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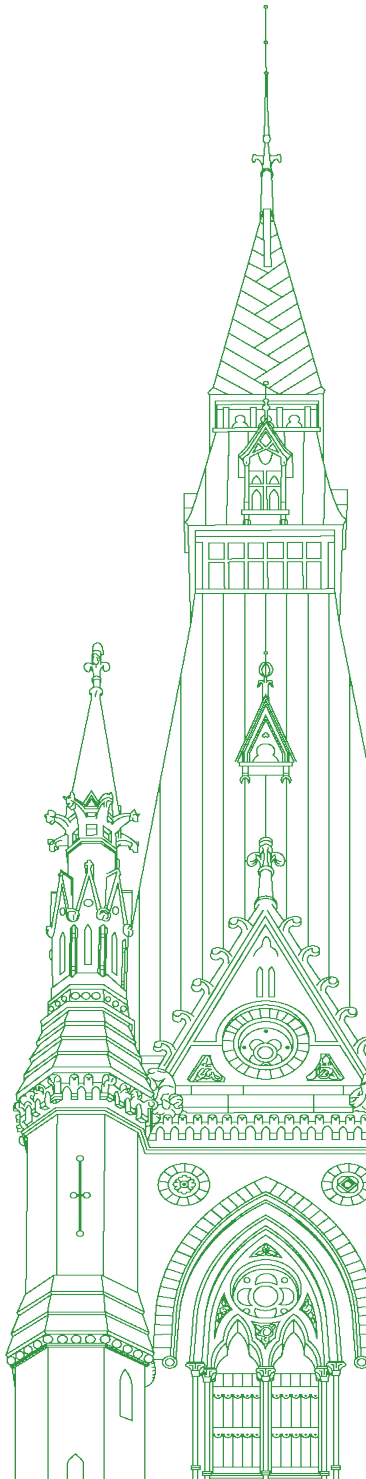

Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, October 22, 2024

● (1110)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 133 of the House of Commons Standing Committee on Health.

Before we begin, I would ask everyone in the room to have a look at the guidelines on this card. The measures are in place to help prevent audio and feedback incidents, and to protect the health and safety of all participants, including the interpreters. Thanks for your co-operation on that.

In accordance with our routine motion, I'm informing the committee that all remote participants have had the required connection tests administered. We're having a challenge with Mr. May, but it's not going to further delay the start of the meeting. I expect that we'll get along just fine. I just want you to know that's done.

Before we begin, I would like to remind members that the clause-by-clause consideration of Bill C-277, on brain injuries, is this Thursday. The deadline to submit amendments is in another 51 minutes. At noon today, the amendment package will be circulated as soon as possible after the deadline passes.

Pursuant to Standing Order 108(2) and the motion adopted on November 8, 2023, the committee is resuming its study of the opioid epidemic and toxic drug crisis in Canada.

I'd like to welcome our panel of witnesses. We have with us today Jean-Sébastien Fallu, associate professor, Université de Montréal, appearing online.

We have Masha Krupp in the room. She is a mother who has lost her daughter to a methadone overdose, and whose son has an opioid addiction.

From the City of Toronto, we have Dr. Eileen de Villa, the medical officer of health.

Thank you all for being with us today. As has been explained to you, you will have up to five minutes for your opening statement.

[*Translation*]

I now give the floor to Jean-Sébastien Fallu, who is appearing by video conference.

Mr. Luc Thériault (Montcalm, BQ): Mr. Chair, could I ask the interpreters to speak closer to the mike?

Thank you.

The Chair: Thank you very much, Mr. Thériault.

I don't think I need to repeat your request. I'm sure the interpreters will do as you asked.

Mr. Jean-Sébastien Fallu, welcome to the committee.

The floor is yours.

Mr. Jean-Sébastien Fallu (Associate Professor, Université de Montréal, As an Individual): Thank you very much, Mr. Chair.

Mr. Chair, Vice-Chairs, Members of Parliament, thank you for giving me the opportunity to testify on the study of the opioid epidemic and drug toxicity crisis in Canada, a subject I have been advocating about within organizations for ten years.

As an associate professor at the Université de Montréal for twenty years, I am also editor-in-chief for the journal Drogues, santé et société and a full-time researcher at the Centre de recherche en santé publique at the Institut universitaire sur les dépendance, and the Recherche et intervention sur les substances psychoactives Québec, or RISQ. I also founded the Groupe de recherche et d'intervention psychosociale, or GRIP, which has been operating in harm reduction in festive environments for almost thirty years. Finally, I am someone with lived and ongoing experience with drug use.

It would have been nice to be with you in person, but I am currently in Lisbon for two science events: the Lisbon Addictions 2024 conference and the International Society of Addiction Journal Editors meeting. Yesterday morning, I presented with Carl Hart, a world-renowned neuropharmacologist, who has written several books, including his latest, *Drug Use for Grown-Ups: Chasing Liberty in the Land of Fear*, which is an essential read.

The drug overdose crisis, or rather the drug poisoning crisis, is above all a crisis of public policy and stigma. My testimony is primarily focused on the stigmatization of people who use drugs as well as policies and their adverse effects. I will pay particular attention to the importance of an informed discussion and highlight the social determinants of health.

The COVID-19 pandemic exacerbated the drug epidemic. The number of deaths has increased from roughly 3,700 in 2019 to more than 7,300 in 2022. Contamination (fentanyl and analogues, nitazenes, benzodiazepines, etc.) also plays a central role in this escalation. It is crucial to understand that criminalizing and punishing people who use drugs is ineffective, stigmatizing and aggravates the situation. Despite the complexity of the situation, one thing remains clear: Stigmatizing people who use drugs impedes their access to care and escalates the crisis.

We need to refocus our analysis on the root causes of this crisis: contamination in an unregulated market due to prohibition policies, failure to prioritize the social determinants of health, and stigma and social exclusion.

Stigma manifests in at least three forms: self-stigma, social stigma, and structural stigma. Stigma is associated with many harmful effects. First, there is dehumanization—which is bad, because we're talking about human beings. There is also shame, loss of self esteem, distress, anxiety, depression, social isolation, and increased substance use—which is the exact opposite effect that very stigmatization is seeking to achieve. There are also decreased requests for assistance, discrimination in access to housing, care and employment. These effects lead to poverty, a deterioration in mental health, incarceration and even suicide. In short—and this is not a slogan—stigma kills.

Stigma is a social determinant of health. Reducing stigma is an essential goal, despite ideological discourse that suggests otherwise. Reducing stigma includes using people-first language that's accurate, balanced and unbiased; educating the public, and transforming social representations, all with the ultimate goal of transforming laws and policies around drugs.

Substance use has always been an integral part of the human and animal experience. Trying to eradicate these behaviours is like opposing the very nature of human beings and animals or trying to beat air. As a result, prohibition and criminalization not only fail to achieve their goals but aggravate the situation by exacerbating the crisis.

Moreover, our neoliberal policies contribute to misery and poverty. Prohibition policies create a toxic market that escalates the crisis. That is the prohibition paradox. What's more, the social determinants of health are far from optimal. In the face of these toxic markets and the failure to prioritize social determinants, we insist on stigmatizing, excluding and blaming individuals, which only exacerbates the problem.

● (1115)

For decades, our approach to substances has been stigmatizing and disconnected from reality. Rather than asking why, we continue to use the same approach with the hope that we'll achieve different results.

In closing, I would add that some people say decriminalization in Oregon or British Columbia was a failure, but that is not true. Decriminalization is only a small part of the solution. It does not solve problems of poverty, access to housing, health care, social services and treatment. The same holds true for access to decent jobs. In terms of solutions, several insufficient and irrelevant proposals are often put forward.

However, having read the briefs and testimonies, I can see that the majority of recommendations are in line with mine, which includes: rethinking drug policies in favour of an approach that is geared towards public health and human rights; promoting harm reduction services as well as access to health care and social services for people who use drugs; investing in all social determinants of health, including access to care and stigma reduction; decriminalizing, regulating and legalizing drugs; implementing harm reduction policies; and finally, developing more services and decentralizing them to avoid clustering.

I can define and clarify these recommendations as I answer your questions.

Thank you for your attention to this matter. I'm available to answer your questions.

The Chair: Thank you, Mr. Fallu.

[*English*]

Next, Ms. Krupp, welcome to the committee. Thank you for being with us. You have the floor.

Ms. Masha Krupp (As an Individual): Thank you.

I want to thank you all for inviting me to speak today, for giving me the opportunity to share my lived experience with the methadone treatment and safe supply programs.

I'm going to touch very lightly on one issue.

My daughter, Larisa, died in September 2020 from methadone toxicity, 12 days into her methadone treatment. I wanted to bring this to the forefront because there are other ways of dying. This was at the hands of a doctor at Recovery Care here in Ottawa who did not conduct an opiate tolerance test on her prior to starting her on the methadone program. Unfortunately, 12 days into her program, she overdosed because of the dose the doctor gave her two days prior.

I think it's important to know that methadone is a great tool to get a person on the path to recovery, but we also have to look at how it's dispensed and prescribed, and whether the doctors prescribing this know what they're doing and are not skipping any steps.

What I really want to talk about today and focus on is the protracted and lived negative experience with my son, who is in active addiction. He's been under Dr. Charles Breau's care at the Byward Market Recovery Care location on Rideau Street since June 2021, and on safe supply under Dr. Breau's care since the fall of 2022. He's prescribed 28 hydromorphone pills daily, in addition to his current dose of 45 milligrams of methadone. He was on methadone last year, as high as 165 milligrams. He's still using street drugs. Three years later, my son is still using fentanyl, crack cocaine, and methadone, despite being with Dr. Breau and with Recovery Care for over three years.

