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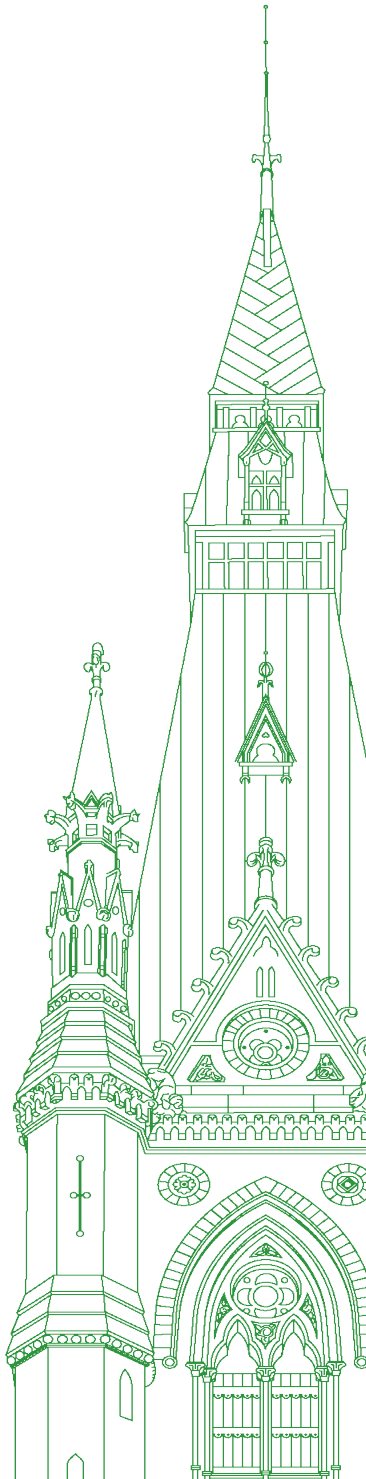
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Chair: Sukh Dhaliwal

Standing Committee on Health

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● (1105)

[*English*]

The Chair (Sukh Dhaliwal (Surrey Newton, Lib.)): I call this meeting to order.

Welcome to meeting number 39 of the House of Commons Standing Committee on Health.

Today's meeting is taking place in hybrid format, pursuant to the Standing Orders.

I would like to remind participants of the following points.

Please wait until I recognize you by name before speaking.

Those participating by video conference, click on the microphone icon to activate your mic, and please mute yourself when you are not speaking. At the bottom of your screen, you can select the appropriate channel for interpretation: floor audio, English or French.

Members in the room, if you wish to speak, please raise your hand. Members on Zoom, please use the “raise hand” function.

I will remind you that all comments should be addressed through the chair, but I will give a lot of freedom here. As long as the witness and the honourable member are in eye contact, I will not interrupt the conversation.

I have one suggestion for the witnesses. If you see a hand raised, either by myself or by the honourable member who is speaking, please try to stop or wrap up immediately. That will help.

The clerk and I will manage the speaking order as best we can. We appreciate your patience and understanding in this regard.

Pursuant to the motion adopted on Tuesday, September 23, 2025, the committee shall resume the study on the opioid epidemic and toxic drug crisis in Canada.

I would now like to welcome our witnesses for the first hour.

Appearing as an individual, we have Mr. Adam Zivojinovic, journalist. From the Canadian Centre on Substance Use and Addiction, we have Dr. Caudarella. From the Canadian Mental Health Association, we have Vice-President Sarah Kennell and CEO David Smith, who is appearing by video conference.

Ms. Kennell and Mr. Smith, you will have five minutes, so you have to decide who will speak or if you want to split that time.

I would like to remind you that committee members may ask questions in either French or English. If you require interpretation, please take a moment now to prepare your earpiece and select the listening channel that you need.

As I mentioned, each organization will have five minutes for opening remarks.

We will give the floor to Mr. Zivojinovic.

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

Adam Zivojinovic (Journalist, As an Individual): Thank you for inviting me to speak to the committee today. I just finished chemotherapy last week, so I apologize in advance if I exhibit any brain fog during my testimony.

My name is Adam Zivo. I'm a freelance journalist best known for my weekly columns in the National Post and for my reporting on Canada's drug policies. I'm one of the country's leading critics of the harm reduction movement and, specifically, safer supply. Among other things, my work has been extensively cited by Canadian politicians at the federal, provincial and municipal levels, and it has also been approvingly referenced by leading American drug policy experts and the B.C. RCMP's investigative services and organized crime division.

In early 2023, the National Post published a 10,000-word investigative report that I wrote, based on interviews with around a dozen addiction experts, predominantly frontline physicians. They told me that based on what they were hearing from their patients, it was clear that safer-supply hydromorphone was being widely diverted to the black market. Why was this happening? Hydromorphone may be as potent as heroin, but it is roughly 50 times weaker than fentanyl. Since most safer-supply recipients are addicted to fentanyl, their free hydromorphone generally cannot get them high, even at maximal doses, so they rationally sell or trade their pills for their drug of choice. In this way, safer supply does not mitigate the use of illicit fentanyl but rather subsidizes it.

My interviewees consistently said that, thanks to safer-supply diversion, the cost of an eight-milligram hydromorphone pill crashed from $15 to $20 each to $1 to $5 each, or less than a can of beer. For context, just two or three of these pills is enough to elicit an overdose in an opioid-naive user. Worse yet, the availability of safer supply seems to dissuade addicts from seeking evidence-based, recovery-oriented treatment. Bear in mind that the doctors I initially interviewed were based in Vancouver, Toronto, Hamilton and Ottawa. Their stories were remarkably consistent, despite their disparate locations.

When my report came out, harm reduction advocates dismissed my findings as anecdotal, which—perhaps not incidentally—was the same tactic used to undermine early reporting on the OxyContin crisis in the 2000s. Though I agree that anecdotal evidence is not ideal, it filled a gap left by harm reduction researchers, who have refused to make any serious efforts to measure diversion. Most of the studies that support safer supply consist of nothing more than interviews or surveys with recipient addicts who pinkie swear that the program is fantastic and that diversion is negligible or benevolent. Harm reduction activists have inexplicably framed these glorified customer testimonials as objective evidence of success and, in some cases, even claimed, against all evidence, that flooding communities with diverted pharmaceutical opioids is a good thing, as if the OxyContin crisis didn't demonstrate the opposite.

I subsequently produced over 50 follow-up columns and reports on safer supply. I interviewed half a dozen former drug users in London, Ontario, who testified that within their circles, between 50% to 80% of safer supply was diverted. I interviewed two Vancouver-area teenagers who had tragically developed fentanyl addictions after getting hooked on diverted safer supply. I then interviewed their former drug dealer—a teenage boy in rehab at the time—who spoke at length about how he trafficked thousands of safer-supply hydromorphone pills in Vancouver's Downtown Eastside on behalf of the infamous Brothers Keepers gang. I found dozens of examples of safer supply being trafficked on Reddit—sometimes hundreds or thousands of pills at a time, often photographed in their original prescription bottles. Online dealers portrayed the program as a money-printing machine and joked that the government was giving out hydromorphone “like candy”. I quoted them directly on that.

Through some badgering, I had three Ontario police departments release their annual hydromorphone seizure data. It showed that between 2020—the year safer supply became widely available—and 2023, such seizures exploded by roughly 3,000% in London, 1,000% in the Waterloo region and 1,500% in the Niagara region. The London police explicitly attributed this trend to safer-supply diversion, and they confirmed in a press conference that organized crime was involved at every level.

However well-intentioned safer supply might be, it has clearly been a disaster for Canada. Ontario, British Columbia and Alberta have all restricted access to it, but more must be done at the federal level, including total abolition or prohibition, if necessary.

Thank you for your time. I'm happy to answer any questions you may have.

● (1110)

The Chair: Thank you, Mr. Zivo, and I wish you well.

Now we will go to Dr. Caudarella for five minutes.

Please go ahead.

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

This is our fourth appearance before this committee since it began studying the opioid crisis in December 2023. We've shared data. I've shared my experiences as a family doctor.

Our vision has been straightforward. We want to coordinate a national response that makes sure that every door is a door to help. It's one that's grounded in compassion and guided by evidence but is really central to the needs of communities and communities' desires to be healthy, connected and safer.

Since this study began, almost 14,000 people in Canada have died from apparent opioid toxicity. We released something just last week, highlighting the fact that 70% of people who died in Ontario last year did so in private residences. I share this to remind us that the crisis extends well beyond what we too often think is something affecting others and happening only on the streets, whereas, really, this is killing our neighbours, our friends and our families. Each of these people represents someone who's left to cope with an immeasurable loss.

In our previous testimony, we emphasized that no single intervention will resolve this crisis.

[*Translation*]

We need access to treatment, recovery supports, harm reduction and measures that protect community safety. These aren't competing priorities.

[*English*]

We often forget about prevention. We look at it as a nice-to-have or something on the side.

It was over 10 years ago that we first started declaring emergencies around this. Those people who are dying today were kids then. Between then and now, we have had thousands of missed opportunities for each of those individuals to do something to save their lives.

This perspective needs to apply as well to public safety. That's why the CCSA has been investing a lot more time recently in looking at how we can help so that young people are not recruited into organized crime.

[*Translation*]

We've emphasized that substance use treatment must become a routine part of health care, rather than a separate system that people struggle to navigate.

We've experienced this first-hand. We work with cardiologists, family doctors and pediatricians across the country to ensure that everyone who comes to a children's hospital will be treated and asked the necessary questions so that they can find answers and get help.

