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Chair

Mr. Neil Ellis

Standing Committee on Veterans Affairs

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● (1530)

[*English*]

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

Mr. McColeman.

Mr. Phil McColeman (Brantford—Brant, CPC): Chair, before we begin the testimony today, I know my colleagues and I would like to speak to the three motions before the committee, which were presented at our last meeting. They were submitted to the clerk within the appropriate period to consider them at committee. I'd like to proceed with the discussion of the first motion.

First of all, I'd like to say to the witnesses here in the room and those who are teleconferencing that the issues before this committee, frankly, are very urgent in terms of what faces our country and the chaos that exists in government today. This will not be relevant to what you're here to testify on today. Thank you for your understanding of the fact that we want to address issues that are relevant today for veterans and that are of utmost importance and urgency. Thank you for coming anyway.

It was interesting today, Chair, that during question period in the House of Commons, we were lectured over and over again by the government House leader about how there's utmost respect for committees and utmost respect for addressing the issues. She said that we are working together as a committee on the current and most pressing issues. One of the most pressing issues actually arose—

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): I have a point of order, Mr. Chair.

Can three motions be moved at once or do they have to be moved separately?

The Chair: He moved the first motion.

Mr. Doug Eyolfson: Okay. I just wanted to clarify that. Thank you.

The Chair: Could you repeat the first motion you moved for the committee?

Mr. Phil McColeman: I'll speak to and read the first motion. It is:

> That the committee invite the acting minister of Veterans Affairs to appear on the Supplementary Estimates (B) on February 25 or 27, 2019.

This is the 25th, so obviously, we know that our agenda today does not include the interim minister coming in as a witness to discuss the estimates, which is the financial appropriations for Veterans Affairs for those of you who are listening in. They amount to $323 million in the supplementary estimates that are requested by Veterans Affairs Canada. This money would be spent on veterans' benefits and they need the scrutiny of this committee, and through this committee to the floor of the House, before they are read into the record as having been deemed approved, which would be this Friday.

I mentioned that this was urgent, when we brought it up during the last committee meeting and asked for the committee to pass what's called a unanimous consent motion for us to be able to table this then, to be able to speak to it and then invite the minister. That did not happen. We were in open session, so it wasn't a closed-door meeting. It wasn't an in camera meeting, but the Liberal members, who have the majority on this committee, all voted in favour of not moving forward with unanimous consent. In fact, that was a barrier to this committee dealing with the spending of government on veterans, essentially saying, “No, we don't need to scrutinize and we don't need to call the chief minister for veterans affairs”.

I might back up a bit first, because I really should give the chronology, so that everyone has the right context here.

When the previous minister, Jody Wilson-Raybould, was in her position, after having been changed from the Attorney General's role to the role of veterans affairs, which was a much discussed issue today on the floor of the House of Commons because many considered it a demotion, with most in the media wondering why she would be demoted. It's been thoroughly talked about publicly that she was removed from her position as Attorney General because of the SNC-Lavalin affair, which was totally relevant today on the floor of the House of Commons.

However, the defence of the government has been to just put up the government House leader and say today, on multiple occasions, that this government does not interfere or put up barriers to the work of committees. However, last week, we had the barrier to the convention that we would hear from the minister, whoever that might be at the time, on the appropriations and spending of government. Now they will not be able to come to committee on a timetable that will meet the requirement for this committee to have scrutiny and have input. We were turned down.

We were told, sanctimoniously I might say, over and over again, that somehow the government was going to do business differently, especially business at committee, and not be obstructionist to opposition members when we wanted to follow the conventions of the committee, yet they did that in our last committee meeting. They basically stopped the committee from moving forward with an invitation to the minister to come and be asked questions about the spending of government for veterans. That's what happened. Those are the facts.

Then today, we get this unbelievable repeated line that somehow it's the opposition who are the ones who are responsible for the dysfunction of committee work. The dysfunction occurs when government members, who have the majority, decide to take the route that this committee took. As I shouted across to the minister, she should come to veterans affairs and watch the committee and watch what they did last week.

● (1535)

The issue, going back, is the fact that we had a new minister put into this position, Jody Wilson-Raybould. In January, she took over as minister. In fact, I remember, on social media, watching her transition into the role. She was meeting with veterans within her community, but she also was meeting with the members inside Veterans Affairs Canada and the bureaucracy in Charlottetown.

