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Mr. Neil Ellis

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● (1530)

[*English*]

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

This is our 100th meeting. The Standing Committee on Veterans Affairs resumes its studies on homeless veterans and on medical cannabis and veterans' well-being.

In relation to the study on homeless veterans, we are pleased to welcome Debbie Lowther, chair and co-founder of VETS Canada; and Ray McInnis, director of veterans services, Dominion Command, along with Dave Gordon, homeless veterans representative, Dominion Command of the Royal Canadian Legion.

Unfortunately, Ken Hoffer, president of the Society of Atlantic Heroes Recovery, had to decline his appearance for health reasons. He'll try to appear at his convenience.

Witnesses, you have up to 10 minutes for your opening statements. A round of questions will follow.

I'll start with Ms. Lowther.

The floor is yours.

Ms. Debbie Lowther (Chair and Co-founder, VETS Canada): Mr. Chair, ladies and gentlemen of the committee, my name is Debbie Lowther. I am the chair and co-founder of VETS Canada. Thank you for the invitation to appear before you today, and thank you for undertaking this very important study of homeless veterans. It is a privilege for me to be here to share some of our insight as it pertains to the topic.

VETS Canada is a national not-for-profit organization with an aim to provide assistance to veterans of the Canadian Armed Forces and RCMP who are homeless or who are at risk of becoming homeless. We were founded in 2010 and are located across the country, with hundreds of dedicated volunteers who directly assist veterans. With a headquarters in Halifax and our volunteers across the country, we have responded to over 6,000 requests for assistance from veterans and their families from coast to coast, 24 hours a day, seven days a week, including holidays. We are currently taking between 200 and 300 requests for assistance each month.

Those requests come to us in a variety of ways, through our 1-888 phone line, our website or social media platforms, and most recently through our newly opened veterans drop-in and support centre here in Ottawa as well as our recently announced veterans support centre in Edmonton. Some of those referrals are from other organizations or agencies. Approximately half of our referrals each month come from Veterans Affairs Canada case managers.

Since 2010 we've certainly learned a great deal about veteran homelessness. We've learned that there is a uniqueness to it that sets it apart from civilian homelessness. To understand veteran homelessness, one must first understand that serving in the military is not just a job or a career; it is a culture all on its own. When you serve in the military, it becomes your identity. Military members are those who are willing to lay down their lives in service to their country, and in order to do so, they develop incredible bonds with their fellow military members.

We know that there are many pathways into homeless, such as poverty, lack of affordable housing, job loss or instability, mental illness and addictions, physical health problems, family or domestic violence, and family or marital breakdown. What sets veterans apart is that they not only deal with all of these same issues but they also struggle with their transition from military to civilian life. I talked about the military being a unique culture. Well, now the veteran is trying to adapt to a new civilian culture, feeling as though they have lost their identity and doing so without the social support network that was always so important.

Our organization conducted a very informal research project. We surveyed a small sampling of veterans we had assisted. We were surprised to hear that the majority of veterans surveyed identified a lack of social support as a bigger issue than health concerns or financial issues.

That survey also told us that the first episode of homelessness did not occur for an average of 11 years post-release. The average length of service was less than 10 years, so there was no annuity in place, and the ranks were sergeant and below.

Since you are the Standing Committee on Veterans Affairs and since half of our referrals come from the department each month, I will talk about our experience as it pertains to our efforts to assist homeless veterans in collaboration with the department.

In 2014 we were awarded a contract by Veterans Affairs Canada, making us their service providers in the field of homeless and in-crisis veteran outreach. That contract ended at the end of September of this year and was not renewed or extended. We were told in June that this would be the case, but we were told to apply for the new veteran and family well-being fund. We were told on September 28 that our application had been approved.

To be clear, we are grateful to the government for the new funding, but the funding that we asked for as part of this new source of funding, based on an increasing need in this area, was only partially approved by the department. We received only half of what we asked for, half of what we need to do our work assisting veterans and their families. As I said, we are grateful for the funding but disappointed that the department has determined that this issue of homeless veterans does not warrant a dedicated service provider.

On June 7 this year, Veterans Affairs held a round table on veteran homelessness which included people from over 60 organizations. The group included researchers, staff from organizations that serve veterans but not specifically homeless veterans, as well as staff from various shelters across the country. VETS Canada, the Royal Canadian Legion, and maybe two or three other organizations were, honestly, the only groups who could say that they occupy the homeless veterans space specifically. Many of the people who were in my breakout group were very frank about the the fact that they were there to learn, because while they may have veterans accessing their shelters or services, they did not have an understanding of the uniqueness of veteran homelessness.

● (1535)

One of the outcomes of this round table was an interactive map, featured on the Veterans Affairs website, with links to over 100 organizations across the country. Most of those organizations are shelters. I count only eight veteran-specific organizations, and of those, one is an organization that brings groups together to network and raise awareness. It does not provide a service to veterans. Two are organizations that are in the process of building housing for homeless veterans, but at this point that housing does not exist.

The interactive map has the Royal Canadian Legion located in Ontario only and VETS Canada located in Halifax only, when we are both national organizations.

My intention here is not to sound critical or negative, but this has become a very crowded landscape and more than anything, homeless veterans, like all homeless people, want to receive help from a credible organization that is going to deliver on what they say they can do. They're not interested in dealing with a connecting agency or a middleman that is just going to refer them to someone else.

We do not naively think that one organization can solve this issue. We realize it takes a collaborative effort, but we also know that a veteran is more likely to accept help from someone who speaks their language, who understands their culture and who can provide immediate support.

In closing, VETS Canada will continue to do its work, regardless of the support we receive or the challenges we face. Our commitment remains strong and resolute, that being to provide emergency support to veterans and their families in need, 24 hours a day, seven days a week, from coast to coast.

Mr. Chair, thank you.

I look forward to your questions.

The Chair: Thank you, and now we'll turn the floor over to the Royal Canadian Legion.

Mr. McInnis.

Mr. Raymond McInnis (Director, Veterans Services, Dominion Command, Royal Canadian Legion): Honourable Chairman and members of the parliamentary Standing Committee on Veterans Affairs, thank you for inviting the Royal Canadian Legion to address you today on your study, which will focus mainly on the challenges faced by homeless veterans, the causes that lead to their homelessness, and Veterans Affairs Canada's efforts to address this issue.

On behalf of our dominion president, Comrade Tom Irvine, and our members, I am the director of veterans services at the national headquarters of the Legion here in Ottawa. With me today is comrade Dave Gordon, the homeless veterans representative on our national veterans service and seniors committee.

I'd like to start with some important background that I think is a crucial backdrop to addressing possible solutions. While in the military, individuals are indoctrinated into a regimented system, believing that this system will always look after them. They accept the military culture of teamwork, and rely heavily on that team for support. It becomes part of their very fabric. For some, leaving that lifestyle is a difficult process. Many never truly leave the military culture.

Many factors can impede a smooth transition from military life. Each individual undergoing transition has unique challenges. Military life provides a secure and stable financial environment even when operational deployments are dangerous. Service personnel and their families grow with the military culture and have relatively comfortable lives. In essence, the military is part of their extended family. The bond is strong, and it is hard, if not impossible, for some to break.

The range of issues today, from mental health to severe disability, also complicates the transition process. Mental health is often an unseen disability. Acceptance of the problem, with programs designed to benefit those suffering, has yet to be fully realized. Stigma is a major factor, although great strides have been made to overcome it. Often, multiple disabilities combine to create very complicated cases involving not only physical but also mental health issues. Long-term treatments can be required before someone can achieve their new normal.

The question we need to consider is this: What is the best course of action to help such individuals, people who can ultimately slide down that slippery slope towards homelessness? Regardless of the stage of service—before, during, or after—it is important that all personnel understand the consequences of their service and have confidence in the system. Frankly, it starts here, with the support of the government that ultimately makes the decision to place Canadian service personnel in harm's way. Personnel have to understand and truly know that the system they have been indoctrinated into will look after them and their families without fail.

I'd like to share a little more perspective. Even in normal, non-injury transitional situations, I have seen people who have difficulty leaving the sanctuary of military life. Everything was provided for them. Now they are left to deal with what feels like a foreign world to arrange health care and other services that were once provided by the military. For those who are transitioning with more complex issues, extra care is needed. Knowledge and communication are paramount throughout a military career so that those who need assistance know how to access it. I must emphasize again that whether issues are apparent or not, people who leave service need to understand and trust that support will be there when and if needed.

The Canadian Armed Forces stated that it would revamp the complete transitional process and ensure that only those who are fit to be transitioned are. Close coordination between the Department of National Defence and Veterans Affairs Canada are essential to ensure that no one falls through the cracks and that continuous support is provided throughout. The ultimate aim is that a service person and their family can smoothly reintegrate into life outside the military. This will be a much-needed and positive step.

I mention all of this because it is crucial to know about a veteran's state of being during the transition period in terms of understanding the fundamental factors that can contribute to homelessness.

The Royal Canadian Legion has learned a lot about homelessness over the years, and I'd like to provide a basic overview. We help veterans and their families members get off the streets and turn their lives around through national and provincial programs. We offer financial assistance and other supports for homeless veterans and for those who are at risk of homelessness.

In 2012 the Legion established a national homeless veterans program called Leave the Streets Behind. It was based on the groundbreaking work of Ontario Command a few years earlier. The program's mission is to reach out to homeless or near-homeless veterans by providing immediate financial assistance and support when and where needed. It also connects them with the appropriate social and community services to establish a long-term solution to meet their needs.

● (1540)

We committed $500,000 towards combatting homelessness in 2012. We are still working towards the goal of ensuring that every Legion provincial command establishes a homeless veterans program tailored to meet their unique regional and community needs.

