have vulnerability. Plants only grow where they are vulnerable. Crustacean animals have to climb out of their shells to grow. So does a human being. When you shut down emotionally, you stop developing. Most addicts function on the level of children when it comes to their emotional lives.

Second, I will read you what I wrote in follow-up to that quote:

Dead eyes, broken spirits: in a phrase, this compassionate man summed up the fate of the abused child. Yet there is a bitter irony in his words. The lives of abused children do not end when they are rescued — if they are rescued, as most never are. Many become

teenagers with spirits not mended and reach adulthood with eyes still dead. Their fate continues to be a concern for the police and the courts, but by then they are no longer heartbreakingly sweet, no longer vulnerable looking. They lurk on the social periphery as hardened men with ravished faces; as thieves, robbers, shoplifters; as done-up prostitutes selling backseat sex for drugs or petty cash; as streetcorner drug pushers or as small-time entrepreneurs distributing cocaine out of cheap hotel rooms.

These are the people, then, that the legal system now is charged with pursuing, prosecuting, punishing and jailing. There was an article in *The New York Times* two weeks ago about how the economic crisis is causing a significant increase in the number of runaway kids in the United States — street kids — because people are stressed, families are falling apart, and some parents do not have the money to feed their kids, so these kids run away from home. As *The New York Times* points out,

Nearly a third of the children who flee or are kicked out of their homes each year engage in sex for food, drugs or a place to stay, according to a variety of studies published in academic and public health journals. But this kind of dangerous barter system can quickly escalate into more formalized prostitution, when money changes hands. And then, child welfare workers and police officials say, it becomes extremely difficult to help runaways escape the streets. Many become more entangled in abusive relationships, and the law begins to view them more as teenage criminals than under-age victims.

That is the evolution of the addicted criminal: abused children end up with the peer group, running away from home, engaging in crime and then, sooner or later, they are the ones that the current legislation will now build more jails for. This is Canada's answer to the child abuse problem.

I will finish here. I look forward to the discussion with this distinguished group, but I am telling you that, from the scientific perspective, from the humane perspective, and from a social perspective, what these people need is not more harsh punishment. They need much more compassionate care. Children need much more protection. As a spiritual teacher I revere said, ``Only in the presence of compassion will people allow themselves to see the truth.'' If we want these people to transform their lives, they need not more harshness but less of it. The research literature is also clear that the biggest driver of addictive relapse is stress. The more we stress people, the more they cling to their addictions.

The Deputy Chair: Thank you, Dr. Maté.

Wayne Skinner, Deputy Clinical Director, Addictions Program, Centre for Addiction and Mental Health: I also want to express my gratitude for the opportunity to appear here today. My career in addictions goes back now a long way. I have worked at the Addiction Research Foundation for 22 years, in a variety of roles, many of them clinical. The last 10 years I have been working at the Centre for Addiction and Mental Health, CAMH, the organization that the Addiction Research Foundation was merged into. The area of focus I have been working in is concurrent disorders, or people with

addiction and mental health problems. There has been a growing realization that to work in the addictions area, as in mental health, you need to have skills in both these areas because most of the people we work with have co- occurring problems. That is the framework that has influenced my practice.

I have some comments I would like to read through quickly so that we can get to discussion.

The Deputy Chair: Do not speak too fast. If you want posterity to be able to read the transcript, we need that support.

Mr. Skinner: I will take my time. Thank you.

It is important that there be a public conversation in Canada about the continuing issues and problems related to substance use. This needs to include both legal drugs and illegal ones. These are difficult issues that concern us all, and there appear to be no easy solutions. In many ways, it seems to me we are engaged in an ongoing social experiment where we try a variety of different strategies and approaches intended to reduce harm related to substance use. In finding a way through this confusing terrain, we need to look for evidence; and when we do find evidence-informed directions, we need to be brave enough, in oft-repeated phrase of the founder of the Addiction Research Foundation, David Archibald, who actually passed away this summer, to ``follow the data."

The data, in my view, lead to a four-dimensional approach to addiction policy. Sometimes this is called the four pillars: prevention, treatment, harm reduction and law enforcement. A question we need to answer is what should be the balance across these four fundamental elements that would give us the most effective public policy in the realm of substance use problems. Is there evidence that can guide us to wise decisions?

Over the past decade, I have had the opportunity to give a number of invited presentations and workshops across Canada and internationally about addictions and the problems that co-occur with them, particularly mental health problems. In almost every presentation I make, if I do not bring it up at the start, the issue of the stigma of addiction and mental illness emerges. I have gotten into the habit of talking about stigma from the beginning, and I will do that now.

How we understand and think about substance use problems determines the issues we see, and that then shapes where and how we look for solutions. If we fail to see addiction and mental health problems as health issues, it is easy to fall back into very old, deeply embedded perceptions of addictions and the people with these problems. Those perceptions take us away from the evidence and incline us towards attitudes and beliefs that actually contribute to the problems related to substance use rather than reduce them.

Many images from the past make the point of how, in days gone by, substance use and substance users have been stereotyped and stigmatized. Recently, I had a more contemporary example to add to my collection of illustrations. It is a campaign mailing

that I and many Canadians received in the mail during the last federal election. The flyer states, ``Junkies and drug pushers don't belong near children and families. They should be in rehab or behind bars . . . Keep junkies in rehab and off the streets."

My first reaction when I saw the flyer in my mailbox was disbelief. Then I found myself reflecting on why this was being sent out. As I thought about that, I came to the view that from a political perspective, real intelligence was at work here. When I show this to my audiences, as I have been doing over the last year, I ask them to ignore the issue of who sent out the mailing and who is on it. I want them to think about what it says about us — about Canadian voters, citizens, taxpayers — that makes this a smart thing to do in an election. The authors of the mailing know something about us and they know how to send a message that gets at something. The something they know about us is that addiction scares us and that people with addiction problems scare us. Yet, one in five of us will have a substance use problem in our lifetime. These problems are found in all our families, neighbourhoods, and communities.

However, when we talk of junkies and drug pushers, we do not think of our children, our friends or our families. What happens is we think stereotypes, and the main work of stereotypes is to demean and dehumanize those who become the targets of stigma. Stigma is built on stereotypes that activate fear and invoke negative perceptions that dehumanize others.

It is interesting that you can get away with using the word ``junkies" to describe people with drug problems. The clinical term for someone who is labelled a junkie is that they are ``opioid dependent." By the way, one of the great fears of many people who have substance use problems and who actually are considering treatment is that they will be labelled ``junkies" or ``addicts" or ``drunks" or ``crackheads."

Opioid dependence is a health problem, with diagnostic criteria listed in the *Diagnostic and Statistical Manual of Mental Disorders*. Many other labels circulate publicly about mental health and addiction problems. I cannot imagine any other one that could be used the way ``junkie" is used in this example that would not create outrage and embarrassment.

We need to recognize that advantage can be taken because of the public fears that prevail about substance use problems, particularly by invoking stereotypic language and images that encourage us to see drug users as less than human, as otherly, not our children, our family members, our friends, or even someone else's child or parent or friend. There is a job to be done in fighting stigma related to people who have substance use problems. The reasons for doing that have to do with the values we have as a society, but they also have to do with following the data. The evidence for effective public policy supports health strategies to help prevent, treat and reduce the harm of substance use problems in Canada, not an unbalanced approach towards more law enforcement and mandatory minimum sentences.

I know there have been submissions to the Commons and the Senate standing committees that make the case for laws, policies and practices that even up the balance across prevention, treatment, harm reduction and law enforcement, including a submission that was made by the place where I work, the Centre for Addiction and Mental Health.

The key themes I saw emerge in that body of evidence include the failure of proposed changes in the law to address the roots of addiction and the risk that they will actually increase the harm to individuals and to society, including the fact that prison itself is the setting where too many people experiment with intravenous drug use for the first time.

