HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

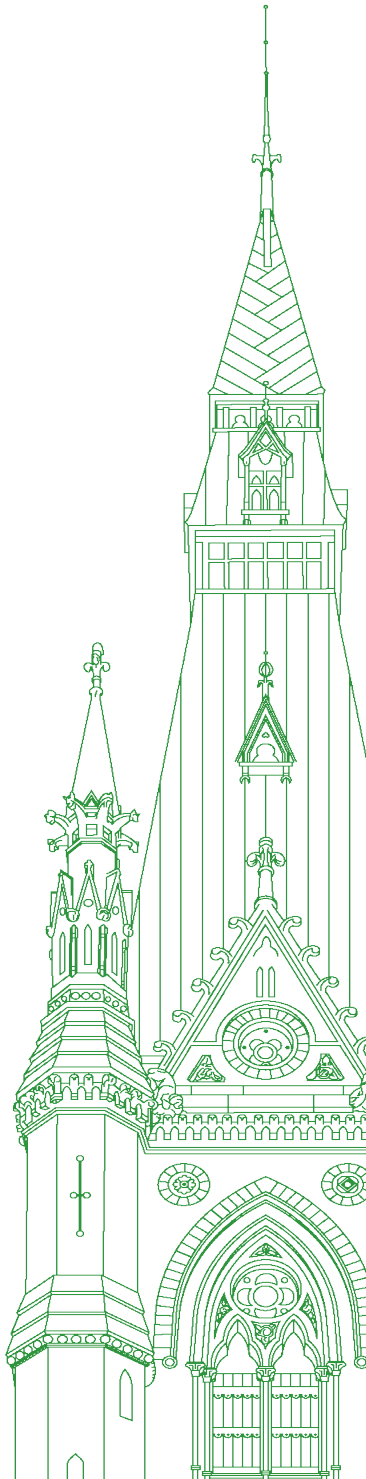
44th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 145

Tuesday, December 10, 2024



Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, December 10, 2024

● (1105)

[*English*]

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

Welcome to meeting number 145 of the House of Commons Standing Committee on Health.

In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

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.

With us here in the room, from the Canadian Centre on Substance Use and Addiction, we have Dr. Alexander Caudarella, CEO. Online, appearing as an individual, we have Angela Welz. Representing the International Centre for Criminal Law Reform and Criminal Justice Policy, we have Dr. Peter German, president and executive director. Representing Planet Youth, we have Dr. Pall Rikhardsson, chief executive officer.

Thank you all for being with us here today. As I expect you have been advised, you have up to five minutes for your opening statement.

We're going to begin with Ms. Welz.

Welcome to the committee. You have the floor.

Ms. Angela Welz (As an Individual): Thank you for this opportunity.

My name is Angela Welz. I live in Edmonton, Alberta. Tragically, my youngest daughter Zoe died from an unregulated, poisoned drug supply. Zoe was a beautiful, smart, athletic, creative and determined young woman with a bright future whose life was cut short by the lack of harm reduction options for youth, inadequate on-demand voluntary treatment, restrictive, prohibition-based policies and a toxic drug supply.

Zoe began using substances at the age of 15 after her grandmother's passing and upon learning of her father's terminal cancer diagnosis. Drug use became a way for her to escape her overwhelming anguish and helplessness. After one of her friends died from drug poisoning, she asked for help to get sober, and we quickly investigated securing treatment care for her. We were told that she would have to travel to Calgary and that the wait was going to be at least three months. This wait was too long for Zoe. Ultimately, it failed. After that, she never brought up voluntary treatment again.

I first learned about Alberta's protection of children abusing drugs model, or PChAD, at a parent support group meeting. PChAD allows parents or legal guardians of youth under the age of 18 to ask the court for a protection order for their child. This protection order means that the child will be taken involuntarily to a protective safe house for up to 15 days for detoxification, stabilization and assessment.

In a state of desperation, I moved forward with the PChAD order, although I was apprehensive and felt intimidated by the process. After an emotional disclosure to an AHS counsellor, I was granted the requisition to go to court. I did not expect the open courtroom, which was filled with other family court cases. I had to stand before a judge, swear an oath and recount the circumstances that had led me to this point. I felt judged as a terrible parent, and the experience left me deeply traumatized.

I was granted the court order. Since it's valid for only 50 days from the time it is granted, the clock started to tick immediately. No opportunity presented itself to act on the order until a couple of weeks before it was to expire. Zoe came home feeling unwell. I took her to the hospital. She was given antibiotics. I was to bring her back every four hours for treatment. Given her aggressive infection, I pleaded with the ER doctor to admit her, but he refused. When the antibiotics were completed and while she was sleeping at home, I called the police to enforce the PChAD order. They arrived, woke her and escorted her out in handcuffs to a waiting police car in front of our home, with neighbours watching.

Zoe was furious and felt deeply violated and betrayed by this. At that moment, I realized what this process had done to our relationship and wondered if she would ever be able to trust me or any authority figure again.

While the staff at the safe house were kind, they provided little information, citing privacy reasons. Part of the detox is having family conversations, but that didn't happen because Zoe refused to see me. Near the end of her 10-day stay, she agreed to see me and begged me not to apply for the five-day extension, so I didn't. Zoe was released into my care at the end of her detox, with a follow-up treatment plan she chose not to share with me. I brought her home. Later that night, she ran away and met a friend she had made at the safe house. The next day, both girls were arrested for liquor theft. This was Zoe's first arrest, which brought on new challenges for her. Zoe died on November 7, 2016 from fentanyl poisoning, less than four months after her 18th birthday.

Let me be clear: Zoe didn't die from addiction. She died from a broken system and the unregulated and poisoned drug supply. Since my daughter died, I have learned that care should never be forced or coerced, and treatment should never be housed in a jail, as some provinces propose to do—including Alberta, which plans to move the PChAD detox program to the Young Offender Centre. How much further can we criminalize substance use, and how much longer will we cause more harm than good?

I have shared my lived experience and the tragic story of Zoe for years now on behalf of Moms Stop the Harm, but the deaths caused by the toxic drug supply continue at a rate that is catastrophic to so many families. As a country, we have regressed significantly, especially in the way harm reduction has been vilified by all political parties. Instead of being recognized as a vital tool in saving lives and supporting people of all ages who use drugs, harm reduction has faced misinformation and political resistance.

It is my hope that we can finally work together to come up with a comprehensive and compassionate plan, beginning with harm reduction services and on-demand voluntary treatment to help end these preventable deaths among youth.

● (1110)

A healthy recovery is possible only if people are alive and well supported. In my experience, involuntary care is not the answer to any hope of that happening.

Thank you.

The Chair: Thank you, Ms. Welz. Please accept our heartfelt condolences on the loss of your daughter.

Next, representing the Canadian Centre on Substance Use and Addiction, we have Dr. Alexander Caudarella here with us in the room.

Welcome back, Dr. Caudarella. You have the floor.

Dr. Alexander Caudarella (Chief Executive Officer, Canadian Centre on Substance Use and Addiction): Chair, vice-chairs and committee members, thank you for inviting the Canadian Centre on Substance Use and Addiction, or CCSA, today.

As you know, the world is rapidly changing. The impact of drugs and alcohol is pervasive. We recently hosted a delegation from the European Union Drugs Agency. We have much in common. We're home to multiple jurisdictions, communities, languages and cultures. There are several differences, but our work together is showing us that we're both facing a rapidly evolving drug landscape.

Drugs are increasingly everywhere and touch everything. This rapid evolution and the threat it poses to people's lives calls for creative, tangible and, perhaps most importantly, reproducible innovations that save lives. There isn't a silver bullet, but I believe our future will be saved by millions of little things and everyone has a role to play. We have much to learn from each other.

[*Translation*]

However, Canada has earned a reputation as a land of one thousand pilot projects. When it comes to moving beyond these efforts, we have much to learn from each other and from listening to communities and diverse perspectives. Every community deserves to feel safe, and every person deserves access to the services and care they need where and when they need it. Those two concepts can and must coexist.

