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Chair

Mr. Neil Ellis

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● (1540)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): I'd like to call the meeting to order.

The Standing Committee on Veterans Affairs undertakes two new studies today. One is homeless veterans and the other is medical cannabis and veterans' well-being.

In relation to the study of homeless veterans, we're pleased to welcome two witnesses by video conference. Unfortunately, we have video conference problems today, so we will have Faith McIntyre, Director General of Policy and Research Division, Strategic Policy and Commemoration by video conference, and on the phone from Mississauga, with no video, will be Robert Tomljenovic, Area Director.

Ms. McIntyre, you have 10 minutes.

Ms. Faith McIntyre (Director General, Policy and Research Division, Strategic Policy and Commemoration, Department of Veterans Affairs): I'll begin the opening remarks and turn to my colleague to complete them.

Thank you very much, Mr. Chair, for the opportunity to speak to you about this very important topic.

As noted, my name is Faith McIntyre, and I'm the Director General of Policy and Research.

Veteran homelessness is unacceptable in Canada, and one homeless veteran is one too many. A picture of homeless veterans is not easily available. According to Employment and Social Development Canada's coordinated point-in-time counts, which were carried out on a specific date in the early spring of 2016, in 31 different locations across the country, veterans accounted for nearly 5% of all homeless Canadians. An additional similar study regarding point in time was conducted in the spring of 2018, and we are still awaiting the results.

Veterans, similar to the general population, become homeless as a result of complex and interrelated issues, for example, health status, personal problems such as family breakdown or violence, employment instability, poverty, lack of affordable housing, and addiction. However, what sets veterans apart from the general homeless population is their transition from military life to a civilian culture and a civilian world.

We find that many veterans have experienced traumatic and dangerous situations as a result of their military service and often struggle with the after-effects of these experiences. As well, we find that homeless veterans tend to become homeless much later in their lives, quite a while after their release.

A 2013 Canadian Forces mental health survey identified that one in six regular Canadian Armed Forces members identified symptoms of at least one of the following mental health conditions in the past 12 months: depression, panic disorder, PTSD, general anxiety disorder, and alcohol abuse or dependence.

The Veterans Affairs Canada life after service studies identified that approximately one-quarter of veterans released from the military since 1998 have experienced a difficult transition.

As the federal department responsible for veterans' well-being, we have the lead to ensure a whole-of-government approach is taken to address veteran homelessness, and this is a top priority for us. The effort must be a collaborative one. It takes the whole community to support the well-being of veterans and their families. The key to making progress will be in continuing to forge strong partnerships with a variety of organizations that are equally as passionate and charged with this issue.

On June 7, 2018, Veterans Affairs Canada hosted a round table on homelessness in Ottawa, which included over 70 participants from 65 national and regional organizations. The participants were all identified as subject matter experts in the area of homelessness, particularly focusing on veterans. As a result of this round table, an interactive map has been developed and is live on our external website. It identifies resources across the country that can provide supports to homeless veterans.

We are working on Coming Home, Veterans Affairs Canada's strategy to prevent and end veteran homelessness. This strategy proposes a number of objectives that will ensure that Canada's homeless veterans receive the support they need to achieve housing stability and well-being, and assist in reducing the likelihood of veterans from ever being homeless.

Veterans Affairs Canada, along with the Canadian Armed Forces and other government and community partners, are working closely to ensure that finding homeless veterans becomes easier. Our proposed homelessness approach is broken down into four themes: lead and engage, by improving collaboration and leadership; find, by improving outreach and identification; assist, by improving mechanisms to assist homeless veterans; and prevent, through optimizing veteran well-being.

[*Translation*]

Several initiatives are already under way. For example, the return of the veteran's service card was recently announced. This will allow veterans to more easily be identified and to feel a greater sense of community.

In addition, we have developed a new homeless veteran poster, which will be distributed to over 2,000 areas within Canada.

We are also partnering on improving the military-to-civilian transition mechanism to ensure a successful transition to civilian life by bridging members releasing from the Canadian Armed Forces to the support they require.

In budget 2017, Veterans Affairs Canada established the veterans emergency fund, along with the veteran and family well-being fund.

The veterans emergency fund provides emergency financial support to veterans, their families and their survivors whose well-being is at risk due to an urgent and unexpected situation. More than 450 veterans have already benefited from this program.

As announced earlier this month, Veterans Affairs Canada has chosen 21 organizations out of 155 applicants to the veteran and family well-being fund, awarding a total of $3 million.

Of the 21 organizations selected for the fund, three have specifically identified their projects to assist homeless veterans.

The three organizations are Veterans Emergency Transition Services Canada, or VETS Canada, the Respect Campaign and the Old Brewery Mission. Other organizations among the 21 are indirectly involved but will still take positive steps to support homeless veterans.

We are excited to work with these great organizations to improve the state of veteran homelessness in Canada.

● (1545)

[*English*]

I will now ask my colleague Robert Tomljenovic, who has joined you by teleconference as indicated by the chair, to speak to you about what is being done in the area offices.

Mr. Robert Tomljenovic (Area Director, Department of Veterans Affairs): Thank you, Faith.

Good afternoon, Mr. Chairman and members of the committee. Again, I apologize for the technical difficulties this afternoon.

My name is Robert Tomljenovic and I'm the Area Director for the southwestern Ontario area at Veterans Affairs Canada. I am responsible for about 100 employees located in five area offices and service locations and three integrated personnel support centres, or IPSCs, serving over 12,120 veterans living in the area.

I would like to thank you for the invitation to appear before the committee. I'm happy to be here with Faith to provide more details about our work to prevent and address veteran homelessness on the ground.

As you know, homelessness can result from a magnitude of life situations that an individual may experience. Research indicates that veterans, like the general population, become homeless as a result of complex and interrelated issues such as health status, personal problems, employment instability, poverty, lack of affordable housing, addiction issues and others.

However, veterans are unique from the rest of the population in that their experience within the military may have significantly contributed to the factors that led them into homelessness. Some veterans have faced extreme situations such as combat, injuries, high levels of stress, and long absences from families, home and supports.

The goal for us, as the front-line team for Veterans Affairs, is to create an increased awareness with our community partners to help identify homeless veterans. To do so we have adopted a few strategies.

Our case managers and other VAC staff work with a number of community organizations to identify homeless veterans in the local areas via a number of outreach initiatives, such as reaching out to local shelters and first responders and engaging in community activities geared towards assisting the homeless population.

Veterans Affairs Canada has 38 office sites across the country, and our staff within each location is working with veterans who are homeless or at risk of becoming homeless, and with local homeless organizations and service providers.

We also work closely with the Canadian Armed Forces to improve the transition of members from military to civilian life. Early intervention is one of the most critical components of a successful transition process and can prevent difficulties that may result in homelessness.

As Faith mentioned, since April 1, 2018, we also have the veterans emergency fund which allows us to attend to immediate financial distress as quickly as possible at any time of the day—evenings, nights and weekends.

We have veterans service agents across the country available on call. These VSAs have been trained on how to apply the veterans emergency fund and they have access to subject matter experts to help them with any complex cases.

We understand the needs of veterans in Calgary can differ from those in Halifax. We must be flexible and nimble to adjust to the needs of the person and the community.

VAC is the catalyst to bring key partners and stakeholders together, such as VETS Canada, the Royal Canadian Legion, Soldiers Helping Soldiers, Veterans Helping Veterans, Aboriginal Veterans Autochtones, and other organizations focused on the issue.

Continued discussion and dialogue among all of our organizations is an essential part of the way forward to preventing and ending veteran homelessness.

Thank you again for the invitation to speak to you today.

The Chair: Thank you.

We'll start with six minutes, Ms. Wagantall.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you, Chair.

Thank you both for being here today and being part of this study. It's much appreciated.

I'd like to start out asking a question around the emergency fund of $1 million that is now available to our veterans. I understand that the service managers have now been informed on how to release those funds. When did it go live? When were funds released from that $1 million to veterans?

Mr. Robert Tomljenovic: The veterans emergency fund became effective April 1, 2018, so as of that date we would have started to receive applications, and payments that were approved would have gone out. I don't have the specific details on when the first fund application was approved, but as of that date, we went live with the $1 million.

● (1550)

Mrs. Cathay Wagantall: So you can't tell me what date the funding started to go out. I had heard a number of scenarios where it wasn't available on April 1. Are you telling me that it was all set up and structured, ready to go, that calls were taken and it was being distributed right as of April 1, 2018?

Mr. Robert Tomljenovic: Yes, to my understanding that is what occurred. I can tell you, in my area offices, we started getting applications as of that date.

Mrs. Cathay Wagantall: To process funding to go out the door when you got the phone call?

Mr. Robert Tomljenovic: Right. We would receive the application and then we would review it. Then the process would be, if it was approved, that we would pay the funds for whichever emergency it was being requested for.

Mrs. Cathay Wagantall: That's fine, thanks. I just have a lot of questions. I don't mean to cut you off.

Mr. Robert Tomljenovic: That's okay.

Mrs. Cathay Wagantall: I'm aware of VETS Canada, and I'm really pleased to see the groups that you're choosing to work with in regard to homelessness and getting a quick out the door response to things. My understanding with them is that, even as of September, in the first two months of being open here in Ottawa, they had 65 referrals from case managers to go there, because they could get the money out the door more quickly than going through VAC directly.