The difficulty in making a distinction between users and dealers is an important point that these submissions have made. Law enforcement in this area keys on the street level, where the most vulnerable will be subjected to and become the primary targets of the new legislation. Those who deal and import and run the illegal drug business will continue to evade detection and arrest.

The potential negative impact of tougher laws will be particularly hard on Aboriginal communities, where, as Dr. Maté said, these populations are overrepresented in treatment and in jails already. In some Aboriginal communities, the rate of opioid dependence is as high as a quarter of the adult population. Mandatory minimum sentences would add to the overrepresentation of Aboriginal people in Canada's prisons.

The lessons from the United States and other jurisdictions with experience with mandatory minimums reveal significant unintended negative effects. These include escalating correctional costs without reducing crime or drug use.

The cost-effective advantage has been shown repeatedly to go to investing in treatment and prevention rather than incarceration.

Drug treatment courts merit permanent funding, increased availability and extended eligibility, and they should be seen as integral to a comprehensive continuum of services and supports for people with substance use problems and the many health problems that co-occur with them.

Let me put a human face on the issues related to problematic substance use that the committee is considering. I have a couple of illustrations here that are meant to characterize some big problems, but they also describe real people and their problems. One of the things we see with severe and persistent substance use problems is the co-occurrence of many other problems, including mental illness, physical ill health, social marginalization and disadvantage, and involvement with the criminal justice system. These problems and the way they are treated actually deskill people and erode the social capital that anyone needs to have a good and healthy life.

Let me tell you about Peter. Peter is someone I met because he was a client in the methadone program that the Addiction Research Foundation and now CAMH has operated for the treatment of opioid dependence since the 1960s. Methadone is not

without controversy, but it is actually one of the most evaluated pharmacotherapies in the whole health field. The evidence is that people who stay in methadone treatment have lower rates of relapse and recidivism to jail and higher rates of social integration and functioning. When methadone treatment is enhanced with psychosocial treatment services and they take on the bio-psycho-social approach that Dr. Maté referred to, those approaches are the best practice for this population. Despite that, there is a lot of stigma associated with methadone treatment and stereotyping of people who are patients there.

Peter came to the program after he had been released from a federal institution. He was in his early forties when he joined the program. His history revealed that as a young man onward he actually spent more time behind bars than in the community. He experimented with heroin, but his real drugs of choice were prescription opioids. He found they had better quality control and, increasingly in most Canadian cities, were more available than heroin. He had a series of arrests for robberies and property crimes, all in the service of money to pay for these drugs. Having been in jail more than out, he had learned how to live successfully and peaceably in the prison world but nowhere else. His problem upon release was that he found himself removed from a world whose rules he knew and where he had support and status. He was a model prisoner. He was released to a world with no family support, no friends, no job, where whatever plan he had gradually fell apart, but this time he opted for a methadone program because he figured that if he could be protected, if you will, from his urges to use drugs, he would have a reduced risk of relapsing and going back. The problem was that, on the outside, life was miserable for him. He was becoming actively depressed and anxious, and issues from his early life, including physical and emotional abuse, started to surface. He usually drugged himself for that before. When he did the math, he came to the view that his chances might be better back behind bars than on the street. He was wondering whether he should intentionally recidivate and come back. He has hung in there. He has had active support for his addiction and mental health issues. He has been able to find peer support from people in recovery and connected to a faith community.

Recovery in such a situation is a long journey over rough terrain where there is lots of bad weather. Here, someone has a slowly developing sense of personal competence, connectedness and accomplishment. He is making his way. He wants to succeed, but he had a long-standing belief, going back to his childhood that, to use his words, he was a loser, and it might not be in the cards for him to succeed. In the most painful of ways, he has actually continued to struggle to make his life on the outside rather than giving up and going back.

Every year, CAMH gives out the Courage to Come Back Awards. Now they are called Transforming Lives Awards. Although Peter never wanted or received such an award, there is something in his spirit that embodies the courage to come back. One of the challenges in working with people is how to find and kindle in people that willingness to keep believing that there is a possibility for them in the real world. Putting people in jail for longer periods is a way of making more Peters, not the Peter who finally, through therapy and social support, is taking hold of his life, but the Peter who came to us more skilled in living in prison than living in the community. There is a convenient thought

that putting people away makes everyone else safer, but the evidence is that it makes the person worse in terms of physical and mental health and in terms of the skills, competencies and support that people need to make it on the outside. More men and women who are socialized to life in correctional institutions become more deskilled and demoralized about making it in the real world.

Sylvie is a woman who died of an accidental overdose earlier this year. She never had periods of extended incarceration, but she was in contact with the law, usually probation, throughout much of her adult life. You could call her a junkie. She would say that disparagingly about herself, actually. She did not use heroin. She was mainly using prescription drugs. She found it too easy to get these drugs from some doctors. When she began working with mental health and addiction professionals, we were not able to make good connections with these doctors so we could coordinate care effectively for her. Sylvie was a child of a racially mixed marriage, a very attractive woman, but she had a life of problematic, exploitive relationships. Ironically, more recently, she was becoming more engaged in treatment and trying to see if she could find a way out of this. She had gotten connected to a mental health court and a mental health team and to addiction services. She wanted to leave the lifestyle that she had fallen into, but she had too easy access to substances when she had a weaker moment. It was too easy to show up in the doctor's office and walk out with drugs.

Technically, you could have called her a drug dealer, too, because she was willing to help out her friends, and they knew she had an easier time getting drugs than they did, so they would often prevail upon her. Life on the streets does have a harsh logic to it, but there is a logic to it, and you can get credit by extending it to people. At times when she needed favours, she had people she could count on because she had helped them out. That is the way things worked. It is an eye for an eye, but there is a credit system as well. It would be nice to have a simple dichotomy between drug users and drug providers on the street level, but all too often it is the same person at a different point in the cycle of finding, using and needing drugs.

Sylvie's story also highlights that the transition periods for people with substance use problems are high-risk times for them. Coming out of prison, withdrawing from drugs, going into or leaving treatment are times of real hazard for people to deal with their addictions. It is not just the relapse risk, but the overdose risks, as Sylvie's story is a tragic example of. Other risks are related as people make these transitions. They need strong systems of support as we are trying to transition people into different phases of life. Having to do it on your own is a formula for failure for individuals.

Another thing to consider when we talk about illegal drugs is that the pathway to these illegal drugs is through the regulated drugs that are readily available in our society — tobacco, alcohol and prescription drugs. These are the gateway drugs. If we want to understand how hard it can be to stop problematic drug use, we need to look no further than tobacco and nicotine dependence to have a compassionate understanding of the challenges involved in changing these behaviours.

There is an important role for law enforcement in identifying and intercepting people engaged in illegal activity. Everyone would agree with that. The evidence is that the better outcomes for people who are drug users who come before the courts are produced by strategies such as drug treatment courts rather than the traditional correctional option of conviction and jail time. I see the relationship between law enforcement and treatment as having great potential, and there are examples of better and worse practices that we could learn from in that regard.

To conclude, in some ways, the challenges we face in social policy regarding substance use are not unlike those faced by people who have the option to work on recovery from substance use or to relapse. There are old habits and attitudes that can lead away from seeing these as health problems that require health solutions. There are old habits and attitudes that lead back to seeing these problems from the perspectives that are deeply ingrained in all of us, just as the habit to use drugs has been deeply established in the person with substance use problems. In both cases, the challenges are the same. Will we fall back to those easily induced behaviours, or are we capable of learning and maturing so that a new set of policies, practices and skills can emerge? They will not remove the challenges we have to face, but they will allow us to address them in ways that are much more compassionate, decisive and, most important of all, effective. If we follow the evidence, we can use a balanced, four-dimensional strategy of law enforcement, harm reduction, treatment and prevention to get there.

The Deputy Chair: Thank you, Mr. Skinner.

Senator Milne: Dr. Maté, what percentage of your clients were introduced to intravenous drug use while in jail?

Dr. Maté: I do not know the answer to that. You would have to look at the broader studies. I do not think most of them were.

