HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

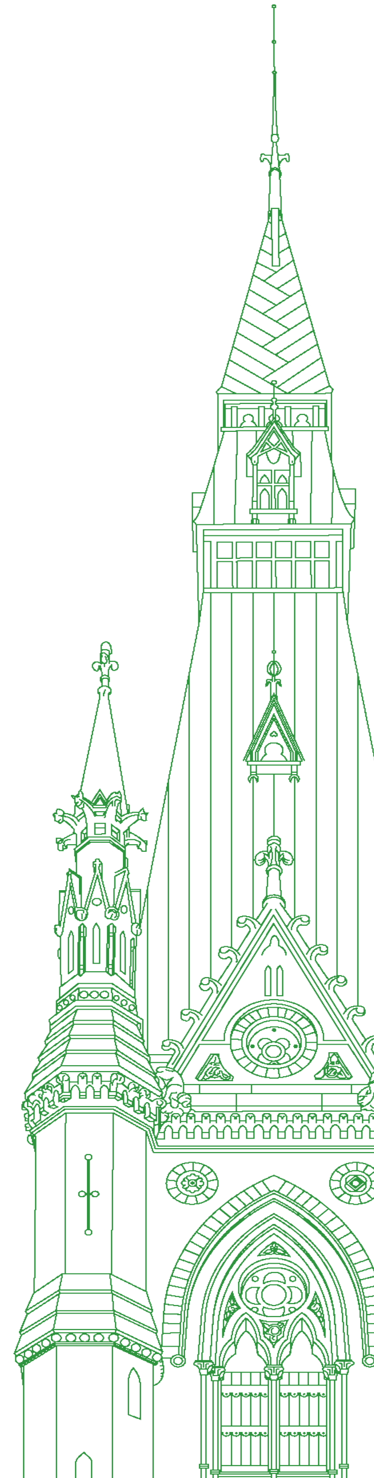
45th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 028

Thursday, April 16, 2026



Chair: Hedy Fry

Standing Committee on Health

Thursday, April 16, 2026

● (1545)

[*Translation*]

The Chair (Hon. Hedy Fry (Vancouver Centre, Lib.)): I call this meeting to order.

Welcome to meeting number 28 of the House of Commons Standing Committee on Health.

[*English*]

We recognize that we meet on the unceded territory of the Algonquin Anishinabe peoples. Today's meeting is taking place, as you can see, in a hybrid format, pursuant to the Standing Orders.

I want to do some housekeeping and remind everyone of the following points.

Please wait until I recognize you by name before speaking. For those participating by video conference, please click on the microphone icon to activate your mic. Please mute yourself when you're not speaking. Otherwise, we will get ancillary noise.

At the bottom of your screen, you can select the appropriate channel for interpretation. It's a little round globe icon. You can pick whatever language you want.

All comments should be addressed through the chair.

For members in the room, if you wish to speak, please raise your hand and the clerk and I will manage the speaking order as best we can. We appreciate your patience and understanding in this regard.

Pursuant to Standing Order 108(2) and the motion adopted on Tuesday, January 27, the committee shall commence its study on the Canadian Centre on Substance Use and Addiction.

I would like to welcome our witnesses.

They are Dr. Alexander Caudarella, chief executive officer; Neil Arao, board member, who is here by video conference; Scott Elliott, board member, by video conference; Susan Russell-Csanyi, board member, by video conference; and Dr. Louis Hugo Francescutti, board member, by video conference.

We also have one of our committee members, MP Parm Bains, who is here by video conference.

This is how it's going to work. I will give every person five minutes to speak. At one minute before your time is up, I'm literally going to give you a shout-out and say “one minute” and then “thirty seconds”, so you can wrap up. If you cannot finish your presentation in that time, you have an opportunity during the question and answer session to elaborate on anything you felt you didn't get to say the first time around.

Yes, go ahead.

Dan Mazier (Riding Mountain, CPC): In recognition of the fact that we started 15 minutes late—

The Chair: I always recognize that, Mr. Mazier.

Dan Mazier: Are we going to have a full two-hour meeting?

The Chair: Yes, we will.

Dan Mazier: Do we have resources?

The Chair: We always do. For future reference, we always take into consideration when we begin and put two hours on to that. That's standard.

Dan Mazier: Thank you for clarifying.

The Chair: We now begin with Dr. Caudarella.

Please begin. You have five minutes.

Dr. Alexander Caudarella (Chief Executive Officer, Canadian Centre on Substance Use and Addiction): Thank you, Madam Chair and honourable members.

I'm Alex Caudarella, and I had the privilege of joining the CCSA three years ago as CEO.

In 1988, all-party support created the CCSA act. It created this arm's-length charity to bring together expertise from across the country and to increase the participation of people in Canada.

CCSA is the only national organization mandated to address both the health aspects and the public safety aspects of substance use. We work to address alcohol and other drug-related harms through a balanced approach that prioritizes both individual and collective well-being.

As a family physician with experience across multiple provinces and territories, I bring evidence-based, compassionate and collaborative leadership grounded in a need to have a real-world impact.

CCSA's CEO is appointed by its board of directors and must be approved by the Governor in Council. This model reflects CCSA's status as an independent national organization created by and accountable to Parliament. CCSA's board is a volunteer board of directors made up of 13 members. Together, they provide governance and strategic oversight, which I'm very thankful to have.

The chair and up to four other directors are appointed by the Governor in Council. Eight additional directors—members at large—are appointed by the board itself.

[*Translation*]

CCSA has many achievements, from launching the country's first addiction and recovery surveys to producing a Canadian substance use costs and harms report repeatedly referred to as the most robust analysis of the impacts of drugs and alcohol.

● (1550)

[*English*]

Since then, our work together has prioritized the many communities we serve, working with them to better understand their needs and leverage science to bring evidence, as a trusted partner, to the grassroots.

Our CCENDU network is a partnership of academics, governments—

Dan Mazier: On a point of order, interpretation seems to—

The Chair: I was about to say that we're having some interpretation problems.

Is it fixed? Good, let's go ahead then.

We stopped the clock, so we didn't take your time.

Go ahead, Dr. Caudarella.

Dr. Alexander Caudarella: Do I go back to the part I did in French and do it again?

The Chair: Start from the top, please. I'm sorry, Dr. Caudarella.

Dr. Alexander Caudarella: It's no problem. I'm sorry you have to hear me say the same thing twice. I'll insert a new word as a surprise, perhaps.

Thank you, Madam Chair and honourable members. I'm Alex Caudarella, and I had the privilege of joining CCSA as CEO three years ago.

In 1988, with all-party support, the CCSA Act created this arm's-length charity to bring together expertise from across the country and increase the participation of people in Canada on this matter. CCSA is the only national organization in Canada mandated to address both the health and the public safety aspects of substance use. We work to address alcohol and other drug-related harms through a balanced approach that prioritizes both individual and collective well-being.

As a family physician with experience across multiple provinces and territories, I bring evidence-based, compassionate and collaborative leadership grounded in a need to have a real-world impact. CCSA's CEO is appointed by its board of directors and must be approved by the Governor in Council. The model reflects CCSA's status as an independent national organization created by and accountable to Parliament.

CCSA's board is a volunteer board of directors. It's made up of 13 members who provide governance and strategic oversight. The chair and up to four other directors are appointed by the Governor in Council, and eight additional directors, who are members at large, are selected and appointed by the board itself.

[*Translation*]

CCSA has many achievements, from launching the country's first addiction and recovery surveys to producing a Canadian substance use costs and harms report repeatedly referred to globally as the most robust analysis of the impacts of drugs and alcohol.

[*English*]

Since then, our work together has prioritized the many communities we serve, working with them to understand their needs and leveraging science, as well as bringing evidence directly to the grassroots. Our CCENDU data network is a partnership of academics, governments, people with lived experience and law enforcement, and it was the first to raise the alarm about fentanyl in 2013. It has continued to expand and now exists in all provinces.

I came to CCSA because of a pair of white shoes I couldn't forget. As a medical student, I met a 10-year-old girl who was crying that she was doomed to suffer a fate like that of her parents around alcohol. She was looking for a way to help her family. I remember her shoes but not her face, because I couldn't bring myself to look at her as I had no tools; I felt so embarrassed. She wanted to build her community, and I came to CCSA because I see this as the vehicle to provide support to communities so they can find the help, the connection and the future this little girl was looking for.

We've been working to build hope and make it clear and easy for everyone to have a role in solving these issues no matter who they are and set them up for success. Our pediatric guidance works with children's hospitals across the country to increase treatment access. Our small cities initiative is working with mayors of diverse backgrounds to find solutions that fit their communities. Our work with industries like trucking, mining and tourism helps them solve these challenges unique to their fields.

Canada's guidance on alcohol and health has put information into Canadians' hands to make their own health decisions. Our public education efforts have led to the most significant decrease in alcohol consumption ever recorded in Canada. Over the past 10 years, weekly consumption has gone from 10 to nine drinks. This is 34 million fewer drinks of alcohol every week, a substantial and impactful decline.

[*Translation*]

Substance use challenges touch every part of society—from health systems, families and communities to law enforcement and governments—and an effective response requires collaboration across all sectors and at all levels.

While communities across the country have common challenges, they are dealing with a series of distinct crises. These hyperlocal contexts must also be considered in identifying solutions.

● (1555)

[*English*]

There are countless other examples of how CCSA is increasing the participation of people, organizations and sectors across prevention, treatment, harm reduction, recovery and public safety.

I'm pleased, Madam Chair, with the committee's continued interest in substance use health, and my team and I remain available to provide the committee with the latest science, evidence and best practices to help inform your work.

Thank you for having me today.

The Chair: Thank you very much, Dr. Caudarella.

I now go to Neil Arao, board member.

Neil, go ahead for five minutes, please.

Neil Arao (Board Member, Canadian Centre on Substance Use and Addiction): Madam Chair and members of the committee, thank you for the opportunity to be here today with you.

My name is Neil Arao. I serve as a Governor in Council appointee to the board of the Canadian Centre on Substance Use and Addiction. I'm also a registered social worker here in British Columbia. In my day job, I'm CEO of one of the largest community-based health and social service organizations in greater Vancouver.

My career has spanned the mental health and substance use system. I began as a concurrent disorders clinician with Vancouver Coastal Health and worked at the Vancouver Detox Centre and with the assertive community treatment teams, supporting people living with severe and persistent mental illness.

I later managed mental health, substance use and criminal justice programs; led psychosocial rehabilitation and predischarge units at the Forensic Psychiatric Hospital; and oversaw homelessness, housing, mental health and substance use services as an executive director. In my spare time, I continue to practise privately as a counsellor.

Through this work, I have supported people experiencing substance use in emergency settings, treatment programs, justice systems and their homes.