We’ve had some successes in bringing communities together. For example, CCSA is working with mayors of small cities across the country to create the first municipally led pan-Canadian playbook of evidence-based solutions for the substance use crises so many communities are experiencing. This involves bringing together all facets of a community. We know that people are tired of being lectured by experts and having their real concerns discounted. They want menus of options they can tailor to their communities. Together, we are working towards actionable solutions, adaptable to local realities, community goals, and budgets.

[*English*]

We find ourselves in interesting times. We know what is needed and what works, but we have failed to implement it robustly. Fewer than 10% of people have access to the care they need. Opioid agonist rates in Canada are half of what they are in Europe. There's little accountability. We don't set ourselves goals. We don't set ourselves timelines. We know that there's an increased capacity for need and for future planning, but we continue to just react. We don't live and invest in appropriate community and family prevention, and we don't create the right community environments. Specialists and specialty services won't save us. We need recovery-informed environments and whole health systems, ones that can prevent harm but also help people get well and stay well.

We have an implementation problem. We need innovation. There isn't a one-size-fits-all approach. We can't tell people what works and we can't go about doing blanket bans on things, either. What we need now—what we needed yesterday—is real impact. We're trying to build a future. Please help us arm it with evidence-based tools to make it a reality.

We should start with what we know works. We need coordinated access and treatment options. For example, for alcohol and opioid use disorders, there's an injectable form of naltrexone. It's shown incredible promise in helping people stay on their path to health. It's even shown promise with methamphetamines. It's a monthly injection. It's an innovation in substance use health care. It's more empowering than going to the pharmacy every day. Injectable naltrexone remains unavailable in Canada.

● (1115)

[*Translation*]

There's an important discussion currently taking place in Canada around mandatory treatment, and it's a great example of what requires a holistic approach. The current conversation largely ignores key aspects: What are we trying to achieve, and how will we achieve it? As a physician, I can tell you that I have no problem keeping people in hospital beds to save their lives. As a society, we need to talk about what it would mean to support people forced into treatment.

[*English*]

As a field, we keep making the same mistake over and over. We need to stop closing our eyes to the reality that there is no intervention that won't cause harm. We must weigh the benefits and the risks and make informed decisions. We must also engage in interventions with our eyes wide open and prepare for unintended consequences. The flexibility needed is what makes differences between jurisdictions that succeed and ones that don't. We must elevate the conversation beyond ideology. If we don't, more people will die and more communities will suffer.

Thank you.

The Chair: Thank you, Dr. Caudarella.

Next, from the International Centre for Criminal Law Reform and Criminal Justice Policy, we have Dr. Peter German.

Welcome to the committee, Dr. German. You have the floor.

Dr. Peter German (President and Executive Director, International Centre for Criminal Law Reform and Criminal Justice Policy): Thank you, Mr. Chair.

Thank you for the invitation to appear before the committee. I regret that I'm not able to join you in person.

Allow me to introduce myself. I was a member of the RCMP for 31 years, rising from constable to deputy commissioner. I also served as deputy commissioner of Correctional Service Canada.

Since retiring from government, I have authored various reports on money laundering and, more recently, on port policing. I teach at a law school, provide expert opinion evidence and am the author of a text respecting Canada's proceeds of crime legislation.

As president and executive director of the International Centre for Criminal Law Reform and Criminal Justice Policy, I have the privilege of guiding our institute as its associates undertake projects within Canada and abroad.

I applaud this committee for examining the drug crisis on our streets. As a long-time resident of Metro Vancouver, I can state without hesitation that the situation today in the Downtown Eastside is worse than I have ever seen before. It has become a wasteland stretching for many city blocks. People are dying at a greater rate than we saw dying of COVID. Small decreases in the number of weekly deaths do not take away from the fact that this part of Vancouver resembles what has been described as an open-air hospice. There are thousands of human beings bent over and struggling to survive.

The housing crisis exacerbated existing issues: the depopulation of our mental institutions, drug addiction and the outflow of indigenous people from traditional territories.

There was a time when you could walk the streets of the Downtown Eastside in peace; not anymore. Many who live on the streets are carrying weapons for self-protection.

The crisis also extends farther afield to the suburbs of Vancouver and the interior of B.C., exemplified by the 2022 murder of an RCMP constable by a homeless person in Burnaby.

I do not pretend to have a cure for this crisis, and many smarter than I have proposed solutions. I believe it is safe to say that all solutions to date have failed. The number of people on the streets far outstrips the services available to them. Prevention, including education, is vital; so is treatment. My heart goes out to our first witness, Ms. Welz, for what she has gone through.

The one word I do not hear, however, is "enforcement", yet it is through enforcement that we get drugs off of the streets. With the necessary amendments to our criminal sentencing guidelines, it can also allow us to provide individuals with a treatment option.

Canada has been referred to as a high-value, low-risk country for transnational organized crime. It provides a platform for criminals to undertake their activities.

All of those things that make Canada a desirable place to live also make it desirable to organized crime. Combine these benefits with a criminal justice system that does not provide swift justice or certain sentences, and we as a country become an easy target for organized crime.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): No.

The Chair: Please mute your mic, Mrs. Goodridge.

Go ahead, Dr. German. I can assure you that that was inadvertent.

● (1120)

Dr. Peter German: Thank you.

For decades, Canada was a prolific exporter of marijuana. Organized crime has moved into the production of much more serious drugs, including fentanyl and methamphetamine. The discovery of super labs in B.C. is emblematic of this evolution. Canada now has the unenviable reputation of being an exporter of deadly drugs, primarily to Asia and Australia.

Unfortunately, it is difficult for police and prosecutors to maintain complex prosecutions. Well-intentioned judicial decisions have all but tied the hands of police and prosecutors through onerous disclosure requirements, which run up against restrictive time limits for prosecutions. For example, in British Columbia, there are virtually no prosecutions occurring for money laundering. There is a plethora of reasons why criminal investigations and prosecutions are much more difficult to undertake in Canada than in the United States.

Closely allied to the foregoing is the security of our borders, which literally define Canada. We need a secure border strategy to put criminals and others on notice that we are no longer easy prey.

Securing Canada's border starts with our leaky ports. We have no dedicated police in our ports. The Ports Canada police was abolished in 1997, replaced by fences, cameras and security guards. Inadequate resourcing of the RCMP has resulted in a dramatic decrease in its ability to undertake controlled deliveries of illegal substances.

The CBSA has a minuscule capacity to examine the millions of containers entering our ports, many of which are then transshipped by rail or truck to the United States. The merger of CP Rail and Kansas City Southern now makes it easier for cargo to transit from Mexico to Canada and back. While the United States has a dedicated border patrol, Canada relies on the RCMP to provide border coverage as an adjunct to other pressing policing duties.

Members of the committee, the status quo is untenable. Simply throwing more money and resources at the problem is like adding furniture to a sinking ship. We can do better. This will require political and bureaucratic will, but most of all, a national strategy to deal with the crisis on our streets. We must no longer be a patsy for organized crime, allowing it to traffic drugs and launder the proceeds. That strategy must involve the federal and provincial governments and include a strong enforcement component.

Thank you. I'm most pleased to answer any questions that you may have.

The Chair: Thank you, Dr. German.

Finally, I believe from Iceland, representing Planet Youth, we have Dr. Pall Rikhardsson, chief executive officer.

Welcome to the committee, Dr. Rikhardsson. You have the floor.

Dr. Pall Rikhardsson (Chief Executive Officer, Planet Youth): Thank you very much, Mr. Chairman. It's an honour to be here.

My name is Pall Rikhardsson. I'm the chief executive officer of an organization called Planet Youth. We are dedicated to exporting and adapting the Icelandic prevention model to different contexts around the world.

I want to explain what that particular methodology is.