Senator Milne: You do not?

Dr. Maté: Not most of them, but some were for sure. I could not tell you.

Senator Milne: That is one of the concerns we have heard. We have heard also from Mr. Skinner about this.

Mr. Skinner: Some of the epidemiological reports suggest that a quarter of the people who are IV drug users have said they were first introduced to it while in jail.

Senator Milne: They went into jail for some other reason in the first place?

Mr. Skinner: Yes. It could have been for other forms of drug use. You could be incarcerated for a cannabis conviction, but in that culture you are in kind of a desperate circumstance and you have access, strangely enough, to substances that you can inject intravenously. Unfortunately, you do not have access to good syringes. I have heard

people talk about using Bic pens and other strange apparatus to administer drugs into their veins. When you hear that, you have no trouble imagining how infections can happen and how you can contract HIV and hepatitis. That is the other concern we have with these problems.

Dr. Maté: The usual trajectory of someone who goes to jail is a difficult childhood, early disconnection from nurturing adults, connection with a peer group in the form of a gang or a street community, introduction to petty crime, escalating criminality and then jail, whether or not drugs are involved. Whether they start to abuse before they go to jail or they begin in jail, the trajectory is usually a troubled childhood and failure of the social system to save these kids. That is why these people end up in jail.

Mr. Skinner: Perhaps I can tell you an anecdote that had a powerful effect on me that illustrates a number of problems that people with these issues have in getting effective care. A gentleman who was in methadone treatment had to stop cold turkey when he was put in jail. While he was in jail, he used intravenous drugs. He was the person who told me about using a Bic pen as a container for drugs that you punch into your vein to try to get the drugs into your body. He became infected with HIV. There is pretty good evidence to trace that infection to those events in jail.

People who are opiate-dependent in methadone treatment and go into jail need to have their medicines continued. That reduces the risk of them doing this. In this case, the individual was in a fairly desperate situation. He was drug seeking and was very vulnerable to the opportunity to use, with pretty dramatic impact.

Senator Milne: You ask in your presentation, Mr. Skinner, whether we are capable of learning and maturing so that a new set of policies, practices and skills can emerge. We heard Dr. Maté say that every drug addict he has encountered was abused as a child and their emotional life was shut down. He said they are no longer capable of learning emotionally and growing emotionally. How can we get over this barrier?

Dr. Maté: Senator, I did not say they are not capable, although I did say they shut down. Keep in mind what Mr. Skinner and I both mentioned, the bio-psycho-social model of development. In other words, people are in a lifelong relationship with the environment. When the environment becomes supportive, nourishing and compassionate, people can develop. There is a function of the brain that is now very well known that is called neuroplasticity. That is the capacity of the brain to develop new circuits later in life. There is currently a best selling book, *The Brain That Changes Itself*, by Dr. Norman Doidge, that documents that, and I mention it in my book as well.

People are capable of transformation, but the conditions have to be right. The issue for me, and I think for Mr. Skinner, is how to provide people with those conditions. From our perspective, more punitive approaches are hardly the way to promote positive transformation.

Mr. Skinner: Your point is a key one. This could be understood from the point of view that it is hopeless so we should lock them up and throw away the key. That is not the message we are carrying. Our message is that the understanding we need to have of people with these problems has to do with their development and their needs, and that there is a recovery trajectory onto which people can be put. There are ways of dealing with these problems that are promising and effective, and there are success stories to be told.

It is not easy work, but there is more promise in doing it that way than in locking them up and throwing away the key.

Senator Milne: You say there are examples of better and worse practices from which we can learn in that regard. Do you have some examples for us, please?

Mr. Skinner: I will speak generally, but there are jurisdictions where the relationship between police and people in the health care system is more antagonistic. In those situations, the attitude is more of a rigid kind of policing. There are other jurisdictions, and Vancouver is a strong example, where the police have been champions in humanizing the stories of drug users. They have made documentaries to promote the understanding that these are not ordinary criminals, that they are people with deeply human problems who are suffering deeply. They elicit responses to that, which is very important. There are these alliances.

Europeans are taking more provocative approaches, such as making heroin available and providing needle exchanges and safe injection sites. The police are very involved in those initiatives.

Dr. Maté: In Vancouver, we have a supervised injection site, but the federal government, unfortunately from my perspective, is trying to shut it down. The local Vancouver police are very much in favour of it, while the federal police force is against it. The evidence in all the studies speaks to its positive impacts health-wise, economically and legally. Nevertheless, in the face of all the evidence, the federal government wants to shut it down, and the RCMP argues the same thing.

We have other harm-reduction facilities. There was a trial in Vancouver recently of providing heroin or intravenous hydromorphone, which is a synthetic opiate. It resulted in decrease in crime, decrease in dysfunctionality and increase in functionality. The same thing has been shown in many studies in Europe.

There is plenty of evidence of what works and what does not work. All I am asking of my profession, the medical profession, society in general and the legal system in particular is that we follow the evidence, follow the data, as Mr. Skinner quoted someone as saying. We have the evidence. It is not even controversial. The problem that stands in the way of applying the evidence is simply the attitudes that Mr. Skinner mentioned.

Senator Milne: If you have some of those studies available, Dr. Maté, we would like to receive them in order to study them.

Dr. Maté: I will be happy to send a sheaf of references.

Senator Milne: Thank you.

The Deputy Chair: Further to that, if there is anything you want to provide us with later with regard to what we have discussed this morning, please send it to our clerk.

Dr. Maté: Mr. Chairman, I would be pleased to leave you a copy of my book, for one thing, if anyone wishes to read it. It contains all the references, including the scientific literature.

The Deputy Chair: Thank you very much.

Senator Banks: I am not a permanent member of this committee, so I have not heard the previous evidence on this bill. I am substituting, unfortunately, because of the subject you just spoke on, Dr. Maté, for Senator Campbell, who knows a lot about what you have just spoken about. I do not.

We all admire what you do and the commitment you have made to work where you do. The environment in which you work is not, you will agree, a universal one. In fact, you said yourself that it is distinct in some respects. I believe you said it might have the highest concentration of drug users in North America.

I will argue that all generalities are false, including the one that says there is no choice involved here or that his is always a disease. I think it is a little bit of both. I suggest that sometimes it is a matter of choice.

Sometimes people who become drug addicts have not had those terrible things that you talk about having happened in people's pasts. I know some of them, and I suggest that if it is possible, as in the case of several of my friends who have previously been what would reasonably be described as junkies, they have ceased to be junkies as a matter of choice, then there was a matter of choice at the other end, too. There are people who, despite the information that is readily available and despite having not been abused as children and not having had dysfunctional childhoods, become drug addicts for other reasons. They may be in the minority, but they become drug addicts.

It is not possible to argue that everyone in our society does not understand that it is a bad idea the first time to stick a needle in one's arm and shoot up heroin. No one can say, ``I did not know that. I thought it was harmless." That is just not on.

Would you agree that there are drug addicts who are drug addicts because they at one time made a choice to try it?

By the way, I am unalterably opposed to this bill for reasons that have to do with nothing medical.

Dr. Maté: I appreciate that.

Senator Banks, I would like to say that what you say is music to my ears, but it is not in this particular case. First, you cannot argue with the evidence, including the study I quoted where there was a 4,600 per cent increase in the risk when the child had all those adverse experiences.

Senator Banks: Pardon me, but I did not say that those things are not true.

Dr. Maté: I know you did not.

Senator Banks: But there are people —

Dr. Maté: No, I understand exactly what you said. There is no question that the vast majority of hard core substance users had the trajectory I described.

As you say, there are some people you look at and they did not have those particular hardships. However, what you do find, and I have dealt with many of these people as well in my practice as a physician, while there may not have been overt trauma or abuse in those families, there was always some significant emotional loss and stress on the parents that particularly affected the development of a sensitive child.