As soon as he was put on safe supply, he started diverting his safe supply. Most of the patients I see coming out of this clinic on Rideau Street—I see them in front of me—coming out of Dr. Breau's office, coming out of the pharmacy right in front of where I'm parked. I've taken pictures. They're counting out these white pills. Dealers come out of nowhere, and they hand them a little thing wrapped in plastic. I see them move a couple of feet, and they're smoking and injecting right on the street. This is my experience with safe supply, my experience with my son.

I have gone in to see Dr. Breau myself, as has his father, over the last two and a half years, asking for a treatment plan, asking for counselling, letting the doctor know that he's using fentanyl, that he's using crack cocaine and we're worried about overdosing.

The doctor really didn't respond to anything. His answer to me was, my son is the one who has to ask for the treatment plan, not me. For the last couple of years I have essentially been monitoring my son. I moved in with him. In fact, three or four weeks ago, I had to call 911 because he overdosed. This is all under the care of Dr. Breau and Recovery Care clinics. We're into three-plus years. Why am I still calling first responders when these clinics, as is my understanding, under SUAP are receiving millions of dollars in funding, $10-million plus to date? Their websites purport to have a treatment plan, individualized for each patient, mental health counselling for each patient. They have one mental health counsellor, to my knowledge, across four clinics, who is only available virtually more often than not.

As someone with lived experience and who has observed what is going on outside of the Recovery Care clinic on Rideau Street for the last three years, for the diversion I'm witnessing, not just with my son but with the people outside the clinic, this is not working. I feel that safe supply has its place and can be helpful, but the dosage has to be witnessed. You can't give addicts 28 pills and say, here you go. They sell for $3 a pop on the streets. You've got drug dealers.... I know this for a fact, through my son. I've seen it. They come to your home 24-7. You can call at 2:00 in the morning. They take your hydromorphone pills. They supply the crack.

● (1120)

Fentanyl is now down to $60 a gram. It used to be $120 or $170. Addicts are like my son, who still wants to get clean through the type of care that he's receiving at Recovery Care specifically, because that's my lived experience.

Dr. Breau, in my opinion, knows what's going on, because I told him that I suspect my son is diverting. I want to know why he's getting so many pills. Where's the treatment plan? Where's the mental health counselling? I need to save his life. Three years in, I should not be calling 911; they're already overextended.

In closing, what I want to say is that I see no evidence of all this SUAP funding—which is taxpayers' dollars, yours and mine—being spent on treatment and recovery at Recovery Care for their patients. I believe that we have to move away from what is a harmful drug legislation model to a hopeful recovery-focused model, where you've got detox treatment, mental health treatment, assistance in acquiring housing and employment skills. I believe that safe supply can work only if it's witnessed and dispensed and there's a treatment plan attached to it.

As I said, I've been trying to keep my son alive for the last three years. He's been in the safe supply program. I have spent hours, weeks and months—his father and I—as we've been looking for a treatment program. We've been looking for something that's based on recovery. At this point, what we see is that all roads point to the Alberta model.

Thank you.

The Chair: Thank you, Ms. Krupp.

Next, we have, from the City of Toronto, Dr. Eileen de Villa, medical officer of health.

Welcome to the committee, Dr. de Villa. You have the floor.

Dr. Eileen de Villa (Medical Officer of Health, City of Toronto): Thank you very much. Good morning. I do appreciate the opportunity to appear before the committee today.

As you have heard, my name is Dr. Eileen de Villa, and I'm the medical officer of health for the City of Toronto.

As I believe this committee is aware, I contributed to a joint brief, along with colleagues from Montreal and Vancouver, that was presented to this committee earlier this year. That brief spoke to the nature of the toxic drug crisis in Canada's largest urban centres, so I'm very pleased to be here today to join you and expand on that information that was already provided and certainly to answer any questions you may have.

Before I go further into my remarks, I do want to note that as I talk about data that are related to the crisis, to the epidemic that we see today, I'd like to note that I do so with respect and with a deep appreciation for what these data mean. As you have just heard from my fellow witness, we're talking about people. We're talking about people who are our loved ones, our friends, our families and our colleagues.

One of the reasons I'm here today is to share with you some stories from our clinic, where I have an incredible team of colleagues who support hundreds of clients every single day.

I simply cannot overstate the heroic efforts of our frontline service delivery partners, some who work directly with me and some who work throughout the system in Toronto. They have seen the epidemic escalate over the past decade, as my fellow witness, Professor Fallu, mentioned. My colleagues have experienced immeasurable grief, as have many communities throughout Canada. My colleagues have saved thousands of lives, and they continue to show up every day to work despite the enormity of the loss that they have experienced and the unrelenting nature of the epidemic we are witnessing.

I do want to tell you about our clinic in the heart of downtown Toronto operated by us at Toronto Public Health. We offer a full range of services and referrals, and we actually see a very high volume of clients every year. In fact, last year, 2023, we supported 18,575 client visits, and over 21,000 client visits to our supervised consumption service at Toronto Public Health in 2022.

As you know, supervised consumption service sites are clinical spaces for people to bring their own drugs to use in the presence of trained health professionals. I know this committee has heard that Canadian and international evidence and our own experience in Toronto show that these sites do save lives and, yes, we do connect people to social services, and we are a pathway for many to treatment.

There are currently 10 of these sites located across Toronto operated by a range of health providers and funded by a variety of sources. The demand—and need—for these services is high.

Across the 10 supervised consumption sites in Toronto, there were just over 96,000 visits in 2022 and just under 95,000 visits in 2023. Amongst these visits, staff at these services responded to almost 2,000 visits in 2022 where overdoses occurred and almost 2,300 in 2023. We saw those many visits with overdoses, and we responded to them.

In addition to providing medical interventions for overdoses, the sites also offer thousands of referrals to health and social services annually, roughly 6,500 in 2022 and almost 10,000 in 2023. In addition to providing direct medical care, we know that the sites serve as an important entry point to a fragmented, although well-intentioned, health care system. We do help link individuals to further sources of care and, of course, to connection, which is an important component of that care.

When people talk about harm reduction, this is what it looks like in our clinical spaces. These harm reduction efforts are meant to work hand in hand with connecting clients to a range of treatment options.

● (1125)

At Toronto Public Health, we operate the only injectable opioid agonist therapy clinic in the city. We currently have funding to provide this treatment option to roughly 35 clients at any given time, although I can tell you that this funding is time limited.

This program offers injectable hydromorphone to medically and socially complex clients who may benefit from this treatment approach, which is delivered on site in our clinic and in an observed fashion. This particular program also includes wraparound services and supports for clients, observed doses and monitoring, a coordinated referral network, case management, and overdose and prevention education.

Eligibility for this program follows national clinical guidelines and focuses on those who are at greatest risk of overdose. I should note that the average length of treatment in this program is a little over 50 days—53 days roughly—although every client will have a different experience. That's the case when we see other health issues and health matters. There may be an average, but there is a slightly different experience, depending on which person we're talking about.

When it comes to this kind of treatment, we have observed and noted that some people will start and stop treatment multiple times. That's why it's incredibly critical that we have a range of options available to meet individuals where they are in their journey.

When we look at our data, we see that since opening the doors, the program has served a wide range of clients, ranging in age from 24 to 62, with 73% of the clients identifying as male.

● (1130)

The Chair: I would ask you to wrap up, Dr. de Villa. You have some people anxious to ask you questions.

Dr. Eileen de Villa: I will wrap up. Let me just tell you a little bit of a story.

The Chair: Be quick, please.

Dr. Eileen de Villa: With respect to this service, we have seen really incredible results.

I was just telling my fellow witness here, before the committee began, about an individual client who presented to our service. She was pregnant at the time that she presented to our injectable opioid agonist therapy program. She went on to have a successful pregnancy, a healthy baby, has actually successfully completed the treatment and is now housed. She has actually gained custody of her other children and is living a happy and healthy life.

I think there is lots of opportunity here. There are a range of issues and a range of options that need to be made available. We've heard about the importance of policy, but we need strong approaches as well—prevention, harm reduction and treatment—that take into consideration all the conditions that optimize health and give people the best chance of reaching their full potential.

Thank you very much.

The Chair: Thank you.

We're now going to begin with rounds of questions, starting with the Conservatives for six minutes.

Mrs. Goodridge, go ahead, please.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you to all of the witnesses for being here today.

I'm going to start out.

Masha, I'm so sorry for the loss of your daughter. You are wonderful for the support you're giving to your son in helping him find recovery.

After nine years of very marked change in addiction policy where this Prime Minister, Justin Trudeau, has decided to flood the streets with dangerous opioids and create....

Mr. Chair, thank you. The mic of the witness was not on mute.

Can I have my time back?

The Chair: Yes, go ahead.

Mrs. Laila Goodridge: Thank you.

After nine years of marked changes in Liberal addiction that's flooding the streets with dangerous opioids, legalizing drugs like crack and heroin in British Columbia, and normalizing drug use for a whole new generation, do you believe that has played a role in making it harder for your son to find recovery from addiction?

Ms. Masha Krupp: I certainly believe that the safe supply, as it's been administered to him in the last two and a half years, has definitely played a role because he's.... The word is “diverting”, but let's use the real word: it's called "trafficking".

I've had the police over to talk to him about what he's doing. He fears law enforcement enough that he's not wanting to go to jail. He doesn't have a criminal record.

Yes, in my view and my lived experience, with the safe supply in my son's case there's no treatment attached to it. It's just the doctor giving him all of these pills. He diverts them, gets the drugs he needs and he's still an addict.

In my view, if he didn't have these pills and was receiving methadone, or if he was receiving his hydromorphone under witness dosage and there was a treatment plan attached to it, I believe it would be successful.