[*English*]

Improving services alone is not enough. One of our greatest challenges is actually putting that evidence into practice consistently and at scale. This is why the CCSA is working directly with communities to help bridge the gap between knowledge and action. We've worked with over 30 small towns to identify practical solutions that work for them. We've come out with a playbook for action that has over 50 of these evidence-based things, but also how they can decide if they're appropriate for their community.

There are no heroes in this. There are not going to be any statues for victorious leaders after this. If there are heroes, they're completely unsung and they live in communities, trying to build hope, but you're never going to see them on the news.

There's no perfect model, and there's no perfect solution. Oversimplifying complex things doesn't help anybody. In fact, it makes the problem much worse.

The reality is that there are many things that we know work. We need to stop telling people exactly which one of those solutions is right for their community. Instead, we have to help them so that they do a lot of what works and they do it really well.

We also need to hold ideas accountable through independent and transparent evaluation so that we're not causing harm or extra harm, because, ultimately, there's always some harm involved too. This is where national leadership can make a difference.

● (1115)

[*Translation*]

Lasting progress requires more than individual organizations working in isolation. It requires clear and shared goals, co-operation across governments and sectors, accountability for results and measurable outcomes. In particular, we need to determine whether more people can access care, whether harms are declining and whether communities are becoming healthier and safer.

[*English*]

We all have a role to play in addressing this crisis. Every conversation is an opportunity for compassion. For someone afraid to ask for help, a few words can make the difference. Communities are telling us they're ready. We have principals saying they want to work with police chiefs. We have businesses that want to work with emergency departments. Everyone's recognizing that they have a role to play, and they want to take even more action.

All I'm saying is we need to play our role. The CCSA is here and happy to help, as it was set up to do. We want to help your committee and achieve these things all together.

Thank you very much.

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

We will now go to Madam Kennell and Mr. Smith for five minutes.

Please go ahead.

Sarah Kennell (Vice-President, Policy, Partnerships and Advancement, Canadian Mental Health Association—National): Thank you very much, Mr. Chair.

Good morning, and thank you for the invitation to appear before this committee.

The Canadian Mental Health Association delivers free frontline community mental health and substance use health services in more than 330 communities across the country in all 10 provinces and the Yukon. We see how problematic substance use affects people, families, workplaces and communities, and what is needed to find a path to recovery.

Building Canada strong will require federal leadership to address and sustain progress toward addressing the opioid crisis and supporting a productive workforce. The construction, trades, mining and agriculture sectors, which are mostly made up of men, account for over one-third of opioid toxicity deaths, which will have a direct impact on our ability to deliver on our anticipated major projects.

We can address this crisis through sustained services across a continuum of community-delivered care, from prevention and treatment on demand to long-term recovery, such as supportive housing.

The 2017 federal bilateral mental health and addictions agreements are filling an important gap by providing access to care that isn't covered through our public health insurance. This investment expands access to community-based services and strengthens connections into primary care, but this funding is at risk.

A recent one-year extension of federal bilateral funding offers temporary relief, but it fails to shift from short-term interventions to lasting solutions. Predictable, long-term funding is essential to maintain services and retain the skilled workforce that delivers them.

My colleague Dave Smith, CEO of CMHA Peel Dufferin, will speak to examples of such services that are prioritized under Ontario's road map to wellness, which receives federal financial support through the bilateral funding.

Dave, it's over to you.

David Smith (Chief Executive Officer, Peel Dufferin Branch, Canadian Mental Health Association): Thanks.

CMHA Peel Dufferin serves a catchment area of about 1.7 million residents west of Toronto, across Peel region and Dufferin county, including the cities of Mississauga, Brampton, Orangeville and Bolton, as well as the Toronto Pearson airport and a significant rural area in northwest Toronto. We provide a range of community-based mental health and addiction services, with several programs focused on addictions.

Our rapid access addiction medicine program provides assessment and medication-assisted treatment and counselling. These services are based in local communities, and clients access them from where they live. Once stabilized, individuals are connected to ongoing primary and community-based care. The greatest benefit of these programs is that there's a clinic open every day somewhere across the region, so that clients get the help they need at the exact point that they are ready. The staff also have relationships in the communities where clients live, helping them access primary care, food and housing.

We also lead on a homelessness and addiction recovery treatment hub, which is an Ontario-wide approach to addressing addictions and homelessness. These hubs provide integrated care in one location, with peer supports, primary care, mental health and housing specialists all under one roof. There are also helpful practical supports like laundry, showers, food and clothing. The hub focuses on housing stabilization by helping people with the issues that stand in the way of their success.

Further, we provide the region of Peel's homelessness outreach services and have concurrent disorder services within our mental health teams, all aimed at supporting people immediately when they are ready for change.

In both Peel and Dufferin, we continue to deal with capacity issues. Despite seeing a 15% to 30% drop in the number of opioid deaths and hospital visits, we are still seeing constant changes in the drugs of choice and the mixes that require attention and understanding, and our services remain fully utilized. Limits to funding mean we are able to operate clinics in local communities only one day per week, leaving clients to either travel significant distances or delay treatments to another day. Further funding would mean that we could reach deeper into areas where we currently do not offer services and further increase the level of support, the immediacy of intervention and the likelihood of success.

● (1120)

The Chair: Thank you very much, Mr. Smith and Madam Kennell.

Before we start the round of questions, I would love to welcome MP Leslie Church to the meeting. I'm sure you will participate a bit later on.

My request of the honourable members is that when you ask the questions, because there are multiple witnesses, you name the witness you are asking the question of.

My request of the witnesses is, again, to please keep eye contact with the honourable member who's asking questions, because it's their time. As soon as they raise their hand, please stop.

Thank you.

With that, we can go to round one and Madam Konanz for six minutes.

Please go ahead.

Helena Konanz (Similkameen—South Okanagan—West Kootenay, CPC): Thank you, Mr. Chair.

My first question is for Mr. Zivo.

Thank you for being here today. As you spoke about in your introduction, British Columbia has been in a public health emergency for a decade now because of our deadly addiction crisis. Thousands have died. There's no dispute about that.

On Saturday, British Columbians overwhelmingly chose a new government that will evaluate the Eby NDP government and the federal Liberals' prior addiction policies. Having reported on these matters for some time, when it comes to policies like drug consumption sites or so-called safe supply, where should governments look to make changes to address the addictions crisis and reduce the number of overdose and toxic drug deaths?

Adam Zivojinovic: I'm going to focus specifically on safe supply and skip the supervised consumption sites.

Regarding safe supply, I think abolishing it entirely is a reasonable response. In 2025, a study published in JAMA showed that the implementation of safe supply in British Columbia was associated with a significant increase in opioid-related hospitalizations and was not associated with a decrease in opioid-related deaths.

Now, the underlying methodology had some issues. It was a synthetic difference-in-differences analysis. Essentially, they looked at these two indicators in B.C. and compared them with other provinces. The problem was that there wasn't a peer control group here, because Ontario had some degree of safe supply as well. This kind of methodology always has its problems. It's not the same as RCTs or anything like that. At the same time, it heavily suggested that safe supply is not saving lives. I think we can have fewer hospitalizations if we remove safe supply here.

If we're going to keep safe supply in some way, I think the changes recommended to the CPSO, the College of Physicians and Surgeons of Ontario, earlier this year would be quite productive. One of the main recommendations was that the provision of safe supply be limited to six weeks. Basically, the idea here is that if you provide safe supply for a limited period of time, you can use it to incentivize people to take treatment rather than provide an alternative that dissuades them from getting better.

● (1125)

Helena Konanz: Thank you for that.

Mr. Zivo, I know you've spent a lot of time speaking with advocates and doctors, but you've also spent time speaking with people with an addiction who are in encampments and on the streets. For those who are suffering on our streets, which, being from B.C., I'm aware of—it's throughout the country, but B.C. seems to be worse off, at this point anyway—do they see accessible resources for recovery?

Adam Zivojinovic: From my understanding, no. When I speak with people who have recovered from addiction and when I speak with municipal leaders who are advocating for more resources, the thing I hear time and time again is that there are so many options available that entrench addiction, such as getting free opioids, but access to recovery is very limited.

For example, Stéphanie Plante is a city councillor in Ottawa. Her ward contains most of the supervised consumption sites in the city. She and I are friends. She has repeatedly complained about the fact that drug users in her ward will talk about how they can go to a site and consume drugs under supervision, but when they want to access recovery-oriented services, that's just not available there.

Helena Konanz: I was a city councillor myself in Penticton, British Columbia. I was told not that long ago that if someone were to walk into our council chambers and say, “I need to go back to my family, and I need help,” it would take two years to get to the first step for the detox bed. That's two years. In other words, it's a failure.

I'm wondering if you might be familiar, Mr. Zivo, with the recent B.C. court case in which a group known as Drug User Liberation Front had their drug trafficking conviction initially overturned on constitutional grounds. Health Canada actually rejected this group's application to run a consumption site, yet the group received $200,000 from Vancouver Coastal Health to run the site illegally. They were improperly storing black market drugs being sold for profit. The judge said the practice was urgently needed to address a public health crisis of epic proportions.

In your opinion, Mr. Zivo, is drug trafficking urgently needed to address a public health crisis?

Adam Zivojinovic: No. I think the underlying problem is that the judge who evaluated that case had a very poor understanding of the addiction crisis and drug policy in general. I actually read that ruling quite closely. I was going to write a column about that in the National Post, but then the cancer got in the way.

She said there was an urgent need for non-medicalized safer supply, which is essentially a code for drug legalization. She didn't actually cite any supporting evidence. She cited a few reports. For example, there was one report that was published by Dr. Bonnie Henry, who is B.C.'s top doctor. In that report, Dr. Bonnie Henry explicitly says there is no real evidence for drug legalization, but she wanted to extrapolate from the evidence base for “medicalized” safer supply, which is what we have right now. The evidence base for medicalized safer supply is already very weak. It's basically non-existent. You can't jump from that to drug legalization.