Ontario's was the first provincial command to develop and offer the Leave the Streets Behind program in November 2009. Through their efforts, the Legion established a network of support through Veterans Affairs and various shelters across the province to provide transition assistance to homeless veterans. Through the generosity of Ontario Command branches and the Legion's ladies auxiliaries in the region, they have disbursed over $2 million. They have a partnership with Mainstay Housing in Toronto and are supporting three locations in Toronto: Parliament Street, Bathurst Street and 10 apartments in the Pan Am village. To date, Ontario Command has assisted 667 homeless veterans in 139 communities in Ontario, and that includes 62 female homeless veterans.

B.C./Yukon Command provides financial support for Veterans Manor in Vancouver's east side and for Cockrell House in Victoria, a transition house that is presently full. There are nine rooms there, and they are constantly full.

Alberta/Northwest Territories Command operated a food bank for over 20 years and today works directly with the Calgary Food Bank to assist many veterans in the community. The command is also engaged with first responders, social services and Veterans Affairs Canada in identifying and assisting homeless veterans. Although they do not keep detailed statistics, their estimate for providing emergency shelter for veterans in the past three years would be over 60 veterans and families. The number of veterans who they have helped with rent to ensure they do not become homeless would be more than double that number.

Nova Scotia/Nunavut Command launched the veterans outreach program, bringing together community resources and establishing partnerships to provide proactive assistance to homeless veterans.

Those are four key examples of concerted work in the area of homelessness within our commands. Not all commands collect statistics on homeless veterans with the same detail as the Ontario Command, but all branches and commands have assisted homeless veterans in various ways.

I can tell you that the overarching message is clear: The system of helping homeless veterans is not one size fits all. We all know that the reasons for homelessness are complex and are the result of the combination of a number of factors: mental illness, substance abuse, poverty, a poor labour market, a decrease in affordable housing and catastrophic events such as family violence or family breakup. We have learned that giving someone a roof does not fix the problems that pushed him or her into homelessness in the first place. We first ensure that they have secure shelter and work with them to determine the problem and then the best way to solve the root of the problem.

We have heard, for example, that some homeless veterans do not actually want the social responsibility of having and maintaining accommodations. While there is no single solution, we felt that we had to start somewhere. Recognizing the need for a coordinated national strategy to address the issues facing homeless veterans, the Legion coordinated and hosted a homeless veterans forum in April 2014. This meeting brought together national organizations working with homeless individuals, but with a key focus on veterans. It was determined that further efforts to address veterans homelessness could benefit from establishing a smaller working group to define the best path to combat veteran homelessness.

The Royal Canadian Legion Veterans Homelessness Advisory Committee was formed and is chaired by our dominion president. There are representatives from Veterans Affairs Canada, CAF, the Salvation Army, the Good Shepherd Ministries, the Mental Health Commission of Canada, ESDC, the Ontario provincial command of the Legion and VETS Canada.

Together, we are gaining a better understanding of the problem and are networking and discussing solutions. The forum and our working group have helped identify priority areas and knowledge gaps. Let me name the key ones: transition barriers; outreach and communication; services and programs; and, accessibility and coordination of efforts.

Why do we have so many homeless veterans? Consultations like the ones I've just described have told us why. Now we need to focus on solutions.

Veterans Affairs Canada is the department responsible for looking after our veterans, so I ask now, why doesn't Canada have a national strategy on tackling veterans homelessness? In 2016 we were briefed on a VAC homelessness strategy and action plan in the works that would be veteran-centric, evidence informed and outcome based. We were told that it would enable VAC and partners to better find and assist homeless veterans and veterans in crisis and prevent veteran homelessness. To date, we have seen no sign of progress.

Comprehensive case management to include assistance in finding housing and connections to supports within the community are required now.

● (1545)

A life skills program to provide learning and networking opportunities for veterans is needed now. Veterans served and sacrificed for our country, and it is our duty to now stand for them and ensure that they have access to the care and support they need.

On behalf of all of our veterans, I ask, when can we expect a national strategy to combat veteran homelessness?

Chairman, we thank you for the opportunity to make this presentation, and we await your questions.

The Chair: Thank you.

Mr. McColeman, you have six minutes.

Mr. Phil McColeman (Brantford—Brant, CPC): Thank you, Chair.

Thank you, Ms. Lowther and Mr. McInnis, for your two organizations' focus on this all-important issue of veterans homelessness.

A couple of weeks ago, we found out that the veterans emergency fund six months into the fiscal year had only 35% of funding remaining. The question was asked as to what will happen after the fund is depleted. The answer was that the government would fall back on your organizations to pick up the slack. Were you aware that this was the comment of the government? What's your reaction to it?

Mr. Raymond McInnis: No, I was not aware that was the comment made.

I know of the veterans emergency fund. We've been dealing with it since it came out across the country in various forms. We have always, I would say, backed up the emergency fund on many occasions across the country, but I was not aware of that statement. Why could they not reload that budget? If the budget is for the emergency fund and there's money, in fact, that should be replenished based on how much they're using and the number of occasions. I have yet to see the budget saying 35% left, or how much they had. I know they can contribute up to only $2,500 per individual. We contribute more than that, so I'd like to see more than that. It should be replenished.

● (1550)

Mr. Phil McColeman: Do you have any comments, Ms. Lowther?

Ms. Debbie Lowther: I also had not heard that statement, but I can say that, even with money still left in the emergency fund, we are backing them up now in situations where they cannot authorize use of the emergency funds or in cases where they don't want to submit the application for the emergency funds. They are relying on us now even with funds remaining in the fund.

Mr. Phil McColeman: Your testimony was that you are receiving about half of what the demand and need from Veterans Affairs Canada is. Is that 50% shortfall then picked up through the other revenue you receive from other organizations that back your work?

Ms. Debbie Lowther: Yes, the shortfall is picked up through private donations from kind and caring Canadians.

Mr. Phil McColeman: Are those coming through organizations like True Patriot Love and others that are fundraising for veterans on various fronts?

Ms. Debbie Lowther: Yes, we have in the past received a few grants from True Patriot Love.

Mr. Phil McColeman: Okay.

Mr. McInnis, are there any comments from you? Is this coming out of poppy fund revenue? Is it to pick up the shortfall that the government's not funding?

Mr. Raymond McInnis: I wouldn't call it a shortfall that the government's not funding so much as if there's a veteran out there who's in financial need—as you know, or maybe you don't know, the Royal Canadian Legion doesn't accept any government funding. All of our funding is done through the poppy fund and operational funds. We have a national Dominion Command poppy trust fund. Every command has a trust fund as well. Certain commands, like Ontario—and I'll let Dave speak to that—have their own homeless veterans fund. When it comes to the poppy fund, as long as the veteran is in need and they come to us, we will assist them.

Mr. Phil McColeman: Okay.

We read in our briefing documents that a survey done by ESDC estimated that there are approximately 2,250 homeless veterans on the streets. Does that number jibe with the numbers you're experiencing in terms of demand, 2,250 on the streets? I shouldn't say on the streets. I guess the word is homeless. Sorry.

Mr. Dave Gordon (Homeless Veterans Representative, Dominion Command, Royal Canadian Legion): I would suggest to you that it's a false statement. I was asked by a reporter, probably four years ago now, how many homeless veterans there were. I answered, “How many snowflakes fell in the last snowstorm? Nobody knows.”

Mr. Phil McColeman: Okay.

Mr. Dave Gordon: We're finding that a lot of veterans don't want to identify. In fact, in my hometown we have a homeless veteran living in a tent. We recently offered to get him off the street. His basic response was, “Leave me alone. I don't want your help.” There are individuals who do not want help.

As to the number, 2,000 or whatever it was, nobody knows.

Mr. Phil McColeman: I understand with regard to the issue of the veteran who is out there. In fact, some homeless people care not to have help for whatever reason. What techniques do you have or what things are you doing to address the issue and to make a breakthrough to the individuals you discover are veterans? Are you doing anything that you consider to be innovative in terms of an approach that brings them out of the condition they have found themselves in?

Mr. Dave Gordon: When we first started, we offered a shopping bag from Shoppers Drug Mart. We went through Moss Park one time in Toronto and saw seven of those bags. We offer kits, or backpacks now, to Veterans Affairs. Most Veterans Affairs offices in Ontario have them. Hopefully, they'll be across the country soon. We offer those. A lot of times it takes more than one visit or one chat with a homeless veteran to get them to trust. Maybe it will be the second or third time we'll offer the backpack or the veteran's caseworker will offer the backpack.

We also provide gift cards, such as Tim Hortons cards. We'll take them to Tim Hortons and sit down and have a coffee and donut or sandwich or whatever it is they want. We offer them gift cards. If we find accommodation for them, our ladies' auxiliary will furnish the apartment. We provide apartment kits with a $250 value. They have dinner plates, any cutlery, or whatever you need to start up in an apartment.

We just signed this week our third dental program with St. Joseph's Health Care in London. We also have a dental program in Ottawa and Toronto.

● (1555)

The Chair: Thank you.

Mr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair.

I'd like to thank all of you for coming.

Ms. Lowther, could you speak to what metrics you use to identify and track veterans who are either homeless or at risk of being homeless? Are there any indicators that can be used to help track this?

Ms. Debbie Lowther: We use a two-pronged approach, proactive and reactive. Proactively, we have volunteers who actually go out into the streets. They walk the streets and visit the shelters looking for veterans and offering assistance. On the reactive side, we do take referrals from other organizations and from veterans themselves.

With regard to tracking them, we do keep a comprehensive database of all of the veterans who come our way. A good portion of what we do is on the prevention side. When veterans come forward who may not be homeless but look like they're on that trajectory, we pay closer attention to those veterans. We want to get to the root cause of why they are at risk.

Mr. Doug Eyolfson: Thank you.

Mr. Gordon and Mr. McInnis, do you have anything to add to that?

Mr. Dave Gordon: We have a one-page document for them. When we first started, we had a six-page document, but we cut it down to one page. Veterans just don't want to fill out a lot of paperwork. We have a document that we can have faxed to our office. Depending on the time of day we receive it, we can react.