That begins already in uterus. You can stress women when they are pregnant, or animals, and predict that their offspring will be more likely to have dysfunctions later on. Already the development starts happening. A study after 9/ 11 looked at women who were pregnant at the time and suffered post-traumatic stress disorder as a result of the World Trade Centre disaster. At one year of age, depending on which stage of pregnancy the women suffered the PTSD, those children had abnormal stress hormone levels. The high stress hormone levels are a risk factor for addiction, because addiction is one way of regulating stress.

In no case I have ever looked at of any kind of addiction to anything, whether it is the effect of substances or behaviours or legal or illegal drugs, did I find that they had had the emotional support that healthy development requires.

I am speaking as a parent as well, and as a workaholic father and as a workaholic physician. I know the kind of emotional losses my children experienced because I was not around for them. They were not abused, there was no trauma, but there was a lack of something they needed.

Then those children who are not well-connected to adults tend to connect heavily with their peer group. They may not have been abused, but once they get connected to the peer group, according to the research literature, they are much more likely to start using drugs.

There is another book I have co-written on the influence of the peer group on child development, called *Hold On to Your Kids*. In short, I do not agree that these people did not suffer losses; they just may not have suffered the degree of loss that the bulk of substance abusing addicts have suffered.

This issue of choice is a question of how you understand human beings. Yes, on the trivial level, on the surface level there is a choice. I will put a needle into my arm. That is a choice you are making. People are not aware of what is driving that choice. People are not aware of their unconscious mechanisms, which are mostly responsible for the decisions they make.

Furthermore, not everyone who uses the drug will be addicted. Most people who try heroin will not be addicted to it. Most people who try cocaine, alcohol, tobacco, cigarettes will not become addicted. In some people who use that stuff, if there is susceptibility there, then the drug and the susceptibility will lead to the addiction.

This issue of choice, I do not agree that people make it. People do not make a free choice to be an addict. They may choose to try something at one time, but they do not choose to be an addict; nobody does.

Finally, the people who choose later on to give up their addiction, that is true, they do. Usually that is because they had some support in their lives. They have had some compassionate support. As I quoted earlier, only in the presence of compassion will people allow themselves to see the truth. The people who successfully make it are usually the ones who found some program, or some individual in their life, or some other support, to compassionately accompany them on their journey. It still was not a matter of their own individual strength. It took a lot of strength individually, but it was still based on that bio-psycho-social model of support.

With those comments, I would respond to yours.

Senator Banks: The last thing you said is certainly true.

Dr. Maté: Thank you.

[*Translation*]

Senator Carignan: We have heard all kinds of testimonies, from people who treat substance abuse, from people who are in the prison system at the administration level for prisons and penitentiaries, or who work in the judicial process and they all have different perspectives and different point of views. I think we are facing a complex problem which calls for a complex solution involving different actors and different systems. I am told that Senator Banks would like to pay tribute to you for the difficult work that you do with people in the grip of — I won't say illness, because I want to follow the theory — this addiction and this is a great honour.

However, the question that comes to my mind comes from the comment you made about the fact that there was no evidence that putting people in jail reduces the crime rate. The Bill, as the Minister of Justice explained to us, is only a tool in a tool box that aims to solve the drug problem. I think you are an extraordinary tool to tackle drug problems, but there are other tools which must be used and this one targets specifically trafficking.

As this Bill targets traffic, and not necessarily drug addicts as such, at some point in their lives, those people have had access to drugs because beyond the biological process and the others, they have had access to drugs. Don't you think that targeting traffic and reducing accessibility, the people you deal with, who were young at some point, who have had an easy access to drugs, may have developped a habit because of that easy access, beyond the other family, biological and other contexts. Don't you think that by restricting access and tackling traffickers, we will solve the drug problem because we know it's not the only tool we have?

[*English*]

Dr. Maté: Thank you, senator, for your question. We have had 100 years of evidence on whether or not trying to interdict the supply of drugs through legal means actually works. The evidence from anywhere in the world is that it does not matter how drastic and draconian you make the legal situation; it simply does not interdict the supply of drugs.

There is a retired American judge, Judge Gray, in California, who said that trying to repeal the law of supply and demand is like trying to repeal the laws of gravity. You cannot do it. First of all, it is not a tool that works.

Second, as Mr. Skinner pointed out, the distinction between addict and supplier is a very murky one, especially at the street level. Because their stuff is illegal, they have to commit crime in order to get the money for it. One of the ways to get money is by selling drugs to one another and to other people. In fact, the illegality of it creates more traffic rather than diminishes it.

As for being one tool amongst others, Mr. Skinner mentioned the four-pillar strategy of harm reduction, prevention, treatment and law enforcement. From my perspective, senator, there are no four pillars in Canada. What we have is three toothpicks and one pillar.

In terms of the amount of money that is devoted to each of these areas, overwhelmingly it is the one that has been shown historically not to work, which is legal enforcement, and the others that have been shown to work are starved for support. It is a question, too, in a society — especially these days when we are very conscious of finite economic resources available for social programs — of where we put the energy and finances. I am saying we are putting them into the wrong effort, based on all the evidence.

By the way, I appreciate the intention. There is no question that the intention behind the law is to stop a terrible thing from happening. I do not question the motivation of the

minister or the governing party or anybody who supports the legislation, but I am saying that the evidence is just not there to support it.

Mr. Skinner: I want to say that the intention seems clear, but when you look at it, really this becomes a tool. In law enforcement I think the low-hanging fruit are the people living on the street. Law enforcement already is pretty good at getting those individuals, and the logic of a mandatory minimum sentence is we do not care about the circumstances. If we get you, we will really hammer you with this and you will have a serious penalty.

It seems to me that, in a way, the logic of that could only be directed at people on the street. If we were fortunate enough actually to arrest somebody really high in that system, I would imagine the legal penalties that would come to them would be huge if we could describe their involvement in these activities.

That is my concern. This good intention will have an unintended negative effect of further creating punishments directed towards the more vulnerable people in our society who are already highly policed in this area, and they do not have the supports they need in the other three pillars, as Dr. Maté said.

If you look at the seizure data from the RCMP — just the quantities of drugs that are seized every year — over 90 per cent of the seizure data is about cannabis. The amount of policing that is successfully directed against drugs like cocaine, heroin, crystal meth and ecstasy is trivial by comparison. The magnitude is more than 90 per cent cannabis seizures.

That also paints a disturbing picture, because the profile of cannabis use in Canada is very extensive. It is now approaching tobacco in terms of the annual prevalence of use. I think something like 17 per cent of Canadians admit to smoking cannabis in the past year. Again, what are we doing with these policies, and what will be the directions of police enforcement? That is where we need to be worried.

The intention is really sound. Again, I am hopeful that there are more mature ways, if you will, that we could actually have more collaborative relationships between the four pillars and be working more successfully on these things, but this approach has a long history to it, and really the evidence is just against it.

[*Translation*]

Senator Carignan: As far as treating drug addiction, having had somebody in my family that was addicted, I have realized that it is almost impossible to treat somebody who does not want to be treated.

How can we help that person accept to be treated? You have talked about the case of Peter, which was interesting. He has taken his decision after being sent in jail a few times, after having met people, having had support services in the prison. Maybe that

Peter would not have taken this decision if he had not been sent in prison, if he had not met some people who, through an intellectual process, helped him decide he needed a treatment. Could we not use our prisons not only for long term incarceration, but to help people withdraw from drugs, having access to support and help and get those persons to choose treatment? Could it not be a positive aspect of prisons?

[*English*]

Dr. Maté: It is certainly true that some people choose, at some point, to undertake a path of recovery. The question is what conditions are needed to encourage that choice. There is no evidence that harsh punishment is the way; it is usually the opposite.

The Catholic monk Thomas Merton wrote that before people can believe in victory they have to have a taste of victory. What that means in this context is that they have to experience support and compassion. Then they are much more likely to choose their recovery path.