Frankly, as I said to her personally, both in writing and in person, I was so looking forward to working with her because she is a person of incredible integrity and incredible background, with huge qualifications to take on this role. I was very much looking forward to her and she was very receptive to working....

In fact, I took to her an issue that I considered to be a very non-partisan issue. It was an issue that was brought to me over the holidays by a veteran who wanted to be sure that every World War II veteran who served in the liberation of the Netherlands—and in those days, during World War II, it was Holland—had received the medal that the Netherlands came out with to specifically honour Canadian veterans. His father-in-law, who had recently passed away, had not received the medal. When this veteran found that out, he wanted to make it his project to find out who had received it, which families had and which families had not. He wanted to make sure that every family, whether it was going to the family of a deceased veteran or whether the veteran was still living—and by the way, there are very few of them still living—properly got the medal of the serving veteran.

I thought that this is a great way to start what I would almost call an icebreaker, something for me to suggest to the minister. I went to Jody Wilson-Raybould and said to her, “Here is the situation. Would you like to work on it together so that we can advance this in a very non-partisan way?” She told me verbally, as we met, that, yes, she'd be very interested. I was very much looking forward to that and, in fact, expressed my regrets, as well, because we know what happened.

The story goes on that Jody Wilson-Raybould decided that she was going to resign from her post as veterans affairs minister the day that the Prime Minister tried to vindicate himself on the SNC-Lavalin case by saying that her presence in cabinet speaks volumes and tells the story, really. Then, hours later, she resigned.

With regard to that resignation, we know that she had the best interests of veterans at heart, and the reason for her resignation wasn't about veterans. In fact, she said some very gracious things during the short period of time that she was the minister. In fact, that's when she visited because she had promised—even after she was removed from her position.

● (1540)

Mr. Peter Fonseca (Mississauga East—Cooksville, Lib.): Mr. Chair, I have a point of order.

The Chair: Yes.

Mr. Peter Fonseca: This is not relevant to the motion.

The motion is on supplementary estimates.

The Chair: He has a point there.

If we could get it back into—

Mr. Phil McColeman: I'm weaving all this into what we are here to do with the supplementary estimates.

Mr. Peter Fonseca: It's not relevant, Mr. Chair.

The Chair: Yes, it's not relevant.

Mr. Phil McColeman: What are you saying to me, Mr. Chair?

The Chair: Move on. Keep going—

Mr. Phil McColeman: I will. Thank you very much.

The Chair: —but try to bring it back.

Mr. Phil McColeman: This is my time.

The Chair: Try to make it relevant, please.

Mr. Phil McColeman: I'm making it relevant by giving context to the fact that Jody Wilson-Raybould had said she would be at this committee for scrutiny of the estimates, and she said she would be here on Wednesday of this week, when she was minister. She said that.

An hon. member: To whom?

Mr. Phil McColeman: It was in our schedule that she was going to be here. In fact, the minister had been invited to come to this committee.

That invitation, by the way, Mr. Samson, was declined on the same day The Globe and Mail first reported on the allegation of criminal activity by the Prime Minister's Office, before she resigned. Before she resigned, she declined the invitation on that day. Previous to that, she was scheduled to come.

What we're asking in the motion, and what we had asked for unanimous consent from your side was.... We understand the sequence of events. That's what I'm outlining to the committee. We understand what they were. We would like the acting minister of veterans affairs.... By the way, the $323 million of spending and appropriations to veterans is the single-largest expenditure in the supplementary estimates. There's no larger expenditure asked for in the supplementary estimates.

However, this committee put its foot down at the last meeting saying, “No, we won't approve the discussion of the motion to get the interim minister here.” We've gone through the procedural way, or the procedural wrangling, because we thought the committee would act in a non-partisan way and say yes. That's been the usual course of action.”

Jody Wilson-Raybould was planning on coming until she declined on the day of The Globe and Mail story, yet we have to come here today with only one day left of committee time—unless the committee wants to choose to hold more meetings this week—with one regular meeting left, without any action or approval from the government side to say, “Yes, we will extend this to the minister and we will make every physical attempt, every attempt we can, to get him here to answer our questions.”