The Icelandic model is a system of prevention focused on demand reduction when it comes to alcohol, tobacco and other drugs. It originated in Iceland. It was developed back in 1995 or 1996, when drug and alcohol use was running rampant among Icelandic youth. If you asked a random teenager back then whether he or she had consumed alcohol and been drunk in the past 30 days, the answer was yes, at 42% or 43%. If you ask a random teenager today in 2024, 6% will answer yes to that question.

The methodology was developed over time. We at Planet Youth have systematized how this model is implemented and adapted to different contexts. We are currently in 22 countries, operating with 53 partners—15 in Canada are focusing on adapting the model. The model itself is based on sociological theories dating far back about the importance of the social environment for kids. In every kid's life, there are four factors that are very important in the social environment, and very important for how they develop and behave: family, peer group of friends, leisure time and school, since that's where they spend most of the time. The tenets of the Icelandic prevention model focus on changing the social environment and these factors so that kids, as they're growing up and becoming teenagers, will make different decisions, which impacts the risk of them becoming substance users.

The model itself is based on different principles and focuses on the social environment, not on individuals. It doesn't focus on telling kids to just say no. It focuses on changing the social environment around them, so they will behave differently when they grow up. It emphasizes community. Community action is at the root of this prevention system, so we engage and empower that community through data and the ability to define actions based on that data. It also acknowledges that this is a challenge that just takes time. It is not a magic solution or silver bullet. This is something that needs time to work.

The method itself is based on 10 steps. The first two are preparation. The next three are collecting data from the children and giving them a voice so they can tell us how they are feeling and about relationships within the four domains I described earlier. After that, the data is put to work. We define actions and dissemination strategies. Then we implement those over time. Now, the data element is critical. All of our partners base decisions about what to do on data. In the model and in our work, getting data back to the partners within eight weeks, regardless of how many students are surveyed, is critical, so they're basing decisions about the kids on fresh data—right here, right now.

The guidance program we run is divided into five-year processes or programs. The first year is when we establish a baseline. There's a knowledge transfer. Then we define what to do, implement that and measure again in the third year—not the same kids but rather the kids subjected to the interventions. Basically, we're measuring the impact of interventions, not individual kids. The fourth year is an implementation year, and the fifth year is a measurement year again. The whole idea is that communities become self-sufficient and continue this process without the help of us or other agencies after that.

We are very much focused on the impact of this. Like I said, we're in 22 countries with 53 partners, and we are running evaluation studies of the interventions being carried out in those contexts. To reiterate, we are not exporting what was done in Iceland. The model does not include interventions. We're exporting and adapting the process by which these results were achieved in Iceland. The interventions and actions always have to be contextual, as we are seeing in the Canadian projects.

● (1125)

The evaluation studies do support that this is having an effect, both on the processes that are being carried out and the impact of the protective factors on the outcomes.

Thank you very much.

The Chair: Thank you, Dr. Rikhardsson.

We'll begin our rounds of questions with the Conservatives for six minutes.

Ms. Goodridge, go ahead, please.

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

I want to thank all of the witnesses for their testimony here today.

Ms. Welz, I'm deeply sorry about the loss of your daughter.

Mr. German, I apologize for interrupting you. I have a sick little guy at home, and I was explaining to him in the background why he couldn't get Alexa to play stuff.

Just to get started, you co-authored a report in 2023 entitled “Policing Our Ports”. What core issues did you identify? What were your key recommendations from that?

Dr. Peter German: Thank you, Ms. Goodridge. I have two grandchildren. I understand exactly what you're dealing with.

Essentially, the report highlights the fact that there are no port police in Canada. How do illegal drugs and human cargo, for example, and other commodities that organized crime traffic in get into our country? They have to come in through the border. That means by plane. It means by vehicle. It means by railway. It means by ports.

Vancouver, for example, is our largest port in Canada. Millions of containers come into this port all the time. There is a lot of contraband coming in. There are seizures. We know that contraband arrives, and yet we have no dedicated port police. That was the number one issue. Our port police, as I mentioned in my opening statement, were abolished in 1997. They have not been replaced. Then there's the federal component. The RCMP simply doesn't have the resources to do what they used to do in the ports.

That would be essentially what we highlighted.

● (1130)

Mrs. Laila Goodridge: From my understanding of the Vancouver Fraser Port Authority's terminal, approximately three million containers a year go through that port. Is that correct?

Dr. Peter German: At least, yes; there is an expansion under way at Roberts Bank terminal, correct.

Mrs. Laila Goodridge: How many of these containers are searched for drugs versus how many are not searched?

Dr. Peter German: I don't believe CBSA releases that number, but we know that it is a very, very small percentage. They would not release that information to us. We also know that even fewer are searched outgoing. As I mentioned, Canada, being a producer nation of drugs, is exporting drugs. Those drugs will oftentimes go by way of ships.

It's a very small percentage. About 30% of what comes in is transshipped into the United States. It actually falls to the United States to do our job for us if we can't do it.

Mrs. Laila Goodridge: Does this make Canada especially attractive to organized crime?

Dr. Peter German: Yes. As I indicated, a number of factors make Canada attractive. I mean, all the good things about Canada make it attractive. We have good transportation, good communications, good governance and all of those things. It means a very stable environment.

We also have a criminal justice system where we don't lock people up and throw the key away. Even getting there is difficult. It is very difficult for police and prosecutors to maintain complex cases. You see money-laundering cases falling by the wayside time and time again. You see police throwing their hands up in frustration trying to make financial crime cases, conspiracy cases and so forth. It's just very difficult to obtain a conviction.

If you're transnational organized crime, what better place to hang out?

Mrs. Laila Goodridge: Does this lead to the fentanyl epidemic we're seeing here in Canada, as our ports are so leaky?

Dr. Peter German: Well, it's certainly one avenue for access to Canada. Fentanyl, as we know, is an extremely dangerous drug. Organized crime traffics in fentanyl, just as they do in methamphetamine. If it's not produced here, then it has to come here somehow. It either crosses the U.S. border or comes in through the ports or airplanes. We actually do a pretty good job of interdicting drugs coming in by air, if they're on the person. Air cargo is a little bit different.

By far and away, though, most cargo entering our country comes via the ports. That is why ports are so important.

Mrs. Laila Goodridge: Thank you. I find that, actually....

Is there a difference between how we treat our ports in Canada and how the port is looked at in Seattle?

Dr. Peter German: We highlighted that in our report. We looked at the American model. The American model is about having, generally speaking, port police. The port police are sometimes a transportation police. For example, in Seattle, our nearest city to Vancouver, they have a well-established port police force that looks after the Sea-Tac airport—the international airport—as well as the seaport.

We also talked to port authorities in Seattle and elsewhere. They can't say enough good things about their port police, because they provide a form of community policing. They know everybody. They know management. They know the unions. They know the terminal operators. They can resolve a lot of issues that our municipal police department simply can't, because they are not in the ports.

The Chair: Thank you, Mrs. Goodridge. That's your time.

Next we have Ms. Kayabaga.

Go ahead, please, for six minutes.

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

I would like to extend my condolences, as well, to Ms. Welz. Thank you for your continued work and advocacy, and for keeping your daughter's memory alive.

I also extend a welcome to all of our witnesses.

Perhaps I can start with you, Ms. Welz.

Could you share a bit about the continued stigma around those who are struggling with addiction? What are your thoughts, and what suggestions would you make to see that evolve?

● (1135)

Ms. Angela Welz: Thank you.

I've been working, for over eight years now, to try to mitigate stigma. It's a very uphill battle. The narrative has to change among so many of us, and we just aren't there yet. We use stigmatizing language. We put people down, particularly people who use drugs. People use drugs for a variety of reasons. My daughter started using drugs to cope with the loss of her grandmother and the potential loss of her dad. He died 18 months after she did. It's been very difficult, and it's a cause very dear to my heart.