From my perspective, substance use impacts people, families, communities and systems in very interconnected ways, and in my work, I have seen approaches grounded in compassion and inclusion in which people with lived and living experience and families help shape responses. I've also seen the challenges that arise when accountability, evaluation and evidence-informed approaches are not consistently applied.

I joined the CCSA board because I believe this complex issue can benefit from perspectives across provinces, community-based organizations, clinical systems and professions. CCSA's work, including its focus on accountability and quality in bed-based treatment settings and its examination of the intersections between housing instability and substance use, reflects the importance of taking a systems-level approach.

In my experience, when people speak about a continuum of care, there's often an absence, whether it's prevention, harm reduction, treatment, recovery or enforcement. All these components must be discussed, but not in isolation. It must also reflect culturally relevant and community-based approaches within each stage. Approaches do not need to be mutually exclusive, and they can all be part of a coordinated system of care.

Many of the people I have worked with who experience significant substance use challenges have also experienced trauma over time, and addressing trauma early, supporting prevention and providing people with tools and supports can influence longer-term outcomes. Recovery is supported when the systems that interact with people, including health care, housing, justice, education and child welfare, are all aligned and responsive to their needs.

My role as a board member is in governance, and this includes supporting scientific integrity, ensuring public funds are stewarded responsibly and reinforcing the importance of accountability and outcome measurement. It also includes ensuring that CCSA continues to provide Parliament with balanced, evidence-informed guidance.

Canadians expect compassion; they expect competence, and they expect accountability.

Thank you. I look forward to any questions.

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

I now go to Scott Elliott.

Welcome, Scott. You have five minutes, please.

[*Translation*]

Scott Elliott (Board Member, Canadian Centre on Substance Use and Addiction): Madam Chair and members of the committee, my name is Scott Elliott and I'm from Vancouver, British Columbia.

[*English*]

For the past eight and a half years, I've served as CEO of the Dr. Peter AIDS Foundation in Vancouver. Prior to this, I was a senior executive and leader for notable organizations, and I served on numerous not-for-profit boards.

I'm a gay, HIV- and hep C-positive man living through 39 years of active recovery from drug and alcohol addictions.

Stigma, shame and discrimination are not abstract concepts to me; I've lived with them for most of my life. However, rather than limit my ambitions, my lived realities have given direction to my career and purpose to my life. I have earned my voice as a trusted leader in the complex care space. It has shaped my empathy for Canadians who struggle with mental health issues and addiction. This is part and parcel of the reason I chose to volunteer as a board member for the Canadian Centre on Substance Use and Addiction.

My organization, the Dr. Peter Centre, has been operating since 1997. We manage a clinical day health program for more than 500 participants, a 24-hour licensed care residence and enhanced supportive housing that balances dignity and health care.

While we began as an AIDS organization, the centre is never about serving just one population. We have 28 years of experience working with what we call the “sidelined 2%”. The sidelined 2% is the nearly 750,000 Canadians who face extreme overlapping challenges—mental illness, addiction, homelessness, cognitive decline, trauma, institutionalized racism and medical issues, including HIV, HCV, etc.

In my decades of experience, I've seen that many will never be able to achieve sobriety and that many will never live independently without support. I've seen over the decades hundreds who have relapsed time and time again and hundreds who've died because the support and services they needed did not exist for them.

Today, I appear before this committee and provide witness testimony as a volunteer board member for the Canadian Centre on Substance Use and Addiction. The capacity of my role is to work alongside my fellow board members to further the CCSA's legislated mandate to provide leadership on substance use health and to reduce alcohol, drug and other addiction-related harms.

The CCSA acts as an independent adviser to governments, producing evidence-based research to inform policy, programs and public awareness, all the while fostering collaboration across sectors to improve community resiliency and safety.

Working on the front line, I see innovative solutions every day. I also see that these solutions remain isolated in one program, in one city or in one province when they could be informing practice across the country. Such complex challenges require coordinated and strategic responses, strategic implementation across jurisdictions and de-siloed funding and policies across health, housing, mental health, indigenous services and public safety.

The CCSA has the mandate and the convening power to help bridge those gaps, connect evidence with action and ensure that Canadians across the country have access to effective care.

● (1600)

This kind of leadership matters now more than ever.

Thank you.

The Chair: Thank you very much.

I now go to Susan Russell-Csanyi.

Please begin for five minutes, Ms. Russell-Csanyi.

Susan Russell-Csanyi (Board Member, Canadian Centre on Substance Use and Addiction): Thank you, Chair and members of the committee, for the opportunity to speak with you today.

My name is Susan Russell-Csanyi. I bring to this work professional experience, governance experience and first-hand experience supporting those in the intersectionalities of substance use, addiction, child welfare and social systems. I spent the early part of my life in the foster care system, which has informed my understanding of how public systems interact over time and how gaps in coordination can affect outcomes for young people and families. This experience has shaped my professional interest in system effectiveness, risk reduction and accountability.

In my personal life, I have lost five people close to me to the harms related to substance use. Three of them—Adrian, Josh and Katharine—lived in British Columbia. I am speaking from Winnipeg, where I lost my sister Andrea, as well as a young person with whom I worked closely. Four of the five individuals who died had prior involvement with the child welfare system. While each circumstance was different, this overlap reflects a broader, well-documented challenge in the intersection of child welfare, health care and public safety systems. These experiences have reinforced the importance of timely intervention, continuity of care and a coordinated response that reduces health risks and community impacts.

Professionally, I have worked across child welfare, health and advocacy settings. I am here today to speak to the intersections in the walks of life as a board member of the Canadian Centre on Substance Use and Addiction. My colleagues have already highlighted that CCSA is a national organization with a legislative mandate to provide objective, evidence-informed health advice on substance use and addiction. Our work spans through public health and public safety. Our work supports government. Our work supports service providers and communities through research, surveillance, knowledge mobilization and cross-sector collaboration. CCSA's mandate is to reduce substance-related harms while improving the safety, health and population-level outcomes for all Canadians.

As a member of the board of directors, my role is one of governance and stewardship. This includes upholding the CCSA's nonpartisan mandate while ensuring that the organization's work remains evidence-based, credible and aligned with public interest and responsibilities. It is also to provide oversight and to support strong leadership, sound decision-making and effective use of public resources. My perspective as a board member is informed by my frontline experience, my youth advocacy and my work across multiple public systems. My work includes the appropriate and respectful inclusion of lived expertise when it strengthens relevance to the program and system effectiveness across all non-profit, business and political sectors.

Beyond my role at CCSA, I am actively involved in community service. I am a founding and current member of the national council of youth in care advocates, which works hand in hand to broaden the knowledge related to public health and public policy. My academic background includes a bachelor's degree in kinesiology from the University of Manitoba, with a focus on physical health, wellness and well-being, along with a public policy certificate from the United Way. Together, these things support my interest in prevention-oriented, health-centred approaches that contribute to public safety and system sustainability.

I chose to join the CCSA board in January 2026 and serve alongside all of my colleagues, who remain committed to fulfilling the governance responsibilities in support of evidence-informed, balanced approaches to substance use and addiction that protect both individual well-being and community safety.

Thank you for your time. I would be pleased to take your questions.

● (1605)

The Chair: Thank you very much, Ms. Russell-Csanyi.

We'll now go to Dr. Louis Hugo Francescutti for five minutes, please.

[*Translation*]

Dr. Louis Hugo Francescutti (Board Member, Canadian Centre on Substance Use and Addiction): Thank you, Madam Chair.

Thank you to the other members of the committee.

I left my beautiful province 46 years ago and moved to Alberta. I'm always happy to have an opportunity to speak French, but today I'm going to speak to you in English.

[*English*]

I'm an emergency physician. I'm 72, and I love what I do. I'm still practising at the Royal Alexandra Hospital in Edmonton, one of Canada's busiest emergency departments.

As my colleagues have attested to, we have a problem across the country with patients who present as homeless, with mental health issues, with addiction issues or all the above. These are, without a doubt, the most complex patients we see in health care today.

I'm excited. It is the highlight of my week to join you and share a bit about what I know—and, more importantly, to find out what you know—that we could do differently in our society to better meet the needs of these individuals.

As past president of the Canadian Medical Association, as past president of the Royal College of Physicians and Surgeons and having sat on the board of Accreditation Canada and other organizations that are national, I bring a bit of depth to the conversation.

When I was asked to serve as chair of this board in December, it was an honour that I couldn't pass up. Having had one board meeting, I can say that the men and women who surround us in the staff at the CCSA are amongst the best I've ever worked with. If there's any way the CCSA can be of value to you as you set policy in this area, which is so important, and then try to bring along our partners in the provincial governments, territorial governments and municipal governments, we're here to serve your needs.

I look forward to any questions you may have today.

● (1610)

The Chair: Thank you very much.

We will now go to the question and answer period.

I want to let the witnesses know that there's a time limit on the question and answer period. Whether it's six minutes or five minutes, it includes both the question and the answer. I'm going to ask you to be as concise as you can so that we don't run over time, which would mean that you don't get to finish what you're saying.

We will begin with Ms. Konanz for the Conservatives.

Helena Konanz (Similkameen—South Okanagan—West Kootenay, CPC): Thank you to all of you for coming. Thank you for your work in the field of addiction. It's extremely important.

This week marks the 10-year anniversary of B.C.'s declaration of a public health emergency due to the overdose crisis, yet more Canadians since then have died of a deadly drug overdose than on every battlefield during the Second World War. Eighteen thousand of them were British Columbians.

There is a reason The Canadian Press called this a "Decade of death". Overdose deaths peaked during the decriminalization pilot project in B.C. Too many public spaces look unrecognizable compared to even a few years ago. Too many lives are still lost.

Dr. Caudarella, during your testimony to the Senate in June 2024, you said, "supervised consumption sites [should] become more embedded in the overall health and social systems...as a front door to wellness."

Is it still your advice to the Canadian government today that more drug consumption sites be embedded across Canada?

Dr. Alexander Caudarella: The context of the statement was to say that there's a need for an interconnectedness of care. A supervised consumption site can't function on its own. It can't function independently from the community in which it sits either.

The idea I was trying to bring forward was that you need systems that are connected with each other. If you're going to have open doors to wellness, you need ways for people to go from the supervised consumption site into treatment, into recovery, as well as to see people like me in primary care. I think a connected system is what we're talking about in this collaborative way.

Helena Konanz: I agree that we need such a system. In my community, if someone at a consumption site needs help, there is none for them.

I know you've spoken about these sites being accountable to the community, but many residents feel that they aren't accountable. These sites often create pockets of open drug use throughout communities and leave glass, needles and tablets on playgrounds.

In the spirit of community accountability, would you support something like a buffer zone between these sites and local schools or day cares?

Dr. Alexander Caudarella: With this, we need to understand that there are no one-size-fits-all solutions. Even in Ottawa, where I live now, when they're debating where my son's school needs to go, the community's involved in where the school goes, what it looks like, what role it'll serve and how it will mitigate potential harms. Blanket solutions don't meet local needs, which is part of the issue.