What this tells us in a way, and leads us to, which is part of my second motion—and I'm still speaking to the first motion, Chair—is that if the minister is not prepared to come and discuss the largest spending item in supplementary estimates (B) by the government in a timely fashion to meet the requirements and convention of the House, then really that calls for the appointment of a permanent minister instead of an interim minister. This is what we address in our second motion, when we get to that point in our deliberations here today.

Let me tell you about the kinds of things that are in supplementary estimates (B) that should be scrutinized. These are the very benefits that our veterans rely on, and in some cases, as the PBO has accurately set out for us last week—the PBO, being the Parliamentary Budget Officer, an independent person doing a study—supplementary estimates (B) includes allocations for what the government calls pension for life, and its fulfilment of that promise to veterans.

Let me tell you what the government promised veterans. It promised veterans they would get the equivalent of the pre-2006 new veterans charter pension plan. It was called the veterans pension act. It's relevant, Mr. Chair, because what the PBO reported on last week, as we found out, was that there are veterans, in fact the most seriously injured veterans, who will not receive the amount of money they were getting under the new veterans charter, let alone what they would have received under the Pension Act.

● (1545)

In fact, over the life of their benefits, the average amount that they will not receive from the pension for life is $300,000. There have been several veterans' advocates, one of the most fervent ones being Sean Bruyea, who, by the way, has gone out publicly to say that the pension for life scheme that this government proposes for veterans and will be implemented through the supplementary estimates never did meet the standard of what the Pension Act had provided. It is breaking the promise that this government made to veterans when they campaigned in the last election and said that this is what they would do should they form government.

They failed on that, because when you do the analysis, as the PBO has put forth, it absolutely does not meet that. In fact, in one category, the most seriously injured and multiply disabled veterans, it does not meet the new pension benefits that they were getting. Do you think that we would have questions of the minister as to how the money is to be allocated and spent after we've found out the new and current relevant information that was provided last week by the Parliamentary Budget Officer? You bet your bottom dollar we will. We would ask him tough questions if he were to come.

I highly suspect today that we will face—if this ultimately comes to a vote—the same barriers and the same open committee acceptance of what we should do to be closed.... By whom? By the majority of the Liberal members on this, because that's what we've been experiencing to this point, so why should it change? I keep rolling over in my mind why it is that the minister would not come and want to be asked about the supplementary estimates. Perhaps he doesn't want to come because he's the interim minister. He already has a portfolio and he has added this to his portfolio. Maybe he thinks he's a part-time Minister of Veterans Affairs, which he may well be.

As the government and the neutral chair decide on what they can do procedurally as they meet on the Liberal side of the room, it appears that again in committee the whole line that we've been given by the government today in the House of Commons, by the government House leader, is a total sham. It's totally outright misleading to say that we would have in some ways been able to bring this minister here to talk about supplementary estimates (B) before this committee on Wednesday.

I know what they're saying. They're asking, “How can we we shut this guy down?” They're saying, “He's just going to continue to talk for the whole committee meeting.” I may well do that, but I'm telling you, this is of the utmost importance, because on this side of the table we have very few tools in our tool box to use when it comes to emphasizing the point of what we think is right for veterans. What we think is right for veterans is that we scrutinize every dollar that goes into Veterans Affairs for one simple reason: to get the best value ending up in the hands of our veterans and to stop the over-administration and the overload of bureaucracy that exists in the system. We know it exists. We've had the people here and have talked to them previously.

I keep hearing from veterans about the type of the money that is spent. Of course, the government continues to use a number and say, “Oh, we've spent $10 million.” It doesn't matter to them. It doesn't matter.

What matters are the principles of what runs this, the principles of fairness and of making sure that there is the proper appropriation going to the various programs. We don't know whether there is or isn't until we ask questions of the minister and he, by the way, brings along his top management people from the ministry, from the Veterans Affairs Canada office, so that we're able to ask them questions as well—and that's typically when the minister comes.

● (1550)

We've been denied this so far. Maybe that will change today. Maybe the minister will come on Wednesday so that we can ask the right questions. I truly hope that is the case.

The former veterans affairs minister and the person she replaced when she was demoted because of the SNC-Lavalin situation.... Minister O'Regan came. He came on a timely basis. He took our questions and we appreciated it.

I have no idea why there was resistance put up by the government at our last meeting. This was a motion that was so non-threatening, yet we're told today that this government has the utmost respect for doing the conventions of their committee work in the highest level and highest regard. We heard that over and over again today. It's enough to make someone sick, to hear it as many times as we heard it over and over again.