As it stands now, to me it's not successful. It needs to be overhauled. There has to be regulatory oversight.

You're flooding the market, using taxpayers' dollars, with lethal opiates that are making their way into high schools. Adolescents are paying up to $10 a pill for hydromorphone.

How could this be helping us?

● (1135)

Mrs. Laila Goodridge: Well, I think that actually leads into my next question. Do you think that the government calling this “safe supply” and using that term and making it seem like these are somehow safe is a responsible word?

Ms. Masha Krupp: It's an unsafe supply in my view, as a mother with a lived experience in observing how Recovery Care dispenses their safe supply. It's not safe. It's only safe if it's witnessed or, like the doctor here, in their clinic, where it's a witnessed or injectable dosage.

Then I'm all for it, but you need oversight. You need to be audited. You can't dispense these kinds of drugs to addicts and expect them to take them as they're prescribed—like, come on....

Mrs. Laila Goodridge: It's interesting. Do you believe that the government has effectively become the drug dealer in cases like your son's?

Ms. Masha Krupp: Well, let's see. The doctor is dispensing the hydromorphone pills by legislation—federal government legislated. You've got the federal government. You've got the doctors involved. You've got the pharmacies. Then you've got the street drug dealers. I would have to say that at a higher level, yes, our Liberal government right now is acting like a drug lord maybe: here's your hydromorphone, the doctor gives it here, here's my son and there are the street dealers. It's a chain, so yes.

Mrs. Laila Goodridge: It is terribly concerning.

In one of the things you said in your opening statement, you talked about how your son goes to this Recovery Care clinic. You have to take him every single week, but all he gets is a scrip, and he does a drug test. He doesn't actually get any counselling.

I went onto the Recovery Care website. They talk about mental health, and they seem to talk about the fact that this exists, but you're saying that in the two years that your son has been part of this program, he hasn't received mental health support. Is that correct?

Ms. Masha Krupp: No, the only thing is that when I have faxed letters to Dr. Breau, or the few times my son allowed me to go to talk to him, he would come home with a sheet of photocopied anything anybody could access, you know: Narcotics Anonymous, the mental health crisis line, the suicide line.

It's almost an affront to me as a taxpayer and a mother of an addict, because I know they're getting this funding. Are you telling me that with your $10 million-plus you can't have an extra counsellor in your clinic on site?

None of the things they claim in their website, in my experience over three years, has ever been realized with my son.

Mrs. Laila Goodridge: To your knowledge, has he actually received counselling from a counsellor at Recovery Care clinic?

Ms. Masha Krupp: No.

Mrs. Laila Goodridge: Has he ever to your knowledge received virtual counselling from a counsellor associated with Recovery Care clinic?

Ms. Masha Krupp: I think once. The counsellor's name is Jimmy. My daughter had the same one, even though she was at a different Recovery Care clinic location. Jimmy was the counsellor across all four clinics.

Because this was during COVID, initially during COVID it was all done virtual. My son did agree early on in the program, before the safe supply kicked in, to speak to...because we, as his parents, were giving him ultimatums: if you don't do counselling, we're going to have to.... You know, we were trying to leverage some sort of consequences. He spoke to Jimmy once. For the second appointment, Jimmy dropped it. For the third appointment, my son dropped it. That was it.

Mrs. Laila Goodridge: That's incredibly troubling. Thank you so much for sharing.

My next question is for Dr. de Villa, really quickly.

You say that they are witnessed in the City of Toronto. Is that what you were pushing for was all witnessed...? Is that why you moved towards trying to get Toronto to have decriminalization and a legalization of drugs like crack—to have more witnessed programs? Or was this to just have a free-for-all?

Dr. Eileen de Villa: Through the chair, what we're trying to do is provide evidence-informed advice around how to address a very, very challenging situation on the ground—

● (1140)

Mrs. Laila Goodridge: Witnessed—yes or no?

Dr. Eileen de Villa: We offer a clinic service that is witnessed, but I recognize that there is a range of different options that are required to meet the different needs of different people.

The Chair: Thank you, Dr. de Villa

Thank you, Ms. Goodrich.

[*Translation*]

Mrs. Brière, you have six minutes.

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you to all the witnesses for joining us today.

[*English*]

Thank you, Mrs. Krupp, for sharing your story with us.

[*Translation*]

Dr. de Villa, you heard the questions asked by members of the Conservative Party and the answers provided by Ms. Krupp.

Under what circumstances should the injection or use of drugs without a witness be permitted?

Are there situations in which that possibility should be excluded?

[*English*]

Dr. Eileen de Villa: Through the Chair, I thank you for your question.

I think that each encounter with an individual patient, as is the case in any medical encounter, actually rests with an assessment of what the individual's needs are and how best to meet them. I will be very upfront with the committee: I'm a public health physician, so I actually am not actively engaged in individual patient care, but from my training when I did do individual care, it is incredibly important to actually understand what the unique diagnosis is for the person in front of you. What are the circumstances in which they live? How, then, do you provide the best evidence-informed treatment intervention, recognizing what the best medical treatment is. How do you make that medical treatment as successful as possible, given the unique living circumstances of that person?

We know that, whether you're treating high blood pressure or diabetes, each person will require a slightly adjusted version of the treatment. There are general guidelines, but how to apply those guidelines depends on that individual and what actually makes sense.

[*Translation*]

Mrs. Élisabeth Brière: Thank you.

Mr. Fallu, thank you for participating in this meeting, even though you are currently overseas.

You heard the questions and answers. My question is quite simple: What do you think of them?

[*English*]

Mr. Jean-Sébastien Fallu: I think I'm going to answer in English this time.

First of all, I'm also deeply saddened by any drug deaths, because of the many factors involved. I ask the chair and the members of the committee that we stop politicizing this debate. I said in my testimony that we need a fact-based debate.

Policies have not changed that much. There have been no major policy changes in the last nine years. We're still under criminalization and prohibition, and we're still stigmatizing people, which prevents them from accessing treatment. We're not flooding the streets with drugs; prohibition is flooding the streets with drugs. Of course, there may be diversions, but that's only a tiny part of the major problems we're facing from decades of prohibition that brought this toxic supply. That's the fact. Experts agree on that.

If we don't change our way of thinking, we're just going to continue this crisis and these deaths. People are dying. When I hear that we should adopt a recovery model, I'm sorry, but we've already been in a recovery model for decades. That's where the money is—way more than in prevention or harm reduction. There has been a tiny change in the last years, which was deeply needed, to add other tools to a continuum—a spectrum of services to answer different needs and walks of life.

The Alberta model.... This is a false dilemma. It's a sophism, and it's not prevention or harm reduction or treatment. We need all those things. We need everything. Any serious person I know who will defend harm reduction will also be in agreement with recovery. In fact, in his testimony, Dr. de Villa told you that harm reduction accelerates access to treatment, to recovery, because it's a first contact for people. Even with the Alberta recovery model, I'm sorry, but we just learned that they're under-declaring deaths, so that model is not one to follow.

We need to have more recovery, of course, but we need to change our way to address this problem. That's what I think about it.

● (1145)

[*Translation*]

Mrs. Élisabeth Brière: Thank you for your answer.

Do you have solutions or recommendations to propose?

Mr. Jean-Sébastien Fallu: The solutions and proposals are the ones I mentioned in my remarks. I could elaborate on those, but, indeed, you will never solve such a problematic issue without doing a number of things. We must invest in all the social determinants of health. We have excellent care in Canada, but it's quite difficult to access. People are struggling to access health care and social services. There is a crisis in access to housing, and the policies in place stigmatize people and exclude them. That creates a toxic market. Let's stop kidding ourselves.

Canada first banned poppy tea and opium, and then morphine, heroin and fentanyl. Every time a substance is banned, other more dangerous and unknown substances emerge. A toxic market exists because of our own policies.

We refuse to recognize that substance use is part of human nature. I've said it before: It will never go away. We must find a way to regulate the market. It exists, and it will always exist. We must choose whether to allow organized crime to control the market, leave it in the hands of multinationals, or entrust the government with the responsibility. There are risks, of course, because there will never be a perfect policy. There are certainly drawbacks to each of them, but we have to find the best one. The best policy is not to back down on prohibition; it is to provide a framework for the policy.

The Chair: Thank you, Mr. Fallu.

Mr. Thériault, you have six minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

Ms. Bruyère already asked the questions I had for you, Mr. Fallu. I will now try to clarify a few points.

Could you explain what you are referring to when you talk about structural stigma?

Mr. Jean-Sébastien Fallu: Structural stigma comes from policies and regulations, whether they're general laws or rules from within organizations. Fundamentally, our laws will dictate what we do in relation to drugs.

At its core, stigmatization is a process by which individuals are labelled as non-mainstream and immoral. As long as legislation is designed to punish and prohibit de facto substance use, there will certainly be stigmatization.

My presentation yesterday was about the importance of reducing the stigma of drug use rather than reducing drug use itself. People, and even ideologues who claim to be experts in the field, have spoken out on this issue. This is the case, for example, of Mr. Keith Humphreys, who wrote an article in The Atlantic containing many false arguments and many red herrings. Such people are relying on botched logic.

Structural stigma is caused by our laws. By prohibiting normal human behaviour that has existed since the dawn of time—and always will—we stigmatize, exclude and kill people. As I said, stigmatization has so many negative effects that, in the end, it kills people.

Mr. Luc Thériault: Earlier, you touched on the fact that Alberta was under-reporting mortality rates. You said you'd learned that the number of deaths reported by Alberta was lower than the true number.

How did you find out about this?

Mr. Jean-Sébastien Fallu: That observation was made by an independent author. I could track down the source of this document, which was published just two days ago.