Helena Konanz: Do you think that a consumption site should be next to a playground?

Dr. Alexander Caudarella: There's a lot of context about where it is. There's no reason one can't balance safety and health.

Helena Konanz: Do you think they should be? Are you saying that, at times, it could be next to a playground?

Dr. Alexander Caudarella: People have a right to feel safe. If having a site near there doesn't make them feel safe, the site shouldn't be there.

Helena Konanz: Excellent.

Dr. Alexander Caudarella: However, if the community comes together and feels that it has a way to address it properly, it should be the community's decision, along with everyone who lives in the community.

Helena Konanz: Do you believe that a community should be able to vote democratically on where a consumption site should be? I'm not sure that's happening, at least not in B.C. I come from local government, and the community didn't vote on where the consumption sites would be.

Dr. Alexander Caudarella: Part of my issue has been that we read a lot about the tragic news in the newspaper. We say, "Oh, that's really sad." I really want everyone to feel that they have a role, not just around voting but in seeing themselves as active participants in helping their community members. When you look at places where harm reduction, treatment and recovery have succeeded in the world, it is because of broad community uptake. Yes, communities need to be involved.

● (1615)

Helena Konanz: I agree. I think communities should have a vote as to where consumption sites should go.

Dr. Caudarella, this is really important: I view the decriminalization pilot project to which B.C. was subjected by Ottawa and Victoria as a costly and deadly failure. I'm not the only one. Even Premier Eby said it did not work. Longer than a year ago, during the last election, he said that it wasn't working.

Health Canada officials, who appeared here, refused to explain if they viewed it as a success.

However, others disagreed. For example, Dr. Bonnie Henry, B.C.'s public health officer, said she was disappointed by the reversal of decriminalization in B.C.

What do you think? Would you want to continue another decriminalization pilot program after the devastation it caused in B.C.?

The Chair: You have 39 seconds to answer.

Dr. Alexander Caudarella: When you talk to people and when you look at the evidence, people want people to be healthy. I don't think they want end-users to be criminalized. I've said this many times. You'll also see in public statements I've made and the organization has made that law enforcement needs the tools to target organized crime.

Helena Konanz: Do you feel it worked in B.C., yes or no? Did this pilot project work in B.C.?

Dr. Alexander Caudarella: The CCSA wasn't involved in the rollout or the evaluation. There are a lot of lessons to be learned.

Helena Konanz: That's good, but was it successful? Would you do it again?

Dr. Alexander Caudarella: It's a very complicated issue about what worked and what didn't work. Ultimately, we need to see—

Helena Konanz: A lot of people died.

The Chair: Excuse me.

Helena Konanz: A lot of people died.

The Chair: Can we—

Helena Konanz: It didn't work. I hope it's not being brought back to any community or any province.

The Chair: The time is up on this question.

May I ask the committee to allow people to at least finish their sentences before we cut them off? I know this is a very tense subject, but I think we can let the witnesses, who bothered to come here to help us, answer the questions and finish their sentences.

Thank you very much.

I'll go now to Ms. Jaczek for the Liberals for six minutes, please.

Hon. Helena Jaczek (Markham—Stouffville, Lib.): Thank you, Chair, and thank you to all our witnesses for their very interesting testimony.

I will confess I had not heard of the Canadian Centre on Substance Use and Addiction until we came here to study it today, even though I've been a practising physician in Ontario for many years.

However, when I look at the purpose in section 3 of the act, it certainly sounds like an incredibly worthy purpose. It states:

> The purpose of the Centre is to promote increased awareness on the part of Canadians of matters relating to alcohol and drug abuse and their increased participation in the reduction of harm associated with such abuse, and to promote the use and effectiveness of programs of excellence that are relevant to alcohol and drug abuse

Certainly, the board members we heard from have a great deal of experience in relation to their own careers and so on.

My first question is for you, Dr. Caudarella, from a scientific point of view. I presume you collect data, first of all, as to the prevalence of substance abuse across Canada. Do you have the full co-operation of the ministries of the provinces and territories? How do you access the data to know the size of the problem?

Dr. Alexander Caudarella: Thank you. That's an excellent question.

We undertake a number of different things.

First, as I mentioned before, we have a Canadian substance use costs and harms study. Part of that is looking at over 20 different administrative databases, all the surveys done and all the vital statistics. With that, we produce what we feel are the country's best prevalence estimates. It's where we see that alcohol use has gone down and cannabis use is increasing. We want to use it, increasingly, to help communities plan more for the future.

In addition, we recognize that data is complicated. This is where our network comes in. We take all the data from drug seizures and surveys and match it to everything from what cops on the street are feeling and seeing to what doctors in emergency rooms are feeling and seeing—and how that connects. It's why we've been able to produce recent reports on new additives and drugs, or on why deaths seem to be decreasing.

Further, we're working closely with provinces and territories on some very specific data points. Right now, we're engaged in understanding the number of treatment beds available in this country, the needs in each jurisdiction and whether we're meeting them appropriately.

We don't want to create data that's just on a shelf. We want to create data that people are actioned to use and that we're told people actually need. We're very proud of the data work we do, and we're really looking forward to doing more and more in collaboration with the hundreds of organizations in this country that we're very thankful to work with.

● (1620)

Hon. Helena Jaczek: In other words, many of these organizations use your data and adapt what they are doing, presumably, based on what the data tells them.

Dr. Alexander Caudarella: Yes. In addition to the data being very frequently referenced in provincial legislatures and federal pieces, we're hearing more and more that, at the local level, people are using it to make decisions.

This is why, for example, in our most recent project—which is happening here in Ottawa—we're trying to take some of those costs and harms as data points and then apply them at the local level. Ideally, as we do more and more, we should be seeing fewer criminal justice costs and more appropriate housing—the different pieces around this. We see a lot of use of this, but we're pushing ourselves. This has been a big goal of mine over the past three years that I've been here.

You're a physician. You admitted that you hadn't heard too much about us. We are really working to change that. This is part of why we're present at every big conference happening. We now have relationships and partnerships with most of the major organizations. We're working with cardiologists. We recently published how they can do more to help patients who use drugs. We're trying to reach people where they are. We're working with primary care providers regarding alcohol and helping them understand how they can do more to help people with respect to cannabis. Physicians, right now, don't know what to say when people come through the door and ask, “Should I smoke pot or not?”

You're right, and we're actively working to have a bigger and bigger presence. We have more partners every day. It makes me very proud that we're working more with people.

The Chair: You have one minute and 10 seconds.

Hon. Helena Jaczek: The act references programs of excellence. Can you point to a specific initiative that seems to be resulting in a positive effect?

Dr. Alexander Caudarella: I'll talk about our small cities initiative.

We want things to land in people's backyards better. It's not just about whether it works in the evidence and is implementable.

Of the two projects that came up and that we were able to feature, one was in Lethbridge. If, one day, you decide you don't want to use drugs and want help, you could find a low-barrier job—

The Chair: You have 30 seconds.

Dr. Alexander Caudarella: —that day to help clean the streets or help build. You'd be paid for that.

Similarly, in our small cities initiative, we worked with Timmins, Ontario. Suboxone, or opioid agonist treatment, is still hard to come by. We don't have high enough treatment rates across the country. They got their paramedics to dispense on site so that somebody wouldn't need to see a doctor. They could start feeling well that very minute, right away.

I don't want to look away from some of the best innovations happening in some of the smallest places in this country. One of the biggest lessons we've learned is that we don't need to look just at Toronto, Vancouver and Montreal to see what's happening. There are some best practices coming out across the country. Our job is to make sure those are interconnected.

The Chair: Thank you, Dr. Caudarella.

We'll now go to Monsieur Blanchette-Joncas for six minutes, please.

[*Translation*]

Maxime Blanchette-Joncas (Rimouski—La Matapédia, BQ): Thank you very much, Madam Chair.

I would like to welcome the witnesses joining us today.

My first question is for you, Dr. Caudarella, and it's a simple one. Have you seen any indication that the fight against the opioid crisis has been a priority for the federal government over the past 15 years?

Dr. Alexander Caudarella: I would say it has been a priority, but in different ways for different governments. The reality is that there has been so much suffering that there's often a desire to be the hero and take credit. However, it's becoming clear that no single government or minister will emerge as the hero; it will take millions of individual actions.

This Liberal government has done a lot, but we need to see more and more co-operation between different departments and between different levels of government. We want the federal government to work with the provinces and territories, as well as with municipalities.

● (1625)

Maxime Blanchette-Joncas: Since we're talking about levels of government working together, I'll give you some concrete examples.

Since 2011, so for more than 15 years, Quebec has increasingly recognized the expertise of pharmacists in addressing safety issues in the context of the opioid crisis. They have the necessary expertise, they are available to people in the regions, as well as in urban centres, and they have hands-on experience. However, the federal government is preventing Quebec from acting in accordance with regulations that would allow them to go further. We're in the middle of an opioid crisis, but pharmacists have not been granted practitioner status to intervene and combat the crisis.

I'd like you to tell me more about this. How is it that in 15 years, no one in the government has acknowledged that this could be a solution? Quebec has been asking for this for 15 years, and no one is budging, so I have questions. Are these people just not getting it? Do they lack the necessary expertise? Or are there people within the government itself who are under the influence of opioids and therefore unable to act?

Dr. Alexander Caudarella: I don't work for Health Canada. I don't work for the government. However, I can tell you that we spent an entire day in Montreal just a few weeks ago. One of the things we discussed was why the results observed in Quebec were more similar to what we were seeing in France than to what we were seeing in other parts of eastern Canada.

I give presentations. You know, many people in this country didn't know that for many years, death rates in Quebec were 20% of Ontario's. That was a far cry from what we were seeing in Timmins, for example. Our goal now is to more or less figure out how the rest of the country can learn from what Quebec is doing, and vice versa. We're working on that, and we're having a lot of success.

Maxime Blanchette-Joncas: Once again, Dr. Caudarella, I don't think we're accomplishing miracles. That said, what I don't understand is why we're still hindering the process to enable clinical interventions that are useful and could reduce risks for patients, including opioid-related risks. It's been 15 years. I'll refer to my example again, but in my view, it's crazy and unbelievable that a government would make a request to another level of government that ultimately fails to act. I'm using Quebec as an example, but other provinces have also called for this regulatory recognition of the status of pharmacists as health care practitioners.

Just think this: A pharmacist cannot intervene quickly to reduce the risks associated with the use of a substance. In your opinion, doesn't this jeopardize the safety of patients?

Dr. Alexander Caudarella: That's an excellent question.

This is where the Canadian Centre on Substance Use and Addiction really wants to hear from the provinces as well. If an issue like that arises, the centre could produce a report on the scientific evidence and make recommendations.

Again, I can't tell you why the government is doing one thing or another, but we can help you find answers to these questions and develop effective approaches in Quebec and across the country.