We know what that's about. That's about the justification for continuing to cover up the real truth of what happened with the SNC-Lavalin affair, the scandal that they find themselves in and the chaos that this government continues to find. Why? Because the previous minister of veterans affairs, Jody Wilson-Raybould, had the best intentions to be a great minister. I think she could have been a great Minister of Veterans Affairs. I truly do. You can see the integrity with which she handles herself. You can see it through the principled approach that she has taken in making sure—to quote her—that she speaks “truth to power”, as she wrote as she departed the justice department. She has had to endure through this period of time. You can tell that's the kind of person who would have been a great minister had she decided that she couldn't speak her truth without taking the actions that she's taken so far. I've said enough about that.

We have an acting minister. We're told by that acting minister in Parliament last week, by the way, that the Parliamentary Budget Officer is wrong about the fact that the most injured veterans will receive less under the new pension for life scheme.

Perhaps it shouldn't have been shocking. As I looked across at him and said that's not true, he insisted that it was true. Then the next day—on Friday during question period—he doubled down and said they will receive more. When the minister is here, it's part of the estimates to show us the numbers that he sees that the Parliamentary Budget Officer got totally wrong. We went back to the budget officer. He's an officer of the House who is completely neutral. We went back to the neutral report and asked if there was something we missed. Is there something he knows that we don't know? Is there something that the people in his ministry can explain to us to say why he would say such a thing to the members of the House when it wasn't true?

When we went back and drilled down and looked at every chart and calculation with all the information that was provided by Veterans Affairs Canada to the Parliamentary Budget Officer, we found the numbers to be the ones that Veterans Affairs Canada had given him. His own senior management had approved those numbers going to the Parliamentary Budget Officer, with which he made his determination that the most seriously injured veterans will receive about $300,000 less under this new pension for life scheme that this government has brought—a clear broken promise for all veterans, but in particular for the ones who need it the most.

● (1555)

I talked about the $323 million in the supplementary estimates that we want the minister to come and examine. I want these other questions answered by his senior management people. I want them to tell us, one way or another, if the minister's correct or the Parliamentary Budget Officer is correct. I would suggest we bring in the Parliamentary Budget Officer as well, at a time when we can query him on his report. His report was broad-ranging. It went through three different regimes. It analyzed each one and compared each one from the time the previous government was in power, previous to 2015, to today. He looked at the cross-section of pretty much everything that's been offered to veterans on the pension issue and on all spending over those periods of time.

I would definitely ask each member to look at that report in detail—in great detail. Spend time looking at that report. This is done by an independent person who's appointed by the House of Commons to make sure that the person is as independent as they possibly can be. It then gives them the latitude to be able to interpret the numbers.

I can remember that when I was on the scrutiny of public spending committee, we were always calling in the Auditor General. The Auditor General would come in and explain how he came up with his numbers when he did Auditor General reports on various parts and operations of government. This is the very same situation we have here. We have deep, deep concerns that the appropriations are being spent in the right direction. This is especially true when we hear from his report—it's explicitly stated, too—that the most injured members of our military, the most hurt from their service who now find themselves veterans in the Liberal pension for life scheme, will receive an average of $300,000 less than they would have under the new veterans charter scheme, the one that existed the day before, let alone going back to the Pension Act they promised they would give veterans the equivalent of.

We need answers to these questions from the minister. Preferably, the Prime Minister would find his way to appointing a full-time minister, treating veterans with more respect than he's currently treating them with an interim minister. They need a full-time minister. They need someone of the quality that Minister Jody Wilson-Raybould was bringing to the table until her abrupt resignation over the SNC-Lavalin affair.

Mr. Speaker, I could carry on with why the accountability, openness and transparency that was promised by this government is reflected in the fact that we experience at this committee the barriers to bringing the interim minister here, yet these are the very tenets they told Canadians they would do differently. I will repeat that they continually mislead in the House of Commons when their House leader gets up and says that they have the utmost respect for committees.

● (1600)

This is one of the areas that this committee has failed tremendously on by not respecting the fact that we have had ministers here on supplementary estimates (B). Every time we've had them in front of us. Right now, there is no respect whatsoever from the interim minister that he would come on a timely basis.