Helena Konanz: Could I ask a quick question? Is this the only example of these pseudo-legalized drug-trafficking sites, or are there more?

Adam Zivojinovic: I wouldn't be able to answer that question.

The Chair: Thank you, Madam Konanz.

We will now go to Dr. Eyolfson for six minutes.

Please go ahead.

Doug Eyolfson (Winnipeg West, Lib.): Thank you, Mr. Chair.

I'd like to thank you all for coming here. This is all very valuable testimony.

Dr. Caudarella, I've read some on this. I was an emergency physician for 25 years, so this is something that was of interest to me before I was in politics.

When we look at nations—particularly nations in northern Europe, but not just in northern Europe—that have very different drug policies, from what I understand, in addition to their drug treatment programs, they have very, very robust social welfare programs aimed at poverty reduction, homelessness reduction, etc.

Would you not agree that these are essential parts of addressing the opioid crisis and all drug addiction problems?

Dr. Alexander Caudarella: Yes, thank you for that.

We've been working a lot, actually, with our European counterparts—last year, we signed a working agreement with the European Commission—because we specifically feel that this isn't an issue about one country's drug policy or approach. It's a bigger issue. You're absolutely right, so the need to look at this holistically is critical.

One thing that's so interesting is that when you start working with communities or frontline physicians like yourself, it's obvious. They understand right away that you need the whole net, that you need the whole thing, to help people along, and these things are intertwined—everything from housing to treatment to different elements.

● (1130)

Doug Eyolfson: All right, thank you.

In my parliamentary career, one of the things I have done is take a tour of Stony Mountain penitentiary, which is just north of Winnipeg. One of the things the people who work there—the corrections officers and even the warden there—were telling me is that a great number of people who have drug addiction problems end up in the justice system, either because they're in possession of or trafficking illegal substances or because of the things they do, like committing robbery to buy their illegal substances. They said that, in the correctional institutions, there is quite inadequate treatment and rehabilitation. One corrections officer told me that we're just basically warehousing people with mental health and addictions issues.

Would you not agree that another big part of this that would help is that, once people are in the justice system, we make good use of their incarceration by giving them proper rehabilitation, proper treatment, and set-ups to live productively in the community?

Dr. Alexander Caudarella: Yes, I think there's no question that you can have a public safety system that helps divert people who actually need help and health care services away from being treated like criminals, while still having a robust plan to go after organized crime, especially transnational organized crime.

In addition to that, what I'd say is that, again, we're always looking for these perfect models. When we look at jails and at prisons, we see that there's the stuff that we've known for 20 years has worked but that is not being implemented across the board. Even if we do what we know works and do it really well in those places—and a lot of it—you're absolutely right. We know that leaving detention is one of the highest-risk times for overdose deaths. People lose their tolerance; they're at high risk. It's really unacceptable at this point that anybody who has an opioid use disorder is not offered treatment and support in a carceral setting, absolutely.

Doug Eyolfson: Thank you.

You just said something that made me think of another question.

One of the issues that I've become familiar with is that detox is only part of this. I have actually heard of dangers with rapid detox systems if you don't also have the rehabilitation afterwards. From what I understand of this, people in a detox program, as you say, lose their tolerance. If their addiction hasn't been properly addressed, then as soon as they're out of detox and they use, they're at a higher risk of overdose due to their decreased tolerance.

Dr. Alexander Caudarella: You're right. It's hard to quantify exactly, but it might actually make people even as much as twice as likely to die from going through only an abstinence-based program, especially if they're forced through it.

I think the necessity for treatment.... This is one of the things on which we have to communicate clearly with the public. It's very hard to understand when you have a loved one, especially a loved one with an opioid issue, and are thinking, “Okay, we just have to get them off the drugs, tie them up somewhere, help them out with it.” We've known for a long time, as you said, that this doesn't work. They need wraparound services. They need support. They need ways that they can cope with it. Often, yes, they need medication and various levels of intervention. There's no question about it.

Doug Eyolfson: All right, thank you. I'm running a little short of time, so I'll ask this quickly.

When we talk about harm reduction sites, supervised consumption sites, we do know that, when people are not ready to quit, these sites help keep them alive.

There's been talk about mandatory drug treatment. Does putting someone in a mandatory drug treatment program work?

Dr. Alexander Caudarella: We released an evidence brief about six months ago. The problem is that it is not clear where and when it can work, if so.

The Chair: Thank you very much. That was perfect timing.

Before we go to Madame Gaudreau, I would love to welcome our honourable colleague from North Island—Powell River, British Columbia. Is that correct?

● (1135)

Aaron Gunn (North Island—Powell River, CPC): Yes.

The Chair: Welcome to the committee, Mr. Gunn. I know that you will participate a little later on in the discussion.

We will go to Madame Gaudreau for six minutes.

[*Translation*]

Marie-Hélène Gaudreau (Laurentides—Labelle, BQ): Thank you, Mr. Chair.

We're carrying out a study. I was speaking with my former colleague, Luc Thériault. He told me that we're still studying the issue, even though we've been talking about increasing vulnerability for decades, particularly with regard to housing availability. The bottom line is that problems become more severe when people encounter difficult circumstances. I have the feeling that we're going nowhere. I've heard what you have to say.

Ms. Kennell and Mr. Smith, when an organization establishes a system for prevention, support and follow-up, how do you explain the fact that funding might last a year or three years and then disappear afterwards, even though you have the solution? How do you handle that?

Sarah Kennell: Thank you for the question, Ms. Gaudreau.

People across the country are asking exactly that question.

[*English*]

We have CMHAs that are delivering evidence-based, compassionate interventions. They are delivered by frontline staff, who are the most passionate people in this country. They keep our communities safe and offer care and support to those impacted directly, their community members and their family members.

Those organizations are funded piecemeal and patchwork by a combination of different funding sources that are short-term and driven by very short-term metrics. As a result, the precariousness through which we deliver care is contributing to the inability for us to tackle this crisis as we should be.

As Dr. Caudarella said, we know what works. It's time to invest in it over the long term. Given the nature of this crisis, it is a pan-Canadian, multi-jurisdictional issue that requires such an approach to address.

[*Translation*]

Marie-Hélène Gaudreau: Investments are being made in housing and people will be provided with a place to live. However, I gather that simply providing access to housing doesn't mean that people can rent or buy it. Quebec has affordable housing as well as social housing specifically designed to maintain a connection. Unfortunately, too many legislators here at this table and in other places think that they can just inject money and consider the issue resolved, and then move on to other matters.

Dr. Caudarella, when it comes to mental health and substance abuse, is it true that these issues can't be resolved all at once?

Dr. Alexander Caudarella: As you said, these issues are naturally quite complicated. For example, we've seen the need to make modifications to homes and housing for people who use drugs.

I'm trying to explain that the solution doesn't lie in any one specific model. Someone in the community must see how connections are formed and how the police work with housing developers. They want to work together. How will we help people? In some programs, participants have started treatment for opioid use, for example. Between 50% and 60% of those people were employed a year later. How will we all make these connections together?

As you said, we're looking at the short-term impact. Hence my point that assessments must be carried out independently, with open and accessible data, so that communities can decide how best to proceed.

Marie-Hélène Gaudreau: Let's be honest. We want to measure the results so that we can claim success. If we can't measure the work on the ground that actually leads to fewer people in need, it doesn't pay off on a political level. We need to ask ourselves whether we can let go and trust the experts, the people on the ground. I'm telling you this because I worked on the front lines 30 years ago.

I'm also thinking of Maison Lyse-Beauchamp, which serves as a model in the Hautes-Laurentides. It now employs 60 people. They work in the warming centre as well as in emergency and medium-term support services. People are realizing this. They tell me that it's a continuum of services and that a person may experience a certain relapse. Any former smokers here may have had as many as seven relapses before deciding to quit for good.

I have 25 seconds left. Do you agree that we must let go of our desire to regulate, ensure compliance and set limits, but that you need a budget because you know what you have to do?

● (1140)

Dr. Alexander Caudarella: I would say to show courage. Often, the only thing that legislators can access is funding and grants. How will we hold people accountable, beyond just using sound bites? Set goals. What goals do we want to achieve? We won't stop overdoses. It's tragic, but no world exists where the number of overdoses is zero. However, can we ensure that 30% more people have access to treatment? Can we ensure that the wait time for treatment is reduced by two months?

[*English*]

Thank you.

The Chair: Thank you.

Now, because that was six minutes and 20 seconds, we will go to MP Gunn for five minutes. Please go ahead.

Aaron Gunn: Thank you, Chair.

Mr. Zivo, has the federal Liberal government directly funded the handing out of deadly, dangerous and otherwise illegal drugs, particularly fentanyl or other opioids, to those addicted to the very same substances?

Adam Zivojinovic: Yes, it has. The federal Liberals are actually very proud of the fact that they invested approximately $100 million into safer-supply pilot programs that were meant to incentivize the prescribing of safer-supply drugs.

Aaron Gunn: Now, when you take a step back and go up to 30,000 feet, here in Canada we've had more than 50,000 overdose deaths since the Liberals came to power: That's more Canadians than died in all of World War II. When you look at their policies to promote the flooding of our streets with drugs—with the pilot of decriminalizing fentanyl, crystal meth and crack cocaine in my home province of British Columbia—do you believe these policies contributed to this devastating outcome?