Maxime Blanchette-Joncas: I understand.

Personally, I associate delays with risks, especially when there is a delay before professionals can intervene to assist people who use opioids. Research shows that, in some cases, administrative delays in modifying or discontinuing a prescription increase risks for patients.

What is your opinion on this?

Dr. Alexander Caudarella: There were many innovations and changes during the pandemic, for example, in the way methadone was distributed and how eligibility was determined.

There is something very interesting about that.

[*English*]

One thing we've learned more than anything is that we sometimes focus a lot on what we're doing, but we don't focus on how we're doing it and if we're doing enough of it. We're always looking for the perfect solution. There's a mix of doing some things too fast and not looking at them closely and, for other things, waiting and not doing....

This isn't just with the federal government.

[*Translation*]

The same applies to provincial and territorial governments. There are various steps that can be taken. I believe there could be a lot more action and evaluation.

Maxime Blanchette-Joncas: I completely agree with you. In fact, you've pointed out a serious problem that, sadly, affects our health care system: We operate reactively rather than preventively. However, science shows us that by focusing on prevention, we reduce costs and move away from risks.

Is our health care system making full use of pharmacists to prevent addiction, or are we still depriving ourselves of a useful solution, which I spoke to earlier?

Dr. Alexander Caudarella: I'm no expert on the subject, but in my opinion, all members of the health care system are probably underutilized. As a doctor, I can tell you that when one of my patients starts feeling unwell, it's almost always the pharmacist who calls me, rather than the patient coming to see me first.

Does that mean every private chain can start increasing the number of prescriptions? No. We saw problems when there were too many prescriptions. Problems should be properly resolved through monitoring and evaluation. We must be creative. There's no doubt about that.

● (1630)

[*English*]

The Chair: Thank you very much.

I now go to the second round. The second round is a five-minute round, with the exception of Mr. Blanchette-Joncas, who gets six minutes because he's a very special person.

Voices: Oh, oh!

The Chair: We begin the five-minute round with Mr. Mazier from the Conservatives.

Dan Mazier: Thank you, Chair.

Dr. Caudarella, who provides the main source of funding to the Canadian Centre on Substance Use and Addiction?

Dr. Alexander Caudarella: The majority of our funding—all of this is publicly available on our website—comes from a contribution agreement with Health Canada and the Government of Canada. We also receive funding—

Dan Mazier: That answered the question. Thank you.

According to the most recent annual report, the centre received more than $11.5 million from Health Canada last year. Is that correct?

Dr. Alexander Caudarella: I believe that last year we received.... Yes, it's probably correct, $11.5 million.

Dan Mazier: The same annual report shows that nearly $9 million was spent on salaries and employee benefits, which account for nearly 70% of your revenues. Is that correct?

Dr. Alexander Caudarella: Yes. We've been making a lot of effort over the past three years to move things in-house as opposed to relying on contractors. We've recruited some of the world's best scientists to come work directly for us.

Dan Mazier: Last year you spent $1.8 million-plus on contractors, so you have some way to go.

As CEO of a federally funded organization, what is your total annual compensation, including salary and bonuses?

Dr. Alexander Caudarella: My annual compensation, with bonuses, I believe, is $270,000.

Dan Mazier: In 2021 you wrote a letter to Health Canada in support of decriminalization of the possession of hard drugs in Toronto. The letter stated, and I quote, “I write this letter of support for Toronto public health's decision to submit a drug possession decriminalization exemption to Health Canada.”

Can you confirm whether you signed this letter, yes or no?

Dr. Alexander Caudarella: Yes. This would have been before I came to the CCSA, when I was a physician at a hospital in downtown Toronto, but yes, I signed it. I believe that, in that year, there were only three arrests made by the Toronto Police Service for possession. There had been a desire to find greater ways to pursue organized crime and violent crime.

Dan Mazier: You answered the question.

In the same letter to Health Canada, you also wrote, and I quote, “decriminalization should be seen as having minimal risk”. Do you still believe that decriminalization has minimal risk, yes or no?

Dr. Alexander Caudarella: Your colleague asked a question about decriminalization, and I think we made a mistake around.... People didn't have the right expectations.

Dan Mazier: Do you still believe that decriminalization has minimal risk, yes or no? Even from what you learned, do you still think that today?

Dr. Alexander Caudarella: In this country, there are almost no arrests for possession right now. I don't think that the decriminalization of simple use is what caused an increase in violence or deaths. What did happen, though.... There are a lot of considerations around things like public use, how law enforcement and health are going to work together—

Dan Mazier: We'll get to the public use in a minute.

Dr. Caudarella, do you support decriminalizing hard drugs all across Canada, yes or no?

Dr. Alexander Caudarella: If you look, we have produced an evidence brief around decriminalization.

Dan Mazier: Do you support decriminalization all across Canada, yes or no?

Dr. Alexander Caudarella: For the end-user, the person who uses drugs in small amounts, there is no benefit to long and, often, ineffective prison sentences, so it's important to look at and consider it.

That being said—

Dan Mazier: Do you still support it?

Dr. Alexander Caudarella: I think that—

Dan Mazier: It's a simple yes or no.

Dr. Alexander Caudarella: Well, but—

Dan Mazier: You tried to qualify it, but yes, you still support it.

Dr. Alexander Caudarella: What you heard me say before, Mr. Mazier, is that every community needs to find its own solutions. This may not be the right fit for every community. I feel that the evidence supports its overall benefit in use, but there needs to be community buy-in and support.

Dan Mazier: I heard that before in your other testimony.

Dr. Caudarella, The Globe and Mail reported that health authorities in B.C. tried to allow the purchase of regulated heroin without a prescription.

The Chair: You have 39 seconds.

● (1635)

Dan Mazier: The health authorities also tried to create, and I quote, “a heroin compassion club”. Do you believe that regulated heroin has a role in treating addiction in Canada, yes or no?

Dr. Alexander Caudarella: There is evidence for heroin-assisted treatment.

Dan Mazier: Yes or no?

I'm tight on time.

Dr. Alexander Caudarella: The regulation of drugs is a very complicated issue, and there's a lot to be said about public safety preventions.

Dan Mazier: I have one last question.

Are you aware that day cares have been forced to shut down after supervised consumption sites opened near them, yes or no?

Dr. Alexander Caudarella: Yes.

The Chair: Thank you.

Dan Mazier: Do you believe—

The Chair: Your time is up, Mr. Mazier.

I'll go to Ms. Sidhu for the Liberals for five minutes, please.

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

Thank you to all the witnesses for being here with us.

My question is for Dr. Caudarella.

Dr. Caudarella, how has federal investment in substance use programs improved coordination and outcomes across Canada?

You were talking about wraparound services. In your remarks, you were talking about cardiology and when people are going to a cardiologist or for primary health care. Can you talk about that?

Dr. Alexander Caudarella: Absolutely.

One thing we sometimes talk about is how we tackled smoking. We made it a whole-of-health issue. It didn't matter where you went. Every door was a place to be supported, treated and helped.

Obviously, this is very different in this context, but I believe very strongly in the power of primary care to deliver many of the services, including opioid agonist treatment and most of the things that are most needed.

People need support. They need coaching and help. They need to be able to individualize the solutions to their local realities. It's why, for example, we're involved in national leading efforts to do work around measurement-based care. How do you measure and make sure people are improving? How do you provide for concurrent disorders?

What we are also seeing increasingly—which is really nice, and maybe this is a reality of a bit more fiscal austerity—is organizations wanting to work together. We're seeing governments wanting to work together. We're seeing people wanting to find the solutions. Being right but having, as Mr. Mazier was saying, day cares closing and people who are upset and frustrated isn't a solution. How do we all work together?

I'm finding that, when I go out and I tell people that they can have a role, that they can do something about this and that primary care physicians can help them, I'm met with tons of enthusiasm. One of my colleagues who's here, for example, went and met all the newcomer clinics and centres. They're very keen to find ways to support their communities. Our job is to reach more people in a more timely way.

Sonia Sidhu: Early intervention is important. How important is prevention?

This government is taking a balanced approach that includes prevention, treatment and recovery. Why is it critical that Canada stay grounded in evidence, and how can your organization support this?

Dr. Alexander Caudarella: There's the piece about evidence, and then there's how people see themselves in that evidence and how that evidence is provided to them in a useful way.

Again, I don't think people are done with data. People want data, but they want data that resonates with them and is useful. I think that's how we move things forward in an evidence-based way. If people see themselves as part of these processes and solutions, things get better. When it comes to the need for evidence, we also....

It has been 10 years of these issues. At first, people very appropriately responded with the here and the now. If you're 18, 19 or 20, and you're dying of an overdose now, you were eight at the beginning of this crisis.

We need to look across this prevention-recovery spectrum. It is absolutely very important. We need to recognize that every single person who goes through treatment will go back into a community that needs to support them. This is part of the nuance around questions we were being asked around regulated drugs or different pieces because, ultimately, community needs to provide an environment that supports the healthiest well-being possible.

Sonia Sidhu: What opportunities do you see to further strengthen collaboration with the federal government to make more progress?

Dr. Alexander Caudarella: There are a few big elements. One is that there isn't a prevention workforce in this country yet. There are probably lots of roles that different things can do.

The second part is that I think most people in this country, unfortunately, aren't even able to access the care that is available to them. When we look at how things like federal government roles can support making sure that all the provincially available services are within grasp and in hand, this can be really important.

The last thing I'll say is that the federal government can have a really important role in which its levers are there, but it also has a role as a partner to the provinces and territories and other levels of government. I think we're seeing an emergence of the ability for these different levels of government to work together. In the past, CCSA has—

● (1640)

The Chair: Please wrap up.

Dr. Alexander Caudarella: —been a big support in terms of creating that.

The Chair: Thank you.

Mr. Blanchette-Joncas, go ahead for six minutes, please.

[*Translation*]

Maxime Blanchette-Joncas: Thank you, Madam Chair.

Dr. Caudarella, you mentioned the authority to prescribe medication earlier, but I'd also like to draw your attention to deprescribing. That's what I was talking about in relation to pharmacists. They currently lack the authority to deprescribe opioids to patients who no longer need them.

In your opinion, doesn't this have an impact on addiction and the associated risks?

Dr. Alexander Caudarella: The issue of deprescribing is an excellent question.

I believe that one of the things we did about 10 years ago was to move too quickly to deprescribe medication for many people without steering them in another direction, to help them seek treatment or obtain appropriate medication. That's what I would say. We haven't really conducted studies in this area, but that's my opinion.

As for the transition, as has been said, pharmacists are the ones who realize that there is a problem. I would like them to have the ability to refer people directly for other treatment or to other doctors if, for example, they are concerned that the person who has been prescribing the medication is not prescribing the right medication.

Maxime Blanchette-Joncas: Okay.