If negative consequences led people to choose recovery, I would not have any patients in the Downtown Eastside, because one could not function and exist in a more harassed, troubled and deprived way than the people who live on the streets of Vancouver do. It is still not enough to force them to give it up. It is precisely because the conditions for support are lacking.

It is true that when my patients return from prison they have put on weight and they look healthier. They may have gone through a very difficult period of withdrawal, but they had decent food and a warm place to sleep. They were not out there in the streets so they actually look better. Very quickly they relapse, because the fundamental issues have never been addressed.

It might be nice to say there was actually a decent treatment and support program in prison, but that is not on. It is just not what happens. What happens is that people are jailed under increasingly crowded conditions with other criminals, and it is a very harsh place to live. I do not know where it exists, this place where people are getting the support they need in jail.

Even then, the issue would not be longer or harsher sentences. The issue would be providing them with support. There is nothing to be said on the punitive side — no evidence in favour of it. It just does not work.

Mr. Skinner: If I could make a comment as well. We run programming where people are mandatory clients, if you will, and they do very well. This area is in the domain of employee assistance programming, where people have basically run out of everything from the employer's point of view, and they could fire this person. However, if you have a substance abuse problem or a mental health problem and you get treatment, we will hold your job for you. Under those conditions, people go into treatment, often begrudgingly and resentfully, but they do well. They do as well as people who are

volitional or voluntarily in treatment. We have examples of where mandated treatment works well. That is interesting to me. How can we do so well there and so poorly in the other mandated circumstance in the criminal justice system?

This may touch on Dr. Maté's quote. With respect to these employee assistance programs, people are motivated because they have something to lose. They do not want to lose their jobs, but there is also other stuff they stand to lose because it is humiliating to lose your job in this way. In addition, there is a part of these individuals you can reactivate. They have a desire to do well and be exemplary to their family and friends. If you can get that motivation going, you can turn it around.

It matters not very much to me when someone comes into treatment. I want to know their motivational level, but I will take all comers into treatment. You can work with that effectively. The evidence in employee mandated treatment programs like this is high.

The Correctional Service of Canada has some very good best practices programs. In many ways, with respect to people who get into those programs, the problem is not the jail; the problem is what happens when they are returned to the community, where there is not enough uptake and support.

There are ways to use situations benignly, but sometimes the situation is actually that people are not being supported in human environments, such that the basic conditions of life are difficult. I hear some of my colleagues in correctional services say that an important program they have is literacy training, and the budget for that is getting squeezed. With respect to many people in jail, we have to realize what we are talking about here: they do not know how to read and write, and you want them to get a job. Jail is a great opportunity to get people literate, and there are people who want these services. The issues are what are the design, the investment, the goal and the strategy. If people have to be in jail, by all means, have the compassion of humane logic and see them as individuals with rehabilitative potential. Invest in that rather than looking at the amount of time they will be locked up. The evidence is that you will see a difference when you do that.

The other thing that needs to happen more is that the link between the service provision of people in institutions and the community must be made tighter. There must be a seamless plan so that when people get back on the street, the uptake is important. Many people recidivate or relapse to drugs within the first 30 days. It is just that simple and that dramatic a problem.

With respect to those transitional periods, we know they are the high-risk periods and we know there are strategies that would be more effective. There are ways we could do this smarter. I appreciate your bringing up this point.

Dr. Maté: You speak about the ``correctional'' service. What an irony that word is, because if you look at the roots of the language, to correct something means to make

something right. The people who end up under the wing of the correctional service are people whose lives have been severely troubled, according to all the evidence.

Corrections would be an opportunity to make it right, but we do not do that. We confuse punishment with making right. The correctional service ought to be called the punitive service, which is a more accurate description of what, for the most part, it does. It is not because correctional services do not have the potential; they do not have the understanding, the funds and the support. That is not how it works. I would very much like to see a ``correctional'' service; we could use one.

Senator Wallace: Thank you very much for your presentations. When I listen to what you have said, it is obvious that your focus is on drug use and addiction. You have lived the life of that, and you know the reality of it. As with all of this, we commend you for what you do. For those of us who are not involved with those problems, thank heavens, because you have seen what it brings to families and society. It is the worst.

To draw this discussion back to Bill C-15, Bill C-15 is focused on drug trafficking and drug production, with a particular emphasis on organized crime. For all of us as legislators, the whole drug trade and drug situation is a difficult one to find magic answers for. We are trying to make incremental improvements.

My understanding is that the direction of Bill C-15 is to attempt to improve the current situation so that we will create communities and a social environment where those who do not have addictions today and are not subject to drug use will not find themselves drawn into the web.

For example, yesterday Mayor Fassbender from Langley, British Columbia, spoke about the realities of drug production in his community and of houses that were used for drug production — marijuana production — going up in flames, battles between rival drug gangs, weapons involved in that and the harm and fear it creates for communities. He literally pleaded with us to do something about it because the current system is not coming close to curbing that kind of activity.

Similarly — and all of us as parents could relate to this — we do not want our youth in situations where drugs are being pushed on them. In civilization today, I know that is difficult to achieve. For that reason, Bill C-15 would create stiffer penalties for drug pushers who are in and near schools and influencing our children.

I say all of that as a backdrop. To a large extent, you are dealing with the drug addiction problem after it has happened, but we as legislators have a responsibility to try to prevent, as best we can, others from being drawn into the system and into those issues.

Dr. Maté, would you not agree that doing everything that can be done to curb drug trafficking and production in our communities is a worthy goal? We can debate how perhaps that can be achieved, but would you not agree it is a worthy goal and is in fact the main focus of Bill C-15?

Dr. Maté: You and I would agree on the goals. It is not a question of divergent goals here but a question of how to get there. In my profession, at least, there is a demand that what we do is based on evidence. I would like to see that applied to your profession as well, which is to say the political world.

If you look at the evidence, what is being suggested here has been tried elsewhere. It was not a creation of some Canadian genius who came up with more punitive and restrictive laws. This has been tried elsewhere in the world. The United States right now is backtracking from it because the jails are overcrowded. With respect to California jails, instead of exercising people, the gyms are now housing three-level bunks. They have run out of jail space in the United States. In California, they have been desperate to let people out of their jails within the last couple of months. Because of the mandatory sentencing regulations, their jails have been overflowing, crowded and unhealthy. Why do we not learn from the example of our neighbour to the south? I forget the exact figures, but the United States has something like 5 per cent of the world's population and 25 per cent of the world's jail population. Those are the statistics, something like that. I will have to look up the exact figures, but it is in that range.

We have their evidence. I understand the frustration and anguish of the Mayor of Langley and the frustration, fear and anxiety of all parents, but there is a difference between the emotive response — such as let us do something, let us control these people — and evidence. The emotive response is the natural human response. We all respond that way. I respond that way in a crisis. That is a natural human tendency, but that is not a basis to put a policy on. Policy needs to be based on evidence. If there is one iota of evidence supporting the provisions of this bill, I would love to see it.

Our desire to make a difference and our frustration at the deprivations that addiction imposes on our society and our young people should not lead us to wrong decisions.

Finally, when it comes to prevention, as I point out in this book, the prevention of addiction needs to begin in the crib. It needs to begin at the first prenatal visit, where we support families, young children and young mothers, particularly the troubled families. Those are the kids drawn to drug use. If they are drawn to drug use, it does not matter how difficult you make it, they will find their drugs. People historically, everywhere, always have. As much as we would like to believe otherwise, it just does not work. To interdict the supply of drugs when the demand for it is there does not work.

There are many things we can do on social, civic, public, municipal, provincial and federal levels, and I would be in favour of many programs that would help support our mutually shared goal here, but I cannot agree with you on the implications of this law. The intention is one thing; the impact is something else entirely. I am predicting right now that 15 years from now, if I am still alive, we can come back and look at this law and see what it has done, and it will have done nothing but harm to the very goals you are committed to.

Senator Wallace: I would agree with you that laws should not be based on emotion. There has to be a solid basis for it. Some of the evidence we have heard, on a community basis, is that communities that have taken tougher sanctions against drug production in their communities have seen a marked improvement. Those examples are in British Columbia.