I can tell you that we have the names of every veteran who's come forward and who we've identified. We can go back in their file and see the help we've given them. We're very happy to say that we've housed about 350 of the 667 that we've found.

We have very extensive stats. We do, as I said, 134 towns and cities; we have found 280 in Toronto, 45 in London, 45 in Kingston, seven in Trenton, two in Belleville, and the list goes on. We have those stats. We can back them up and we can show you the exact amount of money that was spent for any part of that in any one of those towns or cities.

Mr. Doug Eyolfson: All right. Thank you.

Ms. Lowther, I just want to make sure I have this correctly. You said it's on average 11 years after discharge that they become homeless. Is that right?

Ms. Debbie Lowther: Yes. We did an informal research survey with a small sample of veterans, and within that sampling of veterans the average length of time from release from the military to their first episode of homelessness was 11 years.

Mr. Doug Eyolfson: Okay. Thank you.

When you're gathering this information, are you able to gather any trends as to how long they had the troubles that led them to homelessness? I'm assuming that if it took 11 years, they weren't on that trajectory for 11 years. Is there a time frame or are there any common events that you'd say, such that things were going on an even keel for this long and that so many years out, *x*, *y*, or *z* started to happen? Are you noticing any trends in either time frames or events? I know you mentioned some of them, like spousal abuse, substances, and these sorts of things.

Ms. Debbie Lowther: We didn't specifically ask those questions, but what we do know is that often mental health issues, particularly PTSD, take a period of time before the symptoms rear their ugly heads, so to speak. That is one reason why it takes 11 years. The other reason why it can take 11 years is the fact that veterans have great survival skills, so they can kind of get through on their own for a while before things get out of control.

● (1600)

Mr. Doug Eyolfson: All right. Thank you.

Mr. Gordon and Mr. McInnis, do you have anything to add to that?

Mr. Raymond McInnis: Nationally we don't have stats on that nor do we have a lot of research in Canada on Canadian veterans homelessness, but in Ontario....

Mr. Dave Gordon: In Ontario, we've tracked from two and a half to four years, maybe five. We've found that they have become homeless. By the way, our numbers are anywhere from age 17 to 92.

Mr. Doug Eyolfson: All right. Thank you.

We talked about mental illness. I worked in the emergency department for a number of years, and we knew that the vast majority of the homeless in general—not just veterans, but the homeless population—are people with untreated or undertreated mental illness. Has there been any data on the number of these vets who had any underlying mental health diagnoses before their military service? Is that information out there?

Ms. Debbie Lowther: Those aren't stats that we keep, but I can tell you that a number of veterans who we have assisted have disclosed not necessarily that they dealt with mental health issues but that they had dealt with childhood trauma prior to their military service. In some cases we know that their military service has maybe aggravated their predisposition to post-traumatic stress disorder.

Mr. Doug Eyolfson: All right. Thank you very much.

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

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you, Mr. Chair.

Thank you for being here, again. I think it's a testament to your determination to address the needs of veterans and make sure that those who have been left behind are taken care of, and I am very grateful for that.

I want to start with you, Ms. Lowther. Last time we met, you indicated that your contract had ended and that you had nothing and you didn't know what was going to happen. You say that the funding has been partially approved. What does that mean for VETS Canada? How does that impact your organization and what you're trying to do?

Ms. Debbie Lowther: Basically we have a very strong determination that we will just continue to continue on. It does mean that we may have to direct some of our focus toward fundraising. We are currently looking at seeking out the assistance of a professional fundraiser to help us increase our private donations. To be clear, the amount that we got from the family and veteran well-being fund was the same amount that we had received previously under our old contract, so it's not that we received less money. What we did when we submitted our proposal was to look at our increase year over year from the past couple years, and we were able to project the amount that we would need for the coming year, but that's not the amount that we got.

Ms. Irene Mathyssen: Okay, so obviously you're finding more and more homeless vets and they have to be taken care of.

You didn't get a chance to answer this before. What is your estimate in regard to homeless veterans in Canada? Is there any idea? We know that the department says that there are about 2,250 people who have used homeless shelters this year, but is that just the tip of the iceberg? What is your estimate?

Ms. Debbie Lowther: On that number, the 2,250, we do know that it was based on a database that's utilized by about 60 shelters across the country. That does not take into consideration veterans who may be using shelters that don't use that particular database.

It also does not take into consideration those veterans who aren't accessing shelters at all, which we know is the more common scenario. Veterans don't tend to use the shelter system. They tend more toward being couch surfers or living in their cars or surviving rough in the woods. That 2,250 is obviously a very low estimate.

I do like Mr. Gordon's comment about how many snowflakes fell in the last snowstorm, because that's about how difficult it would be to capture that number.

● (1605)

Ms. Irene Mathyssen: Thank you very much.

As I'm sure you know, this Parliament passed unanimously a motion to take all the lapsed spending, put it on the table and make sure that veterans receive that lapsed spending. It was an interesting motion, with 301 in favour to zero. This motion would have provided about $124 million per year to improve services to Canada's veterans, to hire more case managers and to just make sure that veterans were a priority.

If that motion were adopted as policy—we have it on the books, everyone said yes, wonderful, love it—and it actually were to be put in place if they put the money where their mouth is, would the spending from this fiscal year to the next fiscal year ensure that we would be able to speed up approvals for processes and for applications for veterans trying to utilize the emergency fund?

Ms. Debbie Lowther: I do think that if that money were to be utilized.... My understanding of the money being returned is that it was not used for the purpose it was earmarked for and that it could not be used for anything other than that. If the scenario were that the money could be utilized in any way possible, I do think that hiring more case managers, and particularly adjudicators, would definitely help to clear up the backlog of clients.

Ms. Irene Mathyssen: It's interesting, isn't it? We have this pot of money here, but the prescription for it is somewhere over there, so we can't use it. It has to sit in the federal vault, I guess.

I would like to address this to all of you, but I don't know if I have enough time. I still deal with individual cases, with people who are desperate.

There is the case of one young man with PTSD. He was diagnosed quite some time ago. He has attempted to kill himself five times. Every time he thinks that he has a connection with Veterans Affairs Canada, something gets in the way. For example, because of the PTSD, he calls all the time. Once he gets to a certain point in terms of the number of calls, they block him. They cut him off. Just recently, he was cut off on a Friday afternoon, and there was nothing until Monday. This is someone who has attempted suicide five times.

Do you hear about these cases? It would seem to me that if he survives, he is probably going to be homeless at some point. I'll defer to you.

The Chair: We're out of time.

Ms. Irene Mathyssen: I'm sorry.

The Chair: If you can make it very quick....

Mr. Raymond McInnis: Very quickly, yes. As command service officers and service officers in Dominion Command, we actually act as intermediaries with the department in terms of many individuals who, for some reason, whether it's phone calls or they threaten someone, are no longer able to work with Veterans Affairs Canada. The command service officers will assist them, work with them and be the contact with the department for them, so that they don't go into homelessness or any other act.

The Chair: Mr. Bratina, you have six minutes.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): This is a good conversation, and we need to have it.

One issue that keeps coming up, which is very interesting and difficult to deal with, is creating a national strategy for homelessness. When I talk to non-military people and chat about my work with the veterans affairs committee, they think that homeless veterans are in the general population for shortages of housing.

I'm hearing—and perhaps, Ms. Lowther, you could speak to this—that there are veterans who are victims of housing shortages, perhaps in the area of the country where they live, but that many of them also have avoidance behaviours, and they just don't want to be part of anybody's system anymore.

Would you agree that it's going to give us difficulties—not that we're going to hesitate or not move towards that—in creating recommendations for a housing strategy? It will have to be much broader than saying to build more houses. Is that a fair comment?

● (1610)

Ms. Debbie Lowther: Yes, I think building more houses is not necessarily the solution. I think affordable housing is definitely part of the solution.

I've been asked before whether I think that veterans should be considered a specialized population. What I mean by that is whether they should be given priority for housing over another person. If you asked my husband that, he, as a veteran, would say that he would not accept that. In the military he would have been taught that you would give up that housing for somebody else who needs it more.

My personal opinion is that I think veterans should be considered a specialized population and they should be given priority for housing.

Mr. Bob Bratina: Mr. McInnis, could you comment on that as well?

Mr. Raymond McInnis: I believe that we need a lot more affordable housing. With the affordable housing, we also need a lot more case management services. For that—

Mr. Bob Bratina: —program.

Mr. Raymond McInnis: I mean for the whole program.

To go back to the other question about if we had more money—especially on the adjudication side, there are 38,000 backlog claims. People are waiting over a year and a half or two years to have a claim adjudicated.

Under the new Veterans Well-being Act, that changed on April 1, but they have no treatment. It's not like the old Pension Act under which they could get treatment, and then if their claim was favourable, they'd be paid for it. There are people out there waiting for their claim to be adjudicated and they have no treatment. That's wrong.

When it comes to accommodation or new infrastructure, affordable housing will be the key.

You might want to comment about Ontario and how we need affordable housing and not just buildings.

Mr. Dave Gordon: In Ontario we have the three facilities that are mentioned in the brief.

We also are very keen to have affordable housing. We have a developer who came forward in London. He's providing 14 units for homeless veterans. We have a developer in Niagara Falls who's coming forward. He has two or three buildings with 10 units in each building. He'll be putting those forward for homeless veterans. We have two or three other areas we're looking at.

We're also looking at the tiny homes development, to see where exactly we can do that in Ontario. Again, that's up to the municipalities. We'll have to convince municipalities to change their municipal bylaws to allow that size of a building.

Mr. Bob Bratina: Some veterans will have needs other than simply a place to live. Would you recommend that some of the affordable housing that's created be in the form of perhaps a small multi-residential building where several veterans could live together? Is that something that...?