I'm referring to your organization's data, which state that inadequate understanding of the risk of addiction posed by prescription opioids, as well as frequent prescriptions or high-dose prescriptions for pain relief, are the two main factors that have contributed to the opioid crisis in Canada.

Pharmacists are the first line of defence in this crisis. However, their hands are tied because they don't have health care practitioner status, even though this is an essential component in effectively combatting the opioid crisis in Canada. The Quebec government has been asking for this for 15 years. Nothing is happening.

What's going on?

Dr. Alexander Caudarella: I'd be happy to check with my organization to see if I can find more information for you on this topic. I don't think we are making full use of all the resources available in the health care system; there's no doubt in my mind about that. However, I'm not sure about the situation on this specific area.

Maxime Blanchette-Joncas: We'd appreciate it if you could provide the committee with a detailed response in writing.

Dr. Alexander Caudarella: Absolutely.

Maxime Blanchette-Joncas: I think it's an indispensable solution, but nothing has been done about it for 15 years.

Dr. Alexander Caudarella: We can look into that, absolutely.

Maxime Blanchette-Joncas: Let's revisit a topic you're surely familiar with.

Your main funding agreement with Health Canada expired on March 31, 2026. That wasn't long ago. Can you assure us today that your operations will continue uninterrupted—yes or no?

Dr. Alexander Caudarella: Yes. A few weeks ago, we signed a new agreement with Health Canada for the next five years. It really revolves around the idea that what we're doing right now is exactly what's set out in our mandate.

Maxime Blanchette-Joncas: Has there been a reduction in your funding?

Dr. Alexander Caudarella: No, the funding is still $10 million per year.

Maxime Blanchette-Joncas: Is it indexed?

Dr. Alexander Caudarella: No.

Maxime Blanchette-Joncas: That means it's decreased if it's not indexed.

Dr. Alexander Caudarella: We understand the financial challenges in the current environment. That is also why we work with the provinces. We also receive donations from various organizations. Our goal is to grow as an organization.

Maxime Blanchette-Joncas: Speaking of growth, I know there's a government that tells us it wants to build Canada strong. That's its new miracle mantra. The federal government itself acknowledged, on March 27, 2024, that the overdose crisis was one of the most serious public health crises Canada has ever faced. Now you're telling me that it has not indexed your funding and that you'll be able to tackle the most serious public health crisis Canada has ever faced. Are you miracle workers?

Dr. Alexander Caudarella: Of course, we always wish we could have more funding, but be that as it may, I want to make sure that every dollar CCSA receives is well spent. I want to prove that. Whether you give me $5 million or $15 million, I will do the best I can.

Your question gives me an opportunity to mention that we're currently conducting training in this area, and we're very pleased that Health Canada has provided us with funding to do so. We're conducting training sessions for the mining, and oil and gas sectors because, as you said, to build Canada strong, we need to support them.

● (1645)

Maxime Blanchette-Joncas: Listen, I'm trying to understand the inconsistency between what the government says and what it does. I understand that you're not responsible for that. As a legislator and someone who can shape public health policy in Canada, I'm just trying to figure out how a government can say this is the worst crisis in history but not even index your funding. I find it hard to believe that won't have an impact on your operations.

Dr. Alexander Caudarella: As I said, we always wish we could have more money. What's really helpful is that within our organization, we've made improvements to cut back on our spending in several areas, internal operations, financial systems and so forth. We're trying to do as much as we can while cutting back on our expenses. As we've already mentioned, we're trying to attract more and more scientists to the organization. That way, we can work in a more logical manner.

Maxime Blanchette-Joncas: I want to help you with your work. What tangible impacts will this have on your operations and programs?

Dr. Alexander Caudarella: Honestly, we're trying to do more. I know you want—

Maxime Blanchette-Joncas: I'm trying to understand. Right now, I'm having trouble understanding.

[*English*]

The Chair: The time is up in about 10 seconds, so please wrap up.

[*Translation*]

Maxime Blanchette-Joncas: I'd like to have a written response, since I can't get a clear, comprehensive answer.

[*English*]

The Chair: Thank you very much.

I'll now go to Mr. Strauss for five minutes, please.

Matt Strauss (Kitchener South—Hespeler, CPC): Thank you, Madam Chair.

Dr. Caudarella, may I begin by saying how much I appreciate the expertise and enthusiasm you bring to your testimony? It seems as though you're a very data-driven guy. I am too, so I appreciate that.

In preparation for the study, I was trying to find substance disorder rates for Canada as a whole, and when I was doing a web search for that, your organization came up, so you obviously have a role to play in coming up with it. I was concerned, however, because on your website I found a November 2022 paper on the rate of opioid use disorder, and to my read of it, it had data up to 2019. I also found a paper on the use of methamphetamine. This report was dated 2020, and had data, as far as I could tell, up to 2017.

Do you have more up-to-date data on your website? Is it on your website, and I'm just missing it?

Dr. Alexander Caudarella: We're in the process of rejuvenating parts of our website, and it's a work in progress. It's something we've brought in-house to try to save some funds, but the team there is doing a fantastic job with it.

As for your question, yes, we do. We have prevalence estimates up to the end of 2024. They are available directly on our website or through csuch.ca, which is a microsite we've set up. There is a prevalence tool that is interactive; not only can people look at the rates of stimulant and opioid use, but they can also break things up by province, men, women and different things to get the data that's most helpful.

Matt Strauss: Can I get the link?

Dr. Alexander Caudarella: Absolutely.

Matt Strauss: I failed to find it myself. Can you tell me, is the prevalence of substance use disorder in Canada broadly going up or down?

Dr. Alexander Caudarella: One thing we're more confident in is how much use there is. The problem with substance use disorder is that how it's diagnosed, who diagnoses it and how surveys are done have changed over time. This is why we've tried to make different pictures, assessments and assumptions around it.

Matt Strauss: Give me your broad sense. I understand that you should slice and dice it. I'm not going to "gotcha" and say, what about this paper?

I'm asking about your broad sense as a clinician and as a leader in the field. Is this trending up, or is it trending down?

Dr. Alexander Caudarella: I think it's an excellent question. Because the assessment rates are changing so much, it is a hard question, and I can come back with a more specific written answer. However, for opioids we believe it to be relatively flat, if decreasing a bit. We're concerned that there's potentially increasing use amongst young people, but there's potentially less substance use disorder in others.

We're concerned about substance use disorder rates that are increasing, for example, for cannabis in older adults.

● (1650)

Matt Strauss: Thank you for that. I hope to come to my own conclusion when I go through your data.

I'm an ICU physician, and I've been very frustrated with some research. My practice is very downstream, and there are some preventative medicine and family medicine specialists here who are more concerned about upstream things.

It seems to me that in a lot of the talk when we talk about how, as a society, we're going to deal with addictions, we talk about the crisis, deaths and consumption. Ought we not to be more obsessed with upstream interventions, such as how we prevent kids from getting on this in the first place?

I haven't heard anything about that so far today.

Dr. Alexander Caudarella: Actually, we not only created the first prevention standards for communities, school-based and family, but we also have a whole sector of our organization dedicated to that. When we look at the next contribution agreement, not only are we focusing a lot on prevention, but we're also focusing specifically on youth.

Your question is a good one. When we're talking about working with cities, and when talking about this upstream work, there is a tremendous amount. When we're talking about "Canada's Guidance on Alcohol and Health", we're trying to make it a more upstream conversation.

Matt Strauss: This is related, although it sounds very different: Do you think that drinking and driving should be stigmatized in our society?

Dr. Alexander Caudarella: You're asking a good question about whether there is such a thing as good stigma or bad stigma. I brought up smoking, for example; there was probably a good stigma that pushed people off it. Did it go too far, and now people are afraid to even identify and seek treatment? Perhaps it did.

Honestly, we need to look at balance. We need a balance in society in which people feel that other people shouldn't be punished because they use drugs, as those people need help.

Matt Strauss: Thank you so much for saying this, because we've had department officials come and say that the Department of Health is here to fight stigma around substance use disorder. The Conservative position is that when we do these harm reduction sorts of things, are we...? I'm a clinician; I'm focused on my patients, but is there potentially a greater societal cultural cost when we drop a consumption site next to a high school. Would you agree that there's a potential for social harm with respect to upstream interventions and preventing people from getting on the stuff in the first place?

The Chair: Thank you, we've gone over time. Maybe you can address this in another question, Dr. Caudarella.

I'll go to Ms. Chi for five minutes.

Maggie Chi (Don Valley North, Lib.): Thank you, Chair, and thank you to all our witnesses for coming today.

I read through some of the bios of the witnesses, and their backgrounds are very impressive.

My first couple of questions are going to be for Dr. Francescutti.

You are an emergency department doctor...?

Dr. Louis Hugo Francescutti: That's correct.

Maggie Chi: From your perspective, what are the substance use-related pressures you have been seeing very often on the front line?

Dr. Louis Hugo Francescutti: As you know, they're great. We have a variety of patients who present in our emergency department. Some of them have substance use issues. A lot of them have mental health issues. A lot of them have chronic issues.

Some of your committee members were asking for solutions upstream. We've found a solution. We've created a program called bridge healing. It immediately takes someone who's homeless and who's willing to go to a purpose-built building—three storeys, in a community, run by an NGO—and it provides them with the opportunity to get their life back on track. It's free of charge. They can stay as long as they need to. We have three buildings that are harm reduction and one building that's sober living so that we meet the needs of our clients.

We're able to take them from chaos, which is being homeless in an emergency department, and put them into their own room. They tell us that probably the most therapeutic thing we give them is a lock on their door. They sleep for a day or two; they wake up and then we help them. We get them ID. We open a bank account. We find out if they have legal issues. Then we find out what they want to do with their life. We help them with social workers, with pharmacists and with addiction counsellors. We start the journey of recovery. For those who go through the program, there's about an 80% reduction in return visits to the emergency room.

We're scaling up right now in Edmonton. The municipal government is giving us free land. Our Royal Alexandra Hospital Foundation gave us a $10-million donation to get started. Then, working with the feds and the province, providing the operating dollars, we're helping these people, who have very complex lives.

My only advice to this committee is that this is not a simple issue you're dealing with. You know that. It's very complex. We still don't know how complex it is. That's why it is crucial for CCSA to bring evidence that can allow policy-makers to make really good decisions.

● (1655)

Maggie Chi: Thank you for that. The bridge healing program sounds really interesting in terms of addressing some of what I see are probably gaps in the current system.

You said you're scaling up and are now doing it in Edmonton. What are some of your future plans, perhaps, on scaling it in other provinces and hopefully a connected network across the country?

Dr. Louis Hugo Francescutti: We're working out the model so that others can come and ask us how we did it. In Edmonton right now, we want to create a healing house in every distinct neighbourhood. There are over 300. If we were to do this successfully—and we will—it would mean that we would eliminate homelessness in Edmonton within four or five years. This would free up capacity so that we can make absolutely sure we stay ahead of the game.