I don't know what the answer is to that, but it has to start pretty much at the upper levels. Words like “addict” are very derogatory. Using words like “clean” doesn't do anything. It implies that people using drugs are dirty. We need to move forward and change some of the narrative, and some of the derogatory and stigmatizing words we use. There has to be a national educational piece to try to change that. It's very difficult, because it's been ingrained in so many of us for so many years. The war on drugs created that. It's upward of 50 years now that we've been dealing with some of this stigma.

Unfortunately, I don't really see that changing any time soon, unless we, as people, make those changes ourselves.

Ms. Arielle Kayabaga: You talked about the harms and dangers that the laws for protecting children abusing drugs in Alberta created for your daughter.

Can you expand on that? What would you suggest be done differently?

Ms. Angela Welz: As I mentioned, when parents end up going to the PChAD program in Alberta, it's out of desperation. We have nothing else left in our pocket or tool box. I tried every which way to get Zoe into voluntary treatment. She felt completely blindsided by her substance use and by how it affected her so badly. She didn't want to be a burden on the family because we were dealing with her dad's cancer. She didn't want to cause more harm in that way. We tried several times to get her into voluntary treatment. However, as I said in my testimony, three months is a long time to ask anybody to wait, particularly a youth of 15 or 16 years old. It also means they have to stay abstinent because, for most of these treatments, you need to be abstinent. Asking anybody at the age of 15 or 16, let alone an older person, to be abstinent for that period of time is very complicated.

I applaud Planet Youth. I think that's a very good way to start to have a conversation around youth.

Involuntary care, as I mentioned in my testimony, was horrifying not just for her but also for the rest of the family. I knew when I enacted the court order that I had made a huge mistake, and there was no way I could turn that back. Unfortunately, I saw the ramifications of that. It did much more harm than good.

Ms. Arielle Kayabaga: Thank you so much for sharing that.

Just to tie it in a little bit with that, Dr. Caudarella, you talked about accountability, and I wondered what that looks like for you. In your comments about prevention, you talked about making sure that the families and the environments are right.

What are you suggesting that we could do to have better environments and communities that are preventing children from growing up to become part of this disease that has grabbed our communities?

Dr. Alexander Caudarella: On the second one first, look, the good part is that we know that supporting families and social environments, as our colleague from Iceland spoke about, works really, really well.

What we also know is that those kinds of environments not only help people not develop substance use issues, but then, also, what's going to happen to them when they leave treatment, right? You're talking about people who have 10, 20 and 30 years of life after that. They need to stay well. These kinds of environments are really, really key.

One of the things that's most in common across all these things, and it is dramatic, the differences.... For example—

● (1140)

Ms. Arielle Kayabaga: I apologize, but what did they look like, just so we can take those notes?

Dr. Alexander Caudarella: What did they look like?

Ms. Arielle Kayabaga: I think we're running out of time.

The Chair: That's your time.

We'll have a brief answer, please, Dr. Caudarella.

Dr. Alexander Caudarella: Briefly, they look like teaching parents how to be parents. Many people didn't have parents who taught them what parenting looks like. It means going to places where maybe alcohol and drugs are not a necessity to participate in social things. It means having access to prosocial sports and different things.

Very quickly, I'll say for the accountability that it means tracking things. It means evaluating, but it also means setting ourselves targets. We have to talk about more than just death. Death is one measure that's really hard to control. We have to talk about it and set ourselves goals about what is an ideal percentage of people on OAT. What's an ideal percentage of people in wait times to treatment, for example?

Thank you.

The Chair: Thank you, Dr. Caudarella.

[*Translation*]

Mr. Thériault, over to you for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you, Mr. Chair.

Ms. Welz, I want to start by saying that my thoughts are with you. Your participation in this study and what you're doing honours the memory of your daughter.

The witnesses here today are coming at the problem from different angles, and that's a good thing. Some talk about prevention, some talk about treatment, some talk about harm reduction and some talk about enforcement. We need all of that to try to solve this complex problem.

I'm going to start with Dr. Caudarella.

In your presentation, you said that we know what needs to be done and we know what works, but we haven't been able to put it into practice in a meaningful way. Why is that?

Dr. Alexander Caudarella: I think there have been issues with co-operation. The crisis has caused a lot of heartbreak. In response to that, the federal and provincial governments created a thousand different regimes, each proposing a different solution, and I think that ultimately didn't help the situation.

We don't spend a lot of time talking to the communities themselves to find out what they need. We think we know what needs to be done. As you said, people know the drug component or the prevention methods, for example, but it's not a matter of choosing one or the other. All aspects are important, and we have to find a way to integrate them all.

Right now, we're pitting one community against the other, even when we're talking about forced treatment. We're not discussing anything tangible.

I would say that the problem is really one of communication.

Mr. Luc Thériault: You say that we need to raise the debate above ideological issues. I don't want to ask an ideological question by highlighting that, but what are you referring to?

Dr. Alexander Caudarella: If it were any other area of public health, people would naturally accept the idea that there needs to be a spectrum of interventions and that each area of intervention has a role to play.

Let's take the example of Czechoslovakia, which decriminalized drugs. When it did not get the hoped-for result, it criminalized them again. Then it decriminalized them a second time, but in a different way. It's a learning process. It's not that some things are fantastic and some things are terrible. Each thing is terrible and fantastic at the same time.

Mr. Luc Thériault: You say there's an injectable form of naltrexone. I'm not an expert, but I know that there's a molecule called buprenorphine, which, according to your presentation, seems to have the same effect, and it's available in Canada.

These substances would make treatment much easier, since they're injected once a month and completely change the way the person's brain works. We know that a drug addict's world revolves around their daily use, so if they have everything they need to avoid experiencing adverse effects for a month and are even protected from overdoses, that changes the situation.

Why not focus heavily on that solution?

● (1145)

Dr. Alexander Caudarella: You're right, but I would like to clarify something. Buprenorphine and methadone are agonists. So they're opiates. Nealtrexone, on the other hand, is an antagonist, meaning that it blocks the effect of opiates.

Now, I would really like to know why you can have a family doctor in this country, but you can't be prescribed buprenorphine, for example. It was possible in France during the heroin crisis in the 1990s.

Naltrexone is an antagonist, which means it's the opposite of buprenorphine, but it's one of the only drugs available that can be used to treat methamphetamine and opiate addiction in Europe and the U.S. Some people can't or don't want to take buprenorphine, so naltrexone is another very effective option for people who don't want to take an opiate for several years. It's been prescribed in the U.S. for over 20 years.

Mr. Luc Thériault: Before we even think about mandatory treatments, we need to know why it's so difficult to access voluntary treatments. Why do you think that is? Ms. Welz's testimony is quite eloquent in that regard.

Dr. Alexander Caudarella: There are many reasons for this.

First, these treatments aren't accessible. No triage system is in place to ensure that people receive the most suitable treatment.

Second, why do family doctors know exactly where to send a person with diabetes, but have no idea where to send people who ask about addiction treatment?

We can talk about involuntary treatments. However, before that, there are various rather coercive forms of treatment.

For example, the CRAFT approach focuses solely on the interaction between the person and their family, rather than on a professional interaction with the individual. This approach increases the chances of the person receiving treatment by 700%.

We also know that, for some doctors, the success rate in treatment is 90%. We tell them that they must enter treatment or lose their right to practice medicine.

There are many different models.

Moreover, less than 8% of employers in the country have a policy on the treatment of addiction. This means that 90% of workers—most of them—have no course of action if they ever face an addiction problem. This is an issue.

That's why the treatments aren't accessible.

The Chair: Thank you, Dr. Caudarella and Mr. Thériault.

[*English*]

Next we'll go to Mr. Johns, please, for six minutes.

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

First, I want to thank all of the witnesses. I agree with Mr. Thériault that this is an excellent panel with regard to a wide spectrum of harm reduction, treatment, prevention, education and enforcement. It's critical that we have a comprehensive response.