I want to explore this relationship a little bit more, because it pleases me to see that using these veterans organizations is seen as a very positive method of meeting the needs of our veterans. How effective do you find these organizations are in providing veterans services?

Mr. Robert Tomljenovic: It's a community-based approach to assisting homelessness and certainly homeless veterans. We welcome our close partnerships with many of our key stakeholders, and VETS Canada has been one of them. I could tell you the Royal Canadian Legion has been immensely positive, certainly down here in my area in southwestern Ontario. We have a very strong relationship with them.

Even in terms of identifying homelessness and then assisting to try to house them and provide the necessary—

Mrs. Cathay Wagantall: Would you say—and I'm not putting words in your mouth—that it relieves the strain on the department? They play a significant role in dealing with veterans directly and with the backlog that you're still working through.

Mr. Robert Tomljenovic: I wouldn't say they relieve the strain. I would say we work collaboratively. For example, a lot of our referrals will come through the Royal Canadian Legion. We count on them, because often when a veteran identifies, they prefer to identify, for whichever reason, to someone they're familiar with, like someone from the Legion, so we do get a lot of referrals directly from them, and from there we work together to assist.

But, you're right—

Mrs. Cathay Wagantall: Do you refer in the other direction?

Mr. Robert Tomljenovic: Yes, we do, certainly.

For example, if we have a mutual client with VETS Canada, our case managers aren't available on a Saturday at two in the morning, but VETS Canada may know that veteran and then assist over the weekend. We certainly follow up the following week and just have those discussions. They do play a vital role in helping us.

Mrs. Cathay Wagantall: They do.

You mentioned the round table that was held. How many were involved? I don't have it right in front of me. I'm wondering if you could provide the list of the subject matter experts who participated in that round table.

Ms. Faith McIntyre: We had 70 individuals who participated in that round table in June, from 65 national and regional organizations. In order to spare you some time, we can certainly send you the list of the organizations rather than listing them all out for you. We do have that available.

Mrs. Cathay Wagantall: Oh no, I'm not asking you to list them right now, but to provide a list of which ones were part of that round table and who the subject matter experts were. That would be very good. Thank you. I appreciate that.

The Chair: You're out of time. It goes quickly.

Mrs. Cathay Wagantall: It does.

Thank you very much.

The Chair: Mr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Chair, and thanks to both of you for coming.

I have a fair amount of experience with homelessness, as I practised emergency medicine in the inner city for a number of years. I know that in a lot of the homeless—not just vets, but the homeless in general—there's a very significant overlay of mental illness.

From what I've understood from some of the witnesses in other studies when they talk about homeless vets, many vets, due to mental illness or other issues, have more or less gone off the grid, in common parlance, and are very hard to find. Are there any statistics or is there any idea or estimate as to how many veterans might be unaccounted for and may be at risk? You might have a good idea that a person is out there and homeless, but do you have any idea of the numbers?

● (1555)

Ms. Faith McIntyre: Thank you very much for the question. The short answer is no.

It's a population where in certain instances, as you've said, they don't want to be found. They're hard to find. We've had stories of organizations that have found individuals living in the woods or on a boat. Again, it's a matter of working together and finding the contacts. If we find an individual who might know of them, who may have served with them, or who perhaps can reach out to a family member or can help identify a location.... It's very much a puzzle at times and it's about putting the pieces together.

As I said earlier, the data points on homeless vets and vets at risk are not easily available, so we would not have that information to provide.

Mr. Doug Eyolfson: Thank you.

If there are vets who are being followed, are there any red flags in the files that might tell you that this is someone who might be at risk? If you have someone who has been followed and has a number of missed appointments, say, or there are reports of missing pills, are there any protocols or any patterns you see that give you red flags to tell you that you have to go searching for that gentleman?

Ms. Faith McIntyre: I'll turn that question over to Robert.

Mr. Robert Tomljenovic: Sure. I'm just hoping that I understand the question.

For us, in terms of red flags in the field—and certainly case managers will look for this—we look for things such as a veteran who is couch-surfing. If they have no real stable housing and they're having difficulties meeting their monthly financial obligations, then it raises those red flags, where we'll say, “Let's see what we can do with this veteran,” and we'll ask what's going on in the background.

There has been no case—we hope, anyway—that.... When we see those red flags, it doesn't get to the point where we lose them at that point and they become homeless. We hope that by working with the case manager and the community and whatnot we can assist with this, whether that means some sort of mental health treatment or addressing this in terms of addictions or gambling, but as soon as there's a flag that there's potential homelessness, we certainly do pay attention. I would expect the case manager to follow up a little more and just make sure that we don't lose them or that they fall off the grid.

I hope that answers your question.

Mr. Doug Eyolfson: Yes it does. Thank you. That was exactly the answer I was looking for.

Mr. Robert Tomljenovic: Okay.

Mr. Doug Eyolfson: We also heard from some witnesses at other studies when they referred to veterans that some veterans had a combination of things. There was mental illness, but also they're very angry with the system—the military, the government, VAC, all of these things—and some of them, if found, are actually refusing help.

That sounds like a tremendous challenge. Is there an approach to these vets, the ones who have been found but who we're having trouble to convince to take the help that [*Technical difficulty—Editor*]

I'll leave it up to both of you if you have an insight into this.

Mr. Robert Tomljenovic: Sure.

That comment is dead-on. In my offices we've seen veterans who have been identified as being very hesitant to either come into the office or speak to—quote, unquote—a government official. In those instances, we don't rush. The first thing we need to do is build trust with a veteran who has that sort of paranoia with the department, or who, for whatever reason, has had a bad experience in terms of either his military or personal life.

We don't rush case management. We don't rush what we call developing a case plan and goals. The immediate need there is to build trust, even if that means we visit the veteran every day for five to 10 minutes, maybe with a community worker, if the veteran has one.

Until that trust is built, it's very difficult for them to engage. It doesn't always happen. I would say it's a small percentage of our veterans who we find homeless, but it does happen. When we do, we have to approach it with sensitivity. Really, at the end of the day it's up to the case manager to ensure they're building that trust so the veteran can trust that we're there to help.

● (1600)

Mr. Doug Eyolfson: Thank you.

How much time do I have left?

The Chair: You have 20 seconds.

Mr. Doug Eyolfson: I don't think I can do anything meaningful there.

Thank you very much.

The Chair: Okay.

Mr. Johns.

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

Thanks to you both for your important report and for your hard work at Veterans Affairs.

I want to begin with the CBC report from November 19. I'd also like to thank Murray Brewster for his years of solid reporting on all veterans-related issues along with his other fine work.

To quote from Mr. Brewster's story on November 19, he said:

> Both Veterans Emergency Transition Services Canada (VETS Canada) and the Royal Canadian Legion report an increase in the number of cases being referred to them directly by the department, which is either unable—or unwilling—to tap into the federal treasury.

Debbie Lowther from VETS Canada, which is a fantastic organization, said, “They're referring people to us for things like rent.”

My question is simple. Is this true? Is Veterans Affairs Canada referring veterans in need of emergency housing and/or rent to third parties for service?

Mr. Robert Tomljenovic: I can speak to how we've been utilizing the fund here.

As you know, the fund is there really for urgent and unforeseen situations. If we are approached by someone with a need, we will look at it and see what we can do.

I did mention before, however, that there are instances where we work collaboratively with other partners. For example, the Legion has always played a key role in that regard.

I can give you an idea. We do fund, for example, first and last months' rent through the VEF if the veteran finds themself in crisis and in need of housing. We will then sometimes call upon the Legion. They're wonderful here in the Hamilton area, which is one of my areas. They've developed these apartment kits that are full of all sorts of things that someone could use when they first move in. So in that regard, we do reach out to other providers.

As I said, it's a community-based approach. Veterans Affairs can't do the work on their own. They really do rely on the support of others. That's just an example of when we—

Mr. Gord Johns: Thank you.

When you're determining the amount of money for a veteran in need, are you waiting until they're in crisis, until they're getting an eviction notice? How do you determine when you're going to help them out?

What do you do in high markets? I've heard from veterans on the west coast who aren't getting the amount they need. They're living in a shoebox with their kids, and it's not adequate.

Can you respond to that?

Mr. Robert Tomljenovic: To be honest, because my area is in southwestern Ontario, I just in all good faith couldn't comment about the west and that situation.

I can tell you that from our standpoint, we don't want someone to get into a crisis situation, so it's very similar to looking for red flags —someone who might have a gambling issue or addiction issue. We try to prevent that, for example, through reaching out with the community and getting the veteran the supports they need, or maybe getting them to an in-patient program if it has to do with their mental health.

Mr. Gord Johns: I'm talking about people who don't have those issues, who are just trying to find a roof over their heads.

As we know, the veterans emergency fund was introduced in the last federal budget. It provides up to $1 million for emergency financial support for veterans, their families and survivors whose well-being is at risk due to an urgent and unexpected situation.

However, you'll also no doubt know that this government is only meeting 12 of its 24 own service standards. The glaring failure, of course, seems to be an inability to answer the phone in less than two minutes. There are also backlogs for processing applications to nearly every program offered by the department.