Mr. Dave Gordon: We have that now in Ontario, in the three facilities that we have. We also have an office for the care workers. They're teaching the after-care programs. We have that in the three facilities.

Veterans Affairs also have offices. They have an office at the Good Shepherd Ministries on Queen Street in Toronto.

Mr. Bob Bratina: I'm thinking of the difficult cases, like the fellow in the tent, who said, “Don't bother me.”

Mr. Raymond McInnis: You need a combination of both, affordable housing and something like the multi-faith housing complex that will be going up in Rockcliffe, and what's happening in Toronto and across the country. You also need affordable housing where people can live in a community and get back to living in a normal community as well.

Mr. Bob Bratina: Right.

Have you talked to your colleagues across the border about these issues—the American experience?

Mr. Dave Gordon: When we first started the program, we approached their veterans affairs in Buffalo, New York. That's where we connected. We sat with those folks. We went over and spent a day and a half with them. One of the things they strongly suggested was not to try to reinvent the wheel. If somebody has a program, use it. I can tell you that we have.

I don't mind telling you that we've used other people's programs but adjusted them to what we need and want. That's how we came up with this. The program in Ontario is very strong. We're pretty proud of what we've done.

● (1615)

Mr. Bob Bratina: Thanks.

The Chair: Thank you.

Ms. Ludwig.

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

I'd like to thank all of you for the work you're doing. It's incredibly important. Some of this is anecdotal, so I'll ask some questions on data, but I certainly thank you for the work you're doing.

Ms. Lowther, do you live in Halifax?

Ms. Debbie Lowther: I do.

Ms. Karen Ludwig: Okay. I live in St. Andrews, New Brunswick, and my colleague lives in northern New Brunswick, so some of my questions will be more specific to the Atlantic region and will have to do with rural versus urban. I also sit on the international trade committee. We hear very different responses from witnesses based on where they're giving testimony from across the country.

When we look at the location of affordable housing, is there much affordable housing for veterans in Atlantic Canada?

Ms. Debbie Lowther: There's none specifically for veterans, but there is definitely a shortage of affordable housing in Atlantic Canada.

Ms. Karen Ludwig: What would you recommend for affordable housing in very rural settings? I can think of so many maritimers who will leave, especially in the case of service, with Base Gagetown in New Brunswick. and who will end up coming back. They want to be in their home communities. If the wraparound services aren't there, what do you recommend for that? What can you provide to us as insight?

Ms. Debbie Lowther: It is difficult when somebody lives rurally. We do know that there are times when veterans, particularly those who are dealing with mental health issues, don't want to live in urban settings. They do want to live more rurally, where it's quieter and it's better for their mental health. It is certainly a challenge as far as housing goes. I honestly don't know what the solution is to address that issue in rural settings.

Ms. Karen Ludwig: Thank you.

Mr. Gordon or Mr. McInnis, do you have a comment on that?

Mr. Raymond McInnis: I'll just say that in a rural setting, there are challenges getting not only affordable housing but mental health services—everything. It's whatever they can find in that local economy.

As far as coming up with a solution for it....

Mr. Dave Gordon: At the start of a new program, once the veteran knocks on our door and we verify service, the door is open. Our first question is, "What do you need?" Our office is in Aurora, Ontario, and we have a branch in Kapuskasing. We'll call them and say, "We have a homeless veteran in Kapuskasing and we need to find him accommodation." We have 394 branches in Ontario. I can tell you that we can get service done in two hours or within—

Ms. Karen Ludwig: Mr. Gordon, you are a numbers guy.

Mr. Dave Gordon: Yes.

Ms. Karen Ludwig: Is there a common repository that we can feed the numbers into in order to start collecting them?

Mr. Dave Gordon: I can send you a copy of the stats we keep. That's not a problem. We're the only province that we know of...or the only command that we know of. I can tell you that as of this coming Saturday, that's going to change. We're going to get everybody involved so that we can get it together.

We started keeping stats from day one. I was one of the first people on the committee at Ontario Command to start the program. That's where I'm getting all the numbers.

Ms. Karen Ludwig: From your experience, do you see more supports or fewer for veterans than five years ago?

Ms. Debbie Lowther: There's definitely more. In some cases, there are too many supports. As I said in my testimony, it has become a very crowded landscape. It seems to be the issue of the day, so to speak. People are coming out of the woodwork trying to offer support. The key is this: Is there actually a service there? It's the credibility.

Ms. Karen Ludwig: What about conflicts? Is there a common conflict, such as a war conflict that the veterans have participated in, or is it just all veterans, from 17 to 92, as you mentioned, Mr. Gordon?

Mr. Raymond McInnis: Yes. A veteran is a veteran is a veteran. I say that and we're honest about that, because there is so much out there where people do not come forward to submit a disability application because somewhere along the line someone told them that for the service they were in there's not an entitlement to apply. It takes a lot of effort to go back. I have a lot of World War II veterans who didn't serve overseas who were told that they couldn't put in a claim. Trying to talk them into submitting a claim at this time in their life when they want to stay at home and get VIP so they don't have to move into long-term care is challenging.

You talked about how there have been changes. Yes, there have been a lot of great changes, but you have to get the veterans in the door. You have to get them in the door to get them the service they need. Once they're in, you can get through the system, and it's pretty good, but you have to get them in.

● (1620)

Ms. Karen Ludwig: Do you also hear from veterans a concern about reporting a medical condition or a mental health condition to the military doctor while they're in service? I've heard from some who suggest that it can be career limiting.

Mr. Raymond McInnis: Well, for folks who are still serving, we don't need medical questionnaires completed, and VAC doesn't require that for a disability application. It has to be in your service health records. For everyone who was in when we're doing a disability claim that is already diagnosed, those are new. You're talking about people who don't want to come forward because, again, it's a stigma issue. I'm not going to say that it has been eradicated, but we're seeing more people coming forward now than ever before, and the favourable rate on mental health claims right now has to be pretty close to 90%.

They've even changed philosophies there on how they're adjudicating claims. No longer are they giving just a 10% minimum on most. If they can give a definitive adjudication entitlement and an assessment at that time so that they don't need to have that person with a mental health condition come back a year or six months later, because that is a problem as well.... People just want to get in, get the treatment and of course get their disability awarded as well.

The Chair: Thank you.

Mrs. Wagantall, you have six minutes.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you, Chair, and thank you so much, Mr. Gordon, Mr. McInnis and Deb Lowther, for being here today.

I'm going to quote something from another individual who was testifying. Mr. Robert Tomljenovic, area director, Department of Veterans Affairs, was explaining, similar to what you're saying, 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.” In addition, they have also experienced traumatic scenarios.

I can't help but think that homelessness and all of these things that are mentioned are symptoms of a traumatic experience. Whether you're a veteran or not, something has caused you to go down these paths that make life less positive.

Ms. Lowther, your program, Boots on the Ground, says to me that the majority of people with these traumatic experiences in our armed forces are the people who are the boots on the ground, the ones who face the fire, the explosions and all these kinds of issues. I'm so thankful for what you guys do, all of you, in what is really a crisis management scenario. I'm sure you would love to see circumstances change so that there is no homelessness. That's the ideal. I understand that it's not possible, but we could get much closer to it than we are.

Mr. McInnis, I believe you mentioned something around the issue of their needing to be fit to be transitioned. Our goal here has been to help create this seamless transition from National Defence through VAC to a healthy life as a civilian. Would you say that this area.... I know that VAC is not anxious to allow National Defence to be the ones to determine when you leave—and if you leave with an injury, whether it's service-related or not—in order to not have to go through that whole system again in going through VAC.

You were talking about needing more case managers. Can you talk a bit about that? If those circumstances were different, would those symptoms that our veterans face be different, the ones who are truly injured and struggle with these issues, with PTSD and whatnot?

Mr. Raymond McInnis: Yes, it's very important, but I don't like the term “seamless transition”. There's nothing seamless about it. “Smooth transition” would be a better term to use—

Mrs. Cathay Wagantall: Okay.

Mr. Raymond McInnis: —because even the people who are not injured when they leave the military still have a difficult time with transition to the civilian world.

Not to take away from all the civilians in the room, but the health care system is not as nice as it was when we served in the military. In the military, we were taken care of. You go in one door in the morning and you come out in the afternoon and everything was taken care of for you. You didn't know what you had—it was that good.

To me, transition is extremely key. If the Canadian Forces are going to have a mandate to keep you in longer to ensure that when you do transition over you're handed off and in a better state of mind mentally, physically and financially, then yes, a lot of problems will go away.

● (1625)

Mrs. Cathay Wagantall: If we're going to talk dollars, do you think if we invested more in maintaining their salaries until all of these things were dealt with further down the road we would actually, in the long run, end up spending less and having healthier citizens?

I'd like a quick yes or no because I have lots of questions.

Mr. Raymond McInnis: That's a yes from me, as long as they're in the military and they're in this. That's why they are going for the additional positions because then they're going to be paid, and that's what the transition groups are supposed to be for.

Mrs. Cathay Wagantall: Okay. Thank you.

Ms. Lowther, I've been to the new drop-in centre. It is phenomenal, very exciting. I had the opportunity to meet Gary Davis in Victoria last week. Your services, as well as the Legion's, are very commendable. Thank you for what you're doing.

I know that in your first two months with the centre here you received over 60 referrals from case managers, in fact, to deal with emergency circumstances. What were their explanations for sending them to you?

With the emergency fund, what is the most effective way to use those dollars when we're dealing with veterans in emergency circumstances, through VAC or through veterans who are assisting veterans?

Ms. Debbie Lowther: Honestly, when the emergency fund was announced, we had several case managers who told us they don't want to be responsible for administering this fund. They would rather see the department give the money to VETS Canada and let VETS Canada do it.

What are the scenarios in which case managers are referring veterans to us or to our drop-in centre? They're varied, but one common theme is that we have the ability to provide immediate support.