Dr. Caudarella, you talked about the lack of a plan, the lack of a timeline, with the CDSS. They talk about an integrated, coordinated model, but there is no timeline, no plan and no resources to implement it.

I tabled a bill, Bill C-216, which was defeated two and a half years ago. That bill was to put forward, within a year, a plan. I know that some of my colleagues supported it. They wanted to see a two-year window to come back with a plan to respond.

Can you talk about the importance of actually having a plan, what other countries have done—like, say, Portugal—and how they've responded to health emergencies when it comes to substance use?

Dr. Alexander Caudarella: Thank you.

You'll recall that in my last testimony, I spoke a lot about the need for a whole-of-government approach. It cannot be the departments of mental health or mental health and addictions. It has to be everybody, like we heard before: law enforcement, public safety and health, but also the social services. Everyone has to come to the table.

Yes, there's no federal plan, but I don't know that there's a province that has a good plan with timelines very specifically set out. Again, if this were diabetes, heart disease or cancer, we'd say that we want our treatment rates to get to *x* by *x* date. Why are we so afraid to set those timelines and dates?

On the last part, I'd say this. This is going to sound funny coming from a national organization, but we need to have a laser focus on individual communities. They have spoken loudly: They do not want to be told what to do. For example, in the spring, in Lethbridge, Alberta, we're going to be hosting not just a big meeting but the next kind of plan for our small towns. We want to present the evidence to mayors, to decision-makers, and let them decide.

They need a menu of options. They don't need to be told what to do. We need objectives at a national level, but we need to facilitate local players to make the decisions that are right for them. I think that's critical, and that is what jurisdictions have done really, really well.

The last thing I'll say very quickly is that when we talk about risk reduction, that changes now too. It's not just risk to self. We need to start talking about the risk of violence and the risk to society and what we need to do more broadly.

● (1150)

Mr. Gord Johns: I'm just going to build on that really quickly.

You were actually at the Timmins summit, I believe, and we—the New Democrats—have been calling for a national summit. We had a national summit on auto theft, but this toxic drug crisis has killed more people than COVID, I believe, at this point. Can you talk about the importance of that happening?

Also, you're working with the mayors, I think, the small and big city mayors, in terms of localizing the response. Can you speak about the importance of that, and in a short response, if you could?

Dr. Alexander Caudarella: We've had a number of national events. We think that biting off a little bit that you can chew.... We did one with family doctors. We did one with families about how to approach prevention. Now we're doing one with small-town mayors; they have the same problems as big cities, with less money and less resources. They want to get stuff done.

I will tell you that we had people with “Drug Free” in the name of their organization, and we had provincial harm reduction coordinators, and they got along in those meetings. They want to work together. They want to find solutions that work for them. When you put people together in a room and ask them to take something tangible and walk out with solutions, they get along and they work, because at the end of the day everyone wants a healthier Canada.

Mr. Gord Johns: Thank you.

I'd like just a very quick response. You said that no province or territory has a plan that's concrete in terms of implementation. Do you agree that the federal government needs to lead, given that absence?

Dr. Alexander Caudarella: Well, I think that traditionally.... This is a bit of self-promotion, but the last time there was a national framework, it was actually CCSA that led it.

As you know, the provinces have said quite clearly that they don't want the federal government interfering too much in their business. You have a national pan-Canadian organization that's supposed to bring everyone together and work with both—with the federal government and the provinces and the localities. We need provinces to learn from each other and help each other out. I think CCSA can work very closely with the federal government, but I think this is actually totally in our wheelhouse and in our legislated mandate.

Mr. Gord Johns: Thank you.

Dr. German, in your opinion, what are the most urgently needed reforms at the federal level to reduce organized crime and the toxic drug supply in Canada? This could be either legislative changes or changes in the allocation of resources. Do you want to just expand on your testimony so far?

Dr. Peter German: Yes. Thank you for the question.

Really what we need is a national strategy to deal with organized crime and that wraps up money laundering and drugs and other commodities. We need a national strategy. This is not a problem of the police, of prosecutors, of judges or simply of the laws. It's a holistic problem. There are problems in all of those areas.

Obviously, I think, we have to begin with our Criminal Code. Issues such as the onerous disclosure that just swamps prosecutions, I believe, can be dealt with through rules in our Criminal Code that allow for speedier trials. We see this taking place in the United States. It takes place in other jurisdictions. Why can't we do it?

However, I do think we need this overarching strategy first.

The Chair: Thank you, Mr. Johns and Dr. German.

Mr. Williams, you have five minutes, please.

Mr. Ryan Williams (Bay of Quinte, CPC): Thank you, Mr. Chair.

It's nice to be at the committee today. Thank you for welcoming me.

Mr. German, we've heard this week from President-elect Trump, who's claimed that drugs are being transshipped from Canada to the U.S. How credible is that claim?

● (1155)

Dr. Peter German: Well, we know that illegal commodities go south and we know that illegal commodities come north. We could talk about guns coming north. We could talk about drugs going south. I would not hazard a guess on the actual quantum. I don't know if our law enforcement agencies can provide you with anything accurate.

I would say that most statistics are based on seizures. There are seizures in the United States and seizures in Canada. You really have to use a multiplier on seizures. A very small percentage of illegal commodities actually gets interdicted, so—

Mr. Ryan Williams: We have those stats, Mr. German:

> In the 12 months up to September 2024, US border agents seized about 11,600 pounds of drugs entering the United States from Canada. Seizures of fentanyl doses more than tripled between 2023 and 2024, rising from 239,000 doses to 839,000. A year ago, CSIS told Trudeau that they had identified more than 350 organized crime groups....

We have the stats. My question is this: How porous is our border? There's the threat from, of course, the increased use of drugs. Is the threat from the United States credible in terms of stating that we have a porous border and that we're not protecting the border, at this point?

Dr. Peter German: Yes. I think that's the point. You have the statistics. Use a multiplier for how much actually is transiting north or transiting south.

Yes, we do have problems. We have an unprotected border. I get that. Nothing's perfect. But as I mentioned, we have ports without port police. We don't have a border patrol similar to the United States.

We have issues. There's no question about it.

Mr. Ryan Williams: We have issues. We have a failure at the border, and this is now going to linger into a trade crisis. What do we do to fix these borders? What do we do to fix these ports? We had some recommendations this week to increase scanners and to ensure that we provide more funding to CBSA. What are the recommendations to fix these porous borders in order to fix our trade relationships?

Dr. Peter German: I don't recommend just throwing more money, resources and equipment at the issue. That's a bit of a stopgap. It's a band-aid. You need a strategy. There was a strategy some years ago on secure borders. We looked at this very closely after 9/11. We didn't go quite as far as the Americans did, but we certainly did work with them. I think we have to do that again. This is a time for us to get together with the United States and look at joint solutions.

You can look at any one of these issues. With scanning, for instance, we're not going to scan all the containers coming into our ports, but we can develop better intelligence with foreign agencies that allows us to know when illegal substances are being shipped. Things like that are important. It all requires a large strategy.

Mr. Ryan Williams: In terms of the ports as a whole, you've talked about organized crime. How vulnerable are our ports to organized crime at this moment?

Dr. Peter German: The issue is that you don't need a clearance to work in our ports. There are 30,000 employees at the Port of Vancouver. Only something like 6,000 of them have a minimal security clearance. We couldn't get the exact numbers from Transport Canada, but it's about 20%. You do have people with records who are working in the ports.

Now, sure, 95% of people in the ports are upstanding citizens, but it's well documented through media reports and so forth that we do have an organized crime component. That's important to deal with.

Mr. Ryan Williams: We've heard recently that there are increased cyber-attacks on our ports, which is also opening up our vulnerabilities. Have you heard of this? Have you written about this? What can we do about that?

Dr. Peter German: No, I have not written about anything with respect to cyber. That's outside my purview.