As you know, exactly two weeks ago, Parliament debated an NDP motion to recycle all lapsed spending at Veterans Affairs to improve service to Canada's veterans until all 24 service standards are met. My esteemed colleagues at this table, and indeed all members present, voted in support of this motion. It passed unanimously: 301 to zero. If implemented, this motion would provide an average of $124 million per year to improve services to Canada's veterans. That's enough to hire more than 5,000 case managers in the first year, which may not be possible, but should provide some idea of the scale of this wasted resource.

My question is this. If that motion were adopted as policy for the lapsed spending from this fiscal year to the next fiscal year, do you think this would speed up the approval process for applications to the veterans emergency fund?

● (1605)

Mr. Robert Tomljenovic: Just so you know some figures with regard to the veterans emergency fund, as of November 15, there have been 416 approvals, and roughly $676,519 has been put out.

From my experience, we have been quite efficient. We take it seriously when an emergency fund application comes through or a veteran calls in for the fund. We have a fairly quick turnaround time on that.

Certainly we are still working towards increasing our case management capacity in some parts of the country that are having a little more difficulty with staffing than others. That will always benefit everyone in terms of improving service delivery.

I will tell you that when a crisis does come in, it becomes the top urgent issue. We try to deal with that right away.

The Chair: You have 10 seconds.

Mr. Gord Johns: Okay.

From the experience of your case managers and what you've heard from other sources, do you know of any special needs that veterans have that other Canadians do not which may lead to a higher level of homelessness?

Mr. Robert Tomljenovic: I would say that some of the big things certainly are things that they witnessed overseas, dealing with, as you know, post-traumatic stress disorder. As a result, we have a lot of other issues that can come through from there, whether it's addictions and that.

We're finding that some of our clients are dealing with quite complex issues, not just mental health but physical injuries and addictions, which lead to financial crisis, family issues. We're finding that our case managers are working to assist them in a whole multitude of areas.

In that regard, unfortunately, we have veterans who are dealing with a lot more than sometimes the general population just because of circumstances they've found themselves in. In serving overseas and witnessing all sorts of atrocities, and/or just being injured, not just by going overseas but in the line of duty, there's a high risk for injury.

In that aspect, for me, that's the main difference that sets them apart from other Canadians.

The Chair: Thank you.

Mr. Samson.

Mr. Darrell Samson (Sackville—Preston—Chezzetcook, Lib.): Thank you very much, Chair.

I want to thank both of you for your presentations and the opportunity to ask and receive answers.

First of all, I can't say enough about organizations like VAC and the Legion. They are 24-7. That's impressive. They don't stop at five o'clock Friday night and start again Monday morning. I think that's so important. In seeing over 70 individuals at this round table, I've heard feedback that was extremely positive.

Ms. McIntyre, you mentioned that after the discussion, you mapped out a plan. Can you focus on the three main things that came out of that mapping?

Ms. Faith McIntyre: Sure. Thank you very much for the question.

Indeed we were very pleased with the conversation, but it was just a beginning. As I said, working together collaboratively on veterans homelessness with all of these organizations is important, and we have to keep that momentum going forward.

One of the key pieces of the plan was the interactive map, which we went live with. There are over 200 organizations currently on this map, which demonstrates from across the whole country where there are organizations that are able to assist and support veterans. That's available to the public on our website, which was a key deliverable.

We are also working on launching our strategy, Coming Home, on homelessness. We'll take information from all of these organizations in that round table, focusing on themes such as as leading, finding, assisting and preventing.

● (1610)

Mr. Darrell Samson: Thank you.

Can you send us that mapping information, if we don't have it, please?

Ms. Faith McIntyre: We can send you the web link, yes.

Mr. Darrell Samson: The second question is very important.

Our government has worked on a national housing strategy. Is there a connection between the national housing strategy of our government and the work you're doing on homelessness?

If so, please share a few quick points.

Ms. Faith McIntyre: Yes, there is definitely a connection. We work very closely with our colleagues at Canada Mortgage and Housing Corporation, as well as Employment and Social Development Canada, to ensure that veterans are looked at as a particular population in developing the strategy, both for homelessness on the ESDC side and housing on the CMHC side. The answer is yes.

Mr. Darrell Samson: Thank you. I really appreciate that answer.

The third question, quickly, concerns the transition. Is the service card going to help in the transition and tracking, and to what extent? Answer quickly, please.

Ms. Faith McIntyre: Yes. The service card was recently announced. It's there as an identity and recognition, to provide individuals, when they're released from the Canadian Armed Forces, an ability to show a card, to give them an ownership and an identity post-release, which is one of the challenges in transition that we've heard from many veterans. They no longer feel that attachment and that identification to the military. The card will help them do that.

In terms of data and tracking, there is more to come as the card moves forward.

Mr. Darrell Samson: Thank you. I've heard that as well with my veterans.

My final question is a very important one as well. What we say in French is *par et pour*, which means the people who are in that situation should govern that situation. How are we involving veterans to help veterans? They are the ones who can best help and they are the ones who have that trust.

Please elaborate.

Ms. Faith McIntyre: You're certainly bang on.

Many of the organizations, like Veterans Helping Veterans, Soldiers Helping Soldiers, VETS Canada and the Legion, are all made up of individuals who have served, who are veterans. They are the peer support, which is key to being able to find, assist and do the outreach. It's critical.

Mr. Darrell Samson: Of all the ones that you've identified on that map across the country, would you say that most of them have veterans in those organizations?

Ms. Faith McIntyre: Yes, in some capacity.

Mr. Darrell Samson: Could we identify how many have them and how many do not?

Ms. Faith McIntyre: We can certainly take a look at that.

I think that by their titles themselves it's quite self-evident when you look at the organizations, but that is something we can certainly follow up on.

Mr. Darrell Samson: I believe that they would more than willingly join to help because they are the ones who are in the field and who are—

Do I have more time?

The Chair: You have one minute.

Mr. Darrell Samson: I have one minute, wow. You're doing quite well in answering the questions.

Back in 2014, we said there were approximately 2,250 individual homeless veterans. What is the estimate of Veterans Affairs today, and has that number increased or decreased?

Ms. Faith McIntyre: Again, counting homeless individuals across the country is not easy to do. Homeless veterans are even more challenging because many of them don't even want to self-identify as veterans. A lot of times it depends on who asks the question and how they ask the question.

The most recent statistic we have comes from the point-in-time counts, where it's a particular point in time at a homeless shelter, counting how many of those individuals were homeless veterans, and it was 5% of the total point-in-time count across various geographical cities.

The statistic that you're mentioning was a study done by Employment and Social Development Canada, which was a sampling of information. Back then, we looked at the magnitude—

Mr. Darrell Samson: They were only at three-point-something per cent.

For a final question, homeless female veterans—

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

Mr. Darrell Samson: Is there an increase in female veteran homelessness?

You might have an opportunity later.

Thank you.

The Chair: Ms. Ludwig, you have six minutes.

Ms. Karen Ludwig (New Brunswick Southwest, Lib.): Thank you.

Thank you, both, for your very informative testimonies.

You spoke, Faith, about vet to vet. I know when I was doing some work in the Fredericton area, they were not going to disclose anything about themselves, even whether they were a vet, to someone who was not a vet.

Certainly, the characteristics and some of the challenges that they face are unique to their community.

When we look at affordable housing for veterans, is there a model that's a little different from a different community of people in need?

● (1615)

Ms. Faith McIntyre: Yes.

I think veterans helping veterans is an important theme.

My colleague spoke about building trust and how Veterans Affairs Canada has to be patient. We have to be persistent, and we have to build that trust.

I've heard many anecdotes from veterans who, because they've served together, can make a connection, and that trust is automatic. By having that door opened by their peers, we can come aboard, work with them and find them the best way forward.

We did pilot studies on housing models a few years ago with Employment and Social Development Canada in various cities across the country. For the most part, the most successful models were ones that had veterans housed with veterans, where that peer support and that culture was available as part of that housing model.

Ms. Karen Ludwig: Thank you.

My next question is about the transition. Knowing what you know now, does the Department of Veterans Affairs work with DND to help on that transition with a veteran? We think of people who retire. There's always the person in HR who gives the explanation. However, that person hasn't retired yet.

If we're looking at people making the transition from the Canadian Forces into the community, are there veterans involved not only in explaining the transition before they leave but also with family resource centres and the families to explain it?

The other part of that is that I spoke with someone earlier today about why there is an increasing number of homeless veterans. The person said that for those who suffer from PTSD, often the symptoms don't show for five to seven years. Knowing that, how do we better prepare veterans and their families before they leave the military?

Ms. Faith McIntyre: I'll take the second part of that question. I think Robert, my colleague, can speak directly about that transition work, which he and his area offices do.

On the second part of your question, I think that first of all, we know statistically that the majority of veterans come to Veterans Affairs Canada much later after release, after the 10-year mark, for many reasons. One certainly could be that mental health conditions tend to appear much later.

Certainly that's one of the key pieces we identify as well. Homeless vets tend to be homeless much later post-release, again, tied to mental health conditions, which are statistics I shared in my opening remarks.

Having said that, we need to ensure that the supports are available to them pre-release and that we can target any triggers. We're doing a road to civilian life project where we're identifying risk factors and a checklist. We've seen that with mental health first aid-type training as well, asking how they're feeling that day and what's their mood.