Adam Zivojinovic: I would say so, but, at the same time, I think the underlying problem is that maybe some of the lawmakers who supported these policies initially were, unfortunately, scientifically illiterate, and they thought there was an evidence base behind this intervention. They didn't understand that studies that rely on self-reported survey data from drug users may not actually be reliable. I don't fault them for this, because they were duped in a certain way.

However, I am very angry about the fact that, after reports of widespread safer-supply diversion came out from 2023 onwards, there was a defensive response from the federal Liberals, and that it took over two years for them to defund these pilot programs. During those two years, many people developed unnecessary addictions due to readily accessible, cheap, diverted safer-supply hydromorphone.

Aaron Gunn: Yes, I hear what you're saying with regard to the fact.... I'm not trying to prescribe ill motive towards anybody. However, at the same time, do you find that, from the beginning, there should have been some obvious red flags and inherent contradictions? For example, the federal Liberal government took part in a class action lawsuit against Purdue pharmaceuticals, presumably for the role that company played in supercharging the opioid crisis by producing and distributing a deadly supply of opioids—mainly OxyContin—while marketing it to the population as safe. However, at the same time, was our own government not doing the exact same thing? Were they not also paying for the production and mass distribution of opioids—actually, a more powerful one in Dilaudid, or hydromorphone—while marketing it to our population, especially to young people, as safe supply?

Adam Zivojinovic: I mean, I would agree. I find the whole concept of safe supply a bit perplexing. I don't understand why people supported it, given that the OxyContin crisis is the reason that we have an opioid crisis to begin with. OxyContin was so widely available: In the United States it was often covered by Medicaid, so it was essentially a form of safer supply. The barriers to access were minimal. You could just get some fake X-rays and claim that you had chronic pain. If you had a low income, you could get very cheap, basically free, access to opioids. We saw what that did, so why did we believe that giving people free access to pharmaceutical opioids would have any different outcome here?

Further, this isn't the first time that safer supply has been tested out. Sweden actually tried safer supply from 1965 to 1967, and the results were disastrous. There were about 100 safer supply patients in Stockholm. They were given nearly unlimited supplies of stimulants and opioids, clean pharmaceutical drugs, with this idea that it would be a compassionate and non-authoritarian approach to drug policy. They just ended up diverting the majority of it. The area around the clinic became known as a hotbed of crime. The percentage of arrested individuals who showed signs of intravenous drug use increased, from 20% in 1965 to about 33% in 1967, which is a huge jump for two years. Swedish policy-makers ended up shutting down their safer-supply pilot program after just two years.

It's not hard to find this information. I don't understand why Canadian policy-makers and harm reduction researchers didn't look at that example and think to themselves, “Well, maybe this is a bad idea.”

● (1145)

Aaron Gunn: I'm also concerned about some of the perverse profit incentives that have cropped up. Here in Ottawa, there are pharmacies set up right next to, basically, the clinics where these drugs are being prescribed. In some cases, they have overlapping board structures, with many of the same people receiving federal grants. Are you concerned about the profit incentives for some of the clinics that may be prescribing these drugs or the pharmacies dispensing them?

Adam Zivojinovic: Yes, of course. It's very easy to make a lot of money off safer supplies.

Let's say, for example, you own a pharmacy and you have a patient who's stable on methadone. They're coming to pick up their methadone every once in a while, or they're getting their Suboxone carries. They're not coming to the pharmacy that often, so you're not charging that many dispensing fees.

Then, if you have an unstable safer supply patient who's coming in every single day, picking up three different prescriptions, and your dispensing fees are approximately $10 per medication, with 100 safer supply patients you can make about $1 million in dispensing fees a year. In Ontario—

I'm sorry.

The Chair: Thank you very much. You are 20 seconds over.

We will go to MP Sidhu for five minutes. Please go ahead.

Sonia Sidhu (Brampton South, Lib.): Thank you to all the witnesses for being here with us.

We know the opioid crisis is a very complex issue, and no single organization or level of government can address it alone.

Dr. Caudarella, you talked about many sides of that issue.

Ms. Kennell, you said that funding and a pan-Canadian approach are essential. You talked about that.

Dr. Caudarella, can you tell us who needs to be more involved in the response to the opiate crisis? In your opening remarks, you said that the greatest challenge is putting evidence into practice. Can you elaborate on that?

Dr. Alexander Caudarella: Yes, and I think what's really encouraging is that there are a lot of people who want to be involved. That's what we see. They just want to know what to do.

We're going to be releasing a report in the next couple of weeks that talks about the fact that substance use harms cost businesses about $15 million per day, just in short-term disability and absenteeism. I think that businesses have a big role to play in catching things early, in supporting people and in helping people with lived experience in getting work. This is part of why we've been trying to help educate and support...and different pieces.

One thing we've been encouraging is for small-town mayors to really get involved more in how they can do things and deliver things. They find themselves, often, as the coordinators, the traffic police...as different things.

I really think that, at the end of the day, if you're not involved, you should look at this and say, “What's the role I can play?” It really is a civic challenge of that dimension.

Sonia Sidhu: Thank you.

Mr. Smith, I know that Peel is one of the fastest-growing communities in Canada. The Peel Dufferin branch of the CMHA operates a rapid-access addiction clinic. How important are low-barrier points to access to helping people, when they come to connect with the treatment, before any emergency happens?

David Smith: Thank you.

The whole idea of low-barrier access is that you can start somebody when they want to make a change. Trying to be available when folks are looking for help is critical to the success of the intervention. It's also really important to have a full range of supports behind that. It's not just about the addictions issue itself; it's solving some of the underlying social determinants of health issues: food, housing, safety and employment.

Setting the rapid-access addictions medicine clinics inside organizations that can also offer all of these other supports is going to be critical to the long-term success—and we do see regular success. Sometimes, though, we're not able to help people, because we don't have enough resources.

● (1150)

Sonia Sidhu: Your branch has developed culturally responsive programs, including many organizations for Black, Afro-Caribbean and South Asian communities, especially to address the stigma and to improve access to addiction services in Brampton's multicultural communities. How impactful is that program to removing stigma and to giving better treatment to the communities?

David Smith: It's about bringing together a range of different resources. We work very closely with Punjabi Community Health Services. We're a partner in the Black Health and Social Services Hub. Obviously, we're in a very diverse region, with over 50% visible diversity across our entire patch, so working with those communities to blend in our addictions responses with the other culturally appropriate responses that they have, and the connections they have into those communities, is critical. It's about those organizations working together in order to develop the relationships, and then bringing the people who are in those communities to the supports they need.

Sonia Sidhu: Thank you.

Ms. Kennell, do you want to add to that?

Sarah Kennell: Thank you so much, Dave.

I would just add that the new federal agency, Build Canada Homes, is another opportunity for us to look at how federal funding can be leveraged, particularly by setting targets in affordable housing—so non-market housing—and at the federal levers that can unlock access to operational funding to deliver housing first, supportive housing, etc.

The Chair: Thank you, MP Sidhu.

Now we will go to Madame Gaudreau for two and a half minutes.

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Mr. Chair.

I have limited time, so I think that I'll get right to the point. As we heard a few minutes ago, we're urging the government to show courage. The message has been sent. I would now like to invite the witnesses—and I would like to hear their thoughts on this proposal—to give the committee information on what these programs might look like.

For example, it could involve reducing the total number by 30% after 18 months of something. I would really like some details. I hope that the government is told what people need. November 5 is coming up. We just need the money on the table and delivered specifically to service providers so that they can do their jobs.

I would like to hear from the witnesses one at a time. You have one minute for the entire group. Dr. Caudarella, please go ahead quickly.

Dr. Alexander Caudarella: Perhaps it would be best if I provided my response in writing. However, I would like to point out that all parties supported the creation of our centre in 1988. So I also encourage you to find common ground around this table. Canadians are calling for this. They want to see action, but unified action.

Marie-Hélène Gaudreau: Basically, you won't be able to answer. However, we would like to receive your documents and recommendations, which you can send us in the coming days. You have everything that you need. Keep in mind that some models, such as Quebec's current approach, have decided to take the bull by the horns and invest $28 million in emergency funding for this winter. We'll see what happens next, but there has been political will. Give us a reason to press the button, because November 5 is around the corner.

Thank you, Mr. Chair. That was exactly two minutes and thirty seconds, and I'm not a journalist.

[*English*]

The Chair: Thank you, Madame Gaudreau. Your time is up.

We'll go to Dr. Strauss for four minutes.

Please go ahead.

● (1155)

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

My first question is for Dr. Caudarella.

You listened—as I did—to Mr. Zivo's testimony. I wonder if you accept his statements and his accumulated evidence that safer-supply drugs have been significantly diverted into communities.

Dr. Alexander Caudarella: I do think that unfortunately there is an oversimplification of what's happened. I think these are complex issues.

When it comes to safe supply, as with any other intervention, we have to be really clear that there are going to be unintended harms. We need to be clear with the public around that. We need to be clear about what kind of research is needed.

Similarly, though, I think that when we look at harm reduction more broadly, and we look at supervised consumption sites, we need to make it clear where there is evidence and when there isn't. For example, supervised consumption sites were lifted up to help reduce HIV care, etc.

Matt Strauss: It was a pretty simple question. Do you believe that safer-supply drugs have been diverted significantly in communities?

Dr. Alexander Caudarella: There has been diversion of safe supply. Is it driving the deaths? I don't think so. Otherwise, we would have seen it pop up in different pockets and look much different between Canada and the U.S.

Does it need to be addressed? Absolutely—

Matt Strauss: I'm a licentiate in Ontario. Recently—just a couple of weeks ago—my college, the College of Physicians and Surgeons of Ontario, put out a new policy restricting physicians' ability to hand out safe-supply medications.