● (1150)

Mr. Luc Thériault: That information would indeed be quite useful to the committee in drafting its final report.

You said that drugs should be decriminalized, regulated and legalized. However, the debate is becoming polarized. On the one hand, Oregon is backtracking, as is British Columbia. On the other hand, Alberta claims that detoxification is voluntary and that it is the gold standard.

What failed to work in Oregon and what failed to work in British Columbia?

Why do you say it's not a failure? Under what conditions could it have worked?

Mr. Jean-Sébastien Fallu: I could speak about a number of things, but I'll try to be brief.

If we just decriminalize drugs, as some states or provinces have done, without addressing access to care and treatment or without improving access to housing and decent jobs, nothing will change. I'm talking about social determinants. No one ever claimed that decriminalization would solve the overdose crisis.

Decriminalization does ensure that people do not end up with a criminal record. It also allows for destigmatization, but that's not enough. As everyone said, it is a half measure and, since it won't have the desired effects, people will call it a failure and we'll backtrack. That's exactly what was predicted, and I was at the forefront in saying so.

Decriminalization is not going to solve the problems that were born of capitalism or poverty. There are people living on the street who are unemployed, who are homeless and who have mental health issues. Policies need a much broader scope. It's just one small step. We have to go further and regulate the market. Obviously, that is simply one tool in the arsenal.

According to experts, the number of deaths or people with substance use problems is similar, with or without decriminalization. In that case, why do we continue to criminalize people? Why violate human rights and continue to criminalize people if it has no effect?

I will now address mandatory treatment. Scientific data has its limits, as always. Some experts say that mandatory treatment is about as effective as voluntary treatment. Based on my reading of the scientific literature, mandatory treatment is less effective. Most importantly, we need to know how to manage the risk of death or trauma. However, that's not part of the conversation.

As we know, people with addictions often have trauma. How do we determine the threshold for imposing treatment? Shouldn't we begin by looking at the root causes of addiction, such as the social determinants of health and poverty, as well as trauma, for example? Should we not ensure access to care rather than impose mandatory treatment?

In closing, I have one final question. Could voluntary treatment be made available before making it mandatory? It's not even accessible, and there's still a stigma attached to it. In other words, this is not a service that the public and politicians see as a priority when allocating public resources.

The Chair: Thank you, Mr. Fallu.

[*English*]

Mr. Gord Johns (Courtenay—Alberni, NDP): Thank you, Mr. Chair.

First, Ms. Krupp, I also want to send my condolences to you for the loss of your daughter. I also want to thank and commend you for your courage in supporting your son and for your advocacy. It's all of our jobs to help support your son. The goal of this committee and of this study is to provide recommendations to keep him alive and to find a pathway to a better life.

You talked about drug replacement therapy having its place. Can you speak about the place that you would like to see it play?

Ms. Masha Krupp: Do you mean the safe supply and how the hydromorphone is being dispensed?

Mr. Gord Johns: Yes.

Ms. Masha Krupp: From my lived experience, I'm hearing all these answers to questions and all this long-windedness, and I can appreciate it, but I want to know how many people in here, in this committee, have lived what I have lived through. You can talk about references. I point to the Alberta model only because we're desperate as parents to find something that will save his life. There, they are monitored. We need something monitored.

We can't be dispensing drugs that are making their way to the streets. It's a currency for drug addicts and for people like my son. This hydromorphone is a currency unless it's strictly regulated, perhaps in a pharmacy setting or perhaps in a setting like the doctor here talked about, but it cannot be given to them 28 pills at a time, every day, for them to go and trade them for street drugs. You're defeating the purpose of safe supply.

● (1155)

Mr. Gord Johns: Do you feel that the provincial government in Ontario is doing enough to support people who are struggling—the Conservative government there—in this toxic drug crisis we're facing right now?

Ms. Masha Krupp: I don't know very much about what's going on in Ontario—I've been more focused on Ottawa—but from what I've learned today from Dr. de Villa, I would have to say regarding the clinics she's talking about, I would look at bringing my son there because it's witnessed dosage. Maybe that will help. I want to get him away from where he can sell. The only other option I have is to call the police and put him in jail, and that's not an option. I want to get him away from a situation where he is diverting his safe supply—plus all the other patients I see. These people are homeless and marginalized, but they deserve treatment, not selling their stuff, walking around in a daze and collapsing on the sidewalk 12 blocks from here. Any of you members could go down there, walk and see what I see every Friday.

Something has to be done, and I'm not sure which.... I don't want to politicize it, either, but what I'm hearing today from Dr. de Villa gives me a bit of hope for some change. Something has to be done. You're just producing more addicts. You're introducing hydromorphone into the high schools—that's a fact—and if everybody's okay with that, then let's not politicize it: Let's just pretend everything's A-okay.

Mr. Gord Johns: Thank you again for your courage in fighting for your son.

Dr. de Villa, earlier this year the federal government rejected Toronto's application to decriminalize drug possession for personal use within the city's borders. Both the federal government and the provincial government in Ontario say that this is a health issue, not a criminal issue. The Minister of Mental Health and Addictions said in a statement that the city's request didn't adequately protect public health and public safety. We know this is a debate in British Columbia, where law enforcement say they need more tools, but law enforcement, the chief coroner of British Columbia and the chief medical health officer still support decriminalization. Do you believe that decriminalization is an important tool in the response to the toxic drug crisis? Do you think the request could have been modified to address concerns about public safety, like was done in British Columbia, and if so, how?

Dr. Eileen de Villa: I do, as does Professor Fallu, believe that the answer, the solution for us lies in a broad range of interventions. I think we need everything: more prevention, harm reduction and treatment and, yes, better drug policy. The evidence actually shows that this makes a difference, and that criminalizing people for drug use is actually not successful. It wasn't successful for alcohol; it will not be successful for other drugs. I think that's the short version of the story.

I regret that our application was not seen as supportive enough of—and you use the words—"community and public safety". I assure you that, of course, while our application was made while keeping in mind people who use drugs and protecting their health as much as possible, it's also about the rest of the community, right? I'm a public health physician. My job is actually about the population's health, and that includes everybody. That application was developed with a broad range of stakeholders, with public consultation and, yes, with the involvement of law enforcement—although we recognized and we still argue, as does the evidence, that, at the end of the day, when we're talking about substance use, it should be appropriately treated as a health issue. However, policy certainly makes a difference, the environment within which we're operating makes a difference and, as Professor Fallu said on a number of occasions in front of this committee today, we absolutely need to think about the broader social determinants of health. Substance use and substance use challenges do not occur in a vacuum.

● (1200)

The Chair: Thank you, Dr. de Villa.

Mr. Gord Johns: Can you confirm that the police were on board—

The Chair: Thank you, Mr. Johns.

Next we have Mr. Doherty, please, for five minutes.

Mr. Todd Doherty (Cariboo—Prince George, CPC): To our witnesses, thank you for being here today.

To Mrs. Krupp, our family does have lived experience. My brother lives on the street, and has been on the street for years, struggling with his addiction. I lost my brother-in-law to an overdose, also an uncle, so I really, truly, appreciate your testimony today.

Dr. de Villa, is your position today the same as in 2018, when your office released a report in which you recommended the legalization of highly addictive and deadly drugs such as heroin, meth, cocaine and fentanyl? Is that still your position today?

Dr. Eileen de Villa: Thank you, Mr. Chair.

My position is that we need to take an evidence-informed approach to substance use—

Mr. Todd Doherty: Okay.

Dr. Eileen de Villa: —and that the current criminalization of those who use drugs is actually not serving our shared objective of—

Mr. Todd Doherty: So, legalization of those—

Dr. Eileen de Villa: —a better, healthier, society.

Mr. Todd Doherty: So, you agree that we should be legalizing heroin, meth, cocaine and fentanyl.

Dr. Eileen de Villa: I think we should be treating substance use as a health issue, and we need to modernize our existing policy approach to substance use.

Mr. Todd Doherty: You're a public health physician. Is that correct? You're not actively involved in these centres; you're a public health physician who drafts policy. Is that correct?

Dr. Eileen de Villa: I do not provide direct clinical treatment.

Mr. Todd Doherty: Okay. Thank you.

Dr. Fallu, I appreciate your testimony today.

You called decriminalization in B.C. a success. Are you aware that the leading cause of death for children aged 10 to 18 is overdose?

Mr. Jean-Sébastien Fallu: Yes, I am, but—

Mr. Todd Doherty: Is that a success to you?

Mr. Jean-Sébastien Fallu: Do you want me to answer?

Mr. Todd Doherty: Yes, please.

Mr. Jean-Sébastien Fallu: Okay. You know, I'm a scientist, and I know that causal attribution is really complex. You cannot, because something is higher than before decriminalization, attribute this to decriminalization. There have been other factors at play—

Mr. Todd Doherty: Okay.

Mr. Jean-Sébastien Fallu: —such as inflation and housing problems.

Mr. Todd Doherty: I appreciate your answer.

Thank you.

Mr. Jean-Sébastien Fallu: [*Inaudible—Editor*] was a success.

Mr. Todd Doherty: I appreciate your answer.

Forty-seven thousand Canadians have lost their lives since 2016. I struggle to see how that is a success in Canada overall.

I'll go to Ms. Krupp again regarding her comment about safe supply.

We heard from the parents of Brianna MacDonald a couple of weeks ago. She was a 13-year-old who died by overdose alone and in a homeless encampment. Their powerful testimony included how the words "safe" and "drugs" don't belong "in the same sentence".

Would you agree with that?

Ms. Masha Krupp: I would most definitely agree with that.

Mr. Todd Doherty: How old was your daughter when she died?

Ms. Masha Krupp: My daughter was 46.