Dr. Maté: That is true. I am sorry to interrupt, but what happens is that those people, instead of being in Langley, are in the Downtown Eastside. Now let me talk about the problem of the Downtown Eastside. The problem is not the Downtown Eastside but Canada. We need decent treatment, prevention and harm reduction programs across the country. It is easy enough for small communities to say, ``Not in my backyard,'' and to make it hard for drug addicts and petty dealers and force them out, but they do not disappear off the face of the earth. They move elsewhere, and then I get to treat them in the Downtown Eastside of Vancouver, and everyone says, ``What will we do about the Downtown Eastside?'' What creates the Downtown Eastside is Langley putting in harsh programs.

Senator Wallace: Let us for a moment focus it on organized crime, which has major tentacles into the drug trade. Do I take from your comments then that the battle is lost, and we might as well surrender our streets, focus on treatment and accept that there will be addiction? We cannot curb it in the first instance so we will have to deal with it after the fact?

Dr. Maté: No, on the contrary.

Senator Wallace: What is your thought, then? How do we deal with organized crime and its involvement in the drug trade?

Dr. Maté: If Mr. Harper had the genius to appoint me as Canada's drug czar, there are a number of things I would do. First, I would provide more support to young families. I would provide paternal and maternal leaves so that kids stay with their parents, parents bond with their kids and provide them the emotional support, not to stress parents and force them away from their kids as our economic situation is now doing.

Second, I would identify the families at risk through physicians, health authorities and so on, and I would give them extra support.

Third, I would make sure that wherever children are dealt with, whether in daycares or schools, they receive proper emotional nourishment, not just education and pedagogy but also emotional support. I would connect them to a whole network of adults who would be there for them so that they would not be forced into the arms of the peer group. It is mostly through the peer group that kids get initiated into drug use.

When it comes to established drug addicts, I would provide them with their substance of use under medical supervision. The evidence is clear as to the benefits of that.

Criminality goes down and functionality goes up where they study in Switzerland, Germany, Holland, England. These are the things I would do.

When I did that, when I do that, I would immediately take the wind out of the sails of the big drug pushers. If people can get their substances under medical supervision, there is no longer a need for the underground drug trade, or at least it greatly diminishes. Then you could isolate the big pushers from those petty dealers who mostly get caught up in the legal net right now.

There are many things we could do if we applied evidence-based practices.

Senator Wallace: A final comment. I could not disagree with what you said, but I would suggest to you that it takes at least a two-pronged approach. One is to provide a social environment that is comforting and supportive of the general public in the way that you have described it, but I would say the other requirement is, for those who continue to produce and sell drugs into our community, that we deal with it at that level as well. On one side I do not disagree with you, but I think you are ignoring the reality of drug production — with respect I say that — and trafficking. If we do not attempt to address that directly, then it will be —

Dr. Maté: Senator, I do not get too many opportunities to argue with senators, so I am making full use of it. This is a once-in-a-lifetime possibility for me. You have to understand that.

What is the evidence? I am telling you that the international evidence of what you are proposing is in, and it is devastatingly weighted in the opposite direction. I want to know what the evidence is for the value of mandatory sentencing, for all the stuff being done. What is the evidence? It has been done and done and done. The evidence is that it does not work, so what are we doing and why are we doing it?

Senator Wallace: We have had a lot of discussion around the issue of mandatory minimums, not only concerning this bill but other bills as well. There are those who disagree with your proposition that there is nothing to be achieved by mandatory minimums. It may not surprise you that yesterday, for example, we had law enforcement officials, and we have heard from others as well, who would disagree strenuously with you, and they are dealing with the reality of those who are charged and convicted. They would disagree with you and they are imploring us to implement mandatory minimums as a tool, as my colleague Senator Carignan said, and you well know it. There is not one answer out there that will deal with this societal problem we have. I would suggest to you that some out there would disagree with what you said.

Dr. Maté: It certainly is not news to me that people disagree with me. I found that out. However, in terms of the police, the police have been given a certain job. The job is irrational, which is to deal with, through policing methods, fundamentally, a health and spiritual problem, which is addiction. When I say ``spiritual,'' I do not mean any fancy religious connotation. I just mean people are cut off and isolated from the universe

because of their early trauma, so they perceive themselves as alone in the universe. This is the problem of the addict, and the police have been given an impossible job in the context of the job they have been given. The police do not create the laws; they simply enforce them as they are. In the context of police enforcement, it would make a lot of sense to take an addict who has had one conviction and put them in jail for life, because then they would not be out there doing it again. All you need is a lot more prisons, that is all. The police do not have bio-psycho-social understanding of human beings. They come from a certain perspective: ``What will make my job easier? If I can lock these guys away longer, that will make my job easier."

That is not the evidence in the United States. It is the opposite, but I would certainly understand why a policeman would come to that conclusion. It is frustrating for them. They do all this hard work. They have to go to court under difficult circumstances, present the evidence and then they see these people walk again. I can understand their frustration, but that is not a basis for a drug policy.

Senator Wallace: I do take exception with one thing you say. I do not consider myself naive, but I consider our police are there and, I think in the overwhelming majority, see their role to provide us with protection — to protect and provide a more secure society. It is a difficult job. I would suggest to you their primary motive is not to make their job easier. Their job is to protect you and me and our families.

Dr. Maté: I understand.

Senator Wallace: Maybe I misunderstood your point.

Senator Joyal: Welcome. You have been in the field of drug treatment for many years. I understand that you, Dr. Maté, have been there for 10 years.

Dr. Maté: Eleven years.

Senator Joyal: Mr. Skinner, you have been there for more than 20 years, so you have long experience. You have probably been witness to the evolution of the understanding of drug addiction generally. What you know today and what you have explained to us today is probably nuance from what the understanding was 10 or 20 years ago. I understand that it is a science and that it evolves.

You touched on this in a side comment in an earlier answer, but I would like you to expand. On the basis of what you have seen in the last 10 or 20 years and what you see now concerning the rates of recidivism when drug-addicted persons are released from prison, how would you describe the emphasis put in public policy on treatment and prevention versus law enforcement? As you described, your approach to the issue has four prongs. You have the perception that the emphasis of governments is essentially on law enforcement, because it is visible. It is more secure, psychologically, to be told that drug users will be locked away; that is more pacifying, so that honest people can sleep in

their homes. In fact, what emphasis has been put on that approach versus the three other approaches that you feel would be more effective to address the problem at its root?

I am not talking about organized crime. Organized crime is another reality. I think we confuse two things here. We confuse the big dealers with the addicted person who tries to get his drugs by reselling small quantities, and so on. I think the major problem we want to tackle must have as much emphasis on the three other approaches as on that approach.

From the experience you have, how would you compare the importance given to the other approaches versus the approach of law enforcement? Are we not going for the easy solution that seems to be the most effective one — namely, to lock them away — versus trying to treat them or approach them with the medical and psychological support that those people need if we want to be sure they will be cured and not be sent back to prison three months after they have been released?

Dr. Maté: The question can be answered simply. If you look at finances, we can say that what a society values is what it spends money on. Money is overwhelmingly spent on enforcement. The percentages are something like 80 per cent for enforcement to 20 per cent for the other three approaches, or higher than that in favour of enforcement. That is why I talk about the three toothpicks and the one pillar. You cannot sustain a building like that: when you put all the emphasis into one pillar, it will not hold the roof up. No wonder the roof is caving in on our policies. Financially, that is where the evidence is.

In terms of political discourse, I hear little about prevention and about child abuse, which is the basis of most addictions. I hear very little about support for families. Ontario now has the daycare bill, which is another issue. The result is that kids will be more isolated from the parents in their lives, and they will be more with their peer group the whole day. Therefore, they will be more inclined to accept the influence of the peer group and so more inclined to use drugs. Unless, for example in those day cares, real nurturing, adult supervision is provided — not just supervision but emotionally nurturing supervision. Even in the field of the Ontario daycare bill, I have seen nothing about the emotional support these kids need. It is all about providing them with good education, and the parents can pick them up at six o'clock in the evening.