I would ask the members opposite that they give deep consideration to the fact that the Parliamentary Budget Officer's report, in a very neutral and non-partisan way, shot nothing but holes in the future spending through the pension for life scheme. There's an amazingly huge hole for those who are the most injured.

I've met with these veterans. Quite a few of them are in wheelchairs. Quite a few of them don't have their legs. Some don't have their arms. Some don't have mental capacity anymore. These are the ones that the Parliamentary Budget Officer is saying are going to be affected. Money's taken away from them that they would have had under the pension scheme as it existed the day before this new scheme goes into effect.

I want to make that distinction and make it very clear that this is talking about spending supplementary estimates. We're talking about future spending that would go to that, which will ignore the fact that these veterans, the Mark Campbells of the world who are sitting in Edmonton, who know what it's like to have a life without limbs, who know what it's like to deal every day with the mental stress of living a completely new life because he was in a vehicle that got blown up. While most of his comrades did not survive, he survived and he asks himself every day, “Why me?”

Because of the Mark Campbells of the world and others who would say, if you had them here, as they've said to me over and over again, that all they want from their government is the level of respect they earned. To show them respect by taking benefits away through future appropriations to Veterans Affairs Canada is something we cannot allow.

You ask why this is urgent. You ask why we are passionate on this side about this issue. It's because we met with those individuals. We've had them here in Ottawa. We've met them in their own homes and examined how they have to live after their service to this country. Although all things are important to veterans and our study is important to veterans, this is way more important right now because what we're going to have happen is to have it go straight through as though we did study it.

The government members on this committee prevented us from moving forward on this last week, so we procedurally brought it back this week so we could speak to it. They shut down our speaking to it last week, by the way, through a motion of one of their members who said he moved the debate be ended, which is a non-debatable motion called a deleterious motion. You can't debate it. That's the way they got around it last week.

Unfortunately, their scheming can't get around the fact that we can talk to it as long as we bloody well want. And we shall talk to it and we shall be heard on this side. This is our parliamentary prerogative, our parliamentary privilege, we're talking about. This is about doing right for veterans. This is not about figuring out how you shut down the other side, which they so effectively did at our last meeting.

● (1605)

As I said, we have very few ways to do this on this side, when there is a majority on the other side. “Don't worry,” the House leader says. “We want to operate differently. We want to be respecting the committees. They're masters of their own destinies.” Give me a break.

When we talk about the people who will be affected by supplementary estimates (B) in the veterans community, I think about those people hurt the deepest. I also think about the other people who are waiting, who have been waiting or who have sued the government.

Sean Bruyea, by the way, is suing the former minister—two ministers ago now. They're in court together. He's having to sue the minister over his benefits, over something the minister said about him that discredited him.

Do you see a pattern in how this government wants to deal with veterans, with the work of this committee and with what they've been doing of late? Do you see a pattern evolving here of our trying to push the relevant issues of today forward, and of the motion, again, to have the Minister of Veterans Affairs talk about this at our next committee meeting?

I want it to be at the next committee meeting. I think the minister should want it to be at the next committee meeting, not the one after they're deemed read in the House of Commons. That's an option and we may look at that option, but today, we still have time. There are 48 hours before the next committee meeting.

I've seen emergency meetings of various committees where the ministers will drop what they're doing and come, because they know the significance. They recognize the importance. This is how Parliament works. This is how the House of Commons works. We are an extension, as a committee, of the House of Commons.

Maybe members don't take this as seriously as they should. What we are, in essence, is a mini House of Commons, in many ways. We are charged with the responsibility of doing our work and of making sure we scrutinize. In the opposition benches, we hold the government to account on the ways they choose to move forward.

In this case, we have a majority government and we all, ultimately, lose. That's why I will continue to talk. I suspect my colleagues will as well because we know, at the end of the day, that when we give up, when we throw in the towel, they will defeat us. They have the majority vote. That's what they did in the last committee meeting. They defeated us. They can defeat us at any moment. They have to choose, going forward, based on the motion in front of us today, whether or not it's as large, as urgent and as important as we think it is on this side of the table.

I think I'll end my comments there, Mr. Chair. Before I do, can I ask, on a point of order, who is on the speaking list and in what order they're speaking?

● (1610)

The Chair: Mr. Kitchen, Mr. Eyolfson, Mrs. Wagantall and Mr. Johns are on the list.