Mr. Todd Doherty: How old is your son today?

Ms. Masha Krupp: He's 30.

Mr. Todd Doherty: Do you believe that the federal government has fooled people into believing that opioids and other drugs are safe based on the marketing of harm reduction programs?

Ms. Masha Krupp: I believe that there needs to be education for sure. I had to educate myself on safe supply, methadone, things like the half-life of methadone and the recommended doses when you're starting a program.

In my daughter's case, the doctor started her off on a 30 dosage, yet the literature I reviewed across Canada and the United States, including all the medical associations, recommend a 10 to 20 dosage. He started her at 30, and he didn't do an opiate tolerance test. There are all kinds of things that parents need to be aware of.

In terms of Brianna, the tragedy there is beyond me. This is a 13-year-old, and the fact that the parents couldn't get her the help that they desperately tried to get her.... Their hands are tied by policies, by legislation and by the ignorance of the general.... You have to be living it daily.

Let me tell you how I spent my Sunday.

● (1205)

Mr. Todd Doherty: Please wait just one second. I just want to get this online.

Have you witnessed safe supply being diverted into the hands of children?

Ms. Masha Krupp: I haven't with regard to children, but I have with regard to adolescents.

Mr. Todd Doherty: How about teens?

Ms. Masha Krupp: Yes, I have seen it with teens, once, downtown.

Mr. Todd Doherty: It was downtown.

Ms. Masha Krupp: They knocked on our car window. My son had just gotten in from his Friday visit. The boy looked to be about 19, and he tapped on the window. I said to my son to lower it, and the boy asked for hydromorphone. He begged for two pills. He said, “I'll give you 20 bucks.” I said, “I'm really sorry. You can go to the clinic,” and we drove off.

That's right; it was just blocks away from here.

Mr. Todd Doherty: Thank you.

The Chair: Thank you, Ms. Krupp.

Thank you, Mr. Doherty.

Dr. Powlowski, you have five minutes, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Interestingly, I think we perhaps see a little bit of convergence of opinion. I'm not a fan of safe supply for reasons that—can I call you Ms. Krupp?

Ms. Masha Krupp: Call me Masha.

Mr. Marcus Powlowski: —Masha has talked about and concerns about diversion, and for a lot of people on harder stuff, Dilaudid doesn't cut it anyhow, because they go on to use harder stuff. I'm also, for the record, not a big fan of decriminalization. I think the police need to have the legal means to control people who are publicly using and selling drugs.

What you have said, though, Masha, is that you think it's a totally different thing when you're actually witnessing safe supply, where someone gets the drugs there and don't bring it home, but possibly sell it. That is certainly what Dr. de Villa has talked about in this one clinic.

We've heard a lot about the evidence of safe supply. In fact, from my reading of the literature, a lot of the evidence comes from places like Europe, where they've done a lot of heroin-assisted treatment, which is exactly that: witnessed treatment. And this is a Swiss model, where people can come in two to three times per day and get a witnessed dose of intravenous drugs. For the most part, they don't go home with drugs. Someone described our safe supply and getting a whole bunch of Dilaudid as the poor man's version of that because it's more expensive to have a witness program. You, I think, have already said something, but again, for the record, if you had the option of bringing your son to the clinic that Toronto Public Health has where he would get witnessed doses of intravenous medications, would you think that that would be better than the treatment you currently receive?

Ms. Masha Krupp: Yes, and I think I mentioned that to you before we started: If I could take him to a clinic here in Ottawa where he would get an injection, whether it's two or three times a day, most definitely I would.

I also want to clarify that I'm not in support of decriminalizing [*Inaudible—Editor*]...this is just another path. I'm not a supporter of that either. The police do need to have a means.... I have seen the proliferation on Rideau Street and in the Byward market, of all these people, because there's a safe injection site right next to Recovery Care. It's not working; you cannot normalize drug use.

I was there on Friday and I had to go to the drugstore to get something. I'm not a fearful person and I get to know all these people who are diverting and using right in front of the clinic, in front of all the tourists and parents walking by with kids. This guy, he's always got a big stick and he's higher than a kite—you can see that and he's twirling it and sometimes he gets angry. I'm gauging the situation: do I walk around him? Do I wait? Do I go somewhere? Why am I supposed to be dealing with this? Is this safe supply? Is this what decriminalization will do? Safe injection, I support but why are they doing everything out in the open if safe injection and safe supply are working?

Mr. Marcus Powlowski: Dr. de Villa, in that clinic you have, which actually provides intravenous Dilaudid, my understanding is that you only have 35 patients on that drug. I know with the Swiss model with heroin-assisted treatment, they put thousands of people...and these are hard-core drug users; these are not teenage kids. These are not people who have been using it for a few months and maybe spiralling down. These are people who have been using it for years, often people who have repeatedly gone to jail, and they kind of accept it and they failed everything else. Literally thousands of them have been put on it. You have just 35 in Toronto.

Should we be considering expanding that access to the clinics? For example, for Masha's son, that was available for the real hard-core cases, the ones that you can't get off anything else. Should we be opening more clinics like the one you have? I think you told me you were actually going to lose the funding for that clinic.

● (1210)

Dr. Eileen de Villa: Through the chair, very briefly, yes, of course we should be expanding treatment options like the one we have in Toronto and many other treatment options. We should also be expanding prevention options. We should be expanding harm reduction options and we should be modernizing our existing drug policy. It's the notion of decriminalization as a policy support to more access to better services, real access to services, plus addressing the social conditions within which these health challenges take place. The notion here is not to endorse widespread unregulated use, but as Professor Fallu says, the reality is that this is human behaviour. It's incredibly complex, and it requires a nuanced and complex discussion, and nuanced, complex solutions.

To think that one simple change, or one avenue, or one approach will actually change this is just not reasonable. In fact, it's not evidence informed. What I've sought to do across the board, whether it's with decision-makers here at the federal level or at the provincial level, or certainly at the local level, is to put in front of you the best available evidence on the challenges we see that are impacting the health of our citizens.

The Chair: Thank you.

Dr. Eileen de Villa: Thank you.

The Chair: Thank you, Dr. de VIlla.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

Mr. Fallu, as I understand it, you're not the only one arguing that prohibition and criminalization lead to stigmatization. This situation is an obstacle to improving the lives of people with addictions, and even to treatment. Diversion helps to counter some of the stigma. If someone loses their job because of their criminal record, that doesn't get them closer to treatment.

Isn't diversion decriminalization to a lesser degree?

Since we're talking about police forces, they seem to be stakeholders in this approach, particularly in Quebec and Montreal.

Is that the case?

Mr. Jean-Sébastien Fallu: Diversion is the approach Quebec has taken recently, as has Portugal, where I am at the moment. This approach was adopted in 2000, and it was implemented in 2001. It's been 25 years.

It's definitely a step in the right direction. Decriminalization doesn't prevent the police from intervening. Again, we need to have an informed debate about this. The police do respond here in Portugal. They police cannabis across Canada. There are rules. However, decriminalization creates a grey area that allows the stigma to continue. It's certainly a first step, but it doesn't solve everything. We need to stop condemning decriminalization for things it can't fix.

Since Mr. Doherty put words in my mouth, I'm going to set the record straight. I never said that decriminalization in British Columbia was a success. It's probably better than prohibition, but it's a half measure. It's not enough. It doesn't solve all the problems, but at least it solves some of them.

The Chair: Thank you, Mr. Fallu.

[*English*]

Mr. Gord Johns, please go ahead for two and a half minutes.

● (1215)

Mr. Gord Johns: Thank you, Mr. Chair.

I'll follow up on that. We know that Alaska saw a 45% increase in toxic drug deaths last year alone, and its death rate is now higher than British Columbia's. In fact, Lethbridge is triple that of British Columbia where they closed safe consumption sites. In Regina, where they don't have a safe consumption site, it is 50% higher—actually more than that— than British Columbia for their death rate. Baltimore is 400% more than British Columbia. Tennessee and West Virginia are both higher. They don't have safe supply. They don't have decriminalization.

Professor Fallu, you hear politicians blaming safe supply flooding our streets or decriminalization as the drivers of the death rate. Maybe you can comment on that. I will say that in British Columbia, the death rate went from 7.9 per 100,000 to 30.3 under the Christy Clark and John Rustad government in the three years prior to the NDP government, and that actually went from 30.3 to 46 under the B.C. NDP, but then it came back down to 41 since decriminalization.

Maybe you can speak about that because that provincial government didn't have safe supply, and it didn't have decriminalization.

Mr. Jean-Sébastien Fallu: I don't say "safe supply". It's quite unfair to talk, and continue to talk about, safe supply. I hear more Conservatives, if I may politicize this a little, talk about anti-harm reduction, and safer supply advocates use the word “safe supply”. We use the term "safer", because it's safer than unregulated and uncontrolled substances that are on the market. That's prohibition. Prohibition is refraining from have some rules and quality controls. It stigmatizes people.

Safer supply is an attempt to do something, because this problem is basically at its very core a problem of deaths. If people die from overdosing, it's because they don't know what they're taking. I took fentanyl in a hospital setting. I knew what it was. It was under medical supervision. Fentanyl is not a dangerous drug. The danger is not knowing what you're taking. Let's say if you go to a liquor store and buy alcohol, you need to know what's in it. Either it's 5% alcohol or 95%. How can you have responsible use? It's impossible.

Safer supply is a way to have a plaster, a band-aid solution, on something that's very much more profound. It's the absence of control in a context where people use and will continue to use, so we have to find nuanced solutions, as my colleague Dr. de Villa said.

Safer supply is maybe new. We need to continue evaluations, but what we know up until now, the balance is on the side of positive effects.