I am saying that the whole emphasis on the emotional support that children need is lacking from public discourse. I used to be a high school teacher. It is lacking in the education of physicians, educators, psychologists, and so on, let alone in the justice system. When young criminals get inside the justice system, they get little support. These kids have been in foster care serially and abandoned over and over again because their behaviours are difficult. They end up in the juvenile detention system. You might as well give them a crack pipe or a heroin syringe.

I do not see either the public discourse or the finances going into the other three realms. I see it all pretty much flowing in the direction of enforcement of laws that are impossible to enforce.

Senator Joyal: What about the drug court and the rehabilitation support that they could get once they are found guilty of using drugs or consuming drugs or selling drugs for their own benefit?

Dr. Maté: I think the drug court is a brave and useful attempt; it is a useful step in the right direction. It is not the answer, but it is more humane, collegial and less punitive. It is more of an attempt to respect the dignity of the individual, and anything in that direction I would support. A drug court is an encouraging step in the right direction.

Senator Joyal: Would you care to comment, Mr. Skinner?

Mr. Skinner: I think drug courts are important. It is also important to acknowledge that the champions of drug courts have come from the criminal justice system. They are judges, Crown prosecutors, and people who work in the system in Ontario who have innovated and piloted in that area. There is intelligence and knowledge in that system that could be tapped into having more compassionate and effective responses to people with these problems.

Too often, the court's time is preoccupied with human problems that deserve direction. I mentioned earlier that mandatory treatment for people who are about to lose their jobs is an effective way of getting people to change and sustain changed behaviours. Most people do not change because they wake up in the morning and say, ``In my heart of hearts, I want to change.'' Basically, people change when the pain of staying the same is greater than the pain of change, as those of us who do motivational interviewing talk about. When someone is brought before the court, that represents an opportunity to create something that gives the person an opportunity to make a change in their life. Drug courts start to do that. Endorsing drug courts and making drug courts a more systematic way of dealing with these people with complicated human problems is a promising thing to pursue.

Senator Joyal: What about the rehabilitation services in prison? How do you evaluate their availability and quality and their effectiveness in producing positive results?

Dr. Maté: I have been invited to speak in a few prisons in British Columbia. My contact with people in prisons and the correctional system tells me that it is not systematic. It is very much dependent on the particular views and personality of the warden in a particular jail. Some are more compassionate; others are more controlling. They think that by controlling they can achieve their purposes.

My limited contact with the correctional system would tell me that there is no overall systematic approach that embraces the bio-psycho-social perspective. That is not surprising, because even the medical profession is slow to come to it.

There are some encouraging examples here and there, but, overall, we are sorely lacking. Mostly, it is an attempt to control and coerce rather than to promote the recovery and development of the individual.

Senator Joyal: In other words, we have not really introduced that approach in the system per se?

Dr. Maté: No, we have not. Furthermore, with the cutbacks, programs are being cut within the jails and outside the jails. The Government of British Columbia cut the only program for addicted youth in Northern British Columbia. Predictably, those kids will end up in the new jails we are building. This is where we are going, and we are doing it with open eyes.

Mr. Skinner: Those are valid concerns. On the other side, Correctional Services Canada has an addiction research centre in Prince Edward Island. They have developed some good programs. I can think of programs for women with complicated mental health and addiction issues. Again, these are pilot initiatives.

The system is not organized around this. However, there are places to start from if we want to look to that and actually say where the investment should be. Basically, the logic that governs the system is not right now a correctional logic, as Dr. Maté has been arguing. If we wanted to turn that way, there are definitely things we could start tapping into that are there already.

Senator Joyal: In your opinion, that would be much more effective than just to build more prisons or add new cells for the purpose of keeping people in prison longer?

Mr. Skinner: Absolutely. This is very much about how we do the work of dealing with people who have been brought before the law. There are ways of doing it that I think would be much more effective. Ironically, they happen to be ways that are compassionate.

One problem is that we are back to a large level of public arousal that is antipathetic to people who have these problems. There is a pressure to come down heavy on them, but the evidence is that when you do that you make them worse in the process. However, you can have processes that help people with these problems to have better outcomes, as well as helping society to better outcomes. It is not just people individually. This is really a public health issue we are talking about, not just individual behavioural change.

Senator Joyal: If I understand the sense of your testimony, it is that this bill has a good intention, as some senators would say, aimed to target organized crime and the big dealers; however, in fishing, it will get all those addicted persons who happen to be more in need of psychological and medical support than, as you said, the punitive aspect that will be put on them, which will not produce the results that we are expecting.

Mr. Skinner: That is a very good summarizing statement. Senators are good listeners.

Senator Mercer: Like Senator Banks, I am not a permanent member of the committee, but I do have a pretty strong opinion. I do not like this legislation.

Dr. Maté, you said something that puzzled me. I followed along and I agree with your summation that most of these people have come from abusive backgrounds and neglect. However, in your last statement you said something about a daycare bill in Ontario.

Dr. Maté: Yes.

Senator Mercer: Am I interpreting this incorrectly? I hope I am. Are you saying that licensed daycare centres could be a contributing factor to later addiction?

Dr. Maté: I know it seems like a far-fetched statement to make, but here is the point of view from which it comes. Again, it is a book that I co-wrote, called *Hold On to Your Kids*, based on the work of a Vancouver psychologist, Gordon Neufeld. He points out that human beings used to grow up in a network of adult attachments and that it takes a village to raise a child. Human beings historically have always developed in the context of the extended family, village, clan or tribe, so that a child had many nurturing adults with whom to connect, such as uncles and aunts, et cetera. If you go to Africa and walk down a village street, everybody calls you uncle even though you are not blood relatives.

Now, in North America, because of economic changes over the last seven years or so, we have lost that. We have lost the clan, tribe, village, community, and even the extended family. When a fishing village shuts down in Newfoundland and the parents have to go to the tar sands of Alberta, all of a sudden they have lost the context in which the parenting used to take place.

In our society, often two parents have to work to make a living to support the family, so the kids are in daycare. It is not that kids should not be in daycare. If that is where they need to be, that is where they need to be.

American research studied stress hormone levels of kids in daycare. In Romania, in those terrible orphanages under the Communist regime, they measured cortisol, which is a stress hormone. If you measure these kids' cortisol levels, they are extremely high. They are stressed. What they found in American research is that kids in daycare have higher cortisol levels than kids staying at home, except in those daycares where there is a decent adult-to-child ratio and a good nurturing relationship.

In other words, the issue is not whether the child is in daycare; the issue is whether or not there is a nurturing, emotionally available adult present for those kids, who is not just there as a supervisor but also as an emotional nurturer.

In the absence of emotionally nurturing adults, kids' brains automatically connect to the peer group, because they have to connect to someone, just like a duckling has to imprint on someone. If the mother duck is not there, the duckling will imprint on a horse, which is not designed by nature to bring that duckling up to adulthood, nor is a human being or a mechanical moving toy.

In the same way, children attach to other kids now, by default. Once they become attached to other kids, they stop developing emotionally, because immature creatures cannot lead each other to maturity. They are more stressed, and if they are more stressed, they are more likely to use drugs. The danger of the daycare situation is not that kids should not be in daycare per se but that we have to make sure that if they are not going to be at home with parents, they should be in daycares where there are parent substitutes, not just supervisors.

Senator Mercer: If a child comes from a loving, supportive family and if the economic circumstances were such that we would have that traditional family environment that you refer to, if a child has that environment but also goes to child care, as long as that child care is one with a good ratio of caregivers to children, then the risk is not as high?

Dr. Maté: That is correct. In other words, the issue for me is not that kids should be with parents; it is that they should be with nurturing adults.