I'm simplifying it, but when you look at a transition checklist, would any “reds” appear for these individuals? How should we be able to support them, for example, if they've been to conflict many times or if they've witnessed very challenging situations, and be proactive in providing those supports, particularly in a mental health framework, prior to five or 10 years later where it may be apparent?

I'll turn to Robert to answer the first part of your question.

Ms. Karen Ludwig: Thank you.

Mr. Robert Tomljenovic: I think we've come a long way in terms of the transition. In my area alone we work very well at the three IPSCs. I'm particularly thinking of Borden right now, where many more of our releasing members are coming through from south-western Ontario.

Definitely now everyone gets a transition interview upon release with one of the Veterans Affairs Canada staff members who are working out of the IPSC full time on base. The reason we try to give everyone a transition interview is we recognize that if we don't look at what's going on now—you're right—seven to 10 years down the line, they find themselves homeless.

It's that slow progression of mental illness taking effect. Then they lose their job; then their family falls apart, and all that kind of stuff. We try to identify that early. You look for the key things. Have they done a special duty area? Are they suffering from physical injuries? If that's the case, then we can do two things. We can immediately apply for a disability award. Then upon release we can look at things like the rehabilitation program, getting them treatment. We can have an initial assessment of what's going on so we don't want them not to pass through us.

The other thing is that even if people don't identify—they're feeling fine and things are going well—we want to at least give them the knowledge of our programs and services, and to know if ever they feel that things aren't going well or something's changed, to give us a call. It's setting the stage for trying to fix whatever is occurring now. However, if in the future things aren't going so well, they should come back to us then. There's no time limit.

● (1620)

The Chair: Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you both for being here today.

Earlier, my colleague asked how long it takes to get funds from an emergency fund, and the answer was not given, or at least I didn't hear it, but it was that it takes time. How long is the process time to get the funds into the hands of the veterans?

Mr. Robert Tomljenovic: Again, it's a case-by-case basis depending on the scenario. For example, if someone needed to be temporarily housed until we can look at more permanent housing, it would be immediate, which would mean—

Mr. Robert Kitchen: I understand that, sir. I do understand that, but the reality is at this point in time you've had that many people and you should have some way to figure out the average time it takes to get those funds into their hands, whether it's immediate or later.

Mr. Robert Tomljenovic: Okay. Those are probably statistics that may be available. Certainly we could take that back and follow up with you. I just don't personally have the overall statistics on that.

Mr. Robert Kitchen: Thank you.

You yourself have said that over 66% of the emergency fund has already been spent, and there are five months left in the year and winter is upon us. That's when a lot of homelessness starts in certain situations. You basically have less than 34% funding to pay out for these next five months. What we're hearing, and as my colleague Mr. Johns indicated it's out there, is that people are now being pushed from VAC to other support service agencies.

As we get into this time of year, how are you going to be able to cope with helping these homeless veterans?

Mr. Robert Tomljenovic: As we know, the fund has a maximum of $1 million per fiscal year. In the event it does expire—and you're right, winter is coming upon us—certainly in my area my expectation would be that we continue to utilize it in the same manner until such time as the fund expires. If it does, I will tell you, though, prior to the fund.... Like I said, we've had a wonderful relationship particularly with the Royal Canadian Legion. They've been instrumental many times in providing emergency funds. There are other assistance funds and benevolent funds that we can tap into. Those are there, certainly, in the event that the $1 million is spent by the end of the fiscal year.

You're right that with winter coming, there is that possibility. However, our staff have been utilizing those funds for years prior to the veterans emergency fund so it wouldn't be too much for us to seek assistance elsewhere, if needed.

Mr. Robert Kitchen: Thank you.

To date, do you know how many veterans in an urgent situation have been provided immediate over-the-phone support rather than being referred to a veterans assistance line?

Mr. Robert Tomljenovic: I personally wouldn't have those statistics. The veterans emergency fund wouldn't necessarily fall to me as an area director. It's just something I wouldn't be able to answer.

For me, it's when there's an emergency fund that comes in, then we treat it as such. If an application comes in, we have to adjudicate on it. I wouldn't be able to have those statistics. I'm sorry.

Mr. Robert Kitchen: You have a nice poster that's been put out that is not easily accessible to veterans who are homeless because it's being sent to organizations, yet there's a number on it and when you phone that number, it's out of service.

Can you tell us why that may be or is there an avenue that needs to be checked on?

● (1625)

Mr. Robert Tomljenovic: I didn't realize that. I'm assuming the number that's on there is our toll-free number.

Mr. Robert Kitchen: It is, but no one's answering it, after half an hour plus. That's not an emergency response.

Mr. Robert Tomljenovic: Okay. That's something we could look into. I apologize. I'm not aware, and I would hope that if it's some sort of technical issue, we could fix that immediately. I haven't been aware of that.

Mr. Robert Kitchen: The thing is—

Yes, go ahead.

Ms. Faith McIntyre: Thank you. It's difficult, I know, with Robert being on the phone and me by video, but thank you very much for that comment.

As I indicated in my remarks, we are sending out the poster to over 2,000 organizations. It will have our VAC assistance line on it, which is 24-7. I'm not sure what poster you're referring to and what number is on it now, but I'd be more than happy to follow up.

The intent is that it would be the 24-7 VAC assistance line that would be provided.

Mr. Robert Kitchen: That's the poster. Is that not your poster?

Ms. Faith McIntyre: Yes, indeed it is. I expect that's our—

Mr. Robert Kitchen: That's your direct number.

Ms. Faith McIntyre: Yes.

Mr. Robert Kitchen: Someone needs to be checking that.

Ms. Faith McIntyre: Thank you.

Mr. Robert Kitchen: On that note, on emergencies, when it comes to their situation, we have veterans who are sometimes homeless, who are suicidal and they are sitting on that cliff. They phone a suicide hotline. Again, they're being told to phone somebody else.

Our understanding was that this suicide hotline was to provide that immediate response to those veterans, instead of shunting them off to somebody else or finding them a psychologist. At that point, when they've made that call, they're on that cliff. This is an emergency hotline, and that's sad. I'm wondering if you can comment on that.

The Chair: It will have to be a short one. I'm sorry, but we're short on time.

Ms. Faith McIntyre: Thank you. Would you like me to respond?

Mr. Robert Kitchen: Yes, please.

The Chair: Yes, if you could.

Ms. Faith McIntyre: Thank you. I would imagine you're referring to our VAC assistance line, which is our 24-7 line. I will need to follow up. If indeed that is happening, that should not be the case. We will certainly check into that and ensure that folks, particularly in an immediate crisis situation, aren't being pushed off, put on hold or left in other situations that might lead to their not wanting to continue to speak to an individual. I appreciate your flagging it.

Mr. Robert Kitchen: Thank you.

The Chair: Mr. Bratina, I believe you are splitting time with Mr. Chen.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): Thank you very much.

I was reviewing one of those sites where people comment on having worked at a place. One place was VETS Canada. It seems like the overwhelming response is that people are very satisfied. They are happy to work for veterans and do the things that need to be done. There's job satisfaction that goes with it. One thing that was flagged was the shortage of team-building opportunities because your staff is under the gun. We're hearing comments, and there are newspaper articles and so on. Is there an interaction with the staff, in terms of morale and ensuring that they're working to their maximum capacity on behalf of the veterans?

Anyone can answer that.

Ms. Faith McIntyre: Thank you very much for the question. I can start, but I'd turn to Robert as well, who works in the field directly with staff.

It is unfortunate, I think, particularly when there are news articles that come out that paint a picture. We have staff here who are very passionate and who work their hardest to ensure that decisions are made in the best interests of veterans and their families. Taking time and building teams, we've developed a national orientation training program, which is something new. We are working through hiring all of the new staff and building that team, virtually as well as face to face. We're doing things such as holding off-site meetings and using various communications.

We actually just released a pulse survey as well. It's the second one with our employee council to really figure out the pulse of the staff. In response to that, then, what do we need to improve upon or what do we continue doing if things are going well?

Robert, I'll let you speak to some examples from your end.

Mr. Robert Tomljenovic: Yes, sure. Certainly, our staff work very hard. When you're case managing complex issues, certainly it can be challenging and whatnot. I will tell you, though; we talk about a workplace of choice. I've seen Veterans Affairs really try to move in that direction, by offering little things that provide some sort of self-care for our case managers, whether it's flex hours or work from home opportunities.

The other thing that we have now are wellness committees. They have popped up in virtually every one of our area offices. These committees really focus on well-being and helping to boost morale. We allow for some activities. We do some meditation over lunch. We've done chair yoga over lunch. I will tell you, staff have really appreciated that. I think they really benefit from it. It offers a nice balance during that challenging day. We've seen a huge difference from it.

● (1630)

The Chair: Thank you.

Mr. Chen.

Mr. Shaun Chen (Scarborough North, Lib.): Thank you, Mr. Chair.

I want to start off by thanking both of our guests for being with us today.

I want to echo the comments that they and my colleagues on the committee have made with respect to the work of VETS Canada and the Royal Canadian Legion. I'm very lucky to have the Centennial Branch 614 of the Legion just across the street from my constituency office. They do a fantastic job of getting veterans together. They've invited me a few times to their karaoke night, but it always seems to fall on a weekday when I'm in Ottawa. I do hope to join them one day. More importantly, they're really there to help veterans when the help is needed. The fact that the veterans are there to support each other is very, very important and tremendous.