That news release says that addiction medicine specialists across the country were consulted. Was your office involved in those consultations?

Dr. Alexander Caudarella: I do not believe we were consulted, but I can't speak for all of my colleagues.

We do participate in things like Medify and different knowledge-sharing platforms across the country, but I'm not sure that we were consulted for that particular one.

Matt Strauss: The policy is generally more restrictive. Are you aware of it?

Dr. Alexander Caudarella: Yes, I am, and this is, again, where we need to figure out what that balance is, try it out and try different things. There was a time, for example, when methadone was contributing to 30% of the deaths related to opioids in Ontario.

Then they became really strict about the rules. Then, all of a sudden, we had treatment rates of methadone that were a quarter of those that we saw in Europe, so what's the best way to get people access to the treatments they need? I don't think we've even accurately described, as a country, who needs safe supply and in what context, and who's better served by more traditional treatments, including things like injectable opioid agonist treatment—

Matt Strauss: I'm sorry. My time is very limited.

At our last meeting on this subject, Dr. Azar, who is an addiction medicine specialist at St. Paul's in Vancouver, intimated that taking a block aid—depot buprenorphine—cut down on opioid overdose deaths by roughly 100%, and that it treats the cravings associated with opioid withdrawal. Can you explain to me, in brief, why safer supply would be required when a depot buprenorphine exists?

Dr. Alexander Caudarella: Sublocade is a really promising medication, but we're seeing in certain areas that it may have lower retention than others, and we just know it's not going to work. Again, when it comes to.... You're a physician. When it comes, for example, to cancer or diabetes treatment, people are going to need different medications and different treatments.

It's about giving the one that has the least risk possible but the greatest effect for where that person is and what they need and, ultimately, trying to move them to more conservative, less costly and more effective treatments. I think, at the end of the day, that the system can do this. It just doesn't need to be ideological, and it needs to stop pretending—

Matt Strauss: The new CPSO policy requires an opioid agonist therapy such as buprenorphine to be given in conjunction with safe supply when safe supply is given. Do you agree with that aspect of the policy? Does that make sense?

Dr. Alexander Caudarella: I think it's really necessary that things be co-offered at the same time, but in what we see from evidence, for example, for injectable opioid agonist treatment programs and heroin programs throughout Europe, is everyone going to succeed on traditional opioid agonist treatment? No, not necessarily. Will the vast majority? Yes. Do we need to make sure the vast majority have access? Yes. Does it mean that there's a role potentially for innovative things? Yes. Do they need to be evaluated more robustly? Yes.

Matt Strauss: I'm sorry. I'm really limited for time—

The Chair: Thank you, Dr. Strauss. Your time is up. We are already 20 seconds over.

We'll go to MP Church for four minutes.

Please go ahead.

Leslie Church (Toronto—St. Paul's, Lib.): Thank you, Mr. Chair, and thank you for having me here at the committee today.

Let me see if I can squeeze in a few questions before we wrap up this hour.

First of all, for Mr. Smith, I just wanted to say that I had the pleasure of meeting with your Ontario branch back in the spring. I thought that the model you have, which would save emergency department resources by diverting mental health and addictions cases directly to some of your CMHA branches, was very innovative.

I wanted to know from you, first, what you're seeing overall in terms of the benefits of that approach, and what are some of the barriers to scaling it up further.

● (1200)

David Smith: We do a number of different interventions to try to divert this from emergency departments.

Interestingly, I had a conversation a couple of months ago with our most local emergency department, the William Osler hospital. They're seeing fewer mental health and addictions clients for the first time in many years. I think a lot of that has to do with how quickly we can get them into our crisis services through our outreach services in encampments and shelters. We connect into the worlds where people are using and start to provide addiction medicine solutions, as well as the social and counselling solutions that can help.

Leslie Church: Yes, it seems that's a way of providing very focused care and support via different pathways to other elements of the recovery and treatment process.

Thank you for that.

I want to acknowledge the presence in the room of Mr. Howard Sapers, whose career in public service I've followed for more than 30 years. I was on the board.

Maybe I'll pivot to Dr. Caudarella of the CCSA.

Thank you for your testimony here today. I want to ask you about the playbook for practical interventions in the smaller communities you mentioned, because that sets out the spectrum of policy responses that are necessary to address this.

Could you talk a little about taking that playbook into account? What do you see as the federal role? What can this committee do? Is there one thing we can really focus on to help communities embark on the journey of ensuring that they have the right options in place?

Dr. Alexander Caudarella: Look, there's always more money needed.

In reality, a lot of communities have capacity and want to build capability. It's about how the federal government can help make sure that, when people find solutions that are right for them in that moment, they can get support throughout. In Canada, we don't have a prevention workforce. How do we build that up? How do we support that?

In Canada, we have a lot of trouble when people want to come to two or three different sectors. They have business people. They have the police. All of our funding pockets are specific to one department—to Public Safety's needs, to Health Canada's needs or to different things like that. How can this come together in a more unified way? How can the federal government hold accountable the people it's funding in a way that is clearer, so that, again, it's producing actual results?

At the end of the day, communities want to work with their provinces and the federal government, but they also want things that are more uniform. If you were to ask a person about all the different federal government programs happening in a town of 150,000, it's probably dozens, so it's hard for somebody to list them off. How can the federal government play a coordinating role, so that everyone getting federal money in a community is working with one another and working towards common goals?

This is where CCSA wants to be the hand helping people go a little further, coaching them and supporting them. Ultimately, we're never going to be the funders of this. We're not going say, “We can help you collect those data pieces.” The federal government could understand that many of these communities have valuable data to provide. They know what's going on. They know what's happening.

The Chair: Thank you very much.

With that, I would like to thank the witnesses for their time today.

We will now suspend the meeting. We will meet our second panel of witnesses shortly.

● (1200)

_____(Pause)_____

● (1210)

The Chair: The meeting is back in order.

I would like to welcome the witnesses who are joining us for the second hour.

Appearing as an individual, we have Dr. Conrod, clinical psychologist and professor of psychiatry and addiction at the Sainte-Justine university hospital centre, Université de Montréal.

From the Centre for Addiction and Mental Health, we have Dr. Ali, scientist and principal investigator, Canadian research initiative in substance matters, Population and Global Health Institute.

Welcome to both Dr. Conrod and Dr. Ali.

Before I go further, I would say please wait to speak until we recognize you. For the participants who are participating by video conference, click on the microphone icon to activate your mic, and please mute yourself when you are not speaking. At the bottom of your screen, you can select the appropriate channel for interpretation: floor audio, English or French.

For those in the room, you can use the earpiece and select the desired channel. The honourable members are very familiar with this. Committee members may ask questions in either French or English. If you require interpretation, please take a moment now to prepare your earpiece and select the listening channel you need.

I'd remind you that all comments should be addressed through the chair, but I usually waive that comment. Witnesses, if you can keep eye contact with the honourable member who's asking the question.... It's their time. As soon as either they raise their hand or I raise my hand, then I would request that you please stop and let the floor go to the honourable member.

Honourable members, if you can say who you're directing your question to, that will make it easier as well.

With that, we are going to the opening remarks. I'll give Ms. Ali five minutes.

Please go ahead.

● (1215)

Dr. Farihah Ali (Scientist, Centre for Addiction and Mental Health, and Principal Investigator, Canadian Research Initiative in Substance Matters, Population and Global Health Institute): Thank you, Chair and members of the committee, for the opportunity to appear today.

My name is Dr. Farihah Ali. I'm a scientist at the Centre for Addiction and Mental Health, an assistant professor at the University of Toronto, and the nominated principal investigator of the Ontario node of the Canadian research initiative in substance matters.

Today I'll present findings from our independent, CIHR-funded evaluation of British Columbia's drug decriminalization policy, for which I served as a co-principal investigator.

Our evaluation combines administrative health and policing data; interviews with people who use drugs, police and service providers; public opinion surveys; and implementation research.

B.C.'s decriminalization policy began in January 2023. It allowed adults to possess up to 2.5 grams of specified illegal drugs for personal use without criminal penalties, subject to certain conditions.

The exemption was substantially narrowed in May 2024 to exclude most public spaces, and it expired in January 2026. The original framework, therefore, operated for only about 15 months, an important consideration when interpreting its effects.

I will highlight four key findings from our evaluation.

First, decriminalization substantially reduced drug possession-related enforcement, but these gains were reversed following the amendment. The most direct and measurable effects were in possession enforcement. Our analyses found a 68% reduction in possession seizures overall and an 87% reduction in seizures involving 2.5 grams or less during decriminalization. Recorded possession incidents in persons charged also declined relative to other provinces. Following the May 2024 amendment, possession seizures and incidents returned to levels statistically indistinguishable from those before decriminalization. These findings demonstrate that legal protections can meaningfully reduce possession enforcement but that these gains depend on the scope and continuity of the policy.

Second, legal protections were not consistently experienced in practice. Some people who used drugs reported less fear of arrest and better interactions with police during the initial decriminalization policy period. Others described confiscations even below the 2.5-gram threshold, stigmatizing encounters and outcomes shaped by individual officers' discretion.

Police officers, for their part, reported uneven training, unclear guidance, and challenges interpreting and implementing the exemption alongside public order responsibilities.

The 2.5-gram threshold also failed to reflect some people's patterns of use, tolerance levels or polysubstance use.

After the amendment, people experiencing homelessness faced particularly limited access to spaces where possession remained protected. Some describe moving to more isolated locations to avoid police, raising concerns about unwitnessed overdoses.