Senator Mercer: We are talking about quality of child care as opposed to child care.

Dr. Maté: Absolutely, we are talking about quality. However, I am concerned that that is not sufficiently understood in our daycares. In our society, there is the phenomenon of kids connected to other kids far more than ever before. If they are not with each other physically, they are texting, phoning and emailing each other. In other words, the main influence on our children's development has become other children, which is developmentally and educationally a total disaster.

Senator Mercer: In universities and colleges across the country where we teach people early childhood education, do we teach them this idea?

Dr. Maté: No. I was here addressing the Canadian Institute for the Family, which mostly gets its support from people who support the Conservative Party of Canada. I was asked to address the group earlier this year, in March or February. I was pleased to be there, because they understand the importance of family and emotional support. I do not agree with their social perspective, but I agree with their emphasis on the importance of emotional support and nurturance for children. Unfortunately, that perspective is lacking in pedagogy, in the education of teachers, daycare workers, physicians, or anyone, for that matter. The importance of emotional attachment, which is the very basis for child development, is largely ignored in the education of the people who look after kids. It is all about intellectual pedagogy rather than emotional connection.

The Deputy Chair: I, too, have a few questions.

Mr. Skinner, do you have access to data on the prevalence of addiction in Canada? I heard you referring to some numbers, and we will hear from the Canadian Centre on Substance Abuse, CCSA, with regard to their numbers on the prevalence of use.

Mr. Skinner: Yes.

The Deputy Chair: However, with regard to the prevalence of addiction in Canada, do you have numbers on that? If you do not have that data with you, could you provide it to us?

Mr. Skinner: I do not have that with me. I am actually using their data about prevalence, which includes determinations of problematic use.

The Deputy Chair: The CCSA numbers?

Mr. Skinner: Yes.

The Deputy Chair: Then we will have access to that.

Mr. Skinner: If there is anything in addition, I will be happy to provide it.

The Deputy Chair: I do not know whether you have read clause 5(2) of the bill, which refers to drug court.

Mr. Skinner: Yes.

The Deputy Chair: In proposed new subsection (5) at the end of that clause, the bill says, ``If the offender successfully completes a program . . ." How do we measure whether the offender has successfully completed the program?

Dr. Maté: Yes, how do you measure it?

Mr. Skinner: There are ways.

The Deputy Chair: Obviously, you understand that we choose words in the bill for a reason, so we have to understand exactly what it means to be successful.

Mr. Skinner: Is there a provision in the bill already, in the background, to actually provide the measure?

Senator Nolin: No. That is why I am a bit puzzled by the word ``successful."

Mr. Skinner: Indeed, colleagues of mine in program evaluation have research skills and could help you with that. You are right to ask how we actually quantify that. What objectives will we set as the measures that this has been effective?

Obviously, there are things like the number of people who reoffended and the number of people who actually enter addiction treatment programs, and ultimately you would want a quality-of-life measure where you actually had the person who was affected subjectively report that the supports they received because of this actually improved their perceived quality of life and their functioning and their healthier lifestyle. Those are more difficult things to achieve, but usually these markers are towards a goal of social reintegration and

personal health. However, probably for your evaluation you will set your markers quite low, what happened in the year after or whatever, and there are ways of doing that. There is definitely scientific method that could be helpful in doing that.

Dr. Maté: I have to say, senator, too, that the usual measures we use are whether this person has used drugs. You can do urine tests or hair samples and know whether somebody has been using drugs over the last few days or months. Have they attended the meetings regularly? Have they gone to their counselling sessions? Have they checked with their parole officer? You can measure that. What you cannot measure is what transformation is taking place inside them. You can measure external behaviour or parameters, but you cannot measure internal transformation, and that will show up one or two or five or ten years later by what trajectory their life has followed. There is no way you can measure those things in the short term because they are long-term outcomes.

The Deputy Chair: Mr. Skinner, the way it is written, the court must be convinced that there was a success unless it imposes the mandatory minimum, which has been suspended.

Mr. Skinner: I see.

The Deputy Chair: So if you were in front of a judge who asks whether an offender was successful, you would rely on the set of answers you gave me, but you, Dr. Maté, would say, ``I do not know because how to evaluate whether the bio-psycho-social environment of the offender was properly evolved. That, we do not know. Nobody knows."

Dr. Maté: In short, I can say yes, they have not used drugs, they have come to all their meetings, and they seem sincere. I can say those things. I cannot talk about long-term success in front of a court.

Mr. Skinner: Certainly there are experts in our organization from a scientific methodology point of view. I am being more hypothetical in my answer. I just realized as you were speaking that your concern is actually the information that will inform a judge's decision.

The Deputy Chair: That is the bill we are being asked to adopt. We need to convince ourselves that the bill will be workable. If you have experts working with you who have written on this or have something they can offer us to reflect on, please inform the clerk, and we will gladly read that.

Mr. Skinner: I will. Thank you.

Senator Milne: Supplementary to that, Senator Nolin, I was taken by Senator Campbell on a very superficial tour of the Downtown Eastside a few years ago, but I also served on the board of Rapport House in Brampton, Ontario, which was a shelter for addicted teens.

My question really follows from what Senator Nolin asked you about. How available are the drug treatment courts in both Vancouver and Toronto to the people that you deal with, your patients, Dr. Maté? Would expanding the drug treatment courts help? There are only six in Canada.

Dr. Maté: I know, and the one in Vancouver is very recent, only in the last couple of years or even less. Statistically, I cannot tell you how available it is. I do not keep such figures. As I say, I regard them as an encouraging, more enlightened step in the right direction. I would like to see both the drug courts themselves and the ethic that informs the practice of drug courts be more widespread in this country. That is my only comment.

Mr. Skinner: The numbers speak for themselves, senator. There are only six, as you say. The span of availability is restricted. I know other submissions have called for the increased availability of these, and I think it would be wise policy at this point to do that.

The Deputy Chair: To add to your answer, Mr. Skinner, the bill also refers to the new concept of provincial programs. It is not only restricted to drug treatment court but is expanded to provincial programs, so it will probably expand the access to services.

Dr. Maté: Senator, if I may make a point: Recently I gave a talk at Simon Fraser University, and there was a policeman there from Victoria. He told me about something that I would encourage you to explore. I did not know about this program myself. He told me that at some point in B.C., a policeman had the power to force people into treatment for a six-month period. If they did not follow treatment, they could be re-jailed. I really had not known about that, and I do not know the name of that bill or legislation. He said it was finally stopped because it just did not work. It would be worthwhile for your committee perhaps to hear from someone who is familiar with that program and why it was finally curtailed.

The Deputy Chair: Do you remember the name?

Dr. Maté: No, I do not.

The Deputy Chair: If we had some information about that, we could explore it.

Dr. Maté, how many youth are included in the addiction population of the Downtown Eastside?

Dr. Maté: As I say, I have been working there for 11 years. I have been struck by the increasing number of young people coming down there.

The Deputy Chair: When we are referring to youth, we are talking about ages 18, 19 and younger?

Dr. Maté: I am talking about people in their teens and late teens. I do not tend to treat the ones who are the street kids, as they are not the population I serve, but I have been struck

by the increasing number of young people down there, particularly going to the crystal meth epidemic that has been identified, particularly in B.C. but elsewhere in Canada as well. The population is getting younger. As a matter of fact, some of the older addicts feel more threatened now because of the presence of these more aggressive young people down there.

The Deputy Chair: Thank you both for your testimony and comments. It will be very helpful.

Colleagues, we have to deal with some documents that were referred to by the witnesses that are available on the Internet. In some documents, we have URL addresses. Unless I get a motion from the committee to accept the address as a proper reference, we will have to transcript everything that is on that address. I do not think that would be appropriate. I need a motion that, for documents that are available on the Internet, the URL for documents rather than the documents themselves be appended to the committee proceedings.

Senator Milne: So moved.

The Deputy Chair: So moved. Thank you very much. We meet again in two weeks, on November 18