It doesn't surprise me. The thing to keep in mind is that our ports, as opposed to very advanced ports in Europe, revolve around human beings. Their ports are much more automated than ours. We do have that human component in our ports that you don't see in many other ports.

● (1200)

The Chair: Thank you, Dr. German.

[*Translation*]

Ms. Brière, you have the floor for five minutes.

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Mr. Chair.

I want to thank all the witnesses for joining us today.

Ms. Welz, please accept my deepest condolences for the loss of your daughter. Thank you for sharing your daughter's story with us, for sharing your story with us and for advocating for change in Canada.

Dr. Caudarella, as you know, we have the Canadian drugs and substances strategy. This strategy encompasses a number of aspects discussed today. These aspects include prevention, education, substance controls and access to support services for people who use drugs.

This is a complex crisis. I think that everyone agrees that there isn't any one-size-fits-all solution. You also said that we have an implementation issue. What's the solution?

Dr. Alexander Caudarella: You're right. A strategy exists. The issue isn't a lack of strategy. It's just that we need more right now. We react a great deal, but we need to start planning more for the long term.

In terms of implementation, many resources have been allocated to specialized services. However, what's being done to help family doctors, for example? That's why we wanted to take action at the level of small towns. No small town can put $5 million into a trajectory-changing initiative.

We also really need to look at certain issues. We know that we can take action on four fronts to really reduce substance use. These fronts are price, advertising—in the case of legal substances— accessibility and attitude. How can we change attitudes? For example, we just learned that, in Ontario, more young people aged 13 to 15 are using substances compared to last year. Why is use on the rise? Is it a culture issue?

Why do some countries in Europe, for example, have fentanyl on the scene, but have never faced the same level of drug problem? Why don't some parts of Canada have this issue? It's about implementation, but also about targeting needs. Of course, fentanyl trafficking must be stopped. However, we must also look at the parts of the country that don't yet have a fentanyl issue. Why isn't more work being done in those areas? In Vancouver, it isn't necessarily possible to change the situation. However, fentanyl still isn't very prevalent in many places in Quebec, for example. The same applies to eastern Canada.

The key is to hold discussions in order to focus on the right things. It's also important to support the implementation of measures across the board. Instead of giving resources to specialists and specialized services, it's necessary to help general practitioners. It's important to take action in both the medical sector and in the social services and education sectors, for example.

Mrs. Élisabeth Brière: It's ultimately all about risk factors. Thank you.

Mr. Rikhardsson, thank you for joining us and for providing a brief overview of the Planet Youth model.

As of what age can young people benefit from your program?

[*English*]

Dr. Pall Rikhardsson: Basically, we say that prevention starts at birth. The risk factors, and the protective factors that address those, really have no lower age. Usually, we see these programs and interventions being implemented for kids from around the age of eight until 12 or 13.

As my colleague Dr. Caudarella talked about, it's all about improving the social environment of these kids, increasing social capital among parental groups, providing them with meaningful and organized leisure time activities, and so on and so forth. It's about the environment and changing the environment for the younger generation, so they will behave differently—reducing the demand for drugs and the need for treatment.

● (1205)

[*Translation*]

Mrs. Élisabeth Brière: Thank you.

In your remarks—

The Chair: Thank you, Ms. Brière. Your time is up.

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

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

Mr. Caudarella, I was wondering whether you knew about the Quebec government's 2018-28 interdepartmental action plan on addiction. It includes 14 departments.

During its tour of a number of Canadian cities, the committee discovered that more integration was taking place on the ground in Quebec and that this approach should be promoted. For example, a front-line harm reduction organization may be in contact with a quaternary care hospital that conducts addiction research. These people talk to each other.

What are your thoughts on this?

Dr. Alexander Caudarella: For years, I've been asking myself one question over and over again. Why is the overdose death rate five times higher in Ontario than in Quebec? Many factors come into play. However, I believe that one reason stems from the integration of services, as you said. For example, general practitioners in CLSCs have access to more resources, including psychologists.

A cultural difference also comes into play, of course. That said, I believe that the difference lies mainly in the capacity to conduct a good triage and to take a holistic view of the situation. I'm not saying that everything works perfectly in Quebec. However, I believe that this capacity for integration plays a key role in Quebec's success in this area. We can see this approach in the parts of Europe that have also achieved some success.

Mr. Luc Thériault: Mr. German, your remarks are helpful. During our meetings dedicated to this study, I've often said that law enforcement constituted the least effective component of the national strategy. To some extent, that's what you're saying this morning.

In turn, a number of witnesses said that it was wishful thinking to believe that organized crime could be dealt with strictly by law enforcement.

As someone who is familiar with the issue, what do you think?

[*English*]

The Chair: Answer briefly.

Dr. Peter German: I'm sorry, Mr. Chair. I am not receiving any interpretation and hesitate to answer without that.

The Chair: Okay. Dr. German, on the bottom of your screen, you may see three dots. Try that. It gives you the options of English, French of the floor.

Does that work?

Dr. Peter German: Yes. I have it.

The Chair: Turn that to “English” and we'll have Mr. Thériault repeat his question. Then, can you provide a brief answer?

[*Translation*]

Mr. Thériault, I'll let you ask your last question again.

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

I was saying that, during our meetings dedicated to this study, I've often pointed out that law enforcement constituted the least effective component of the national strategy. Your comments today support this view.

In turn, while more must be done, a number of witnesses said that it was wishful thinking to believe that organized drug crime could be dealt with simply by strengthening law enforcement.

What do you think?

Dr. Peter German: Thank you for the question.

[*English*]

Thank you for the interpretation.

I know that a lot of people say, “The war on drugs is a failure”, and so on, but what would you rather have? Would you like organized crime to make its home here in Canada? We already have enough organized crime groups here.

There has to be an enforcement component that goes along with treatment and prevention. If you choose not to have an enforcement component and allow organized crime to do what it wants in your country, then you have something called “state capture”. You won't have a country. There are many examples of that in other parts of the world, where organized crime essentially runs the country. That's not an option, from my perspective. We have to deal with it.

We also have to deal with treatment. We also have to deal with prevention.

● (1210)

The Chair: Thank you, Dr. German.

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

Mr. Gord Johns: Thank you.

Again, Ms. Welz, you have my sincere condolences for the loss of your daughter. I want to thank you so much for your advocacy.

Can you talk about how we can discourage youth from using substances, while also reducing the stigma that keeps some youth from seeking support? Also, how can we provide harm reduction services to at-risk youth?

Ms. Angela Welz: That's a difficult one to answer, but I'll do my best, given my situation.

With what happened to Zoe, it happened to us so quickly. I'm always careful to lay blame on the family unit or parental situation. We were an amazing family and didn't have any issues at all with any of our children. I think what happened to Zoe was unexpected, because of the trauma she experienced with loss and the idea that her dad was going to pass.

There has to be more support for youth. There have to be areas where youth can go and feel comfortable being around other youth. The situation right now is so complicated because of social media, peers and the availability of drugs.

I understand that we may need to use enforcement to protect the ports and prevent bringing those illegal substances in, but that's not going to stop the deaths, unfortunately. We need to tackle the supply that is out on the streets right now. We know that if we take some of those drugs off the street, it's just going to make the drugs that are there and available more toxic, because you're essentially taking that supply away. It's a supply and demand thing.

Mr. Gord Johns: Can you speak a bit more about what supports you wish had been available for Zoe—and not just for Zoe, but for you?

Ms. Angela Welz: There was no support for us with Zoe. In 2015, there was AADAC, which is no longer part of Alberta Health Services. There were some services at AADAC that she could access, but again, it was not something she was able to access on a regular basis.

For family support, it was impossible. There was nothing for me to look at, other than the PChAD model.

With Moms Stop the Harm, we now have two support groups that help people. We have “Holding Hope”, which is for those who are supporting a loved one through their substance use or recovery, and we have the “Healing Hearts” component, which, unfortunately, is for those who have lost a loved one.

