Testimony of Keith Humphreys, OBE, Ph.D. to the House of Commons Standing Committee on Health hearing on the opioid epidemic and the toxic drug crisis in Canada, December 11, 2023, Ottawa.

Thank you for the opportunity to speak with your distinguished committee today. My name is Keith Humphreys and I am the Esther Ting Memorial Professor of Psychiatry at Stanford University School of Medicine and a former White House drug policy advisor to U.S. Presidents Bush and Obama. Today I will briefly summarize some of the key conclusions of the Stanford-Lancet Commission on the North American Opioid Crisis, which I chaired and which published its main conclusions in the Lancet medical journal last year. The Commission comprised North American clinicians, scholars, and policy makers who carefully studied the opioid crisis in the U.S. and Canada and made recommendations for how to resolve it.

In both of our countries, the opioid crisis originated in the health care system when insufficiently regulated pharmaceutical companies and health care providers increased per capita opioid prescribing by about 400% in a little over a decade. The fact that these drugs were legally made and of consistent, known quality did not stop them from addicting millions and killing hundreds of thousands of people across North America. Some of those who suffered were patients, others were individuals who gained access to medication prescribed for others that was given or sold to them through diversion. When prescription opioids are distributed in the community with little oversight, it is easy for each person who receives them not only to become addicted but also to initiate addiction in others.

To their credit, both the U.S. and Canada have subsequently taken significant steps to make opioid prescribing more judicious and safe. However, the expansion first of heroin and later of fentanyls in illicit drug markets has continued to cause great suffering, as you all well know.

The Commission recommended the expansion of robust evidence-based prevention programs targeting individuals not yet using opioids coupled with treatment and harm reduction strategies for

those who are already addicted. Many of these strategies are in place in multiple locations across Canada, including methadone maintenance clinics, syringe exchange services, drug courts, residential rehabilitation programs, and initiatives that distribute the overdose rescue drug naloxone. The Commission saw no reason that harm reduction and treatment programs could not be offered side by side: promoting public health should be a shared journey and not a competition.

The Commission also endorsed the goal of recovery from addiction for all services, meaning that while it is clearly valuable and moral to save someone's life today for example from an opioid overdose, it is important not to yield to the soft bigotry of low expectations by assuming that surviving from day to day is all an addicted person could be helped to achieve. Tens of millions of people in North America have recovered from addiction, restoring their health and humanity while simultaneously benefitting their families and communities. Increasing the number of people who leave active addiction and enter recovery is a worthy goal to which all service providers and policymakers should aspire. This is the animating spirit of the recovery-oriented system of care currently being built in Alberta, a model I had the privilege of advising on over the last year, and which I believe should be spread nationally.

The Commission recognized that "safe supply" programs which distribute pharmaceutical opioids and other drugs in the community are a subject of significant discussion in Canada, so I will close by mentioning that the Commissioners were skeptical of such programs. The reason is simple: we have seen this movie before. If handing out prescription opioids with minimal supervision were good for community health, neither the U.S. nor Canada would ever have had an opioid epidemic. The first decade of the crisis should have taught us that the fact that a drug is legally produced and of known quality is no barrier to it causing addiction and death.

Further, as the early years of the opioid crisis showed, it only takes a small amount of diversion to new users for an opioid distribution program to increase the prevalence of addiction. Even if we

assume optimistically that 90% of people in a safe supply program take all provided drugs exactly as prescribed, and the other 10% divert only enough to each generate 1 or 2 new cases of addiction a year, the number of addicted people doubles every 5 years. The Commission therefore recommended keeping faith with the prevention, treatment, and harm reduction strategies I have just described which have evidence of making our shared addiction crisis better rather than worse.

Thank you again for the opportunity to testify today. I look forward to your questions.