Third, we did not detect statistically significant changes in broader health outcomes, including treatment, harm reduction, hospitalization, emergency response or drug poisoning deaths; however, removing criminal penalties does not itself expand treatment or harm reduction services, create housing or change the toxicity of the unregulated supply.

Service providers described insufficient resources, limited policy-specific training and little change in service delivery. Some people who used drugs initially reported reduced stigma and greater dignity but described a reversal of these experiences following the amendment.

Fourth, our public opinion surveys found growing opposition to decriminalization. Many respondents evaluated the policy against expectations for reductions in overdose, crime and public drug use or improvements in community safety, outcomes broader than those the possession exemption could directly deliver. Our work on policy communication and media coverage also identified gaps in accessible public information and increasingly negative framing.

Public concerns about neighbourhood conditions and safety deserve to be taken seriously. At the same time, perceptions about the policy's effects must be distinguished from empirical evidence that particular changes were caused by decriminalization.

I will leave the committee with three key take-aways.

First, decriminalization should be evaluated against its intended objectives. Reducing criminalization is a meaningful outcome.

Second, policy design and implementation matter. Possession thresholds, enforcement practices and access to legally protected spaces influence who benefits from the policy.

Third, decriminalization alone cannot address the toxic drug crisis. Broader health improvements require sustained investment in treatment, harm reduction, housing and other supports.

B.C.'s experience highlights both the potential and the limitations of decriminalization and underscores the importance of policy design, consistent implementation and complementary health and social supports.

● (1220)

Thank you. I welcome the committee's questions.

The Chair: Thank you very much.

We will go to Dr. Conrod for five minutes.

Please go ahead.

Professor Patricia Conrod (Clinical Psychologist and Professor of Psychiatry and Addiction, Centre hospitalier universitaire Sainte-Justine, Université de Montréal, As an Individual): Thank you very much, Chair and members of the committee, for inviting me to speak to you today.

I'm Patricia Conrod. I'm a clinical psychologist and professor of psychiatry and addiction at Université de Montréal. I hold a tier one Canada research chair in preventive mental health and addiction. In June 2025, I was appointed as scientific director of CIHR's Institute of Neurosciences, Mental Health and Addiction.

I'm joining you today from Montreal, which is recognized as the unceded territory of the Kanien’kehà:ka nation.

I'm speaking today as a scientist with more than 30 years of experience studying the developmental pathways leading to substance use disorders and evaluating preventive strategies that reduce risk among children, youth and adults. While much of the research I will discuss has been supported by CIHR, I'm not speaking on behalf of CIHR today. The views expressed are my own and supported by evidence. I also have no financial conflicts of interest to declare.

Substance use disorders remain the leading causes of disability, premature mortality and lost human potential in Canada. Research led by the Centre for Addiction and Mental Health in Toronto estimates the economic costs of substance use at approximately $60 billion annually; however, less than 1% of these costs is invested in prevention. Over decades of research, we have learned that substance use disorders emerge through a complex interaction of biology, development, life experiences, social relationships and environmental influences. One of the strongest predictors of future substance use disorder and harms is the early onset of substance use.

This is particularly concerning because Canadian youth continue to report significant levels of substance use. Findings from recent national surveys suggest that yes, more youth are delaying the onset of alcohol and tobacco use, or choosing never to use at all, but youth cannabis use and illicit drug use have plateaued over time, and non-medical prescription drug use is increasing. For these reasons, strategies that aim to prevent or delay the onset of youth substance use must remain a cornerstone of Canada's response to the opioid crisis.

Effective prevention works upstream by addressing risk before substance use problems become established. Youth substance use does not occur in isolation; it's shaped by individual, family, social, economic and community factors, including mental well-being, family support, school connectedness, cultural identity and access to opportunity.

Young people today are navigating increasing mental health challenges, evolving substance use patterns and a toxic and unpredictable drug supply. These realities strengthen the case for prevention approaches that are evidence-based, developmentally informed, culturally relevant and responsive to the needs of diverse communities.

The prevention evidence base is clear in a number of areas. Population-level policies, such as minimum age laws, enforcement of age restrictions, graduated licensing, impaired driving laws, minimum pricing and restrictions on advertising all reduce youth exposure to addictive substances and help shape healthier social norms. There's also evidence supporting psychological interventions that build resilience and self-regulation. These are often school-based, but the evidence depends on the intervention being delivered and the developmental stage of the population.

Universal prevention programs with primary school-age children that promote social competence, self-control, problem-solving and healthy decision-making show some benefit, but the effects are modest. During adolescence, when young people are exploring their identities and gearing up for independent decision-making, cognitive behavioural interventions show the greatest benefit, particularly if they're targeted toward individual risk factors.

In contrast, evidence for brief motivational interventions with older youth—even though they make a lot of sense—as well as these broad, community-wide initiatives, remains limited at the current time.

My research indicates that focusing on this critical adolescent developmental period is a very promising approach for two main reasons: One, our research is showing that early onset of substance use is interfering with cognitive and brain development; and two, risk is easily measured at this stage and modifiable in this developmental window.

Our research is showing that substance use disorders don't emerge from entirely separate processes. They arise from variation in the same personality and neurocognitive systems that shape traits like curiosity, risk-taking, emotional sensitivity, impulsivity and independent thinking. I think we all agree that these qualities are often tremendous strengths, but also, young people need to be assisted in managing these.

● (1225)

If I can take one last minute to say that there are interventions that are designed to help young people learn to manage these strengths—

The Chair: Dr. Conrod, I have to cut you off, because we are already 25 seconds over. I'm sorry. You can always come back to those points when members ask questions.

Without further ado, we will go to Dr. Strauss for six minutes.

Please go ahead.

Matt Strauss: Thank you, Chair.

Ms. Ali, I was interested to hear [*Technical difficulty—Editor*] British Columbia experiment on decriminalization. It's my understanding, as you described it, that it was legal to carry 2.5 grams of different drugs, including fentanyl. From my own understanding, 2.5 grams of fentanyl is enough to kill 1,000 people. Is that your understanding?

Dr. Farihah Ali: The 2.5 grams is a cumulative threshold. It encompasses other types of substances, not just 2.5 grams of fentanyl per se.

Matt Strauss: Would it be legal to carry 1,000 deadly doses of fentanyl under this rubric?

Dr. Farihah Ali: I wouldn't necessarily equate 2.5 grams to 1,000 deadly...what you're suggesting, but I would say that, yes, it's a lethal amount—or it could be, possibly.

Matt Strauss: I would think that 2.5 milligrams is roughly a lethal dose, from my own practice. Is that not your view?

Dr. Farihah Ali: Yes, I think 2.5 grams can absolutely be deadly—

[*Translation*]

Marie-Hélène Gaudreau: I have a point of order, Mr. Chair.

Marie-Hélène Gaudreau: Mr. Chair—

[*English*]

Dr. Farihah Ali: —particularly depending on its potency, concentration—

The Chair: There is a point of order.

There were some interruptions when Dr. Strauss was speaking. I think it's hard for interpreters to...so please....

I'll stop the watch. Perhaps you can repeat your question, Dr. Strauss, and then we will go to Dr. Ali.

Dr. Strauss.

Matt Strauss: I'm so sorry. I think the IT folks did ask me to speak up.

You would agree that 2.5 milligrams is a lethal dose, so 2.5 grams would be 1,000 of those. That's just mathematics. Is that not enough fentanyl to kill 1,000 people?

Dr. Farihah Ali: Absolutely. I think the 2.5 grams of fentanyl, as I mentioned, can be absolutely deadly, particularly depending on its potency, its concentration and the individual's tolerance.

I think it's really important to clarify that B.C.'s decriminalization policy did not make these substances legal or safe. It removed criminal penalties for possession of these small quantities under specified conditions. The 2.5-gram threshold was a cumulative possession limit across several substances, not a recommended or safe amount to consume. Importantly—

● (1230)

Matt Strauss: Yes, I certainly hope nobody was recommending that.

I'm just trying to make an analogy to firearms laws. If I were carrying an amount of explosives or ammunition enough to kill 1,000 people, that would generally be criminal in Canada, but we'll leave that there. It just seems crazy to me that this was the threshold.

You talked about this experiment in decriminalization reducing criminalization. Isn't that tautological? If I stop arresting people for possession, then there will be fewer arrests for possession.

Dr. Farihah Ali: Yes, absolutely, but as I mentioned, the policy was implemented inconsistently. There were a lot of issues in terms of police officer discretion and training and the application of the law. In some areas, we did see that, yes, overall enforcement and possession rates reduced. Alongside that, there were other issues related to the implementation, which is what our evaluation really spoke to.

Matt Strauss: This question is for Dr. Conrod.

Dr. Conrod, in preparation for these meetings, I was looking at a map of opioid deaths per 100,000 in Canada. With a few exceptions, it almost seems like a straight line. If you start in the west, the overdose death rate is the highest. As you go east, it diminishes, such that Quebec and then the Atlantic provinces have the lowest rates of death.

From your 30 years of experience, do you have a Gestalt reason for that geographic pattern being observable?

Prof. Patricia Conrod: I would say that, initially, Quebec in particular was less targeted in marketing strategies that promoted prescription opioids, and practices were a little more conservative with respect to prescribing opioids for outpatients.

The landscape, as you know, has changed dramatically. In fact, Quebec and some other maritime provinces—I'm thinking of New Brunswick—are actually seeing more rapid increases in opioid overdose deaths. Even though the absolute levels are lower, they have actually seen greater increases over the past couple of years than other provinces that are demonstrating a decline.

I think it's very difficult to make broad conclusions at the moment about what is driving increases or decreases.