As others have said, we try to prevent people from ending up in this situation. I've yet to meet an addict who wants to be an addict. I've yet to meet someone who's homeless who wants to be homeless. These men and women are reaching out to us. They're asking for our help. I can't tell you enough about the moral distress it causes us as health care providers to “treat 'em and street 'em”. There should be a law in Canada that says if someone shows up at a health care facility who's homeless, they should not be discharged into homelessness. This would be a bold vision for creating a stronger Canada.

Maggie Chi: Thank you so much for all the work you do.

My next question is for you, Mr. Elliott. In your opening remarks, you mentioned innovative solutions that you've seen in your work and the potential for scale. Can you share a couple of examples and some of the challenges you've been seeing in terms of scaling? What are some things that either community or government can do to support that?

Scott Elliott: I'll give a brief example of the Dr. Peter Centre and how we function. It's a holistic care model. Normally, people who access our facility would probably come because we serve great food. They would come for breakfast or lunch. In there, they get put into a path of care. We have nurses and nurse practitioners on board who are able to look at them and work with them immediately. Over time, we'll get the people into such therapeutic sessions as art therapy, music therapy and counselling.

Then, as I mentioned, we also have housing programs and subacute nursing care. The population—

The Chair: Thank you very much. The time is up, Scott. You can follow up on that in another round.

Thanks very much, Ms. Chi.

I'll now go to the third round.

I'm going to Mr. Baber for five minutes.

Roman Baber (York Centre, CPC): Thank you very much, Chair.

Thank you very much, Dr. Caudarella, and welcome.

I understand that you're a strong proponent of safe supply.

Dr. Alexander Caudarella: I'm not sure where you would have obtained that information.

Roman Baber: Obviously, you're an advocate for safe injection sites.

Dr. Alexander Caudarella: One of the unfortunate things is that.... Harm reduction has been around for 30 years. We need to be very careful not to look at the different pieces in different ways. When we talk about supervised consumption sites, when we talk about injectable opioid agonist treatment, when we talk about safe supply—even "safe supply" means very different things in different contexts—and when we talk about drug checking or different elements, it's very important to be very specific and to look at what we can do in different ways.

Roman Baber: Fine.

Would you agree with me that safe injection clinics tend to increase criminality in local neighbourhoods, rather than decrease it?

Dr. Alexander Caudarella: On our website, you can find an evidence brief we did last year on supervised consumption sites. The evidence thus far from across the country is that supervised consumption sites do not increase the crime in the neighbourhoods around them, and they don't increase violent crime either.

That being said, as I was saying to your colleague, we have to meet communities where they are. If communities don't feel safe, it doesn't mean that we need to be dismissive of that. We need to have conversations about how we help people feel safe.

● (1700)

Roman Baber: Are you familiar with Chief Truong of the London Police Service?

Dr. Alexander Caudarella: Not personally, no.

Roman Baber: You've probably heard that he garnered quite a few significant headlines last year when he testified that a considerable amount of safe supply opioids in London are diverted for criminal purposes. Are you familiar with that testimony or that practice?

Dr. Alexander Caudarella: Yes, I am familiar with the testimony.

Roman Baber: In fact, Chief Truong testified that the diversion of safe supply drugs makes up the majority of all drugs seized by London police. Is that a yes?

Dr. Alexander Caudarella: I can't speak to the specific data in London, but there has been data published around the proportion of opioids that are prescribed in every city that are related to safe supply or not, and it varies significantly from city to city.

Roman Baber: Basically, the London police concluded that the majority of drugs they seize are safe supply drugs, rather than street drugs. Do you find that perplexing?

Dr. Alexander Caudarella: I can't speak to the specific seizure data in London. I can speak to broader trends across the country around seizures. Prescription pills are a piece of them, but they still remain a small piece compared to precursors and other synthetic drugs.

Roman Baber: In your understanding, what is done with the diverted supply? Why is it being diverted?

Dr. Alexander Caudarella: Unfortunately, diversion has been an issue for a very long time. It needs to be considered very seriously.

Roman Baber: What is it? Can you tell me?

Dr. Alexander Caudarella: People will purchase pills or things, and you're going to see this with benzodiazepines and with opioids. They'll purchase it, because they can't get prescriptions themselves, so they'll probably take it.

The Chair: You have one minute.

Roman Baber: People take safe supplies and sell them as illicit drugs on the street. That's what the practice of diversion means, according to policing.

Sir, are you familiar with the name Karolina Huebner-Makurat? Do you know who she is?

Dr. Alexander Caudarella: Yes, I do.

Roman Baber: That is a woman who was gunned down outside South Riverdale Community Health Centre in Leslieville, in Toronto. Do you remember that episode?

Dr. Alexander Caudarella: Yes, I do. I lived a five-minute walk from there at the time.

Roman Baber: She was a mother of two children. They no longer have a mother.

The Chair: You have 20 seconds.

Roman Baber: Do you believe that it would be safer for someone to live next to the South Riverdale Community Health Centre or further away from that centre?

Dr. Alexander Caudarella: The evidence thus far demonstrates that there is no risk of increased violent crime around a supervised consumption site. That being said, as our organization has said repeatedly, law enforcement needs to be provided with the resources to target violent crime and transnational organized crime, which is becoming increasingly complex and, yes, increasingly violent in the pursuit of trafficking and other things.

Roman Baber: You're saying that violent crime around a consumption site is the same as everywhere else.

The Chair: Mr. Baber, the time is up. I'm sorry.

Dr. Alexander Caudarella: Yes, sir, that is what the evidence says thus far.

The Chair: Your time is well over, actually.

Ms. Jaczek, you have five minutes, please.

Hon. Helena Jaczek: Dr. Caudarella, the chair of the board, Dr. Francescutti, has given us an example of something he feels is incredibly important—in other words, getting a roof over somebody's head who is homeless, who shows up in the emergency department and who has abused substances. It's a gap in many communities across the country that are not providing this, so this sounds like a very important initiative.

How do you promote this as an organization? What does CCSA do with recommendations that come from board members and the discussion, I'm sure, on a regular basis? How do you disseminate information about gaps in service to provinces, territories and municipalities?

Dr. Alexander Caudarella: That's an excellent question. Multiple pieces are needed.

The first one is that often more data clarity is critical. What is happening? This is why, for example, we're undertaking those studies to understand what the treatment needs and gaps in communities are.

The second piece is to help to really understand what the needs are in a community more specifically and what the implementation challenge might be. For example, that's why, when we talk about the small cities initiative, we're not talking only about what initiatives worked in other cities but also about the facilitating factors that might increase or decrease the likelihood....

Sometimes you hear that it's the fact that the police chief was willing to meet in a health system for the first round table. That broke the ice. It's also what the implementation challenges are that might help. It's not only how things go but how they spread. Sometimes it's about connecting people as well. For example, one of the pieces we're deeply involved in is an initiative called digital front door, in which people have access to a triage that will help them. They ask for help, and then it sends them to either a doctor or a peer, depending on their needs or all of these different elements.

We need to understand...and people need to be connected, to know what's happening and to be able to implement those things. This is where our networks and our reach are very powerful. Also, our ability to evaluate the evidence and compare different programs can be very important.

● (1705)

Hon. Helena Jaczek: Do you send this information to Health Canada? Do you in any way try to tell them how transfer payments to provinces and territories might be structured, with specific recommendations to address specific needs of the population you're serving?

Dr. Alexander Caudarella: We're fortunate to have a very good relationship with Health Canada, as well as with provinces and territories. They frequently come to us asking what the advice is, what the evidence is, what things might work in their jurisdictions and how. It's something that gives me a tremendous amount of hope.

It's the same thing with Health Canada. They may come to us and ask what the evidence is, what pieces might work in a particular community or even—you're right—what some best practices are.

It's not only in this country. A few months ago, we signed an agreement with the European Union Drugs Agency, because we want to bring home even more of these best practices from around the world so that people have menus of options to choose from that really are the best of the best. It's why we're involved in global standards right now around not only what needs to happen in pediatric care but what should happen for concurrent disorders. People have mental health and substance use issues at the same time. What is the gold standard of care that we should be offering them?

We're involved in a lot of these pieces, and we often do it in collaboration with other organizations to increase the dissemination. We were talking about cardiologists, for example. They are the ones who are going to disseminate that to all the heart doctors about how exactly we can improve the care of patients like that.

Hon. Helena Jaczek: Do I have more time?

The Chair: You have 42 seconds.

Hon. Helena Jaczek: Are there any other international best practices that you could quickly illustrate for us?

Dr. Alexander Caudarella: We're doing a lot in the prevention space around that, to try to bring some of these things. A lot of the things that can be looked at are in reducing violence, how to deal with that, and how to reduce elements....

There was a previous question around stigma. How do you not become overly permissive with substance abuse? At the same time, you want to make sure that no individual who uses drugs experiences stigma. It's that the individuals aren't stigmatized, but at a population level, we're working to try to reduce the amount of problematic use.

This is something that other countries have wrestled with a lot. They have tried different approaches and different communication approaches. For example, we're working with some international organizations that want to speak to people in Canada who don't speak English as a first language, to support them in culturally relevant ways. I think you're going to see a lot of really interesting things coming from this.

The Chair: Thank you, Mr. Caudarella.

Now I'll go to Monsieur Blanchette-Joncas for two and a half minutes, please.

[*Translation*]

Maxime Blanchette-Joncas: Thank you, Madam Chair.

Dr. Caudarella, what concrete results can your organization point to in terms of actually reducing addiction?

Dr. Alexander Caudarella: There's a lot of talk about opioids, but when it comes to alcohol, we can't ignore the impact this research has had—and not just on people with an addiction. We're seeing numbers go down on that front, but we also know that most cancer cases affect people who are not addicted. That's why we want to see reductions across the entire population.

In addition, we recently conducted a study to determine which parts of the country have seen a reduction in the number of deaths linked to opioids and stimulants, and to explain the reasons for that.

● (1710)

Maxime Blanchette-Joncas: I'm trying to understand how you measure the real impact of your actions on the ground. What are your performance indicators?

Dr. Alexander Caudarella: We have several. We have a system and a department at the centre that actually measure that.

We don't interact with clients directly, and that's why we want to find out whether people are using our work and whether patients' lives are improving. One unfortunate reality in this country—and the reason we're stepping up our efforts in relation to metrics-based care—is that, in most cases, we can't tell whether people are getting better or not. This is therefore a solution we currently have, not only to support health care systems, but also to help identify indicators that every province and territory can use to try to evaluate performance.

Maxime Blanchette-Joncas: Based on what you just said, you don't know whether the situation is improving or getting worse for most people. That means you don't necessarily have enough reliable data to say that current policies are working.

Dr. Alexander Caudarella: One of the tools we have, for example, is the skills of those who work with us. We can demonstrate that the level of support provided by a site that has worked with us has improved.