The Chair: Thank you, Dr. Fallu.

Next, we have Mr. Moore, please, for five minutes.

Hon. Rob Moore (Fundy Royal, CPC): Thank you, Mr. Chair.

Ms. Krupp, regarding the term “safe supply”, or “safer supply” as the previous speaker said, Conservatives didn't invent that term. It is through listening to those with lived experience like yourself that we're seeing the evidence of this approach being anything but safe.

When I hear your description of your son's experience and your experience, nothing about it sounds safe. Nothing about it sounds safer. You referred to his so-called safe supply as a currency, and the now its prevalence in high school, its diversion, and the lack of traceability of this so-called safe or safer supply.

Can you comment a bit on that? In your opening remarks, you mentioned that your son is still using crack cocaine and fentanyl. Is he still using these hard drugs while diverting his safer supply?

What about this, in your opinion, is safe?

Ms. Masha Krupp: Again, I'm just going to point to my lived experience with my son. I don't see anything safe about it. How could it be called safe supply, when three-plus plus years later, he's still going to the clinic. He's still seeing the same doctor. All that he's dropped is his methadone, and he's done that himself. I think his methadone should never have been dropped, because the methadone has to be...According to what I've read, you can't drop the methadone if you're still into fentanyl.

All of that is to say that three-plus years later, he's getting his methadone. He's getting his Dilaudid. The Dilaudid is a means or currency for him to continue using crack cocaine, so it's not safe, because he's still using unsafe street drugs. The whole purpose of the safer supply program was to divert addicts from using harmful street drugs.

That's not happening, in my experience. Not only is he continuing to use harmful street drugs, but the safe supply that he's being administered every day by a doctor is making its way where it should not be, which is in the skateparks—my son was a skateboarder. Adolescents have money to buy these pure hydromorphones. I cannot call this safe. Otherwise, my son's results would be different. We're not talking about a month or 30 days; we're talking about three and a half years. There's your experiment of our lived experience of safer supply. Take it from me, it's certainly evidence-based and fact-based.

● (1220)

Hon. Rob Moore: Thank you.

Professor Fallu remarked that nothing has changed in the last decade. In fact, there have been tremendous changes in law. I'm thinking specifically of the current Liberal government's Bill C-5 that now allows those that are importing, exporting and producing—such as in a meth lab—schedule 1, the most serious drugs, to not serve any time in prison but to have house arrest, which puts them back into the community.

Concerning our evidence about your son being able to obtain these drugs, what message do you think it sends to young people if there's no consequence for someone who's running a meth lab or importing cocaine into our country and, all the while, as you described it, the federal government is handing out this so-called safe supply?

Ms. Masha Krupp: I wasn't aware of the finer points of Bill C-5, so thank you for that. I'm going to educate myself on that.

There have been changes. In fact, methadone was.... I want to bring that because I know the doctor said that methadone was highly regulated by Health Canada up until, I think, 2015 or 2016.

Why all of a sudden can everybody dispense methadone at any clinic? A doctor who wasn't trained to dispense methadone killed my daughter. That's a fact.

In terms of house arrest, that's the most ridiculous thing I have ever heard. In other words, you can come and produce crack and whatever, you can be a liberal in a progressive country, but you cannot.... Hard drug use is not normal. It shouldn't be encouraged to be normal. It should be treated, and it should be pointed to recovery. My son doesn't want to be a drug addict. He doesn't want to use methadone, crack or fentanyl. He wants to be normal, but he's an addict, and we have tried to get him help.

Yes, it is very nuanced, as the doctor has said. First of all, if you're producing drugs and selling them on the street, you go to jail. That sends a message. Perhaps people have to start a vigilante thing, and we'll take care of the drug dealers as parents.

Hon. Rob Moore: Well, unfortunately—

The Chair: Thank you, Mr. Moore.

Thank you, Ms. Krupp.

Hon. Rob Moore: Am I out of time, Mr. Chair?

The Chair: Yes, you're out of time.

Next we'll have Ms. Kayabaga, please, for five minutes.

Ms. Arielle Kayabaga (London West, Lib.): Thank you, Chair.

I also would like to extend my condolences to Masha.

Thank you so much to all of you for being here.

My questions are going to be for Mr. Fallu.

[*Translation*]

Good afternoon, Mr. Fallu.

[*English*]

Earlier someone mentioned something about the Alberta model. I looked it up because I've heard about it, but I thought, “Let me dig in a little bit,” when you mentioned it.

The Premier of Alberta said that the Alberta model is working, yet we're seeing that the opioid crisis has contributed to nearly 90% of the deaths in Alberta.

What are your comments about the Alberta model, and what can we learn from the facts?

● (1225)

Mr. Jean-Sébastien Fallu: Thanks.

First of all, once again, I want to say that we have to have a fact-based debate. I never said, as MP Moore said, that nothing has changed. I said that there were tiny, small changes. Please, let's talk about reality here.

By the way, I said I'm a person with lived experience of drug use, and I'm a normal person. I'm not addicted. I've been using since I was 15 years old. I have to rectify that. Everybody here probably uses alcohol in our normal lives, too. Alcohol is a hard drug.

As for the recovery model, recovery is very important, but addiction or a substance use disease is one of the most difficult human behaviours to change. We used to call that a chronic health disease. Even after three years, the success of recovery is really tiny.

We have to put the burden on the evidence of recovery, too. It's very difficult to help people to stop using. Helping people to live better lives reduces use, but people have relapse episodes, and they go back. Sometimes it's a long life to get better. Sometimes it's easier or faster, but overall, recovery is really important. We need all the tools. It may be effective in some cases, especially when people are ready and have other factors helping that, but having only recovery as a strategy will kill people.

Ms. Arielle Kayabaga: Thank you.

I do want to put on the record that not everybody uses. It's very important to note that because it would be misleading to say that everybody in this room or around our country uses. That's not true.

I have a question about the fact that you're very open about your journey of drug use, and you're a professor. Obviously, there are a lot of young people who listen to you talk about prevention. At the same time, you have been very open about your journey of drug use.

How do you manage to be relevant on drug prevention and be so open without glorifying it? This is something that has plagued many communities and affected many families.

Mr. Jean-Sébastien Fallu: That's a very good question.

First of all, you're right; it's not everybody. It's almost everybody when we include medications over a lifetime. It's really rare that somebody uses neither alcohol, coffee, tobacco nor medications, but it's not everyone who uses.

Yes, I've reflected on that. I don't have all of the time I need here to explain my journey, but it's certainly not to glorify drugs. It's really to destigmatize and change the representations. I say this because all of what we see is completely distorted from reality, because there are a lot of people using. Even healthy, active people in our society, contributing taxpayers, judges, police officers, lawyers, journalists and politicians use drugs. Until we just speak the truth, we will be very bad at doing what we need to do in addressing this complex reality.

As Dr. de Villa said, it's a complex thing. We need complex solutions and a nuanced discussion. I don't want to say, neither.... And maybe that is the problem around these debates. We're not nuanced; it's either good or bad. We need to be nuanced. It's not to glorify drug use.

Ms. Arielle Kayabaga: I'm going to pivot my question—

The Chair: I'm sorry. That's your time, Ms. Kayabaga.

Ms. Arielle Kayabaga: I have no more time? Okay.

The Chair: Next is Ms. Goodridge, please, for five minutes.

Mrs. Laila Goodridge: It's Dr. Ellis next.

The Chair: Dr. Ellis, go ahead, please.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thanks very much, Chair.

Thanks, everybody, for being here. I have just a couple of comments.

First of all, Mr. Fallu talked about depoliticizing the situation. I would draw everybody's attention to a social media post in May that reads, “Hey everyone, @PierrePoilievre is a #PublicDanger. He is way more toxic for society than all drugs.” That doesn't sound like depoliticizing this incredibly important debate to me.

That being said, Ms. Krupp, thank you very much for your testimony. I had a chance to read it, and I really appreciate your being here. I apologize for not being able to be here right away.

We talked a little bit about methadone and, of course, the tragedy that happened in your family related to methadone. I once was a family physician and had a licence to prescribe methadone. At that time, it was necessary to prove your competence as a prescriber before you were allowed to prescribe methadone. In my reading, those regulations changed in 2017.

In your mind, if that regulation continued to exist, would that have changed the outcome in your family if you had a competent prescriber?

● (1230)

Ms. Masha Krupp: If those regulations were in place, I believe that, most certainly, my daughter would be alive because the physicians that were dispensing prior to 2017 had to be trained. Now they are not.

For example, Recovery Care has four clinics across Ottawa. Guess how many doctors have the certificate for addictions. One. It's Dr. Charles Breau. None of the other doctors at all the other locations, including the one that my daughter went to, has addictions training.

Mr. Stephen Ellis: Those comments, of course, are very concerning. I think it's something that this committee needs to take into consideration as we draft recommendations around how things need to change in the future.

Dr. de Villa, I found it interesting. I had a chance to read some of the comments you've made.

On behalf of Canadians, am I right in saying that when you talk about legalization and some of the proposals you put forward, you didn't believe there would even be an age limit on the use of unregulated drugs in this country? Is that true?

Dr. Eileen de Villa: Let's be clear. What I have put forward, and what we put forward at Toronto Public Health, is in respect of decriminalization and a nuanced discussion on how to create drug policy that actually better supports health. That has to be a part—

Mr. Stephen Ellis: That wasn't my question. My question was very specific: Does your policy include the fact that there would be no age limit?

Dr. Eileen de Villa: Our decriminalization application did include young people, whom we recognize are actually also very much suffering from addiction—

Mr. Stephen Ellis: I'm sorry, but again I'm going to interrupt you. You're giving us a word salad.

On behalf of Canadians, your legalization program did not have any age limit whatsoever.