To be very clear, the front-line staff at Veterans Affairs Canada are kind, caring people, and they are doing a wonderful job with the ability they have. They do deal with legislation and very restrictive policies and procedures, whereas we have the ability to be an outside-the-box organization. We don't have to have somebody sign off on a briefing note to expend some money, so we have the ability to be more responsive quickly.

Case managers know that, so I think....

Mrs. Cathay Wagantall: Thank you. Yes.

It's clear that you are doing a good job, Mr. Gordon, in regard to the database and information, something, quite honestly, we find there is not enough of, which I don't understand.

If you are doing that, do you see that it would be advantageous for groups that are succeeding in serving veterans if you share that information? You said there are really too many. Is Ms. Lowther aware of which ones you are serving in certain areas and whether there is overlap?

My husband was in the ministry and there were many times when people would come who truly needed help, but if you communicated throughout the area you would know that they had been to multiple areas and had not necessarily taken advantage of the assistance needed.

Do you see that database needing to be more comprehensive?

Mr. Dave Gordon: That's a good question.

We support and work with all the other organizations—VETS Canada. We've assisted them, and with department kits, and help if they come to us. Any organization that comes to us and has a homeless veteran who needs help, we're there.

Mrs. Cathay Wagantall: Do you both know who you are serving?

Are you serving the same people? I guess that's what I'm asking.

The Chair: If you could, please answer that quickly.

Mr. Raymond McInnis: We're not double-dipping.

The Chair: Okay. Thank you.

Sorry, that ends the panel today. I know that hour went very quickly.

On behalf of the committee, I'd like to thank all three of you very much for appearing today, and for all you do for the men and women who serve.

We will recess to clear the room. We'll start momentarily with our other panel.

● _____ (Pause) _____ ●

● (1630)

The Chair: Order, please. Could everyone take their seats.

This is the study on medical cannabis.

We're pleased to welcome, by video conference from Hamilton, Dr. Jason Busse, associate professor and associate director of the Michael G. DeGroote Centre for Medicinal Cannabis Research, McMaster University.

With us in Ottawa we have Dr. Zhang, assistant professor, psychiatry department, University of Saskatchewan; and Mr. Cohen, master of science student and combat veteran, department of pharmacology and psychiatry, University of Saskatchewan.

We'll start with 10 minutes from each of you for opening statements, and we'll start with the video conference with Dr. Busse.

Dr. Jason Busse (Associate Professor, McMaster University, As an Individual): Thank you very much. Good afternoon, honourable members of Parliament. I appreciate the opportunity to address the House of Commons Standing Committee on Veterans Affairs.

As noted, I'm an associate professor in the department of anaesthesia here at McMaster as well as the associate director in our cannabis research institute.

The cannabis research institute here is funded by philanthropic donation. We receive no industry funding, and our mission is to develop an evidenced-based understanding of cannabis, both in terms of its potential therapeutic benefits and also its associated harms.

Our centre's activities broadly include the synthesis and dissemination of current best evidence, the conduct and support of innovative research in areas where evidence is lacking, and the creation of a research network including both faculty members at McMaster and external partners including Dr. David Pedlar, the scientific director of the Canadian Institute for Military and Veteran Health Research.

My research in particular focuses on evidenced-based medicine, chronic pain, disability management, opioids and cannabis.

We note that military service is associated with health risks. Recent surveys have found 41% of military personnel report the experience of chronic pain and 23% report intermittent pain. Military personnel develop higher rates of psychiatric disorders such as PTSD and anxiety than members of the general public, and they are at greater risk for both suicide attempts and completion.

Regarding the potential role of medicinal cannabis to assist our veterans, we have at present moderate quality evidence that suggests cannabis may reduce chronic pain, but effects are typically modest. Our group here at McMaster is currently revising and updating this evidence synthesis. We anticipate our work will be completed in the first half of 2019.

Regarding the current evidence to support a therapeutic role and management of symptoms associated with anxiety or PTSD, we have anecdotes but we have very little evidence to make conclusions either supporting a benefit or refuting a role.

We have some observational evidence that has shown that, in areas where cannabis becomes available for medicinal use, suicide rates in general seem to track down. We also have observational evidence that veterans who present with cannabis use disorder are at higher risk for suicide attempts. This is another area where more research is needed before we can make firm conclusions.

There are a number of side effects associated with cannabis. These include dizziness, fatigue, euphoria, confusion, disorientation. Cannabis use disorder or addiction occurs in about 7% of regular users over their lifetime, and the adverse events associated with cannabis are predominantly tied to one cannabinoid, THC. The cannabis plant contains more than 100 active cannabinoids, the most studied of which being THC and CBD. CBD may have some therapeutic properties, but it is neither psychoactive nor addictive.

This suggests that cannabis products that contain predominantly CBD may be associated with much fewer adverse events than the plant as a whole. Despite the limited evidence for benefits and the known and suspected harms, the general perception about cannabis seems to be increasingly enthusiastic.

A 2017 survey of more than 16,000 Americans in the general public found that 81% believed cannabis had health benefits; 9% believed it had no risks; 22% believed it was not addictive. These perceptions are not in line with current evidence.

We also know that authorization for medicinal use is increasing in Canada. According to Health Canada's registry of patients, there were about 8,000 who were authorized to use medicinal cannabis in 2014, and at present this figure is closer to a quarter of a million. The rapidly expanding therapeutic use of cannabis suggests a triumph of marketing over evidence. I would suggest there may be some relevant lessons to be learned from Canada's experience with opioids for chronic pain.

● (1635)

At present, over 7,000 veterans in Canada have been authorized to receive medicinal cannabis, and the matter of dosing has been contentious. The precise dosing is not available from current evidence, and a dose of cannabis does not consider the potency, particularly the percentage of THC that may be available in a product. In addition to that, the product of cannabis can be consumed either through inhalation or through ingestion and the way in which you take it in affects both the time of onset and the duration of effects.

VAC currently reimburses up to three grams per day in general for medicinal cannabis and up to 10 grams with approval for exceptional cases. These are not excessively conservative policies relative to other countries. For example, Israel reimburses only one and a half grams per day, the Netherlands 0.68 grams per day. If you look at the data from Health Canada regarding how much cannabis those who are authorized to use it for medicinal purposes are currently accessing, on average it's about 0.75 grams per day. The likelihood of an individual consuming the very high end of what's allowed, 10 grams per day, suggests they are at higher risk for developing dependence and possibly cannabis use disorder. The result of this means that withdrawal symptoms would result if their dose were tapered rapidly or if the product were made unavailable to them, and as such there is a need for both caution and compassion considering veterans who are currently using medicinal cannabis, in particular at higher amounts.

What is needed to promote evidence-based authorization of medicinal cannabis? We need randomized controlled trials to establish effectiveness of cannabis for promising indications. Observational data, which is what we have most of, cannot establish causation, and such trials should enrol adequate numbers of patients to make firm conclusions, follow individuals for a long period of time, six months to a year, and consider capturing both benefits and harms of cannabis use. We require more real-world observational data at the same time. Veterans and other medicinal cannabis users can be enrolled in research cohorts and followed forward in time to look at patterns in change of use, the effect on their symptoms and the development of both long-term and rare events.

We also need guidelines to help veterans, other patients and clinicians make evidence-based decisions around medicinal cannabis. The most applicable area for this would be chronic pain. That's where we currently have the bulk of evidence for the application of medicinal cannabis.

At the same time, evidence alone is not sufficient to make clinical decisions. Because of the likely modest benefits, and the known and suspected adverse events, the decision to pursue a trial of therapeutic cannabis is not straightforward. We require values and preference research so we understand what patients are willing to trade off, given the evidence for potentially modest benefits and the development decision aids would help facilitate shared care decision-making.

On a positive note, with the dedication of appropriate resources, given the current legalization of cannabis and the interest in research, Canada has the opportunity to become an international leader in medicinal cannabis research for both veterans and in general.

In closing, I thank you for the opportunity to serve as a witness for this committee.

● (1640)

The Chair: Thank you.

Mr. Zhang, you have 10 minutes.

Dr. Yanbo Zhang (Assistant Professor, Psychiatry Department, University of Saskatchewan, As an Individual): Good afternoon, *bonjour*, honourable members of the committee and my esteemed colleagues. I would like to express my sincerest gratitude for the honour to be here today.

My name is Dr. Yanbo Zhang. I am a clinician scientist from the department of psychiatry in the college of medicine at the University of Saskatchewan. As a psychiatrist, I treat patients with mental health conditions like depression, anxiety and PTSD. As a researcher, I use animal models to study the therapeutic effects and underlying mechanisms of cannabis as well as other normal treatments for psychiatric and neurological disorders such as depression, PTSD, multiple sclerosis and also traumatic brain injury.

I want to declare my funding sources and potential conflicts of interest. I received research grants from the University of Saskatchewan and also the Saskatchewan Health Research Foundation. I have an ongoing supply agreement from a cannabis company for my animal research, but the company does not influence my experiment design or the outcome of the research. I do not have any financial support or grants received from any industry.

I'm also the secretary-treasurer and the board executive for the Canadian Psychiatric Association. It’s a national professional organization for Canada's psychiatrists and trainees, but here all my opinions are my own, and I do not really represent any of our association’s opinions.

Military veterans have at least a twofold risk of developing PTSD when compared to the general Canadian population. Individuals with PTSD relive trauma through flashbacks and nightmares, and they suffer from extreme fear, irritability, hyper-arousal and negative emotions. Untreated PTSD causes severe and chronic impairment in their cognition, physical health and social functioning.

Psychotherapies are considered the primary interventions for PTSD. Trauma-focused cognitive behavioural therapy, called CBT, is by far the best supported method. CBT aims to change patients’ dysfunctional post-traumatic memories and beliefs and then to reduce or to decrease their response and avoidance towards the traumatic memory. However, due to the stigma, the service access, the cost and the time consumption, few patients engage in psychotherapy. Most patients with PTSD also receive medications like antidepressants, antipsychotics and mood stabilizers, but seldom stay on the medications due to side effects or lack of observed benefit.