Mr. Phil McColeman: Mr. Kitchen is next on my side. Is it Mr. Eyolfson after that?

The Chair: Yes.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): I have a point of order, sir. Mr. Chair, you were looking right at me, and my hand was up before Mr. Kitchen's hand—

The Chair: The clerk took the order.

Mrs. Cathay Wagantall: You should correct it.

The Chair: That's the way the list is.

Mr. Gord Johns (Courtenay—Alberni, NDP): What is the list?

The Chair: Mr. Kitchen is next, then Mr. Eyolfson, Mrs. Wagantall and Mr. Johns.

Mr. Phil McColeman: That being the case, I think I'll continue to talk about how important this is, because I suspect I know what my Liberal colleague will do, which is to stop debate, which he has done on numerous occasions. When we get to his comments, he has said before to this committee, as he did last week, "I move to adjourn debate".

When that happens, it's a deleterious motion. It gives clear direction to say that there will be no further debate. They vote to end debate and then we don't deal with the issue. It drops dead on the table, so to speak. I regret that other opposition members won't be able to speak to this before the government has a chance to shut down our conversation.

Of the many committees I've been on over my 11 years here on Parliament Hill—in a minority Liberal government, majority Conservative government, minority Conservative government and now a majority Liberal government—the obstruction that is happening right now in committees totally contradicts what this government said it was going to do. In fact, it has moved it to another level in some cases, of flexing their muscle as a voting machine to get what they want.

When we talk about supplementary estimates (B), every time this has come before any other committee I've been involved with, there has been no discussion of "Let's reconsider doing this" or "Let's reconsider calling the minister." It's always, "Yes, let's get on with it. Let's get the minister here and let's scrutinize the spending as we should."

These are taxpayers' dollars. These are the dollars that people at home have sent in to the government. It baffles me. It's the money of hard-working people who are honest and pay their taxes that's represented in the $323 million. Some of it might have been borrowed, because this government has a penchant for borrowing money they don't have. However, that said, it's money that we are accountable for—every one of us as a member of Parliament.

When I think back to the structures that have been put in place for us to have the honest truth about government and I hear the Parliamentary Budget Officer describe, in no uncertain terms in his report, that the future spending vis-à-vis the appropriations, supplementary estimates and the estimates, when they eventually get approved.... It's unconscionable to me that we would allow a committee to use their partisan bullying and not address it.

This is what they did last week. This is exactly what they did. They shut down debate.

● (1615)

Mr. Darrell Samson (Sackville—Preston—Chezzetcook, Lib.): Mr. Chair, on a point of order, the member is repeating over and over again the same information.

I would like you to rule on that, please.

The Chair: Why don't we have a bit of a break?

Mr. Phil McColeman: Sounds good to me.

The Chair: Let's have a 10-minute coffee break.

● (1615)

(Pause)

● (1625)

The Chair: I call the meeting back to order.

Mr. McColeman, you still have the floor.

Mr. Phil McColeman: Thank you, Chair.

The good news is that I think we can move on from this, but before we do that, I do want to give my colleague, who is second on the speakers list, the opportunity to make his comments. Then I believe it's Mr. Eyolfson after his comment.

I yield to Mr. Kitchen.

The Chair: Mr. Kitchen, you have the floor.

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

Thank you for being here.

As we discussed last week, this issue of inviting the minister is an important issue. To be able to discuss the supplementary estimates and for us to scrutinize them before they're presented to the House is a tremendous responsibility on our part, as a committee, to make certain that we've looked at this the best we can for all our veterans.

When the Parliamentary Budget Officer came out with his report the other day, I received numerous phone calls from veterans within my riding, a lot of them concerned about what this meant and the huge implications it has. When I'm able to respond to those constituents of mine.... Actually, some of them are from outside my constituency and I just happen to know them, and they also called and had major concerns. In fact, among them was even one who is presently serving with the forces and about to be medically released. He has some major concerns, especially when he reads documents.... For example, I'll just quote here from the executive summary of the Parliamentary Budget Officer's report.

It says:

> As presented below, PBO found that the Pension Act regime is the most generous for the veterans and the most expensive for the federal government. The Pension for Life regime is slightly more generous than the Veterans Well-being Act regime.

These veterans have big concerns about that. They have concerns about the most injured veterans being worse off now than they were before.