Matt Strauss: I'd be interested in your drive-by view of it. When you're talking about upstream factors, it seems to me that social isolation and cultural alienation are the most upstream factors for whether I would develop a problem with opioids. It seems to me that some provinces with more of a sense of place and cultural identity may be more protected. Do you view those kinds of ideas as potentially protective?

Prof. Patricia Conrod: At the moment, I'm not sure the evidence would support that. It's a worthy question of investigation, but I would say that mental health is a strong driver of early onset substance use and substance-related problems. Young people in Quebec do report slightly higher mental well-being than those in other parts of the country, and that's very well documented in some of the population surveys, but it's a very small difference, and it wouldn't account for that. I think the drivers of substance-related harms in this opioid crisis are multiple, and they have changed dramatically over time.

Matt Strauss: Sure, but I have limited time, so—

Prof. Patricia Conrod: Quebec has implemented some more restrictive policies around drug regulation that might contribute to protection, and I could tell you more about a couple of them if you'd like to hear it.

Matt Strauss: Well, I just want to move on. We have such short time.

I think both of you and many of the other previous panellists mentioned this idea of wraparound services, which I take to mean housing with complementary counselling and addiction treatment, and sometimes prescription service.

At a high level, does incarceration not include these things? If I'm incarcerated as a result of criminality related to opioid use disorder, I am given housing. It is also my understanding that addictions treatment, counselling and other rehabilitative services are available in prison. Is that your understanding?

● (1235)

The Chair: You are 15 seconds over, so I am sorry, Dr. Strauss. I have to go to MP Chi for six minutes. Please go ahead.

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

One thing that I think has really become clear throughout this study, especially this session, is that responding to this opioid crisis requires us to look at the whole spectrum and continuum of care, from prevention to helping those who are already struggling with addiction and other mental health challenges. The federal government has made significant federal investments across that spectrum, including a historic $500-million investment in the youth mental health fund, as well as support for community-based services through the substance use and addictions program and emergency treatment fund.

My first question is for Dr. Patricia Conrod.

Dr. Conrod, I think you've touched on this during your opening remarks. Your research is focused on early targeted interventions and preventions and how they can help young people and equip them with the skills that reduce their risk of developing substance use disorders. How important is it that we address youth mental health and substance use prevention together, rather than waiting until young people start developing more serious problems?

Prof. Patricia Conrod: I think it's extremely important, and I think that the evidence supports that approach. It's not a solution for everyone. Therefore, I think we need to maintain supports for young people who are in at-risk situations or who are living with risk factors themselves. They need to be supported with mental health supports at various developmental stages and potentially throughout life.

I will add that one very promising approach to the effective drug and alcohol prevention programs is to partner with integrated youth services and to have integrated youth services be a support to schools as they are implementing evidence-based programs. This is a model that has been developing. We've been partnering in implementing the prevention program with Youth Wellness Hubs Ontario and Foundry. The integrated youth services are now working with schools to implement upstream mental health interventions with school counsellors. They are there to support where needed, and if the brief upstream interventions are not enough for a particular setting or individual, there's more support available. It's a really nice model, I would say.

Maggie Chi: Thank you so much.

You mentioned the integrated youth services and the hubs, and that's exactly what our government has invested in through the youth mental health fund. There has been a significant amount of investment in expanding community-based youth mental health services.

Again, going back to your research, what would you say are the biggest opportunities to continue making that impact in substance use disorder prevention in young people?

Prof. Patricia Conrod: I think we have clarity on what interventions work, but I would be remiss if I did not discuss the implementation challenges. Delivering in schools is, I believe, the most promising and the best way to deliver equitable mental health and drug prevention, because you can deliver it to a whole grade and everyone will receive it. However, communities are encountering challenges as they're trying to implement at scale. Resources are constrained. There are workforce shortages, and there is staff turnover. We also lack a sustained investment in infrastructure to support preventive mental health. Nobody has taken this on as their primary responsibility.

We need a workforce that's appropriately trained, ideally consisting of members of a professional body who have access to expert supervision and who function within a stepped care approach, as I just described, so that you're going from brief intervention in schools to more intensive mental health and psychosocial supports when needed.

Our experience is that when evidence-based programs really are embedded in how school boards or health authorities work, they are more easily sustained and are more effective. At the moment, however, there is no real sustainable health system to deliver preventive mental health.

Maggie Chi: Thank you so much, Dr. Conrod.

During your remarks, you were cut off for one minute. I just want to see if you have anything additional to share as part of your opening remarks.

● (1240)

Prof. Patricia Conrod: Thank you very much.

I do want to say that we've published some secondary analyses of the original studies to directly evaluate these middle-school-based interventions targeting young people who are self-reporting psychological risk factors for early onset substance use and related harms. We have identified that we're at the stage in developmental neuroscience where young people can tell you about their level of risk, and we can intervene around that risk using very light-touch, brief cognitive-behavioural interventions.

With respect to prescription opioid use, the evidence is a little less clear. However, one thing we did report recently is that there are solutions to the risk for polysubstance use in high-school-aged students. That is a very robust risk factor for who will go on to develop serious problems with substance use. I think we have a number of very promising programs that just need more systematic investment and support as we attempt to scale these across the country.

The Chair: Thank you very much.

We will go to Madame Gaudreau for six minutes.

Please go ahead.

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Mr. Chair.

Ms. Conrod, can you respond to the question asked by my colleague, Dr. Strauss, regarding the management of drugs and medications in Quebec?

Prof. Patricia Conrod: I would love to, but I'm really not an expert on the topic. I'm much more comfortable talking about the developmental factors involved in substance use disorders. I know that a recently published report shows that opioid prescribing practices in Quebec are currently on the rise. In the past, we saw fewer prescriptions issued. However, these practices are now changing. The trends are heading in a direction that raises concerns.

Marie-Hélène Gaudreau: Is there a correlation between the rise in the suicide rate and the increasing use of opioids?

Prof. Patricia Conrod: I think that I'll need to give you an answer later.

[*English*]

Perhaps, Farihah, you have an answer to this question.

I will have to get back to you, though, with a clear summary of the evidence on that topic.

[*Translation*]

I can say that programs geared towards young people who show risk factors for substance use disorders protect them from these disorders and from suicidal thoughts. It's quite difficult to demonstrate that suicide can be prevented. It requires large-scale studies. However, we have already published information showing that suicidal thoughts among young people can be reduced through youth substance use prevention programs.

Marie-Hélène Gaudreau: Thank you.

Ms. Ali, based on your work with people who use drugs, what changes when a person obtains, for example, stable housing or a minimum level of physical security? Does this affect their ability to access care and does it contribute to risk reduction?

[*English*]

Dr. Farihah Ali: Thank you for that question.

Absolutely, I think stable housing and financial security can make an enormous difference in someone's ability to access health care, engage in treatment and reduce substance-related harms. When someone is experiencing homelessness, much of their daily life revolves around meeting basic survival needs, such as finding somewhere to sleep, accessing food, staying safe and sometimes even managing withdrawal. Under those circumstances, attending medical appointments or consistently engaging in treatment becomes much more difficult, and we have the evidence to prove that.

We also know that housing instability can increase exposure to unsafe environments and situations where people may be using drugs alone, for instance, increasing their vulnerability to overdose, and we've seen this in our own research. People who use drugs, whom we interviewed, frequently described housing insecurity, poverty and difficulty accessing these basic resources as barriers to treatment and recovery. When someone has that stable housing and a degree of financial security, they're better positioned to engage with health care and maintain treatment as well as build those supportive relationships.

● (1245)

[*Translation*]

Marie-Hélène Gaudreau: Thank you.

How can we implement policies—or even programs—to ensure a systemic approach and to give workers the freedom to provide appropriate care to clients who technically vary widely in terms of their processes or challenges? What do we need? We need this in our study report.

[*English*]

Dr. Farihah Ali: That's a really important consideration as well. I think that one of the most important things we can do is move away from a rigid, one-size-fits-all approach and give service providers the flexibility, resources and budget for the individual needs of their clients.

People who use drugs are a very diverse population. Someone experiencing homelessness may need very different supports from someone who has stable housing but, for instance, is struggling with mental health challenges or opioid dependence, and we have seen this again in our own research. Providers frequently describe fragmented funding, restrictive eligibility requirements and limited coordination between services as barriers to delivering this comprehensive care.

I think governments can address this through more flexible and, importantly, sustained funding that allows organizations to really integrate addiction treatment, harm reduction, mental health care and housing support, rather than funding each service in isolation. We also need to involve people with lived and living experience in designing these programs, because they understand where the gaps are.

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Mr. Chair.

Thank you, Ms. Ali and Ms. Conrod.

[*English*]

The Chair: Thank you, Madame Gaudreau.

We will go to Mr. Bailey for five minutes.

Please, go ahead.

Burton Bailey (Red Deer, CPC): Thank you, Chair.

I would like to ask both witnesses, Dr. Ali and Dr. Conrod, if wraparound services are available in prison. Could you please, respectfully, give your responses to the clerk, so they can be tabled for this report?

Thank you.

Dr. Conrod, I'm going to go very quickly, because I'm so limited on time.

Are you familiar with CoRE, the Canadian Centre of Recovery Excellence?

Prof. Patricia Conrod: Yes. It's in Alberta.

Burton Bailey: They recently did a press release entitled “Research shows overdoses cause irreversible brain injury” that made an “[u]rgent appeal for changes to addiction treatment”.

I'd like you to comment on youth brain development and what you've seen through your research work on the effects of drugs on the brain. Despite this being obvious, the lasting effects on the brain are often mentioned when discussing the opioid crisis, but I think it's important to note for the record and inclusion in this report.

Prof. Patricia Conrod: Thank you for your question. It's an important one.