My colleagues have mentioned the emergency fund. I know that this fund provides up to $1 million every fiscal year. This is a new fund, from my understanding. When was this fund first put in place?

Mr. Robert Tomljenovic: The fund first came into effect April 1, 2018.

Mr. Shaun Chen: It's 2018. Prior to that, if veterans needed access to emergency funding and support, and they called Veterans Affairs Canada, what would happen?

Mr. Robert Tomljenovic: I mentioned this before. We would look at a variety of third party funds out there, including assistance via the Legion or VETS Canada. We can tap into all sorts of benevolent funds, like the Royal Canadian Naval Benevolent Fund. There were always funds out there that we could tap into. The Soldiers' Aid Commission is another one that we use quite a bit.

There are third party funds out there and available, and those were the ones that we tapped into. The nice thing about the emergency fund is that when it came into effect, it gave.... The decision didn't rest with the staff within Veterans Affairs for those third party funds, but now it does, and that's why it can move more quickly. We're not waiting for a decision to come back.

Mr. Shaun Chen: The decision on whether to support a veteran is made by Veterans Canada. It's a new fund, and there's a tremendous need. This, to me, is in fact a great success because, as was pointed out earlier, 66% of the fund has already been spent for this fiscal year. Veterans are hearing about this, they're calling back and they're getting the supports they need.

What types of situations can you share with us regarding veterans who are getting funding through this emergency fund? What are they facing?

Mr. Robert Tomljenovic: Some of the ones that I've seen that have been approved have been looking at housing. That certainly is a big one, whether they need first and last months' rent or, for whatever reason or due to unforseen circumstances, they can't pay the rent for a month.

The fund is not there to look at long-term assistance, but sort of that short, unforeseen emergency. We've paid for food and anything that's a necessity. I believe, although I can't remember, that we had a veteran whose roof may have been leaking. In that instance, that's something we would look at repairing because of the damage that can happen if it isn't repaired. Those are some of the things that have come my way through the local area office.

The Chair: Thank you.

Unfortunately, that ends our time today for this panel.

On behalf of the committee, I'd like to thank both of you for taking time out of your day and for all that you do for the men and women who have served.

We'll recess for a couple of minutes and get the next panel in.

Thank you.

● (1630)

(Pause)

● (1635)

The Chair: I'd like to call the meeting back to order.

We have some in camera business which we're going to have to get to after this, so I'm going to have to hold you to your time. Try to take it easy on me.

In relation to our study of medical cannabis, we are pleased to welcome, from Veterans Affairs Canada, Dr. Cyd Courchesne, Director General, Health Professionals Division and Chief Medical Officer; and Dr. Alexandra Heber, Chief of Psychiatry, Health Professionals Division.

Dr. Courchesne, the floor is yours.

Dr. Cyd Courchesne (Director General, Health Professionals Division, Chief Medical Officer, Department of Veterans Affairs): Thank you, Mr. Chair.

Good afternoon, Mr. Chair, vice-chairs and members of the committee. I'm Dr. Cyd Courchesne, Director General of Health Professionals and Chief Medical Officer at Veterans Affairs Canada. I'm pleased to be here today with my colleague, Dr. Alexandra Heber, our chief psychiatrist.

[*Translation*]

We would like to thank you for the invitation to appear before the committee in regard to your study on the implications of veterans' mental health as it relates to medical cannabis through the medical cannabis program administered by Veterans Affairs Canada.

[*English*]

We will briefly touch on the reimbursement program for cannabis for medical purposes at Veterans Affairs Canada, the data on program uptake, the approvals process for reimbursement exceeding three grams per day and the most recent research data available to the department.

[*Translation*]

Veterans Affairs Canada's mandate is to provide exemplary, client-centred services and benefits that respond to the needs of veterans and their families, as well as its other clients, so as to recognize their service to Canada and keep the memory of their achievements and sacrifices alive for all Canadians.

Our goal is for veterans and their families to receive the care and support they need.

In 1999, legal access to possess dried marijuana for medical purposes was first approved. Since then, as a result of many court decisions, the way individuals access cannabis for medical purposes has changed significantly. Veterans Affairs Canada has provided coverage for the cost of cannabis for medical purposes since 2008.

[*English*]

Between 2008 and 2014, reimbursement was based on section 4 of the veterans health care regulations and in accordance with Health Canada's marijuana medical access regulations. The marijuana medical access regulations, implemented in 2001, provided limited access to marijuana for medical purposes for a number of conditions and circumstances as defined by Health Canada when authorized by specialists only.

In April 2014, Health Canada introduced the marijuana for medical purposes regulations, which removed limitations related to the authorization for specific conditions, and the requirement for authorization by a specialist was changed to a medical authorization.

It also provided individuals with a medical need to access quality-controlled dried marijuana produced under secure and sanitary conditions by licensed producers. In June 2015, licensed producers were permitted to produce and sell cannabis oil and fresh marijuana buds and leaves in addition to dried marijuana.

In August 2016, Health Canada's access to cannabis for medical purposes regulations were introduced, which set out provisions for individuals to grow a limited amount of cannabis for their own medical purposes, or to designate someone to produce it for them.

While cannabis for medical purposes is still not an approved therapeutic drug in Canada, the access to it continues to grow. With the advent of these new regulations, Veterans Affairs Canada subsequently experienced a significant increase in requests for cannabis for medical purposes reimbursement.

● (1640)

[*Translation*]

In its spring 2016 report, the Office of the Auditor General recommended that Veterans Affairs Canada improve the management of its drug benefits program to consider the health and well-being of veterans, as well as cost containment.

As a result, the department conducted an internal review, which involved consultation with medical professionals, subject matter experts, licensed providers and veteran beneficiaries. The result of this review led to the implementation of Veterans Affairs Canada's reimbursement policy for cannabis for medical purposes on November 22, 2016.

The 2016 policy allows eligible veterans to be reimbursed for a maximum of three grams per day of dried cannabis, or its equivalent in cannabis oil, and fresh cannabis at a fixed rate per gram.

The decision to reimburse for three grams per day is based on data obtained through consultations and research. Veterans Affairs Canada brought together a panel of Canadian medical experts, who recommended a very cautious approach to the use of cannabis for medical purposes, with some indicating one to two grams per day was a reasonable amount for the vast majority of cases.

Veterans Affairs Canada also reviewed current scientific evidence and consulted with veterans, stakeholders and licensed producers. The decision is also consistent with Health Canada data, which indicate that the average Canadian is authorized less than three grams per day.

[*English*]

The approval process to obtain a reimbursement from Veterans Affairs Canada for cannabis for medical purposes requires that veterans have an authorization from a medical practitioner, and that they be registered with a licensed producer from Health Canada's website. The documentation is received by Medavie Blue Cross, which sends it to Veterans Affairs Canada for a decision. Medavie Blue Cross sends the decision letter to the veteran on behalf of Veterans Affairs Canada.

To ensure greater rigour in the department's approach, a process for approving exceptional requests was put in place in November 2016, when the policy was introduced.

While reimbursement requests for up to three grams per day require a medical authorization document from a general practitioner, or a nurse practitioner in some provinces, requests for more than three grams per day may be approved only when supported by additional documentation from a medical specialist with expertise in the veteran's diagnosed condition. For example, if the veteran is eligible for treatment benefits associated with a mental health condition, the specialist's document would be provided by a psychiatrist. For pain due to cancer, an oncologist could provide the supporting document.

Each exceptional claim is reviewed on a case-by-case basis. The medical specialist's supporting document must include a rationale for the use of more than three grams per day, confirmation that there are no contraindications when using cannabis for medical purposes, and an indication that alternative treatments have been ineffective or contraindicated.

Similar to other treatment benefits reimbursed by Veterans Affairs Canada, the exceptional approvals process is a mechanism to help ensure the health and well-being of the veteran remains at the forefront of any decision.

Veterans Affairs Canada reimburses only for medical treatments authorized by the veteran's physician or health care practitioner. The department does not prescribe medical treatment.

VAC considers the veteran's own physician to be in the best position to identify and authorize the most appropriate treatment to address the patient's health condition.

● (1645)

[*Translation*]

In 2017-18, a total of 7,298 veterans were reimbursed for medical cannabis, at a cost of approximately $51 million. While the number of veterans seeking reimbursement continues to rise, the cost per veteran has decreased.

An analysis of expenditure data for the nine-month period between April 1 and December 31, 2017 revealed expenditures of $39 million. Had the 2016 reimbursement policy for cannabis for medical purposes not been in place, it is estimated that costs would have been $91 million for the same period, indicative of a potential cost savings of $52 million. This meets the Auditor General's recommendation to contain costs, while ensuring the health and well-being of veterans.

A comparison between December 2016 and December 2017 provides further evidence of the policy's impact. In December 2016, Veterans Affairs Canada reimbursed an average of 155 grams per eligible veteran, at an average cost of $11.28 per gram. In contrast, in December 2017, reimbursements declined to an average of 89 grams, at an average cost of $8.38 per gram.

On December 31, 2017, approximately one year after the reimbursement policy was implemented, of the 6,119 veterans with active medical authorizations from their health care professionals, only 734 veterans, or 12%, had exceptional approvals in place. This is in sharp contrast to the previous year.