Dr. Eileen de Villa: Through the chair, it was a decriminalization application to the federal government and, yes, it considered young people, who are also suffering with challenges of substance use, in order to protect their health.

Mr. Stephen Ellis: Dr. de Villa, I am going to interrupt you there, because you continue to say your same line over and over again. I understand why you're doing that. I assume it's because you're embarrassed to come out and say what the actual truth is.

On behalf of Canadians out there, of course, those of us on this side of the House do realize that young people suffer with opioid use disorder—of course we do—but in the policies we've read that you've put forward, you're talking about legalization, which you want to argue and call by a different name but also not admit the fact that it includes no age limit for young people.

Dr. Eileen de Villa: Through the chair, it was an application to the federal government for decriminalization. Yes, it considered young people, because they are actually suffering and stigmatized related to their drug use and, as well, you'll note that our strategy in the City of Toronto does consider a very broad range of approaches.

We recognize that it is not a simple solution that will actually get us where we, I believe, want to get to, which is a healthier, thriving community.

Mr. Stephen Ellis: Yes, I thank you for that, Dr. De Villa, but what I would suggest to you—

Dr. Eileen de Villa: We actually need better drug policy. We need more more prevention. We need more harm reduction—

Mr. Stephen Ellis: What I—

Dr. Eileen de Villa: —and we need more treatment.

Mr. Stephen Ellis: Excuse me, Ma'am—

The Chair: Dr. Ellis, go ahead with your last question.

Mr. Stephen Ellis: Thank you very much. I appreciate that, Chair.

What we're seeing here is the fact of the matter that neither of Mrs. Krupp's children was born wanting to be addicted to drugs. Everybody over here realizes that, but I think, Dr. de Villa, that what you're failing to realize, and of course why your proposal was actually shot down by the province, is the fact that nobody in this country now believes that legalization of drugs and giving out drugs for free, especially to kids, is in any way, shape or form going to change the narrative of the chaos and drugs and disruption that policies such as yours are allowing to happen on the streets.

I guess the fact of the matter is—

● (1235)

Mrs. Élisabeth Brière: Mr. Chair—

The Chair: Dr. Ellis, that's your time.

Mr. Stephen Ellis: If may just finish up, Mr. Chair, I hope they're happy with tent cities that now exist—

The Chair: We have a point of order from Ms. Brière.

Go ahead.

Mrs. Élisabeth Brière: I have a point of order.

We are not talking about legalization; we are talking about decriminalization.

The Chair: Thank you, Ms. Brière.

Dr. Ellis, are you finished? Your time is up.

Dr. Eileen de Villa: Sorry—

Mr. Stephen Ellis: I don't think there's anything else to say, but thank you, Chair. I appreciate you. I'm not finished, but yes, my time is up.

Thank you, Chair. I appreciate you.

The Chair: Dr. de Villa, you want 30 seconds to respond.

Dr. Eileen de Villa: If I may—

The Chair: Go ahead.

Dr. Eileen de Villa: —again, I will emphasize that, yes, the application that we put forward as Toronto Public Health—

Mr. Stephen Ellis: I have a point of order, Chair.

The Chair: We have Dr. Ellis on a point of order.

Mr. Stephen Ellis: Thank you very much, Chair.

The time, as we know in this committee...you've been very generous in doling out the time in allowing responses. I think the fact of the matter is, though, Chair, I didn't ask a question. It was a very clear statement that, again, is very important to put forward, considering the fact that Dr. de Villa wants to bring forward whatever her opinion is.

When the question is asked, people, yes of course, have time to respond. I didn't ask Dr. de Villa a question. I would say to you, Chair, that giving her a chance to voice her opinion, as she's done three or four times already, is not in the convention of what we do here. It's well beyond time.

The Chair: You spoke right through the time that was allotted and there is some latitude for the chair.

Quite frankly, I think that it's in the interest of the committee to afford that courtesy to the witness. It was a pretty damning monologue. She wants 30 seconds to respond. I'm going to extend that courtesy.

Go ahead.

Dr. Eileen de Villa: Through you, Mr. Chair, I just want to remind the committee that my role as a public health physician is to actually offer the best evidence-informed advice. That's what I put in front of certainly local decision-makers in Toronto, and that's what I would offer to Canadians, although my purview is obviously for Toronto.

This is evidence-informed interventions. I cannot state enough, one, the application we put in front of the federal government was for a decriminalization approach, which is different from legalization, and it further argues for the necessity for more services across the board, including prevention, including harm reduction and including treatment.

The Chair: Thank you, Dr. de Villa.

Mr. Stephen Ellis: Chair, I have a point of order. I would suggest that Dr. de Villa table with the committee the evidence on safe supply and decriminalization that she has.

The Chair: It isn't a point of order. You're open to make that request. Any member is open to make that request. She's also open to provide any additional information she wishes.

We'll go to Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you to all three of you for being here.

Particularly to Ms. Krupp, thank you for your courage in being here. I add my condolences not only for your loss, but for your current nightmare of trying to help your son, who wants and needs help.

Professor Fallu, can I start with you?

I wasn't aware of that quote that Dr. Ellis shared, but I thought it was an interesting one. What concerns you about a large-c Conservative approach to drug use?

Mr. Jean-Sébastien Fallu: Thank you for the question, because I think it's important to explain it, since Twitter—or X—doesn't allow us to say a lot of things.

The reason why I said this was after Pierre Poilievre made a couple of public statements on harm reduction, drug policy and the drug crisis we're facing, quite frankly, there were a lot of half-truths and even lies. I thought, if we want to have a democracy and we want to have a democracy that works, we need to have an informed, fact-based debate, not some emotional, half-truth arguments. That's why I mentioned that.

I don't necessarily want to personalize this, but any policies that are trying to push further and go on the path of prohibition, repression and stigmatizing language, and policies for people who are human beings, who exist and who have fundamental human rights.... Any policies going in that direction—pursuing what we did for decades, which put us where we are—are really bad and unfounded drug policies.

● (1240)

Mr. Brendan Hanley: Thank you.

It's interesting that you're currently in Lisbon. We have talked about the Portugal model frequently in this committee study. Do you think the differing policy in Portugal is protective at all against the incursion of fentanyl into Europe, and into Portugal in particular? What are your observations there?

Mr. Jean-Sébastien Fallu: That's another really good question.

I have to mention that the Portugal model has been evaluated. As with any political or scientific evaluation, there are limitations, so it's difficult to isolate causes and effects. However, we have, scientifically, a consensus that the model here has more benefits than the reverse.

We have to say the model is still a punishing model. Now it's better, but it's not reaching all drug users and heavy drug users. It mainly reaches cannabis users in big cities. It's not perfect. It's really complex to have policies that work.

We need to try something. Portugal did, and it's no catastrophe. It seems to be a step in the right direction.

Mr. Brendan Hanley: Thank you for that.

Dr. de Villa, in the remaining minute of time—I wish I had more time for all of the witnesses—can you tell me your thoughts on the current political climate, especially within Ontario, where there are now the impending closures of safe consumption sites?

How is the current political climate helping or hurting the pursuit of what you describe as a nuanced approach to a highly complex crisis?

Dr. Eileen de Villa: I'm not a politician. I am a physician trying to provide the best possible advice.

I do find that when the conversation turns to the political, it becomes emotionally charged and takes us away from an evidenced-informed discussion, which is incredibly important when we're dealing with this health issue.

What I can say is that supervised consumption services are among the services that have come under recent attack and criticism. When we look at the evidence that's available in Toronto about the implementation of supervised consumption services, we see a 67% decrease in fatal overdoses within 500 meters of supervised consumption services. We see that there is an impact.

These are the kinds of data that need to come forward. There's no question. There's pain and there are challenges.

Ms. Krupp spoke of her own personal experiences, and those are very real. As I mentioned at the beginning, we're talking about people here, and that's all the more reason for us to really focus on the evidence, to think about the facts and to engage in that very difficult discussion, because oversimplifying and—

The Chair: Thank you.

Dr. Eileen de Villa: —suggesting that one method is good and another is bad and there's no—

The Chair: Thank you.

Dr. Eileen de Villa: —gray or in-between is doing us all a disservice.

The Chair: Thank you.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

The toxic drug crisis is complex and multi-faceted. We must be rigorous in our approach. Solutions must be based on facts. I actually think that playing politics with people's suffering is toxic. I wanted to mention to Mr. Fallu that, during one of the Leader of the Opposition's speeches, the Bloc Québécois asked him about the distinction between legalization, decriminalization and criminalization, and he said they were all one and the same.

You operate at an international level, where that kind of answer would not be given much credence. What's toxic is rising in the House of Commons during question period and mixing up legalization, decriminalization and criminalization and further polarizing a debate about coexistence in Montreal by saying that the Mayor of Montreal wants to legalize hard drugs.

Would you agree, Mr. Fallu?

● (1245)

Mr. Jean-Sébastien Fallu: I agree that anything that isn't based on fact and confuses concepts and people is indeed toxic. Statements like that don't make any sense at all.

Many experts around the world are studying drug policy. There are many policy options, including diversion, decriminalization, de facto decriminalization, de jure decriminalization and legalization. There are many models, and they're not the same at all.

Models like decriminalization don't address some of the issues. For example, is Portugal safe from fentanyl? The answer is no, because, when you have decriminalization, which is sometimes called diversion, you don't have quality control. That means fentanyl can show up there. It's probably already there, but it's not nearly as problematic.

I think we need to have an informed debate, talk about the facts, be informed by people who spend their lives studying these phenomena in depth. There are lots of different schools of thought in the sciences, but people do reach a consensus.