Maxime Blanchette-Joncas: Do you think the results adequately reflect the scope of the opioid crisis?

Dr. Alexander Caudarella: The opioid crisis is complex. That's why we also want to see a reduction in costs and economic impacts in the sectors where we work.

[*English*]

The Chair: Thank you.

Ms. Konanz, you have five minutes, please.

Helena Konanz: I have a question for Mr. Arao.

You told CBC News in 2016 that the number of overdoses you were seeing in Vancouver then was excessively high. The number of overdoses in Vancouver is even higher today, as you know, higher across the whole province, and the number of overdose deaths is significantly higher than in 2016. If overdoses were excessively high then, how would you describe them today?

Neil Arao: Thank you for your question.

In 2016, I was co-managing Insite, one of the first sanctioned supervised injection sites in North America. We started to see those numbers really become inflated.

Since then, as you mentioned, those numbers have grown consistently—almost exponentially. It's really unprecedented. I don't think I can even encapsulate it in a word that would capture how much it's grown.

Helena Konanz: It's shocking.

Mr. Arao, the prevalence of drug consumption sites in B.C. has increased exponentially in the last decade, but so has the number of overdose deaths. Do you view any correlation between these two increases: more sites and more overdoses?

Neil Arao: As Dr. Caudarella was mentioning, the use of the supervised consumption sites is really one intervention in addressing some of those harms. When it's done in conjunction with the communities they serve, there's an identification with the health authorities and the communities of what would be the best approach to dealing with a lot of the overdoses.

Even with the supervised consumption sites, the main intention is to reduce the overall consequences of using solely or individually, and all the overdoses that are related to that—

Helena Konanz: It doesn't really seem to be working, wouldn't you say? The numbers don't work. We've talked a lot today about data. Your organization works with data. This is very obvious data. I would say that the two numbers are both rising: deaths and consumption sites. Do you think they are correlated?

Neil Arao: I don't, because from an evidence perspective, the supervised consumption sites are just one intervention designed to reduce those immediate harms and really connect people to care.

In this function, the number of overdoses that are reversed within those sites is consistently high. Can you imagine if those were absent? The number of deaths would be even higher.

● (1715)

Helena Konanz: You imagine there would be even more.

There's been a lot of talk today about the continuum of care. It's been said that distributing drugs at consumption sites is part of a continuum of care.

I wonder if you could answer my question. I've heard a lot about a need for a continuum of care, for example, but in my community, there's no option for that continuum of care.

If someone's at a consumption site and decides, as you said, to quit drugs—“I'd like to quit drugs, and I want help; please help me”—there's nowhere for them to go. In fact, I was told by a resident involved in this system that in their community, it would be a two-year wait for treatment, and it wouldn't be anywhere in our communities, by the way. They would be sent somewhere else.

After two years...I'm sure you understand what that means. It could be death for somebody. What do you say about opening up these consumption sites yet not having a continuum of care in place, especially in rural communities?

Neil Arao: One of the examples I often refer to is Insite. A really novel thing about Insite was that it had a treatment recovery program right above it. There were two doorways, one to Insite and the other leading upstairs—

Helena Konanz: What do we do? Should we continue to build safe sites, or whatever they are called? Should we continue to build them if there's no treatment available for people to quit drugs, should they wish to do so?

Neil Arao: I agree with your sentiment that all of these different interventions have to be scaled accordingly. If there are harm reduction sites or supervised consumption sites, there also has to be accessibility to treatment. Having something operate in a vacuum or in isolation is not going to solve the problem.

Helena Konanz: Maybe we should hold off on more consumption sites until we build the system and build the continuum of care. Let's build the continuum of care before we build any more consumption sites. I think that's what you're saying.

The Chair: Thank you very much. The time is well over on this one.

I'll go to Ms. Sidhu for five minutes, please.

Sonia Sidhu: Thank you, Madam Chair. My question is for Dr. Caudarella.

Bill S-5, the connected care for Canadians act, is focused on improving secure data sharing across our health system. How important is timely and connected data in responding to the overdose crisis? How can it help frontline providers save lives?

Dr. Alexander Caudarella: Very quickly, I want to address one of the comments that was just made. The CCSA is here to work with your communities. If you are hearing things from your own backyard and from your own constituents, we encourage you to come to us to see if your hospital, university, clinics and providers can be integrated into some of our initiatives to try to improve the care that's offered there. That's an open offer that CCSA has for all parliamentarians. I really encourage you to reach out to us to see how we can support the needs of the community.

To answer your question, you heard from Dr. Francescutti earlier that right now people are often not being provided the care on the spot or connected to care. In this country, the care you receive is often based on where you are, who you are, how you present and whom you happen to meet. I think that because there was such a desire to solve the problems urgently, there was sometimes a fear about working together—because everyone wanted to be the hero—and we sometimes didn't link things together or connect them well.

This is why an organization like ours can be really important in helping to connect those dots. There are things funded by the federal government, funded by the province and funded by the municipality. Sometimes they are even funded by different departments in the provincial government. How do we connect all these things? Absolutely, having more data sharing and having more ability for people to clearly see what's happening, and to see if people are getting better or not, pulls them in.

One part that's missing the most is around community-level data. That's what we're trying to change. We feel that in order to activate people across different sectors, they need to understand. As an example, in one of our workplace things, we were able to find, after interviewing over 1,300 people, that managers in many of the safety sensitive employments had higher rates of use than the employees themselves.

How do we provide them with the data on what's happening, not in an accusatory way but in a way that allows them to act on it? I can't tell you how many mayors of small cities tell us, “Tell me what's happening in my town or city, so I can address it in a meaningful way and provide resources that are actually needed.”

Yes, data needs to be shared across the health sector, but data also needs to be shared much more fluidly across health and law enforcement and across different government departments at all levels of government.

● (1720)

Sonia Sidhu: I have a follow-up to that question. You highlighted that when all levels of government work together, we see real progress. You gave the example of alcohol addiction.

Can you speak to the value of collaboration? You were talking about that just now. Are there any examples you can share in which we have seen governments working together to improve outcomes in substance use? Are there any examples you can share?

Dr. Alexander Caudarella: It's an excellent question. I think we have seen that. There are many examples to choose from.

In Newfoundland and Labrador, we've seen tremendous collaboration among federal, provincial and local governments around alcohol. They are trying to figure out how to get information into people's hands as quickly as possible so that the public health messaging lines up with the messaging from your local physician's office and from different places. It's often about hearing the same thing over and over.

Another instance in we've seen it work very well, as I mentioned, is in Timmins. That's a great place to see municipal, provincial and federal collaboration. Often, it is a strong, local leader who's willing to bring things together.

We've seen wonderful things in Victoria, where there are some interesting partnerships among the provincial and public health elements and the local police to figure out how they can work together. There are all these amazing pieces. Especially when it comes to such things as public safety and public health, we don't need to fear working together. Yes, there are things we need to consider and mitigate carefully, but it doesn't need to be feared in any way.

The Chair: Thank you. The time is up.

I want to tell everyone that we are supposed to use the full two hours. We end at 5:45, so we have time for another round for everyone, if you wish, because we have about 20 to 25 minutes.

I want to correct something for the record. Overdose deaths in British Columbia, and in Canada, have been going down significantly. Opioid deaths have gone down by 22% since July 2024. Stimulant deaths have gone down by 38% since July 2024. It's just for the record that, in fact, deaths are going down in some of these places.

Thank you.

Dan Mazier: Chair, since you brought that up, if it's down by 22%, how many people are dying each day?

The Chair: I don't have that information on hand, Mr. Mazier, but I know it's going down. It's been reported in 2024 and in 2025, and the coroners in various provinces have said it's going down.

Dan Mazier: You don't have it. Can you find that number?

The Chair: A question to ask might be why it's going down.

Dan Mazier: If you could find that number and report it back to the committee, it would be appreciated.

The Chair: I will.

Roman Baber: If I may, I'd like to find out from the chair why she decided to start tracking such data from 2024 as opposed to—

Maggie Chi: I have a point of order.

Roman Baber: —2025, 2015 or 2019. Why start at 2024?

The Chair: I started at 2024, Mr. Baber, because that's when it started to decline. Before that, there was an increase. It's been declining since 2024. That's the only reason I used 2024.

Helena Konanz: Chair, I wanted to ask if you believe that safe consumption sites are working in British Columbia.

The Chair: I'm not a witness here, but I would like to answer that question.

When we had the minister and her bureaucrats here, if you recall, I asked a question about how many overdose deaths there had been since safe consumption sites opened, and I was told there were zero.

Thank you.

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

● (1725)

Matt Strauss: Thank you, Chair.

Dr. Caudarella, it's clear that you bring a lot of expertise and enthusiasm, still, to this testimony, so thank you for that. It seems that you're very committed to reducing harms from substance use disorder and addictions.

You had a conversation with my colleague, Mr. Blanchette-Joncas, about funding, about budgets. Your budget is about $11.5 million. You could do more if you had more.

If the federal government gave you $250 million, how many lives do you think your organization could save with that amount of money? How many organizations could you assist? I'm sure you're able to scale up only so much. What would be a good ROI? How many dollars per life saved?

Dr. Alexander Caudarella: Our sector needs to do more around understanding what those ROIs are. The sector needs more money, but we also need to spend the money better. We have a lot of money from all levels of government that I don't think is being spent ideally.

Matt Strauss: Could you give me your elevator pitch right now? If we wanted to give you an extra $2 million, how many lives do you think you could save?

Dr. Alexander Caudarella: Every day, we're turning away both communities and sets of providers. Well, we don't turn them away. We work with them, but we're not able to help them do everything they want to do and action the next day. I think it would allow us to do more work that would—

Matt Strauss: Could you come up with an estimate and table it with us?

Dr. Alexander Caudarella: Sure.

Matt Strauss: I'd love that. Thank you.

Dr. Alexander Caudarella: What I will say, though—I think it's important—is this: We need to focus a lot more on why people make the decisions they make.

Matt Strauss: On that point, I had a conversation about stigma while speaking with another committee member. You said that you want to make sure no individual person experiences stigma.

If I were to get drunk and drive back to Kitchener tonight—five hours on the highway—do you think I should experience stigma, as an individual, for that?

Dr. Alexander Caudarella: No one should experience stigma for the fact that they are a person who uses drugs. They need to be given support. People are complex, and so are their behaviours. People who use drugs aren't bad people because they use drugs, but this doesn't mean they won't do bad things or things they shouldn't do.

That's why we talk about autonomy and people's ability to make decisions. People make—

Matt Strauss: People are social creatures, though. Perhaps part of the reason I will not drive home drunk tonight is that my parents would be disappointed, my wife would be disappointed and my kids would have negative outcomes from it. I would feel social shame. It's part of what influences my decision-making.

Dr. Alexander Caudarella: One thing we know about prevention—more than anything else—is that telling people not to use drugs doesn't work.