It's on my watch, as a new member of Parliament and a member of this committee. When I sit down and meet with veterans in Remembrance Day ceremonies, they say to me, what are you going to do for us? When I hear from an Afghan veteran who's returned, who would have taken a bullet for his colleague and his comrade at any time while serving, and even today, talk about what happened to one of his comrades who had an IED blow up and lost his legs, his statement to me is, “I need to be here”. And I believe we all need to be here, to speak on behalf and to represent these constituents.

I think it's incumbent upon us that we get the chance to talk about these supplementary estimates, and that we, as a committee, have the opportunity to put these questions, these hard questions, to the minister about the impact this is going to have on our veterans.

I thank you for the chance and the opportunity.

● (1630)

The Chair: Thank you.

Mr. Eyolfson.

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

If I may offer a friendly amendment to the original motion, it's that the motion would now read:

> That the committee invite the acting minister of Veterans Affairs to appear on the Supplementary Estimates (B) on February 25 or 27, 2019, or the subject matter of the Supplementary Estimates (B) 2018-19 and the subject matter of the Interim Estimates 2019-20 on March 18, 2019.

Is that an acceptable amendment to the original amendment?

The Chair: There's the amendment. Is there discussion on that?

Mr. Phil McColeman: That's fine.

The Chair: Mr. Samson, did you have your hand up?

Mr. Darrell Samson: Yes, please.

The Chair: Go ahead.

Mr. Darrell Samson: I'll go with this amendment, but I'm very saddened, because we were already in the calendar, which my colleagues across the floor know very well. The minister was due to come that March week as well, so the hour lost to the witnesses is sad because what we're accomplishing here today is exactly what was happening anyway.

Thank you, Mr. Chair.

The Chair: Now we'll open it up.

Gord, your hand was up first.

Mr. Gord Johns: To Mr. Samson's comments, actually the minister was initially scheduled through an email of the draft schedule to appear on February 27. We have not been formally told the minister will be here on March 18 until now. That is actually not true. I know there have been discussions in the back halls, but there's not been an email sent to anyone at this committee, nor has that been tabled here at the committee until right now.

The Chair: Thank you for that.

Mr. McColeman.

Mr. Phil McColeman: To Mr. Samson, where was that information? We did not get that this was the case, because we have not heard either. We would say the same thing as my NDP colleague just said, that there was nothing we were told anywhere in writing or verbally that was the date we had scheduled the minister. Could I have an answer to that, please?

How did he know it?

● (1635)

The Chair: I don't know if that information came to the clerk today. Did that come today? I don't think so

Let's call a vote on the amending motion.

Mr. Phil McColeman: No, Chair, I'm not letting—

The Chair: Mr. Samson—

Mr. Phil McColeman: No, you know what? I listened to this member in the House, and I have to tell you, it upset me greatly because he took such an over-the-top aggressive approach to describing how we on this side of the House—

A voice: [*Inaudible—Editor*].

Mr. Phil McColeman: Look, it's my time to speak.

Now he has the audacity to come here and scold us, because we didn't know something that was never sent to us. I want an apology.

The Chair: Okay, let's call the vote.

(Amendment agreed to)

(Motion as amended agreed to)

The Chair: Now we can start with the witness testimony.

We have in front of us today GenCanBio Inc., Mark James, vice-president. As individuals we have Ramesh Zacharias, medical director at Hamilton Health Sciences and Tony P. George, professor of psychiatry at the University of Toronto. From Tilray, we have Philippe Lucas, vice-president, global patient research and access.

Since we have somebody from Sydney, Australia, we'll start the first round of testimony with Mr. Lucas, and hopefully we can keep this to around seven minutes.

Thank you.

Mr. Philippe Lucas (Vice-President, Global Patient Research & Access, Tilray): Thank you very much, Mr. Chair and members of the House.

My name is Philippe Lucas. I'm vice-president of patient research and access for Tilray. I'm also a graduate researcher with the Canadian Institute of Substance Use Research, and I'm vice-chair of the Cannabis Council of Canada, an industry association representing licensed producers in Canada.

I'm speaking to you today as a long-term patient advocate for medical cannabis patients. I've been working in the space for over 20 years, initially as a patient, then as a patient advocate and provider, and over the last five years in my role at Tilray. Tilray is a global pioneer in medical cannabis research and distribution. Our products are available in 13 countries on five continents right now.