We obviously don't all agree. Some people think decriminalization is enough. I, for one, disagree, because decriminalization does not address the fundamental issues of the overdose crisis, such quality control, stigmatization, corruption and the ensuing violence.

The Chair: Thank you.

Mr. Jean-Sébastien Fallu: I would just like to clarify, with respect to legalization, that no one here is talking about giving free drugs to kids.

The Chair: Thank you, Mr. Fallu.

[*English*]

Next is Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: Dr. de Villa, the Conservative Doug Ford Ontario provincial government recently announced plans to close certain supervised consumption sites and prevent new sites from opening. This flies in the face of what we heard in earlier testimony from the deputy commissioner of the RCMP and the president of the B.C. Chiefs of Police, from my home province, who both said that we need more safe consumption sites, not less.

Can you please share your thoughts about the potential impact of these closures on people who use drugs in Toronto and on public safety? For example, do you believe that closures could lead to increased deaths and/or public drug use?

Dr. Eileen de Villa: Through the chair, very briefly, I do believe there is real danger associated with eliminating supervised consumption services.

As I mentioned in an earlier answer, we see that supervised consumption services have actually prevented fatal overdoses. They also happen to be a method by which people are able to connect to important social services, and they serve as pathways to treatment. I think the loss of supervised consumption services will mean the loss of those pathways, whether it's to improve social service or to treatment services.

I think, as well, when we look at what this means, we are seeing thousands of people across supervised consumption service sites making use of those services in Toronto. If those services are no longer available, I think what that means is you'll have more and more people, particularly in the face of an affordable housing crisis, actually using in public and creating the kinds of challenges that we've heard many people around this table speak of, to say nothing of the fact that you will have more overdoses happening in the public realm. That will be a draw, I would say, on paramedics resources, on law enforcement resources and on emergency room visits.

There are some real challenges that I foresee associated with this, given our experience with supervised consumption services, but as I've said already to this committee and to all other parties who ask me about this, we need multiple points of intervention. We need multiple approaches. We absolutely need more prevention. Yes, we need harm reduction, and yes, we need treatment, and we need a better policy environment that actually supports people towards better health, whether they use drugs or they don't.

● (1250)

The Chair: Thank you, Dr. de Villa.

Thank you, Mr. Johns.

Next is Mrs. Goodridge, please, for five minutes.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

Dr. de Villa, as part of the application that you guys put in to make it legal for people to possess a number of different drugs, including crack, heroin and meth, you didn't have an age delimitation, so children could legally carry and use drugs as part of the model you put forward. Do you think it is responsible to have a program for children to have a legal method of using drugs in a recreational model?

Dr. Eileen de Villa: Through the chair, the application that was put forward by us at Toronto Public Health was for decriminalization, which, as we've heard, is different from legalization. I do want to make the distinction, and I've said already to this committee and I will say it again, the notion is not to promote or encourage widespread unregulated drug use. It's to recognize that drug use is happening, and it is actually causing harm to people in our community, including those who are young.

Mrs. Laila Goodridge: Okay—

Dr. Eileen de Villa: The notion is to try and reduce the stigmatization associated with that.

Mrs. Laila Goodridge: I appreciate that. We have very limited time.

In British Columbia, they developed guidelines to allow fentanyl to be prescribed in a recreational model to children under 18. Do you support that?

Dr. Eileen de Villa: Through the chair, again, I'm not familiar with the model in B.C., so it's difficult for me to comment on that.

Mrs. Laila Goodridge: Okay. Do you support so-called safe supply being prescribed to children under 18, yes or no?

Dr. Eileen de Villa: Through the chair, what I support is an assessment of individual patients or people who are under care and using evidence-informed treatment to support that.

Mrs. Laila Goodridge: If the evidence—

Dr. Eileen de Villa: I cannot speak towards any specific situation without actually conducting a proper assessment.

Mrs. Laila Goodridge: Okay. Would you want your children to be prescribed highly potent opioids, if they were under 18, without you being aware of that?

Dr. Eileen de Villa: Through the chair, I would want the medical system to provide appropriate care to my children for what situation they have in front of them.

Clearly, as parents, we want to be involved in the care—I get that—and we have particular legislation in respect of consent to treatment. I think that's important as well.

To my mind, what we need to do is create an environment that actually allows for good medical care to be provided to individuals, regardless of their age, and we need all of the approaches to be available.

Mrs. Laila Goodridge: You want it to be regardless of their age. You believe that children under 18 should be allowed to be given recreational fentanyl and hydromorphone without their parents' consent, without their parents' consideration, because that's just a good idea.

Dr. Eileen de Villa: That is not what I said. What I said is that we have existing consent-to-treatment legislation. I think we need to observe the laws of the country.

Mrs. Laila Goodridge: That's fair enough.

My last piece.... I'm just gonna go on a little rant here to Dr. Fallu.

I appreciate that you are a tenured professor. You get to basically say whatever you want because that is your right as a tenured professor. One in five Canadians struggles with addiction. That means that four out of five can use substances and perhaps don't fall into the ugly struggle of addiction. However, one in five does not have that luxury. One in five tries a substance and can't stop. I think it is highly irresponsible for you to be in a position of leadership and to be bragging to your students about how drugs have made you a better person. I don't think that sends the right message to students. I don't think that sends the right message to Canadians. I don't think that is appropriate in any way, shape or form.

I would just urge you to understand that addiction is a real, serious issue. The one in five Canadians who struggles with addiction does not have the luxury to experiment with drugs. They don't have the luxury to walk into a liquor store. They understand that the one drink they pick up might be the last time that they go home to their family.

Frankly, sir, we have an epidemic of addiction in universities, and students in those places require support and assistance. I would urge you to consider your words.

● (1255)

Mr. Jean-Sébastien Fallu: Thank you for explaining what addiction is. Let me explain that stigmatizing people and creating misery with neo-liberal economic policies are both core factors of why one out of every five Canadians is addicted. The fact is that with any approach we might have in terms of criminalization, people are still having addictions. It's a human behaviour. It will not disappear. We have to do what science and lived experience tells us is best to help people and reduce this problem, and this is not by stigmatizing and criminalizing them.

The Chair: Thank you, Dr. Fallu.

The last round of questions is going to be by Madame Brière for five minutes.

Mrs. Élisabeth Brière: Thank you, Mr. Chair.

For the record, we just wasted almost five minutes of our time on a refused request.

Dr. de Villa, if my understanding is right, provinces decide on the training of physicians, what they can prescribe and when, and what is getting reimbursed. They also oversee professional boards conducting inquiries on banned prescribing. Is it accurate to say that provinces have a role to play here?

Dr. Eileen de Villa: Yes. When it comes to the regulation of health care professionals, clearly they have a role.

Mrs. Élisabeth Brière: Can you expand a bit on that?

Dr. Eileen de Villa: There are regulatory bodies for health care professionals. I'm probably best positioned to speak to that which is in place for physicians because that's the one that I'm most familiar with.

There's a training process for physicians to go through in order to acquire their medical licence to practice. Through the various provinces' colleges of physicians and surgeons, there are ongoing expectations that you are meant to uphold in the practice of medicine. As well, for those of us who are specialist physicians, we have obligations to our college, the Royal College of Physicians and Surgeons of Canada. In the case of family medicine practitioners, it's The College of Family Physicians of Canada.

Mrs. Élisabeth Brière: Thank you.

[*Translation*]

Mr. Fallu, during this meeting, we've heard a number of comments from people who are in favour of a comprehensive approach, although I don't like that word. It's an approach that includes everything from prevention to harm reduction to treatment.

Does it make sense at this point to be talking about compulsory treatment when we don't even have enough spaces in voluntary treatment programs?

Mr. Jean-Sébastien Fallu: That's absolutely right.

As I was saying earlier, before we talk about forcing people into treatment, let's start by expanding access to treatment. Treatment is hard to access, in part because people are stigmatized. It's much more complicated than it seems. A lot of things have to happen before getting to that point. It's really a last-ditch solution.

Since I'm being personally attacked, I'd like to clarify something. Until people address the issue of drug use in our society from a health perspective, be it mental health or sexual health, they're only going to make things worse and kill people.

Mrs. Élisabeth Brière: That's the reason it's seen as more of a public health issue than a justice system issue.

Would you care to comment on that?

Mr. Jean-Sébastien Fallu: That's absolutely right. That's why more and more people are moving away from the idea that it's a crime issue and toward the idea that it's a public health issue. It's important to remember that most people who consume alcohol and other drugs don't have a problem. Most people who consume psychoactive substances are neither criminals nor ill. It's a behaviour that exists, and that's exactly why I wanted to talk about it. I wanted to emphasize the fact that the representations some people put out there are completely distorted.

A lot of people use substances and are functioning members of society. Unfortunately, the big problem with prohibition is that it's applied in a very discriminatory way. The most vulnerable and fragile people, people living on the streets, are the ones who suffer the harshest consequences.

● (1300)

Mrs. Élisabeth Brière: Thank you very much.

[*English*]

Thank you to all of our witnesses.

The Chair: Thank you, Madame Brière.

That concludes our rounds of questions.

Colleagues, just as a reminder, we have an informal meeting right after question period, from 3:30 until 4:25, with a delegation from the United States House of Representatives. It is an informal meeting, but it would be a bad look if nobody showed up, so if you can make it, it will be great to have you there. We have a hard stop at 4:25 because they're off to meet the agriculture committee, I think, after us.

To all of our witnesses, thank you so much for being with us today.

Ms. Krupp, please allow me to add my condolences for the passing of your daughter, and my empathy for the challenges you're going through with your son. No parent wants to go through that, and for you to be going through that and to have the courage to speak to it publicly.... Thank you.

Thank you to our expert witnesses as well.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: We're adjourned.