What works is working with families to build good expectations and boundaries. It's about different pieces. Building healthy societies is absolutely critical.

Matt Strauss: In conclusion, you and your organization are going to work to make sure I don't feel stigmatized if I drive drunk tonight.

Dr. Alexander Caudarella: For many decades, we've been doing a lot in the drunk driving space, such as working directly with health and law enforcement, in order to try to reduce those rates.

At no point did I say that people shouldn't be stigmatized for doing things that are harmful, but people shouldn't be stigmatized because they have health conditions. It's very different. It's the same with somebody who has fetal alcohol spectrum disorder and whose cognitive development was impacted by what happened to them. It doesn't mean that if a person commits a crime or hurts someone, there shouldn't be punishments.

We need to understand why people do the things they do. We don't—

Matt Strauss: Stigma is part of it. Every human society has taboos, stigma and customs around shame and forgiveness. To me, this seems to say that here in the west, we're deleting that. We are getting rid of taboo. We're getting rid of stigma, as a federal government prerogative. It seems crazy.

Dr. Alexander Caudarella: What I've said repeatedly, and believe in, is that we want to reduce the amount of substance that is used, because then we see less use at a whole-society level. Does that happen through cultural change? Does that happen through cultural norms? Absolutely, so—

Matt Strauss: I don't think you disagree with me.

I want to give my colleague Mr. Baber the rest of my time.

● (1730)

The Chair: You could give Mr. Baber some time, but he has only 12 seconds. If he wishes to take those 12 seconds, I'm going to cut him off at the right time.

Go ahead for 12 seconds, please, Mr. Baber.

Roman Baber: Sir, is it safe for a child to find a used drug needle near a playground or on a playground, yes or no?

Dr. Alexander Caudarella: Obviously, the answer to that is no, in the same way that—

The Chair: Thank you very much. You answered the question.

We're moving on now, because we're 14 seconds over time.

I warned you, Mr. Baber, about your time. I cannot let one person go well over time. We're now 14 seconds over time. Thank you.

Roman Baber: You said there was a total of 25 seconds.

The Chair: I gave you that. You have no idea how quickly time flies. I'm sorry.

Now we're going to Ms. Chi for five minutes.

Maggie Chi: Since our conversation got cut off because of time, I want to come back to Mr. Elliott and allow him to finish what he was saying before.

Scott Elliott: Thank you.

If we look at the opportunities and solutions that are working in different parts of the country, a lot of these need to come from the frontline organizations themselves. We have a lot of government initiatives and big, great ideas that we push down. The problem is that, as was mentioned earlier, the solutions for this population are acutely local, because every community operates in a different way. Over the past eight years, we've worked with about 400 to 500 organizations across the country, trying to connect them with some of the services they are bringing to the table. Lots of solutions exist.

One of the issues, as already mentioned, is siloed funding in policy. It's also about jurisdiction. Stigma is a thing in the sense that if someone doesn't have the opportunity to talk about something, they're never going to have the opportunity to overcome it.

Maggie Chi: Thank you so much.

My next question is for Ms. Russell-Csanyi.

From what I read, you work with youth. Is that correct?

Susan Russell-Csanyi: I do not work on the front lines with youth. In the past, I've worked on the front lines. My current work is as a consultant on a large research project on the national standards of child welfare.

Maggie Chi: How do you find that your work, your research, has assisted CCSA in making some of the recommendations Dr. Caudarella mentioned? We're seeing a trend towards young people, and I want you to share from your perspective what you're seeing and what you think are useful next steps.

Susan Russell-Csanyi: From my experience, it's helped to underscore the intersectionality, the nature of substance use and the interconnected systems that shape it, as well as advocating for the gold standard—as my colleagues have so eloquently stated today already—that CCSA is working towards. This is the gold standard that's rooted in inclusive evidence, and our work should be community defined. It should be responsive to community needs.

My work on the front lines and in policy, in advocacy and in my own lived expertise has underscored each of those. When I approach my work with CCSA, it is to improve the lives of people in Canada who use substances and to ensure safer communities for all. I have a deeper understanding of how this plays out in the day-to-day because of my lived expertise and the intersectionalities that exist.

Maggie Chi: That's excellent. Thanks so much.

I think I still have time for one last question.

The Chair: You have one minute and 35 seconds left.

Maggie Chi: Thank you. Time passes faster than you think.

Dr. Caudarella, we've heard a lot around the table about trying to, I want to say, oversimplify the issue of addiction and mental health.

I want to ask this. What are the dangers of using a one-size-fits-all solution and oversimplifying the situation? Can you share some of that?

Dr. Alexander Caudarella: When we oversimplify things, people disengage, because this is a problem in which we're in a competition to not only be right but also to, I think, sometimes mislead about the potential harms of things. People don't get what they bargained for. They disengage, and the problem remains the same.

I want to remind the committee members that 38 years ago, it was the standing health committee across all parties that came up with, I think, 20 recommendations of things that were felt should be moved forward. I think the medical field feels very strongly that there are 95% of things in this field that we agree on, if implemented properly, would change things.

One challenge I'd put to the parliamentarians is how we get back to a space in which something this important can be worked across not only party lines but across different levels of government. People are dying, and I think it's important that we find ways to be honest about what's going on, honest about the risks, but also continue to evolve, grow and change our approaches to what we're doing.

We know the solutions. We know how we could turn around and save thousands of lives tomorrow. We just have to be strategic and collaborative about doing it. It's less about cutting down what may not be working perfectly and more about building up what has great potential to work.

● (1735)

The Chair: You have 35 seconds, Maggie.

Maggie Chi: Thank you so much.

I think what you touched on is bang on. It's how to respond with agility and flexibility. If one approach doesn't work, you have to.... We're talking about people's lives. You have to go to the next one, and you have to try different things.

There are some things said about supervised consumption sites not connecting to services. Is that your experience? Is that what you've been seeing?

Dr. Alexander Caudarella: I have clients who have stopped—

The Chair: Thank you.

I'm sorry, Maggie. I let you go about 50 seconds over time, almost a minute. That was my bad; I wasn't paying attention, so everybody can crucify me for that. Okay, there we go.

Now, Mr. Blanchette-Joncas, you have two and a half minutes, please. Go ahead, Maxime.

[*Translation*]

Maxime Blanchette-Joncas: Thank you very much, Madam Chair.

Mr. Caudarella, you spoke of the need to be strategic and to engage in co-operation. Can the government really claim to be tackling the opioid crisis, one of the most serious public health crises in our history, while slowing the growth of federal health transfers? Is that what it means to be strategic and to engage in co-operation?

Dr. Alexander Caudarella: I would say, once again, that I don't represent the Government of Canada. However, there is still resistance, even when it comes to earmarking transfer payments for mental health or substance use reduction. In my opinion, we should spend much less time debating who gets more money and much more time discussing how to improve accountability regarding how that money is spent.

Maxime Blanchette-Joncas: However, as an expert, you would agree that prevention is much less expensive than treatment.

Dr. Alexander Caudarella: Absolutely. Prevention is critical. What gives me hope is the fact that communities are now willing to support preventive measures.

Maxime Blanchette-Joncas: How, then, is it possible to do more prevention work if the resources aren't there? As you know, current health care transfers are set to decrease. The costs of health care systems, including Quebec's, will exceed federal transfers. Cuts will have to be made somewhere. How do we tackle major public health crises when we don't even have the resources to do so?

Dr. Alexander Caudarella: I'm a doctor, so there's no way I could tell you that I want less money going into health care. However, I can tell you one thing.

[*English*]

We have a capability problem, not a capacity problem.

[*Translation*]

Some 90% of health care professionals don't work with people who use drugs or alcohol. We need to involve them more and more. It would certainly be great if we had 10,000 or 20,000 more doctors in this country, that's for sure. However, I would like to see the 30,000 family doctors, like myself, working in this field at least part of the time.

Maxime Blanchette-Joncas: Thank you very much for your response.

Madam Chair, I just want to let you know that I'm going to move the following motion, which I provided recently:

> That, given the Order in Council appointments referred to the committee on March 9, 2026, and March 26, 2026 for the Chief Public Health Officer of Canada and the President of the Canadian Food Inspection Agency, respectively; the committee invite:
>
> Harpreet Singh, President of the Canadian Food Inspection Agency; and
>
> Joss Reimer, Chief Public Health Officer of Canada;
>
> to appear for one hour each to discuss their work within two weeks following the adoption of this motion, and that the committee use additional resources if necessary to meet the deadline.
>
> And that the committee request the Minister of Health to provide, within five days following the adoption of this motion, the complete list of members of the Task Force on the Pharmaceutical and Life Sciences Sector.

● (1740)

[*English*]

The Chair: As you know, Maxime, this has not been given 48 hours' notice. You're tabling it today. We won't debate it today. We'll have to do it at another meeting, because we did not get 48 hours' notice.

Dan Mazier: This is relative to what we're discussing today, since we brought in officials who have been appointed. It's at hand, so it can be considered.

The Chair: I don't agree with you that it is relative to what we're doing today. It's broader than what we're doing today, but if the committee wants to say let's go ahead with it, let's go ahead with it. I'm feeling very generous today.

Go ahead, Maggie.

Maggie Chi: I don't have the wording. I put my interpretation on a little too late. Can we pause to see the wording? I need to see what the wording is.

The Chair: Yes. We'll suspend.

● (1740)

_____________________(Pause)_____________________

● (1740)

The Chair: I call the meeting back to order.

I am asking the committee for unanimous consent to look at Mr. Blanchette-Joncas' motion, because it's not been given 48 hours' notice and it's about a totally different issue. It's about food and public health. It's not really about the issue this committee was trying to talk to.

Do you want to give him unanimous consent to table it? Do I hear a yes?

Maggie Chi: Yes, we give unanimous consent.

If you seek it, you will also find unanimous consent to adjourn the meeting.

The Chair: We haven't asked to adjourn the meeting. I'm asking first if there is unanimous consent for Mr. Blanchette-Joncas to table his motion.

Are you suggesting that the meeting be adjourned?

Dan Mazier: The motion will be passed. Is that right?

We will pass the motion today.

● (1745)

The Chair: We have a motion to adjourn, which, as you know, is not debatable.

Did you say adjourn or adopt?

Maggie Chi: I said adopt first and then adjourn.

The Chair: You don't want to debate the motion. You want to adopt it.

Maggie Chi: Yes. There is unanimous consent.

The Chair: Okay, we don't even have debate. That's great. My goodness, somebody is smiling on Mr. Blanchette-Joncas today.

Somebody up there is smiling on you. We are passing your motion without debating it.

That's great. Thank you.

(Motion agreed to)

The Chair: Did I hear somebody say they want to adjourn?

Maggie Chi: Yes, let's adjourn.

The Chair: Okay, then this meeting is adjourned.

Thank you.

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