Overall, the treatment of PTSD and the outcome are not promising. Studies also suggest that combat-related PTSD is more refractory to current treatments, which is probably due to high a comorbidity of brain injuries, chronic pain, addiction and also some other comorbidities. Medical cannabis has been allowed for PTSD treatment in a few countries, such as, Israel, Holland and Canada.

Although increasing preclinical studies suggest a critical role of the endocannabinoid system in PTSD and the potential of cannabis in treating PTSD, the clinical evidence remains inconsistent. Most trials have limitations, such as, a small sample size or the use of some healthy participants to elicit the anxiety symptoms rather than a real-world PTSD patient. They also use a synthesized cannabis product rather than the whole plant. In addition, the therapeutic dose range and the ratio of different compounds and their effects is unknown.

The systematic reviews, which are the strongest evidence that we normally use to guide treatment, cannot come with the conclusion of any definite therapeutic effects or benefits in terms of cannabis treatment for PTSD.

● (1645)

With little information, the physicians, pharmacists and patients cannot make an informed decision because there's no high quality of randomized and controlled trials on the whole planet of cannabis, which is the major product that has been distributed. It's really difficult for us to make a decision to see whether it should be used or not and what the benefit would be.

Also, there's consistent evidence showing that the heavy and regular use of cannabis with a high THC content is associated with increased risks of cognitive impairment, psychosis and cannabis use disorder, especially in adolescents and young adults, and also in individuals with pre-existing mental health conditions. Given the high comorbidity of depression, traumatic brain injury and substance abuse in veterans with PTSD, the potential benefit of cannabis may be shadowed by the increased risks of cognitive impairment and addiction.

As psychiatrists we are trained to practise evidence-based medicine, which requires us to examine the scientific evidence and to balance the risks and benefits before providing treatment. Thus, many psychiatrists, including myself, are really hesitant to authorize cannabis for treating any psychiatric disorders because we do not know the long-term outcome and we do not know whether the benefit will trump the risk.

On the other hand, effectively treating PTSD is quite a challenging thing. We have to explore new interventions that can benefit our patients. That's why it is critical to understand the therapeutic and adverse effects of cannabis products with different doses and with different ratios of THC and CBD. Research to compare the efficacy of cannabis use and also the currently available treatment, like antidepressants and psychotherapies, are highly needed, so we can find a benefits versus risks profile. Also, we need to determine the long-term effects of cannabis use on the patient's mental, physical and social functions, which is largely lacking at this stage.

The third part is we know that there's a high comorbidity of chronic pain and brain injury and substance use in patients with PTSD. They have a really complicated bidirectional relationship. Adding more studies on the interactions will help us to understand the prevention and the treatment options for the future.

Before obtaining further evidence, the low-risk cannabis use recommendations made by medical professionals should be applied, such as using a high CBD content oil versus using or smoking products with a high content of THC. I believe that the safe integration of medical cannabis can potentially improve the quality of care for the patient, but the robust, large-scale and blind and unbiased studies are needed to achieve this.

Thank you.

● (1650)

The Chair: Mr. Cohen.

Mr. Jacob Cohen (M.Sc. Student and Combat Veteran (Honorable discharge), Department of Pharmacology and Psychiatry, University of Saskatchewan, As an Individual):

Good afternoon, honourable members of the committee. There are no words to say how grateful I am to receive this experience to speak before you today.

[*Translation*]

I would like to talk to you about my experiences as a soldier, tell you about the obstacles we face as veterans when we seek treatment, and discuss the research I am doing with Dr. Zhang.

[*English*]

I would also like to say a big thank you to Dr. Robert Laprairie, who is a cannabis pharmacologist at the college of pharmacy who helped us review this, as well as Madam Kelly Malka from Montreal, who helped me a little with the translation to make sure it was correct.

I did a 1,000-hour primary care paramedic course at John Abbott College in Montreal. Then at age 19, I left to voluntarily join the military. I served with a light infantry regiment in a combat role as a combat medic, and then in 2013 the contract ended. It was up or out; I chose out and was honourably discharged.

I can say that I'm intimately familiar with PTSD, because unfortunately, I have different friends across the military, as well as EMS circles, who were affected in different ways. I know a paramedic instructor and a friend from the military who chose the permanent end to the temporary problem, which was suicide.

I can also say that the transition period is extremely difficult to live through. Many studies have shown that this period may be the most volatile and where there can be very prevalent use of substances.

In my case, I went from being mostly respected and appreciated as the company and platoon combat medic, to having extreme difficulties with licensing bodies to get back to work in a timely manner. Unfortunately, it's really common to hear about cases like this. That, combined with the fact that you're free to consume drugs and alcohol outside of the military or paramilitary organization that you belong to, is often the deadly concoction that leads to unemployment, homelessness, suicides and other devastating outcomes.

In the military, there's a very strong prevalent culture of substance abuse. Soldiers across the ranks often use alcohol as a tool to self-medicate, and even sometimes to let loose after a stressful deployment or stressful longer period. It's also not uncommon to see especially junior platoons be completely hungover for a 05:00 training session.

Also, many soldiers consume dangerous amounts of things like energy drinks and painkillers like acetaminophen and ibuprofen. They're often combined with cigarettes, chewing tobacco and energy drinks.

In my time, there was also a bit of use of synthetic cannabis. The product was called “spice”, which is a very high-content THC product that has negative effects. It couldn't be detected in urinalysis at that time. I think it can now, but I'm not sure.

Having said that, veterans are often their own worst enemy. There's a reluctance to seek treatment, and there's also some difficulty after service in connecting with others for different reasons. The desire for effects to happen right now hinders progress.

Many veterans who suffer from acute episodes of PTSD are often prescribed very powerful drugs like haloperidol and quetiapine, which are usually reserved for cases of severe psychiatric patients. This is an issue, since PTSD is very hard to diagnose, especially in the early stages, and is often comorbid with other conditions like anxiety, insomnia, chronic pain, hearing loss, tinnitus and others.

The stigma of being soft for seeking treatment, along with being given by physicians what many veterans refer to as the “zombie cocktail”, and being stubborn about treatment, can create a never-ending vicious cycle of distress between patient and clinician.

The fact that PTSD is also comorbid itself with different types of addiction is often a valid reason for physicians to be reluctant to prescribe drugs outside of the recommended guidelines, such as cannabis.

It was at that stage in my life I found that many people, especially veterans, talk but don't proactively take it upon themselves to change the solution. I saw also in friends that the symptoms were from very benign to very severe. For example, one just decided that he was going to defer medical school for a year and take some time off to calm down. At the other end of the spectrum, there were a few who needed intensive treatments, medications, and even hospitalization, for insomnia and nightmares in the early stages of PTSD.

I heard anecdotal evidence that there was some relief from these issues with medical cannabis. It was right when I got out. That's when the story of cannabidiol oil for the aggressive seizure condition, Dravet syndrome, really caught my attention.

● (1655)

I also came in contact with a man by the name of Boone Cutler. He was an American army soldier. A direct mortar impact caused a TBI and he found himself addicted to the very medications that the physicians at Walter Reed prescribed him. He switched to high-content CBD cannabis with THC as needed and has since become a radio host, author, columnist, video director and advocate in general. He made the Spartan pledge, which encourages veterans never to take their own life and “to find a mission to help my warfighter family”.

This led me to follow the military model to lead from the front and take it upon myself to study this. I took eight months after honourable discharge before going back. Even now in school student veterans are hardly seen and we're definitely under-represented just because there are hardly any veterans, period, or clubs on campus. It's also really hard to reach out.

Education on the subject is highly lacking. Even in the pharmacology program where I am now, there are still a few professors who are unaware that new technology has allowed for different compounds of the plant to be isolated and delivered in oil form within an accuracy of 0.01 milligrams per millilitre and as much as 0.25 milligrams per millilitre, depending on the company. Many are also unaware that companies registered with Health Canada as licensed producers usually have really strict guidelines to adhere to. The reputable ones, for example MedReleaf, Aurora, Canopy—I'm not endorsing them; I'm just saying—hold not only GMP but also ISO certification, which is a more strict form of regulation. They have many forms other than dried leaves, such as oils, edibles, vaping solutions and creams.

The issue, though, as both doctors have said, is that many studies and opinions contradict each other. There's not only a chasm between countries, but even within a province. For example, the CMA currently does not seem to support cannabis for PTSD. However, the Israeli Ministry of Health supports medical cannabis after traditional pharmacological options fail or if there's not enough help from psychotherapy within two months. In Israel they also recommend low doses of THC for severe PTSD.

Although patients can be authorized medical cannabis and seem to have reasonable insurance coverage, it's often very bureaucratic and confusing to begin the process since there are so many different requirements within each province, as well as at the federal level.

I believe we need more research into cannabis-based medicines so we can demonstrate their efficacy, if any, in individuals with PTSD. There is also a serious need to better educate health professionals as well as professors teaching these subjects so we can distinguish appropriate compounds from recreational and harmful use.

The current guidelines allow for three grams daily. When we think that this is enough to deliver half a gram of cannabis six times in an 18-hour period, it may seem like a lot but many patients, especially patients who have been to combat zones, may have more severe conditions and may require larger amounts, especially if they have a tolerance or if they're using smoked cannabis, since with smoked cannabis, the maximum bioavailability quoted in the literature that I could find was 56%.

At the moment powerful opioid drugs are prescribed to patients with chronic pain roughly every four hours according to the pain guidelines. Given that they're extremely dangerous and that it's also the driving force behind the current fentanyl epidemic in North America, to me it seems logical to allow for possibly higher doses in severe conditions, especially if they're using smoked cannabis.