I think those are really the only options we have for people who experience substance use—for families, anyway.

The Chair: Thank you, Ms. Welz.

Next, we'll go to Mr. Doherty, please, for five minutes.

Mr. Todd Doherty (Cariboo—Prince George, CPC): Thank you Mr. Chair.

Thank you to our guests.

Ms. Welz, I truly appreciate your heartfelt testimony. My thoughts are with you.

I don't know whether you'll have the answer to this question. I don't have the answer for what could save my brother.

The question I would ask you is, what would have saved your daughter?

Ms. Angela Welz: Not a poisoned drug supply. I think if she had wanted to use substances, we could have supported her, as long as we knew those substances weren't going to kill her.

I'm a huge advocate for a regulated drug supply.

Mr. Todd Doherty: Mr. German, I have a question for you.

I worked for a long time in aviation. I spent 25 years in aviation. I was what was known as a security specialist. There were some major events that took place in the 1990s and 2000s that I feel precipitated some of the mess we're dealing with right now. We were going down a coordinated effort with our U.S. counterparts, which I know you're probably very well aware of, on perimeter security. I did a lot of work on that, as I think you did as well.

I'm wondering if you think that had we gone down that path—perhaps it's not too late to go down it—we would be in the boat we're in right now with fentanyl and the opioid crisis.

● (1215)

Dr. Peter German: Thank you for the question.

To a certain extent, it's hypothetical. Looking backward yet forward, I think the reality is that, yes, we should be working with our American friends.

In terms of law enforcement, Canadian law enforcement works very well with its U.S. partners. It always has. It doesn't matter which agency it is. We have that ability, and I think that should be encouraged. Probably, what we're really saying is that any national strategy in Canada should definitely be one that meshes well with the United States, because North America is really one security zone, and we saw that with 9/11.

Mr. Todd Doherty: Thank you for that.

That's exactly the answer that I was looking for. We are one security system.

Immediately after 9/11, you know as I know who was in control of the airspace. Canadians were, because we work very closely with our U.S. counterparts. There are some tenets to border security—inter-service, inter-agency, international co-operation, and intelligence, obviously. We are dealing with the intermodality of shipments of drugs in a porous border system. What can we do to stop the flow of this now?

Dr. Peter German: We have to look at each of the components that we've already talked about, whether it's rail, ports, air, walking across the border—you name it. That's where a strategy comes in. On some we're doing better than on others. I mentioned airplanes. We all get checked very thoroughly before we get into that cabin. Maybe cargo could be strengthened. I don't know. It seems to me that something like the ports, as well as the 49th parallel, just jumps out at us.

Mr. Todd Doherty: Also, in your testimony, you focused on something that was quite disturbing for those of us in aviation. After 9/11, there were secure checks on our ramp personnel, and we found out that less than 2% of our ramp personnel, those who are accessing our aircraft, actually had red passes. How many were actually in the system for three to five years and unable to get security clearances? Now we're seeing the same in our port systems as well. Do you care to comment on that?

Dr. Peter German: It's my understanding that after 9/11, the United States required that all people working in the ports have a minimal security clearance. I believe it's called a TWIC in my ports report. We didn't go that far in Canada. At this point, I mean, it's probably impossible for us to all of a sudden require a security clearance of, let's say, 30,000 people here, but we can start by grandfathering in any new person coming into a port.

Mr. Todd Doherty: To that comment, is Canada seen as the weak link in the system because of our lacks and some of the things? Mind you, we do do some things better, but we have fallen down in our obligation in certain areas. Is that correct?

Dr. Peter German: I think our people are doing the best they can with the tools they have and with the various restrictions they have. I think Mr. Trump's comment, for what it's worth, probably says it all. Whether it is a reality or a perception, we have to deal with it.

The Chair: Thank you, Dr. German.

Thank you, Mr. Doherty.

Next is Ms. Sidhu, please, for five minutes.

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

Thank you to all the witnesses for your testimony.

Ms. Welz, my condolences for your daughter's loss. Thank you for your incredible strength and dedication to this cause, especially given the immense personal loss you have endured. Your work through Moms Stop The Harm is an inspiration for many. Your organization focuses on advocating for the decriminalization of people who use drugs. Can you speak to how this policy shift could help prevent further tragic loss?

I was listening to Dr. Caudarella. He said that more youth between the ages of 13 and 15 are using substances, and that 90%.... Can you talk about what urgent measures we can implement to prevent further tragic loss?

● (1220)

Ms. Angela Welz: Decriminalization is a big issue for us. My daughter was okay until she was arrested for liquor theft, and after that, it created a lot of problems for her. She had to appear in court. She had different things she had to do to resolve her court situation. Criminalizing people is not the answer. We need to step away from that, particularly with youth, and offer them more support, more harm reduction options, more compassionate treatment options and voluntary care. We also need more housing, of course, because there are kids who need housing as well.

Ms. Sonia Sidhu: I was talking about harm reduction and decriminalization.

Ms. Angela Welz: Oh, I didn't understand. Do you mean having more harm reduction available for kids?

Ms. Sonia Sidhu: What compassionate help or education can we give to the kids? What kind of help can we provide to youth so they cannot go where your daughter went?

Ms. Angela Welz: I think there has to be open communication. There have to be harm reduction conversations, rather than vilifying harm reduction as a bad thing. Harm reduction doesn't make people use more drugs; it just makes them educated about how to protect themselves.

Another big thing for youth would probably be drug checking.

Have open, educational conversations with parents so they understand that kids will use drugs. There's no way we're going to stop that from happening, so we need to have an educated approach for both parents and youth in order to understand how to best protect them if they're going to use substances of any kind.

Ms. Sonia Sidhu: Dr. Caudarella, your focus is on decreasing stigma.

Can you speak about how Canada can more effectively integrate substance use, health services and mental health services, and collaborate across sectors, if you're talking about a provincial harm reduction program?

Dr. Alexander Caudarella: I think there's a lot that can be done around collaboration across those sectors, absolutely. We recently released standards—and thank you, Health Canada, for funding that—on what every prescriber needs to be able to do. It's time to say, “It doesn't matter whether you're a pediatrician, a psychiatrist or this and that. You need to be able to do stuff around substance use health.” I think it's about getting rid of this problem across sectors that “It's not my business”. This affects parks and recreation departments as much as it affects law enforcement and different things.

CCSA used to have a program that we're looking at reinitiating, one that really pushes for law enforcement and health partnerships. It has to be a two-way street. There's a tremendous amount we can learn about drug trends from law enforcement that can help us on the public health side. There's a tremendous amount the public health side can do to support law enforcement so they can be more effective.

It's also about setting targets and accountability. I'll tell you an example. I used to work in an emergency department. If you want to see ambulance wait times go down, make that one of the reportable metrics that go up to the province, and tie funding to it. All of a sudden, if funding is tied, everyone is willing to work together.

Ms. Sonia Sidhu: You also talked about ideas and innovation. CCSA recently hosted a summit in Timmins.

Can you talk about what kinds of innovative ideas there are?

Dr. Alexander Caudarella: Yes.

Again, mayors are getting calls because family members can't find supports, or because someone's afraid there might be a needle in a park or something. Working with people where the rubber hits the road has been tremendously effective. Most people actually know what their community needs. They know this when it comes to outcomes, but they don't always know how to get there. A municipal team isn't going to have all of the expertise and policy necessary.

They need a menu of options. We had mayors from Iqaluit, Cambridge, Ontario and Lethbridge, Alberta. They similarly needed a menu of options that could help and evidence-based tools that can change outcomes, but they wanted to be in that driver's seat and say, “Okay, this one will work for me in my setting, and this one won't.” At that local level, getting law enforcement, harm reduction and different people to work together is actually not too hard.

The Chair: Thank you, Dr. Caudarella.

Mr. Moore, go ahead, please, for five minutes.

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

Thank you to all of our witnesses today.

Dr. German, you made a number of comments today that I want to hone in on.