On December 31, 2016, a total of 2,771 veterans, or 66% of all recipients, were authorized for more than three grams per day. This decline in the number of veterans requesting reimbursement for over three grams per day is also in line with Veterans Affairs Canada's focus on supporting the health and well-being of veterans and their families.

On August 31, 2018, a total of 8,175 veterans were being reimbursed for medical cannabis, for a total expenditure of $29.7 million.

[*English*]

On October 17, 2018, the Government of Canada's new Cannabis Act and cannabis regulations came into effect, providing legal access to cannabis for Canadians. The act and regulations also control and regulate the production, distribution and sale of recreational cannabis and cannabis for medical purposes.

To coincide with the coming into force of the new act and regulations, Veterans Affairs Canada has updated its reimbursement policy, which simply reflects adjustments to the language under the new legal recreational cannabis regime. Veterans will experience no change in the current reimbursement process for cannabis for medical purposes. Under the revised policy, Veterans Affairs Canada will continue to reimburse for a maximum of three grams per day of dried cannabis, or its equivalent in fresh cannabis or cannabis oil. Veterans Affairs Canada will only reimburse eligible veterans for cannabis for medical purposes.

[*Translation*]

That concludes our opening statement, Mr. Chair.

We would be pleased to answer any questions you have.

[*English*]

The Chair: Thank you.

We'll start with Mr. Kitchen.

Mr. Robert Kitchen: Thank you, Mr. Chair.

Thank you both for coming today.

Dr. Courchesne, thank you very much for your presentation. You indicated that in December 2016 there were 4,719 veterans receiving medical marijuana; December 31, 2017, 6,119; and August 31, 2018, 8,175.

Do you have any suggestion as to why the number keeps going up?

Dr. Cyd Courchesne: You would have to ask the doctors who prescribe it to their patients. We have no control over that.

We saw a rise with the change in regulations over the years from Health Canada. At the beginning, the criteria were very restrictive and they kept being challenged in court. Every time the courts would come back and say that the rules are too restrictive, so Health Canada would revise them. It was when they removed the requirement to go to a specialist and for anyone with a prescribing licence.... That's when we saw a sharp increase.

● (1650)

Mr. Robert Kitchen: Thank you.

Do you have a breakdown as to years of service, age and sex, etc., for those 8,175 veterans? If not, can you get that for us? Also, do you have a breakdown by rank?

Dr. Cyd Courchesne: I have a breakdown of how many grams the 8,175 are using, but I don't have that other type of breakdown because we don't collect that information.

Mr. Robert Kitchen: Do you know what percentage would be under the age of 25?

Dr. Cyd Courchesne: I would have to correlate that with our findings. I can give you how many of our veterans are under 25, which is not the majority. The majority of our veterans are above 25 years old, because many of them have 10 years or more of service.

Mr. Robert Kitchen: Okay, thank you.

Dr. Cyd Courchesne: We will note that, and I will get that information for you.

Mr. Robert Kitchen: It would be much appreciated if we could have that breakdown so that we can see that information. I like to take a null-hypothesis approach to this, and prove one thing wrong in order to prove the theory.

Thank you.

We know that with the epidemiology and acute risk involved with marijuana alone, such as motor impairment, induced delirium, psychoses and adverse effects on cognition, as well as a chronic risk that can result in use disorders, 68% tend to be lifetime and 1.3% are annual. This is from research I've done. There are only roughly 20 papers I can see out there that support that, using roughly 1,800 patients. The research that I'm aware of is scant.

Do you have any research that would be of value to this committee? If so, can you provide that for us?

Dr. Cyd Courchesne: If I understand your question, you want to know how many of our veterans have substance-use disorder related —

Mr. Robert Kitchen: No. What I'm looking for actually is more from the research point of view. The reality is, as I pointed out, yes, there are risks involved, and I've been trying to find those risks. I can't find anything more. I'm trying to find out if you have more information to justify whether a dose should be three grams versus 10 grams, etc.

Dr. Cyd Courchesne: There's not much research. There is a lot of research on the harmful effects of using cannabis. There has not been much research done on whether cannabis is useful for any medical condition. Part of this was because it was difficult to do clinical research when you were dealing with an illegal substance. To design clinical research, and to do long-term research like this.... Again, this was not a product that was developed to treat medical conditions. This is a product that people use for all sorts of reasons.

The research is scant.

Mr. Robert Kitchen: Thank you. I get it. How can you do a proper study, a research study? If I were on a review board a year ago and you brought me a research paper which said that you wanted to study marijuana, I would have said to you that it's illegal, and there's no way we can do that. I understand. How can you do research on that? However, to make decisions without research, to me, is not acceptable.

We seem to be doing that, especially with some of the chronic conditions that you see with it, such as chronic bronchitis, psychosis disorders, self-harm and suicidal tendencies. We're talking about trying to bring veterans off that edge from that suicidal point. With that said, hopefully we will see some answers come from this study.

● (1655)

The Chair: You have 30 seconds.

Mr. Robert Kitchen: I have 30 seconds. Okay.

Dr. Alexandra Heber (Chief of Psychiatry, Health Professionals Division, Department of Veterans Affairs): By the way, I have some research papers that I can leave.

Mr. Robert Kitchen: Thank you.

Very quickly then, when a veteran no longer gets a prescription but gets authorization for it, does that veteran have to renew that monthly, six months or yearly, or is it ever done?

Dr. Cyd Courchesne: Authorizations from Health Canada are good for one year. Health Canada has the framework for how often they can get it. They require an authorization, and it's good for a year, with a licensed producer.

The Chair: Thank you.

Mr. Bratina.

Mr. Bob Bratina: Thank you very much.

Another way of asking a similar question is: What is the state of research on the cannabis drug? What do we know for sure about what it is and how it works?

Dr. Alexandra Heber: Let me answer that. As Dr. Courchesne said, because of the war on drugs, principally in the U.S., for a very long time it was very hard to get funding to do research. However, there is research available. As she also said, most of it shows the harms associated with cannabis use.

There is actually very little good research showing any positive health effects for the use of cannabis, even though you will see in the popular press that people who tend to use cannabis will talk about how profoundly it has helped them. In fact, the research that is out there, including both reviews and reviews of the research out there on health effects, show overwhelmingly that there are negative effects, certainly on mental health and on physical health as well.

Mr. Bob Bratina: How would you suggest we're actually going to figure this out in the next few years? All we really hear is anecdotal evidence. How would researchers separate the anecdotal things we all hear about from what is real?

Dr. Alexandra Heber: Certainly that's one of the big questions. It's something we've been discussing and trying to look at.

Right now we're putting together some proposals with our research division to look at our own population that is already using cannabis or those who will start using cannabis to perhaps do some kind of a case comparison, at least of matched veterans who are not using cannabis, so that we can look over time and see how these people are actually doing.

One of the concerns in conditions like post-traumatic stress disorder, of course, is that one of the major symptoms that is very hard to treat is the avoidance symptom. One of my concerns is that what veterans and others using cannabis for PTSD are doing is that it becomes a way of avoiding. It is much like when I was in the military and many of my military patients would drink a lot before they came in to see me. One of the first things we needed to do was help them to stop drinking. Again, understandably, they were drinking to mask their really terrible PTSD symptoms. Personally, it's one of the concerns I have.

Again, we don't know. We need good research to be exploring all of these questions.

Mr. Bob Bratina: How is the information that you have collected, in terms of the anecdotal stuff that we're hearing about? Do you have protocols for talking to veterans?

Dr. Alexandra Heber: Right now—

Dr. Cyd Courchesne: When we revised the policy we held workshops and we asked them directly. We use our national stakeholder summit to have breakout sessions and we consulted widely.

The minister also has advisory committees, which is another avenue for veterans to provide feedback. We continue to have summits where veterans are more than happy to provide us with feedback.

● (1700)

Mr. Bob Bratina: Is Veterans Affairs Canada capable of undertaking the research that's required? There are certainly lots of other people who must be considering this. Is there any co-operation among groups?

Dr. Cyd Courchesne: With the legalization of cannabis in Canada there has been more interest in conducting research—the Canadian Institutes of Health Research and the Canadian Institute for Military and Veteran Health Research. All of these organizations are working together and, of course, they know that we have a population of interest, as well as the military. We're part of big consortiums of people with common interests to look at this. We're not alone because it would be impossible for the department to undertake large studies on their own. We rely a lot on CIMVHR especially, which has access to over 46 universities and organizations to do this.

Mr. Bob Bratina: Is there any data showing up yet that with legalization other veterans will decide to use the product to see if it helps them? Are you seeing anything like that?

Dr. Cyd Courchesne: It's really too early.

Mr. Bob Bratina: Okay, thanks.

The Chair: Mr. Johns.

Mr. Gord Johns: Thank you.

Thank you both for being here.

Are you aware if the cannabinoid system is taught in medical school?

Dr. Alexandra Heber: Yes, like other systems, we're taught about it.

Mr. Gord Johns: Now that it's legal, will you be doing more research on this as well?

Dr. Cyd Courchesne: Actually, McMaster University just released an online webcast video for medical students on this, and this was at the request of the Ontario Medical Association. There is more and more interest in educating doctors and the population about these systems, yes.