Pharmacological information regarding dose responses by body weight, route of administration, and also the type of compounds is completely lacking, even non-existent. Studies in human patients are going to be needed to allow the full elucidation of cannabinoid pharmacology. The lack of treatment options without serious side effects and knowing that cannabis products were being used prior to legalization in both Canada and the United States led to my interest in studying cannabis as a potential therapeutic agent for PTSD.

Although it's a controversial topic, there is some anecdotal evidence of veterans using cannabis to alleviate the symptoms caused by mefloquine toxicity. I needed to determine and I hope to show that even if there are safety risks with cannabis, the benefits outweigh those risks.

During my undergrad I optimized an animal model of PTSD to mirror human exposures and conditions. Animals are subjected to daytime and nighttime exposure and then they get daily cage changes to simulate either a combat deployment, or an EMS shift with different personnel. Using this model, we have found that a low dose, five milligrams per kilogram, of CBD oil can really decrease the PTSD symptoms, and does not seem to have any addictive properties. Although the results are promising, it's still really early and we can't responsibly make any conclusions with respect to humans at this time. We do hope to explore different compounds, doses and ratios in both male and female rats before doing larger randomized clinical trials, hopefully with the Legion.

● (1700)

This is going to be the basis, and it's also the goal for my M.Sc. thesis. We think that more knowledge of the intricacies and mechanisms of our body's endocannabinoid systems will allow us to properly define optimal dosing for each strain and compound of the cannabis plant. Human studies into safety for pediatric conditions, such as Dravet syndrome epilepsy, as well as safety thresholds for cognitive effects when using THC are needed to make better decisions. We think these would benefit clinicians and patients alike.

Thank you.

The Chair: Thank you.

Mr. Kitchen, you have six minutes.

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

Thank you, gentlemen, for being here today. I really appreciate your coming and helping educate us on this issue.

I had the opportunity to meet Jacob.

I do believe, Dr. Busse, that I have met you before as well.

I was at the CIMVHR conference and I was enthralled by Dr. MacKillop's presentation on it. He, hopefully, will be here later.

Dr. Busse, I really enjoyed reading your guest editorial in the Journal of Military, Veteran and Family Health. It's extremely enlightening. I encourage everyone to read that. One of the things you talked about in there was how the legalization of medical cannabis was associated with reductions in opioid, antidepressant and anti-anxiety prescriptions. I'm wondering if you can expand on that to the committee.

Dr. Jason Busse: Absolutely. Thank you.

Where that information comes from is observational data looking at different states in the U.S. Currently in the U.S. there are approximately 30 states where they have legalized medicinal cannabis. There are currently another eight states that have legalized recreational cannabis. They've been able to do some time-series analysis. They've looked in these states at the rate of use of different prescription medications before legalization of medicinal cannabis and then after.

Because this is an observational study, there could be other factors that are affecting the use of prescription drugs, but in a number of states they've shown this pattern that the rate of use of prescription drugs and the rate of purchase of these drugs have gone down for drugs typically used to treat chronic pain, anxiety and depression. This doesn't give us enough evidence to say that cannabis is effective in treating these conditions, but it's an interesting and promising observational signal that suggests there could be therapeutic benefit, and that in some cases patients may be substituting their pharmaceutical drugs in place of medicinal cannabis and finding sufficient relief that they are staying with that product.

● (1705)

Mr. Robert Kitchen: Thank you, sir.

I commend all of you for talking about research and the value of it, especially for the potential benefits and the risks that are involved with cannabis use by not only our veterans but also others.

Dr. Zhang, you talked in your presentation about dried smoke cannabis with low bioavailability. When I listened to Dr. MacKillop's presentation, he talked a little about issues with synthetic cannabinoids. I'm wondering, obviously from an educational point of view, why there is a difference with synthetics versus dried product.

Dr. Yanbo Zhang: That is a really good point.

At the very beginning, when the synthetic one was developed, attempts were made to separate the useful compounds and then make them more precisely target the compounds in certain situations. However, more evidence shows that the synthetic ones may lead to a higher risk of psychosis. That's telling us that cannabis as a plant itself has complicated interactions between all those different compounds. So far, the most important parts are THC and CBD. The synthetic one is pretty much all THC without the counterpart of CBD, which is why there is an increased risk of all the side effects.

Even from our current guidelines or recommendations for the low-risk use, we recommend that people use the natural compound that has THC and CBD together rather than using a synthetic one.

Mr. Robert Kitchen: My understanding from that would be that the product that's out there for the general public, for recreational use, is higher in THC, whereas the medical marijuana would have higher CBD, which seems to have a better effect. Is that correct, or is that wrong?

Dr. Yanbo Zhang: The recreational one is quite a variety of products, so it's really difficult to compare. It depends on their strength and the customers' preference, but from a physician's perspective, when I am educating patients, I always tell them: CBD, CBD, CBD.

That's the message I'm sending out, because if you want to use cannabis to get high or for recreational use, you have to have THC. Otherwise, you won't get all the benefits you want. Why bother to use it?

However, when you are using it, the side effects and the long-term consequences probably won't be the consideration at that time. That's why I am even trying to persuade local governments and policy-makers to set a cap for the THC component. We know it's harmful, so why do we still want people to use it? If we could find a way for people to balance getting high and getting a feeling of relaxation without causing too much harm, that would be ideal.

The Chair: Thank you, Mr. Kitchen. You're out of time.

Ms. Ludwig.

Ms. Karen Ludwig: Thank you for your testimony today.

I'm going to start with Mr. Cohen.

First of all, thank you for your service. It's quite rare for someone who has your experience and background to go on and become a pharmacology student studying for a master's, so thank you for doing that. That means a lot.

Looking at your pharmacology program, outside of the research that you're professionally conducting, is it part of the general curriculum in pharmacology to study the impacts and adverse effects and even cross-conflict between other medications and THC and cannabis?

● (1710)

Mr. Jacob Cohen: The short answer is no. There are some professors who have tried. They've provided decent information, but a lot of it I can actually go back and find with a Google search. The problem is that a lot of it is outdated.

For example, a few weeks ago there was actually a presentation where they discussed the number of compounds in the cannabis plant. The presenter quoted a figure from 2011, which was 60. We now know it's over 100, and I think there was just a study that came out the other week that said it's over 115 now. The issue is there's no formal program and information is often outdated.

Ms. Karen Ludwig: Thank you.

On Tuesday we had two doctors appear before us. I found it surprising, first of all, that they knew Veterans Affairs did not prescribe the drugs but, they said, certainly provided reimbursement. That much we knew. In terms of the authorizing specialists, though, such as the psychiatrists and medical professionals, they also said there's little training in medical schools regarding the prescription and uses of marijuana.

I'm wondering, Dr. Zhang, if you could also speak to that. If we think about any type of medication—because I see it as a medication in this case—when it's being prescribed, a significant amount of research is usually done on the impacts. Some people have very complicating situations. They could be taking other medications, or not realize the impact of consuming alcohol at the same time. Could you speak to that?

Dr. Yanbo Zhang: That's a really important issue. I think that, in general, the policy of marijuana use, and even recreational use, is faster than the evidence presented, not just nationally but internationally.

From that angle, medicine, and also psychiatry as part of medicine, is quite conservative in that way. Why is that? People's lives and people's function and quality of life are in our hands. That's why evidence-based medicine is the best we can get. Without that, it's very difficult to tell whether we're doing the right job to treat the patient. All medications have side effects but to a certain extent we know what's going to happen and how we're going to prevent it, which we discuss very thoroughly with our patients.

This is probably the only medication that's not been endorsed by Health Canada. It's not been approved for that but it's being authorized by physicians. We are in a dilemma, in a very dramatic situation. I know some patients might need it, but how could a physician like me go beyond the concept of no harm? The basic ethical thing for us is to cause no harm. Before I know whether it causes harm or not and I prescribe it...that's why I do not do it.

Also, we do not have any training. Our previous training was that it was bad. Suddenly now it's good, but we don't know how good it is. That's the dilemma.

Ms. Karen Ludwig: Mr. Cohen, what's the best way to get information to, let's say, a veteran who is using marijuana, maybe potentially even self-medicating—because as you said, Dr. Zhang, there is a difference in the strength of the THC between medical marijuana and recreational marijuana—so we know whoever is using it has the best information?

Mr. Jacob Cohen: Unfortunately, at the moment the biggest circulation I see of it is through social media and on Facebook, but, it's not bad information. It's surprisingly...there are some cautions, but I think the best way would be to educate people on where to find marijuana, and then perhaps somebody could produce literature or maybe even include it as a discharge package.

● (1715)

Ms. Karen Ludwig: Do I have more time?

The Chair: You have 40 seconds.

Ms. Karen Ludwig: Dr. Busse, what you're suggesting I think is really important. Similar to Dr. Zhang and also to Mr. Cohen, you're emphasizing research and the work you've done.

Research will be critical as we move forward because we're talking about the health of individuals and no government goes into this lightly. We went into this in terms of support, to give people the best possible care.

If you could send any information or a brief on what you're recommending for research, maybe even look at it from a coordinated aspect, that would be very beneficial.

Dr. Jason Busse: I'd certainly be happy to do that.

One of the reasons we're in this funny situation is that usually before a product becomes available for therapeutic use, it has to undergo rigorous research, clinical trials, and you have to demonstrate the evidence that the risk profile is acceptable.

Medicinal cannabis has come onto the scene through a series of legal challenges. Now it's available, and we have to look for the evidence to see what it might work for and what it might not work for. In many ways, the cart has gone in front of the horse here.

In terms of looking at its potential interactions with other drugs, I think that's such a critical question. There is a network in Canada called DSEN, the drug safety and effectiveness network, and they capitalize on the use of large-scale data through ISIS to see where there are drug-drug interactions. Certainly we benefited from that greatly when looking at the opioid guideline for understanding the interaction with benzodiazepines and other sedating medications as a real contraindication. The trial that Mr. Cohen referred to of Dravet syndrome, they did find, with a high dose of CBD, the potential for interaction with other seizure medications.