One, you used the example of those who go through airports, which members of Parliament are all too familiar with. We have checks and scans. We all get checked. I have to think that organized crime in Canada is laughing to see all of us go through those checks when they look at the porousness of our ports and the fact that the vast majority of shipping containers are not being checked at all when they leave the port in Montreal, or any other port in Canada.

Can you comment a bit more on what needs to happen at our ports and the current state of affairs? You mentioned port police. There used to be dedicated enforcement at the ports. This has long since not been the case. What else would be helpful when it comes to our ports and the security of our country?

● (1225)

Dr. Peter German: I do believe that Canada is considered a soft target by organized crime. That's why I mentioned that it's a high-value target but that it's low risk to organized crime. That's only going to increase unless we deal with it.

In terms of the ports, I think I'm probably restating what I said earlier, but I do believe that there has to be a uniformed police component there. You wouldn't want to say goodbye to your municipal police department and not have anyone that you could call. We expect that there will be police that will be doing the routine patrolling.

You also need that federal component. The RCMP is our federal police. Remember, the CBSA is a law enforcement agency. It is not a police agency. It does not conduct investigations outside of the ports with regard to drugs and so forth.

The third issue is the clearances. We have to know who's working in our ports. It's as simple as that.

Hon. Rob Moore: You mentioned in your answer something else I want to hone in on. You mentioned that Canada is a high-value, low-risk environment. I agree 100% with you that it's the case. There's one aspect of that on which I'd like to get your comment. In our country, it used to be that if you were convicted of production of, importing or exporting of schedule I substances—including fentanyl, meth, cocaine and heroin—it would result in mandatory jail time.

The current government's Bill C-5 eliminated that mandatory jail time and, in effect, allowed house arrest for those convicted of moving and producing large quantities of very serious drugs, some of which are wreaking havoc on our streets today, as you mentioned. How do laws like Bill C-5 and like Bill C-75, which created a revolving door in our justice system, imposing on judges the requirement that they release those who are seeking bail and making it very difficult to take someone off the streets who's been arrested for some of these very serious offences...? When you couple those two bills alone, how do they play into Canada's being a high-value, low-risk environment for organized crime?

Dr. Peter German: There are a few things, and I'll be quick here.

Minimum sentences are not something that our courts like, for one thing, so it is important that we have a punishment option. Imposing minimum sentences or requiring minimum sentences has not held up very well in our courts with the charter.

In terms of catch and release, I 100% agree. I think that that's what upsets the public so much: to see people with dozens and dozens of convictions being released. They need other services—I get it. They need treatment. They need a whole lot of services, but what the public does not need is them right back on the streets breaking more windows, creating havoc, walking around with knives, etc. It's very important, I think.

When it comes to the importers, yes, there are people importing drugs. They tend to be low-echelon players. They are the couriers. They are the dupes. They are people who are doing something for a few thousand dollars. Yes, there has to be some sort of a sanction, but it's really getting to the top of organized crime that's important. Bringing down the kingpins is what you want to do.

Hon. Rob Moore: Thank you, Dr. German.

The frustration you mentioned with law enforcement in some of the more complex cases—money laundering, extortion and now these serious, organized-crime drug offences.... You mentioned that when we have, in a sense, lawlessness, we risk even losing ourselves as a state because organized crime just takes over. Are we on that path as a country when you see police officers throwing up their hands and saying how even if they do arrest someone, the person's right back out on the street?

I see that I'm out of time, Mr. Chair, but....

● (1230)

The Chair: Give a brief answer if you could, please, Dr. German.

Dr. Peter German: In some ways, I see myself and others like me as canaries in the coal mine. We have to be alive to these issues. We have a very strong country. We're not about to go down the route of state capture, but we should be aware of it.

The other thing I would point out is the broken windows theory. If you don't deal with little things, they become bigger.

Hon. Rob Moore: That's right.

Thank you.

The Chair: Thank you.

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

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you.

Mr. Rikhardsson, I'd like you to talk a little bit more about Planet Youth and explain how it works. I understand that this is a very upstream intervention, getting kids involved in healthy activities.

I've spoken previously to some of the groups you're working with in Canada on implementing your program. When I asked about my kids, they said to get them in healthy activities. Well, how do I get my kids off the computer and their computer games to do something healthier? The explanation was that you create an environment whereby your kids will just naturally be wanting to be involved in healthier activities.

You've said that there is this 10-step process. First of all, you have to prepare. Then you get the data and you talk to the kids. Then you implement certain action strategies. I guess the strategies are aimed at schools, peer groups and families. Can you give us some concrete examples of what kinds of community interventions or what kinds of school and family interventions you have used that seem to have been productive?

Let me just add a comment before you start. I've worked as a doctor in numerous places around the world. Having kids with nothing to do, especially young males with nothing to do, inevitably leads to bad outcomes.

Maybe you could talk about what kinds of interventions you use.

Dr. Pall Rikhardsson: There are different examples of this, obviously, from our partners. As I said, we don't export interventions, but we work with our partners to develop them. Within these different domains....

I have a 14-year-old and a 16-year-old at home. Getting them out of their room and off the computer is no easy task. It's not they who have to make the decision. It's the environment around them. It's about engaging with parents, as we heard before, and teaching young parents how to be good parents.

We have examples from our partners about building social capital within the schools amongst parents, using interventions like parental cafés, friendship groups and things of that nature so that the parents work together as a cohesive whole within the class. We have that within the leisure time domain. We don't need expensive solutions and to build multi-million dollar parks. It's more about having organized, structured leisure time activities on offer, and not just sports. Some kids hate sports. That's okay.

We just need to have access created to those environments and those offerings and then encourage the kids, from the parental side and from the school side, to participate in them. Even playing computer games, if that is done in a structured, organized environment, can have a preventive effect. You can compete in video games these days with more prize money than some of the tennis camps I go to.

It's the combination of these things. The actual interventions have to be culturally appropriate and adaptable. Again, they range from the community-based, as I was telling you about, to the parents and it's up to what some of our partners do. In Mexico they have national campaigns for parents to spend time with their kids. That has a preventive effect as well.

Mr. Marcus Powlowski: In Canada, certainly in my riding, there is a large indigenous population. Within that population there are high rates of poverty and often high rates of substance abuse. Are you working with groups in indigenous communities in Canada? If not in Canada, I know you work in other countries, so maybe you can talk about what other interventions globally have been effective. You talked about Mexico.

I'd just like to get more concretely into what kinds of interventions we're talking about here.

● (1235)

Dr. Pall Rikhardsson: Yes. We're working in Calgary. The project in Calgary has an indigenous parallel where the model is being adapted even further to the indigenous and first nations realities. We are working with tribes in Washington state that are doing the same. There are different aspects in that context that we have to adapt to regarding data collection and data sharing. Even the reporting needs to be different.

As for the interventions, we have a database of something like 100 interventions that are being practised by our partners around the world. They can be really different. In Australia, for example, they found out that sports was actually a risk factor. The more the kids played rugby, the more they were drinking. Three things led to that. One was the access to alcohol in the clubhouses. The sale of beer was a really important factor. Then there was the permissiveness of the parents. They'd bring a six-pack to the game with them and 13-year-old Johnny would have a beer with his dad. There were the coaches as well. The coaches were not really trained to work with that age group. They were sometimes drinking a beer and smoking on the sidelines, setting a bad example for the kids.

Based on that data, the community in question implemented “train the trainer”. They sent all the coaches to training sessions on how to be good role models. They educated the parents about the harmful effects of alcohol on the developing brain. They cracked down on underage sales in the clubhouse. The interventions were focused on the community.

The Chair: Thank you, Dr. Rikhardsson.

To the folks online, we have alarms ringing here, so we're going to suspend the meeting until we find out what the alarm is all about.

We'll be back to you as soon as we know more.

[*The meeting was adjourned at 13:32 p.m. See Minutes of Proceedings*]