Mr. Gord Johns: On a question from a veteran to me, he asked if you would recommend pharmaceutical drugs like antidepressants or marijuana.

Can you take that?

Dr. Alexandra Heber: Yes, antidepressants are the gold standard treatment for PTSD. We have treatments that have been well tested and well researched and we know work.

Mr. Gord Johns: Would you say that it's more effective to use antidepressants versus marijuana?

Dr. Alexandra Heber: Yes. Again, we have evidence on it. We have no evidence on marijuana except we know that it can have a lot of deleterious effects, like causing psychosis.

Mr. Gord Johns: Now that it's there, are you planning to invest more money in research to examine those benefits?

Dr. Alexandra Heber: Do you mean in antidepressants?

Mr. Gord Johns: I mean in marijuana versus antidepressants.

Dr. Alexandra Heber: Again, this is the kind of research that certainly should be done. I don't know that it will be us, or maybe it will be us in partnership with some of the institutes now that are doing very good research, like McMaster, like the Centre for Addiction and Mental Health in Toronto.

Mr. Gord Johns: It would be great if you could submit those reports to the committee. That would be fabulous and it would help us.

Has VAC received any scientific information with regard to the possible health benefits of medical marijuana?

Dr. Cyd Courchesne: We've done all the review of literature. We've gone to the agencies that can do these reviews of literature for us, looking for evidence—

Dr. Alexandra Heber: —of benefits.

Dr. Cyd Courchesne: Yes, and again there has not been anything substantial.

Mr. Gord Johns: Would you be open to meeting with companies that are doing research in this field?

Dr. Cyd Courchesne: We're meeting with academic institutes that are not linked with producers, with growers that have a financial.... We'd rather stick with academia.

Mr. Gord Johns: Are you doing any collaboration with other countries, such as the United States, Holland, or Australia, when it comes to medical marijuana in respect to veterans?

Dr. Alexandra Heber: We've certainly looked at research that has come out of places like Colorado where they've had this experience. It's interesting because I remember a couple of days ago on CBC radio they were talking about research that's been done there. Once these edible forms are introduced, which look like candy, they've had problems with children overdosing on them. We certainly are learning from the experience of some places like Colorado that have gone through this already.

● (1705)

Mr. Gord Johns: You're not working formally, though, with the Government of the United States or the Government of Australia in collaboration with companies.

Dr. Cyd Courchesne: Through the Canadian Institute for Military and Veteran Health Research, it's an opportunity to exchange with them, to partner, and so we work closely with partners and allied nations that are all represented there.

Mr. Gord Johns: Is it a priority for you to start those kinds of official talks, working collectively?

Dr. Cyd Courchesne: Again, we can't do work on our own. Collaboration and partnership are essential, especially in this field.

Mr. Gord Johns: Some groups believe that using cannabis for medical purposes can help reduce the use of other medications such as opioids for pain or drugs for insomnia and anxiety. To date, VAC has stated it can't draw any conclusions on this issue. Has the department noticed that correlation between higher medical cannabis reimbursements and lower use of other medications by these veterans?

Dr. Cyd Courchesne: No. We looked at that, and it's too early to see an effect. We continue to look at that but in these early years, we have not seen a significant decrease in antidepressants, opioids and all those other medications.

Mr. Gord Johns: If the department hasn't reached any conclusions on this, does it plan to study this?

Dr. Cyd Courchesne: We continue to monitor it.

Mr. Gord Johns: In terms of the backlog for disability benefits, does this affect veterans getting access, potentially, to prescriptions for cannabis?

Dr. Cyd Courchesne: I wouldn't be able to answer that question.

Mr. Gord Johns: Okay.

Thank you, Mr. Chair.

The Chair: Mr. Chen.

Mr. Shaun Chen: Thank you, Mr. Chair.

I want to thank both doctors for being with us today.

Based on Dr. Courchesne's testimony, it's my understanding that the use of marijuana for medical purposes for veterans is in fact nothing new. In 1999 it became legal to possess medicinal marijuana, and since 2008 VAC has covered the use of medicinal marijuana by veterans.

You mentioned the Auditor General's report on this issue. Fortunately, I sit on the public accounts committee, so I'm quite familiar with the Auditor General's reports.

The Auditor General's report that's been referenced by the doctors today states the following in paragraph 4.44:

> While the Department advised us that it covered only the amount of marijuana for medical purposes recommended by the physician or a medical specialist, as outlined in the Regulations, we found that the Department had not established limits on cost or the amount to be covered.

In 2008 there was no limit on the cost of the medicinal marijuana that veterans were using. There were also no specifics provided on how much could be covered. To me, that sounds like there's a lack of a specific framework through which VAC provides benefits to veterans.

Can you tell me what has changed since 2008? Arising out of the Auditor General's report two years ago, what has the department done to contain cost and provide a framework for the benefits that are provided to the veterans?

Dr. Cyd Courchesne: I was not there in 2008, but we have no reason to disbelieve the findings of the Auditor General. It's a fact that we had no formal policy framework. I guess it was that one case led to another, and it sort of—

Dr. Alexandra Heber: —ballooned.

Dr. Cyd Courchesne: Yes.

When the Auditor General made those observations, it was an opportunity for us to go back and look at our processes, put in a policy, and look at what we were paying per gram. This is what triggered several months of consultations. We consulted with medical experts. We consulted with licensed producers. We consulted with veterans and family members. We consulted widely. We did research of literature.

It was a double-pronged process: first, the process for medical, and then the cost, which was done by our colleagues in service delivery by consulting licensed producers. Through negotiating, they came to a fair market value price for cannabis for medical purposes. That's how we landed on our policy of three grams or less at about $8 or $8.50 a gram.

● (1710)

Mr. Shaun Chen: That same report by the Auditor General also critiqued the department's management of the drug benefits list. Medicinal marijuana is one of many ways in which veterans address their medical concerns. It was recommended by the Auditor General that the department look at creating a decision-making framework that would seek specific evidence for deciding which drugs to reimburse and for how much. It was also identified in the Auditor General's report that when they looked at a number situations where veterans were given drugs, there wasn't sufficient evidence as to how those drugs would be helpful to them in those situations. To me this sounds like a larger problem.

How would you say the department is now viewing the drug benefits list? How are they better managing it? Are you more or less relying on the due diligence of physicians prescribing these drugs or medicinal marijuana to give their patients the best medical advice that they need?

Dr. Cyd Courchesne: Following this report, we totally restructured our formulary review committee. We restructured the membership. We put in guiding principles to make decisions, and evidence to be weighed to decide on whether we would or would not list a drug. Cannabis aside, all the other drugs go through the Canadian review committee. In Canada there are recommendations to list or not. We consider those recommendations. We also align with the Canadian Armed Forces. We look at what drugs they have, because when the veterans are released, especially for medical reasons, we want to make sure we have the same drugs on our formulary so there are no gaps in health care as they leave the military.

We've done a lot of work since the report of the Auditor General. It was timely and useful for us to look at those recommendations and to make important changes to the way we manage the drug program.

There have also been some product listing agreements that we're looking at so that if a drug is bought by a federal agency, all the other federal agencies have the opportunity to have the drug at the same favourable price that we've negotiated with the producers.

We've done a lot of changes to the drug program.

The Chair: Thank you.

For four minutes, Ms. Ludwig.

Ms. Karen Ludwig: Thank you, Chair.

Thank you both for your presentations today.

I'm wondering about the prescription itself. The first time someone asks for a prescription for marijuana, is the prescription automatically for a year?

Dr. Alexandra Heber: First of all, it's not a prescription. It's called an authorization, because in fact, unlike other medications that are prescribed by a physician, this is a natural plant that is being.... It's called an authorization. Obviously, the thought behind this was that a veteran or other person in Canada would go to their own physician. They would discuss all the pros and cons of using marijuana versus an antidepressant or something else for their condition, a decision would be made, and the person would be followed.

Unfortunately, in a lot of cases that's not what's happening. We have a small number of physicians who are authorizing a great amount of cannabis for veterans. If a veteran is being followed in one of our operational stress injury clinics, it would not be that psychiatrist. Some of them have, with the patient, tried them on cannabis, but the large majority are getting it from a physician outside of that care team.

This is a problem. I don't think it was a problem anybody could have anticipated, but unfortunately, there's a lot of profit to be made in cannabis.

● (1715)

Ms. Karen Ludwig: It sounds, Dr. Heber, that a lot of this has evolved over the course of time. I find it surprising there's been such a little amount of research since 2008. In fact, a number of the vets who are using marijuana as a form to try to manage PTSD are probably on other medications as well. Is there any research out there to look at the cross-referencing of medications and the adverse effects?

Dr. Alexandra Heber: Again, there's very little at the present time.

Ms. Karen Ludwig: Would you recommend that as an area for research?

Dr. Alexandra Heber: Absolutely. All of this should be researched.

What has happened is the use of marijuana, especially for medical purposes, has far outstripped the research, unlike what we would do with any other medication.

Ms. Karen Ludwig: I represent an area in New Brunswick. I know all of the usage in that province in particular. One of the companies in my riding of New Brunswick Southwest is actually a medical marijuana company well known for the research that has been done there, but they also do the testing on the different strains. Everything is bar coded. In terms of their research specifically they're focusing on PTSD. They will work through a group of doctors, and if there's an adverse effect, they're trying to go back to a particular stage in the processing of it. The other problem they're also recognizing is not everyone wants to take marijuana in a smokable form. They would rather have it in pill form or other forms.