It's early days but we have to look into it seriously.

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

Ms. Irene Mathyssen: Thank you very much to everyone who's here.

It's interesting [*Technical difficulty—Editor*] that we collectively know or have been exposed to is anecdotal.

In regard to the training, I want to pick up from what Ms. Wagantall said, and with what you said, Dr. Zhang, about the lack of training.

How do we get past that? There's clearly a recognition. How do we provide that clinical training? Has the effort been made?

Dr. Yanbo Zhang: I think the most challenging part is that we do not have a unified voice. From different parties and different institutes and different interest groups, the information may come with very different attitudes.

As we know, from the Canadian Medical Association, the Canadian Psychiatric Association, and all the provinces, we've been making a lot of pamphlets and education materials to try to educate our members, based on what we know. However, that's not really helping the physician who prescribes marijuana. Why? Because when we do the education, the majority of physicians do not really prescribe...or authorize it, and it's because of the concerns about the side effects.

So the message delivery is there, but it's not really an efficient way to do that.

Ms. Irene Mathyssen: Thank you.

To go back to the anecdotal, I'm working on the case of a young man who is suicidal. Over the last five or six years, he was prescribed 29 different cocktails of medicine. There were frequent changes. He was in a state of anxiety, depression, and all the things that go with PTSD. He described his experience with marijuana as being the first time he'd had a good night's sleep in two years. His family called it a godsend.

How do we reconcile this? What is prescribed has to be safe, and I understand that. We don't want to injure anyone more than they are already injured, but when a veteran's wife tells me that her marriage is over because he's so anxious and they can't have any kind of life together and medical marijuana is the only thing that seems to help, how do we reconcile all of this?

● (1720)

Dr. Yanbo Zhang: I think this is the challenge of being a psychiatrist. Why? Because even though we have evidence for a lot of things, even for current medications, they might not necessarily work for individual patients. That's why we follow the guidelines made by a majority or a body of psychiatrists who have done enough research on it. We follow the first-line treatments and the second-line treatments, how we switch, how we add on different medications, and, if that's not working, what we do next.

When we face treatment-resistant depression or PTSD, we have to be innovative. We have to be adventurous. In that case, I'm not opposed to or against using CBD oil or using marijuana to help if we can relieve the pain or relieve the stress a patient has after we've tried everything. However, I strongly disagree with the jump to using marijuana as a first treatment without trying everything we already know, because that is dangerous. It will also lead to more troubles than those we're actually try to solve.

There's always a balance. There's always an exception. I do the same thing when we try a medication that has never really been used. It needs to be based on a full understanding between patients and physicians.

Ms. Irene Mathyssen: It's interesting that there's been a lot of discussion about the use of medical marijuana. It's been there for quite some time. We know that. Why is there such a gap between the current research and tracking of therapeutic effects and the fact that, for quite a while, veterans and others have been using medical marijuana? Is it because people felt stigmatized in admitting that they were using marijuana?

Dr. Yanbo Zhang: I think Dr. Busse can probably answer this as well.

Very briefly, I'm thinking that it's because marijuana has only recently been legalized. In the past, the majority of research came from the FDA. They have really strict guidelines. All of the marijuana they use comes from one source. That source of marijuana probably comes from the 1960s in terms of the strains or in terms of the content. That's why a lot of the research....

It's also very difficult to get grants to support marijuana. The majority will be against it. If you look at side effects or substance abuse, you get grants more easily. That's why even the research itself is biased.

The Chair: Mr. Bratina, you have six minutes.

Mr. Bob Bratina: Thank you.

We have an excellent panel. I'm sorry about the shortage of time, because you're all offering us wonderful testimony.

I looked everybody up and you all have great qualifications.

Dr. Zhang, you studied medicine in China. I was in Qingdao with a medical delegation—

Dr. Yanbo Zhang: Wow.

Mr. Bob Bratina: —and saw how traditional and herbal medicines are incorporated into the general practice. Cannabis exists in the Chinese experience. Are there any conclusions we can draw from that?

Dr. Yanbo Zhang: I don't think so. Why that is, is because ancient-time cannabis was totally different. As I just mentioned, in the 1960s cannabis was different. The hippies who did this drug could not necessarily do the same thing here. Also, since the Chinese government took over 50 or 60 years ago, all of the substances have been strictly banned. Now, it's a very strict penalty, so that's why there's almost zero research and zero exposure to marijuana. It's very difficult to get that.

The second one is, even for Chinese traditional medicine, the standard is different from the western medicine here. I do not think they're practising advanced medicine either.

Mr. Bob Bratina: I see.

Dr. Busse, the testimony that Mr. Cohen gave is slightly at odds, and no disrespect, it's great to have this conversation. Mr. Cohen talked about Boone Cutler's story, which you heard. How would a pure researcher evaluate that kind of evidence? What would you do with it? It's obviously so powerful that Mr. Cutler has taken the steps that he has.

What would you say about that kind of story?

● (1725)

Dr. Jason Busse: I think we need to listen to those types of anecdotes. Anecdotes are a form of evidence and if someone has a dramatic improvement where they were completely non-functioning and with the addition of one particular treatment they then resumed employment, became functional and their symptoms regressed dramatically, that's a very important piece of information to work with.

As a researcher, if I was going to test that on an individual, I would embark on something called an n-of-1 trial, which is really a randomized controlled trial done at the level of the individual. I would randomize the intervention between the active cannabis and a placebo in a random order and I would see if the resolution of symptoms tracked according to what they were getting. There is a way to do studies at the level of the individual. I do take Dr. Zhang's point that a lot of the research we have talks about average effects. Even if something isn't working for the average person, there may be benefit for select individuals. What we then want to learn is what features distinguish the individuals who are more likely to receive the benefit, and what features distinguish an individual who is more likely to experience harm, or even to become addicted, so that we can make clinical decisions that are more responsible to those characteristics.

Mr. Bob Bratina: Mr. Cohen, do you have any comments?

Mr. Jacob Cohen: Yes. I'd just like to add something, although it's anecdotal, on another huge issue with researchers. For example, Raphael Mechoulam, who discovered many of the compounds in the cannabis plant, for many years was actually conducting his research illegally and was obtaining his cannabis products from the Israeli police, who he somehow made a deal with.

The biggest problem is that cannabis and proper research, or actual tracking, is lacking. That's why we are where we are today and we have nothing other than anecdotal evidence, even though it's a weak point to go from.

But there are these almost miracle stories of these patients who are helped by it.

Mr. Bob Bratina: I'm fine, thank you.

The Chair: We have time for two two-minute rounds.

We'll start with Mr. Eyolfson.

Mr. Doug Eyolfson: Thank you, Mr. Chair.

Dr. Busse, I want to ask you a question in the very little time I have.

Just for background, I'm a physician. When I was training—we're going back 20 years now—one of the things we had in the formulary was nabilone. I assume you're familiar with that. It was kept in the formulary in pill form—a THC pill. It was used as an antiemetic and for neuropathic pain.

Has there been any research in that form? That's something that has been around and has been on medical formularies for decades now. Is there any research on that with some of the indications that medical marijuana is now being prescribed?

Dr. Jason Busse: Yes, there has been research on nabilone, which is a synthetic THC analogue. You heard Dr. Zhang mention before that it is a strong agonist, so it has very strong binding to the receptors, which is different from the natural form of THC you'll find in the plant, which is a weak agonist.

We do have clinical trials of nabilone for the indications that you've mentioned. There is moderate quality evidence of effectiveness, which is why it was approved. What we now need to understand is if there is a different therapeutic effect between the synthetic THC analogues versus the products you're finding more in the natural cannabis that's more readily available now.

Mr. Doug Eyolfson: Are you familiar with any patterns in the community?

My practice was emergency medicine, so we never prescribed any form of cannabinoid from my practice.

Are you familiar with any prescribing patterns of nabilone in the community, or is that something that's been more or less restricted to in-hospital use?

Dr. Jason Busse: It's more likely restricted to in-hospital use looking at nausea and vomiting associated with chemotherapy.

There is a lot more of the authorization for medicinal cannabis, which we are seeing, based on the increasing numbers that Health Canada is tracking.

Again, a few physicians are becoming quite active in this space as well.

The Chair: Mr. McColeman, you have two minutes.

Mr. Phil McColeman: Thank you, Chair.

Reading from our briefing notes as they relate to veterans—I just want your reaction to this—the most recent data available from the department is that $31 million was spent on cannabis in the first half of 2016-17. This is reimbursement to veterans. The most current data reported is that we've spent $63.7 million on medical marijuana in 2016-17, triple the amount of the year before.

If there is that much take up of medical marijuana in the veterans community.... I've experienced this personally in the special needs community. Some of them have Dravet, and I missed the testimony. In the Dravet community and such, to get a—at least in my area of the world, which is Ontario—medical marijuana prescription, you can do it by a doctor on Skype, largely. You never meet the doctor. It's by Skype. They call them Skype doctors. You're probably familiar with those.

Do you think there is enough understanding through the medical community to justify this kind of growth in the veterans community of the use of medical marijuana? I'm not making a judgment call here whether it's needed or not needed. These numbers are off the map, from what I can see.

● (1730)

Dr. Yanbo Zhang: I can only speculate what's going on.

I wonder if the legalization of recreational use and the decrease of our resistance in terms of using marijuana have influenced the physicians' opinion of using it. You can buy it anywhere, and it's not a prescription drug, then it must be safe, or safer. I think the threshold of ours to balance whether we should give it or not becomes less strict. That can probably partially explain why it's going on.

I don't think there is any evidence shown for the last two years to say that we have reasons to change this attitude. That's just my speculation.

The Chair: That ends our meeting.

Witnesses, on behalf of everybody here, I'd like to thank you for testifying and for all you do to help the men and women who have served.

The meeting is adjourned.