The evidence in relation to the effects of opioids on brain development is non-existent. It's an area that is most definitely worthy of more research.

Most of the research on the effects of substance use on brain development is limited to alcohol and cannabis use, where both are identified as being associated with neurocognitive developmental risk factors and the potential effects of early-onset substance use on brain development.

With respect to the effects of overdose-related anoxia or exposure to very high levels of highly potent opioids, the evidence is also currently quite limited and worthy of further research.

It's a question I'm very interested in, but there's not a very easy answer to provide you with at the moment. It's very complex research, as you can imagine.

● (1250)

Burton Bailey: Thank you for that.

We have tabled this one study. If you have anything else that you'd like to add on that subject, I'm going to ask you to table it.

I'd like to ask you a question. What's more compassionate for kids at risk: programs like the one you've studied, which stop problems early, or handing out high-potency opioids that can get diverted and pull more young people in?

Give a simple answer, please.

Prof. Patricia Conrod: I don't believe we should be thinking either-or here. We should be doing everything at every stage and throughout the course of the problem. We need both, absolutely.

Burton Bailey: Thank you.

You mentioned that $60 billion is the cost of the opioid crisis in Canada and that 1% is spent on prevention. That was you. Is that correct?

Prof. Patricia Conrod: That's correct, but it's $60 billion on substance-related harms, not just on opioids.

Burton Bailey: Yes.

My honourable colleague mentioned that the government is investing $500 million, so that is 0.5%, literally a drop in the bucket, for prevention. What type of percentage do you feel would be appropriate for prevention? Are we looking at 10% as a starting point? We heard from the Canadian Mental Health Association that there just are not the funds for prevention, or for studies, for that matter.

Prof. Patricia Conrod: I fully support that view. I think that 10% would go a very long way with respect to providing communities and schools, where I think there's a lot of potential to do very good prevention work—

Burton Bailey: Thank you, Doctor.

Prof. Patricia Conrod: At the moment, there just aren't enough people to deliver this. If it were easy and if it were just a one-off lecture, we would be doing that. It's not easy work. It's work that has to be delivered in a very skilled way, in small groups where young people are guided in a very responsible way.

Burton Bailey: Thank you, Doctor.

Doctor, I have 20 seconds. I have one very important question. You've created a program. How can we expand this into other jurisdictions, and what kind of uptake could you expect?

Prof. Patricia Conrod: Right now, I think we're in seven provinces in Canada, to some degree. There's enormous interest in implementing evidence-based prevention programs across the country. It's the resources and our ability to support communities in doing this work.

Again, going back to your previous question, how can we better support communities in implementing prevention—

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

We'll go to Mr. Sawatzky for five minutes.

Please go ahead.

Jake Sawatzky (New Westminster—Burnaby—Maillardville, Lib.): Thank you, Chair.

Thank you, Dr. Conrod, for being at committee with us today.

First of all, I'd like to congratulate you on your appointment as the scientific director of the CIHR Institute of Neurosciences, Mental Health and Addiction. Congratulations.

Dr. Conrod, your research on youth substance use and mental health, including the effects of social media and cannabis on adolescent brain development, has helped inform policies in Canada and internationally. Your research in the PreVenture program found that targeted school-based interventions can reduce the long-term development of substance use disorders. I was wondering if you could elaborate on what this program looks like in practice.

Prof. Patricia Conrod: It's a brief program of two 90-minute sessions that are delivered in schools in small, focused workshops to young people who volunteer to take part. What's amazing is that 85% to 90% of young people who are invited to take part will take part. They're interested in learning about themselves and learning about the skills needed to promote independence, autonomous decision-making and good coping strategies.

What it looks like is that you have a trained facilitator who will bring young people together, and they will learn first through stories and narratives shared by other young people who experience similar psychological risk markers. They will learn about how these traits can either set someone up for problematic decision-making or lead to success.

● (1255)

Jake Sawatzky: Thank you very much.

Could you briefly speak to the effectiveness of this program?

Prof. Patricia Conrod: This has been tested in at least eight randomized trials around the world. Two have been conducted in Canada. The most recent trial was a large one with 4,000 young people in Montreal. What we showed is that it was associated with a significant reduction in the risk of transitioning to substance use disorder over a five-year period, and it was also associated with significant reductions in alcohol, cannabis, tobacco and polysubstance use.

Jake Sawatzky: In your research, have you come across how trauma can be prevalent in people who struggle with substance use?

Prof. Patricia Conrod: Absolutely. We have also investigated this to some extent and shown that the psychological traits that set young people up to be at risk for substance use disorder interact with trauma, complicate it and, in some way, shape how someone will respond to a traumatic event.

The outcome of trauma is not universal. It isn't just PTSD and anxiety symptoms. It could also be a more externalizing profile that includes conduct problems and substance misuse. The traits that are targeted in this program are demonstrated to shape how a young person will respond to challenging, difficult and traumatic experiences.

Jake Sawatzky: Thank you.

On another tangent here, could you speak to the prevalence of concurrent mental health and substance use issues and how they can affect each other?

Prof. Patricia Conrod: In young people, they very much go hand in hand. Depending on the study, it's estimated that somewhere between 60% and 80% of young people who have substance-related problems also have some other form of mental health challenge.

The other thing to mention is that mental disorders don't necessarily have to have full onset before they affect young people. Even just the emergence of one or two symptoms, as well as substance use, can very much divert a young person's academic and psychosocial trajectory and have effects on brain development. This is why prevention is so important.

Jake Sawatzky: Thank you.

I think I have 30 seconds, so this is my last question. Could you speak to the prevalence of cannabis use in young people and any potential issues that's causing, particularly in cases of highly concentrated cannabis use?

Prof. Patricia Conrod: I would like to get back to you on the prevalence among young people. Obviously, it depends on their age. It goes up with age, but it's hovering around 50%. It also depends on frequency. Are we talking about lifetime, the past year or the past 30 days?

Yes, the use of high-potency cannabis products has been on the rise since they've been available on the commercial market, and it's something we really don't understand in terms of impacts on mental health or brain health.

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

We will go to Madam Gaudreau for two and a half minutes.

Please go ahead.

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Mr. Chair.

I'll turn first to Ms. Ali and then to Ms. Conrod.

Basically, I was asking myself the following question. Since each province has ample capacity to provide services, what would the study need to show for the federal government to be able to change things?

Yes, we talked about providing recurring funding, finding the courage to let go and placing our trust in—for example—the provinces and stakeholders. That said, I would like to hear your recommendations so that we can include them in the report.

[*English*]

Dr. Farihah Ali: There are several concrete recommendations the committee can make. Recognizing that provinces are primarily responsible for delivering health care, the federal government has an important role in supporting and coordinating these effects.

First, I would again emphasize sustained, predictable funding rather than short-term pilot funding. Organizations need stability to retain staff, build relationships with clients and deliver services over time.

Second, we need greater flexibility in how funding is used. Communities have different needs. Service providers need the ability to adapt their programs rather than operate with overly restrictive funding requirements.

Third, we perhaps need stronger coordination between governments and across health care, housing, mental health and addiction services so people aren't continually falling through the cracks.

Finally, your point about trusting service providers is really important. We need to recognize the expertise of frontline organizations and people with lived and living experience while ensuring accountability and evaluation, so I'd encourage the committee to recommend funding models that are sustained and flexible—

● (1300)

[*Translation*]

Marie-Hélène Gaudreau: Ms. Conrod, you have a few seconds to respond.

[*English*]

Prof. Patricia Conrod: I'll add to those recommendations. The federal government should direct resources towards evidence-based programs, and it could also, for the purpose of promoting more sustained support for prevention, require that a certain percentage of those investments that are directed towards provinces go towards evidence-based prevention, because it is underinvested in, and that's clearly documented.

The Chair: Thank you very much.

On behalf of the committee members, I would like to thank Dr. Conrod and Dr. Ali for the valuable information that they shared.

Also, thank you to our analysts, clerk, interpreters and support staff for the work that they do to make these meetings successful.

With that, before I give you the floor, Mr. Bailey, I have to say something here. Our next meeting will be on Wednesday, October 28, on the draft report of the immigration study.

Witnesses, you can log off. Thank you.

Going forward, I suggest that the drafting instructions for committee reports be discussed during in camera meetings rather than via email. This would allow the committee to provide collective directions to the analysts and avoid conflicting instructions. Members could still submit recommendations via email afterwards.

This was the committee's previous practice and may provide a more efficient and transparent drafting process.

I would recommend that members have their drafting instructions for this study ready for the analysts on Wednesday.

After immigration version one, we will give drafting instructions for the study on the opioids.

With that, I am going to give the floor to Mr. Bailey, because he has a routine motion.

Burton Bailey: Thank you, Chair, for allowing me to speak, and for running such a good meeting today. I know it was a little behind schedule.

I'm seeking unanimous consent for a motion that we brought up last meeting.

> That, notwithstanding the usual practices of the committee concerning access to and distribution of documents,
>
> a) up to three associate members of the committee per party be authorized to receive the notices of meetings and notices of motion and be granted access to the digital binder;
>
> (b) the associate members be designated by the offices of the whips of each recognized party and sent to the committee clerk;
>
> (c) the offices of the whips of each recognized party may each designate one staff member from their office to be included on the committee's distribution list; and
>
> (d) the provisions of this motion remain in effect for the duration of the 45th Parliament, unless otherwise ordered.

The Chair: Thank you, Mr. Bailey.

It is my understanding that the motion has been distributed in both official languages.

Do we have unanimous consent?

Some hon. members: Agreed.

(Motion agreed to)

The Chair: Do I see consensus to adjourn the meeting?

Thank you. The meeting is adjourned.

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