I heard a number of veterans complain when we went from 10 grams down to three grams. Is it in fact the case that if a doctor gets recommended for the authorization the person could get an increase above three grams if it's approved by a doctor or a specialist?

Dr. Cyd Courchesne: What was your question again?

Voices: Oh, oh!

The Chair: It was a long question. If you give the question, you will have to get back to the answer.

Karen, if you have it, we're just....

Ms. Karen Ludwig: The question was basically looking at the 10 grams down to three grams.

Dr. Cyd Courchesne: We decided on a cap of three, because that's all the science and the information we could get from users, but everything above is on a case-by-case basis.

The Chair: Ms. Wagantall.

Mrs. Cathay Wagantall: Thank you very much.

I would just mention that the research is absolutely critical, and we do need to collaborate with other places. Israel would be a good place to collaborate with, I would say, if you're interested in that. They've done a great deal of research specifically on the medical cannabis.

Dr. Cyd Courchesne: Their average usage is 1.5 grams a day.

Mrs. Cathay Wagantall: Yes.

As an anecdotal example, I have a close friend whose husband has been bedridden for eight years on 1,000 pharmaceutical pills a month. His life is being fed, turned over and surviving a great deal of physical and digestive pain due to the pharmaceuticals he's taking, including three stronger than the opioids that people are struggling with right now. He's very much reliant and bedridden.

Someone said to his wife that she had to at least try. She did have the opportunity to get 10 grams in suppository form, which is why she needed the 10 grams. So it's definitely not doing it for pleasure or fun. After his first receiving it, she had her first real conversation with him within half an hour of his receiving the suppository. From there he wanted to go forward with gradually reducing the pharmaceutical load that he was being given. She could not find a doctor who was willing to work with her on that, so she did it on her own, which is very dangerous. To make a long story short, eventually, a year ago, and a year into the process, he walked into my office. He walked into his doctor's office and the doctor's jaw hit the floor, and he said, “What's going on here?”

There are a great number of veterans, I believe, who are discovering there are options to pharmaceuticals, and that the side effects are significantly less damaging to their lives than the effects of multiple pharmaceuticals. So the research really does need to be done. I'm wondering, with the decision of the Auditor General seeing the spike in use, and the spike in expense to the government and to VAC, when you went to research this did you look at what it costs annually to the department for pharmaceutical medications that are used by our veterans? Do you have a number on that?

● (1720)

Dr. Cyd Courchesne: We do.

Mrs. Cathay Wagantall: Can you quickly tell me what it is?

Dr. Cyd Courchesne: I can't right now.

Mrs. Cathay Wagantall: Is it comparable?

Dr. Cyd Courchesne: Well, it's more, because people take way more medication than they use cannabis.

Mrs. Cathay Wagantall: As people were starting to use cannabis, was there a decrease or did it stay the same? Was there an increase in the use of pharmaceuticals at the same time?

Dr. Cyd Courchesne: As I mentioned to your colleague here, we did look at that. We did not see a decrease.

Mrs. Cathay Wagantall: You looked at exactly how much was being spent within the department on pharmaceuticals versus how much—

Dr. Cyd Courchesne: Yes, but all pharmaceuticals are not all for mental health problems, so we—

Mrs. Cathay Wagantall: No, I understand that. I'm talking about PTSD, I would suggest, or depression or those types of issues.

Dr. Cyd Courchesne: We didn't see a concomitant decrease with —

Mrs. Cathay Wagantall: Okay, but do you know how much money was spent on comparable prescriptions for pharmaceuticals?

Dr. Cyd Courchesne: Well, we looked at the total of what we spent on medications per year.

Mrs. Cathay Wagantall: Are you not able to determine how much is due to the same types of conditions that you would treat with cannabis? We really don't have numbers on that.

Dr. Cyd Courchesne: Well, it's difficult because, again, we're not a health care system. These are not patients we follow, who we have any—

Mrs. Cathay Wagantall: We're talking about money being spent, and that was the flag.

Dr. Cyd Courchesne: Yes.

Mrs. Cathay Wagantall: Okay, so now we're spending far less on cannabis, because we've controlled the amount being given to them. I'm not suggesting that there are issues there, because they can get more if they need it. I guess my concern is that, if we're going to look at this, we need to look at it holistically with what we are prescribing to our veterans to deal with those specific issues. There is a great deal of anecdotal evidence in other countries doing research. I think it's important that we do due diligence to find out these decisions.

Do you have a list of the doctors, how many across Canada are involved in authorizing?

Dr. Cyd Courchesne: Well, we could get that information from Blue Cross, because they're the ones who collect all the.... There are more than a handful. We have 8,000 people who are receiving authorizations from their physicians.

Mrs. Cathay Wagantall: I'm aware of one in my province who can give authorization.

Dr. Cyd Courchesne: Right, every doctor in Canada can give authorizations. If you have an MD or if you're a nurse practitioner with that scope of practice in your province, you can provide that, so the list would be very—

Mrs. Cathay Wagantall: It's a question of how many, I guess. That's what I'm asking. How many are authorizing at this point?

The Chair: We'll have to come back for that answer. We're out of time.

Dr. Cyd Courchesne: Absolutely.

The Chair: We'll end with Mr. Samson. I think you're splitting your four minutes.

Mr. Darrell Samson: Yes, I have two quick questions. In talking about specialists, in Nova Scotia we don't have a specialist who can authorize or who does authorize—zero. We've asked VAC to help us out now for two years and we haven't had any success.

Dr. Cyd Courchesne: Well, any specialist can authorize.

Mr. Darrell Samson: There's no specialist in Nova Scotia who's able.... There's only one and he doesn't authorize.

Dr. Alexandra Heber: Again, as a physician—

Mr. Darrell Samson: I'm talking about 10 grams over three grams, specialists.

Dr. Alexandra Heber: Yes, so what you're asking of a physician is to authorize something for a patient, and there's no evidence of what it does—

Mr. Darrell Samson: That's not my question, Doctor.

Dr. Alexandra Heber: If it's for a mental health problem, any psychiatrist can authorize over three grams for a veteran.

Mr. Darrell Samson: There's no one in Nova Scotia who authorizes.

Dr. Alexandra Heber: Well, they may not do it, but what I'm saying is that they can.

Mr. Darrell Samson: Yes, but VAC, are you helping to find doctors who do?

● (1725)

Dr. Alexandra Heber: No.

Dr. Cyd Courchesne: Our policy is to reimburse. My main concern is the well-being and the safety of the veterans.

Mr. Darrell Samson: Of course.

Dr. Cyd Courchesne: When there is a substance that has no proven effect—

Mr. Darrell Samson: Doctors, with all due respect, that's not my question. The question is: Is there a process for receiving more than three grams?

Dr. Cyd Courchesne: Yes.

Dr. Alexandra Heber: Yes.

Mr. Darrell Samson: That process is not available in Nova Scotia.

Dr. Cyd Courchesne: It is. The specialists are not willing, because there is no evidence. They're not willing to provide that authorization to their patients, because their concern is for the well-being of their patients. I cannot force—

Mr. Darrell Samson: With all due respect, Doctor, in other provinces, specialists do so. I'm sure they feel that they are doing the right thing for the veterans. That's my only question. It's unfair for certain provinces to not have access. It's not pushing for or against; I'm saying it's unfair to those veterans.

What type of research would we do? I don't know how I feel, because veterans are sharing their stories. I'm not saying that everybody is right, but I would like to believe that, if I'm getting 100 veterans telling me stories of how it's successful, we are at least trying to analyze, maybe, what is successful and why marijuana is having an effect or not. I get this feeling that their stories are not being considered.

Dr. Cyd Courchesne: We have heard their stories. That's why we have taken anecdotal evidence into account. Even though we know that anecdotal evidence is not scientific evidence, the lack of evidence in the literature right now does not mean there is no evidence.

Mr. Darrell Samson: That's correct. So—

Dr. Cyd Courchesne: That's why, with the anecdotal evidence and the best scientific evidence available, we landed on three grams, which is twice the amount of what Canadians are using now for medical purposes, as released in today's Health Canada report, the survey on cannabis—

Mr. Darrell Samson: We're heading in the same direction now. That's very good.

What research do you foresee where we could take what's there and the testimony to try to dig deeper?

Dr. Cyd Courchesne: Right now we have the best with the evidence we have. If good, solid clinical research comes about that looks at any positive effect of ingesting cannabis in any form you want, and a change in symptoms or positive outcome, we will take that into consideration. But that will need to be done by the scientific, academic, clinical community.

The Chair: Thank you.

Dr. Alexandra Heber: We are looking at having that research done. We are collaborating actively. I'm going to give you a list of three scientists working in this field who have great reputations and receive no funding from cannabis producers. This is going to be very important. When you interview people, the first thing you should find out is whether or not they're receiving funding or have some connection to the cannabis industry.

The Chair: Doctor, thank you, and if you could get those names and that information back to us, it would be appreciated.

On behalf of the committee, I'd like to thank both of you for coming today, and for all you do for the men and women who have served.

We need to break and clear the room quickly. We have about two minutes of committee business.

[*Proceedings continue in camera*]