Tilray has done much over the years to work with Canadian veterans to improve the lives of those who might benefit from the use of medical cannabis. We currently serve more than 500 veterans registered with Veterans Affairs Canada. We're the title sponsor of the Wounded Warrior Run B.C. and the Highway of Heroes Bike Ride. Ironically while we're speaking here today, the Wounded Warrior Run B.C. is on its second day, and you will see veterans—police, military and first responder veterans—running from the top of Vancouver Island down to Victoria over the next week, through sleet, snow and rain, to raise attention, awareness and funds for vets who might be affected by PTSD.

Tilray has put in place some very VAC-specific services to aid veterans who might benefit from the use of medical cannabis. Those include putting in VAC limits where we charge all veterans $8.50 per gram—a sort of discount cost on the grams of cannabis they order from Tilray—to ensure they have access to the full selection of products that they need. We have also put in place what we call the VAC bridge program, which allows vets to order cannabis before their VAC approval goes through, to ensure that veterans are not out of pocket when they're ordering medical cannabis. On top of that, we have VAC specialists on staff who can work through approvals, denials and reimbursements with those veterans.

We're a leader in medical cannabis research, and that includes doing a phase two clinical trial at the University of British Columbia on medical cannabis as a treatment for post-traumatic stress disorder. At 42 participants, that's the largest medical cannabis clinical trial to take place in Canada in at least the last four years, and the first medical cannabis clinical trial to examine the use of cannabis in the treatment of a mental health condition. Over the next few weeks, we'll be announcing a second site for that trial in British Columbia.

Today I want to share, very quickly, the results of the Canadian cannabis patient survey from 2017 that we ran. That survey at the time was the largest survey of Canadian patients to date, with 2,032 responses. I took this opportunity to break out the responses of patients who identified post-traumatic stress disorder as their primary condition.

What we see from these patients is that medical cannabis is primarily used in the treatment of chronic pain and mental health, but compared with other patients, those affected by post-traumatic stress disorder are more likely to be disabled. They're more likely than the general population to report use for anxiety, stress and depression rather than simply chronic pain. They're more likely to use cannabis daily, and to use more than the average patient—2.1 grams per day versus the 1.5 gram average of other medical cannabis patients. They're more likely to use cannabis extracts.

Also, perhaps most important to this committee in looking at the health and welfare of veterans, they're also more likely to reduce their use of opioids, antidepressants and benzodiazepines as a result of their use of medical cannabis. According to data from Veterans Affairs Canada, the recent significant increase in the number of veterans using medical cannabis is paralleled by a nearly 43% decrease in the number of veterans using benzodiazepines and a 31% decrease in the number of veterans using opioids.

Tilray has put in place VAC-specific services to assist Canadian veterans, and today we're here to urge you to reassure veterans of the government's commitment to covering the cost of medical cannabis for veterans who might benefit from its use. We're urging you to remove the punitive excise tax as well as the sales tax on medical cannabis that's affecting critically and chronically ill Canadians across the nation, and to increase research funding to examine the therapeutic potential of medical cannabis in the treatment of post-traumatic stress disorder, traumatic brain injury, mental health and chronic pain.

● (1640)

I look forward to your questions, and I really appreciate being invited to speak to the committee today.

The Chair: Thank you.

Next, we'll have Mr. George, professor of psychiatry, University of Toronto.

Welcome, Mr. George.

Dr. Tony P. George (Professor of Psychiatry, University of Toronto, As an Individual): Thank you for having me.

It's a pleasure to be able to speak in front of this committee on veterans.

I'm a professor of psychiatry at the University of Toronto, and an addiction psychiatrist. I think the previous speaker covered a little bit of what I wanted to say.

I have been doing research for many years now on cannabis and mental illness, in particular on the harms that come with that. I have studied people with psychotic disorders like schizophrenia, mood and anxiety disorders like depression and bipolar disorder, and even post-traumatic stress disorder—PTSD. I think that now with legalization here there are tremendous opportunities to understand the effects both on the general population and on people with specific mental health disorders.

The preponderance of the evidence—and I'm very delighted that licensed producers are actually doing this research—actually suggests a fair amount of potential harm in people with psychotic and mood disorders. Even in the PTSD literature, this is quite mixed right now. Again, I applaud the research being done in this area. Moreover, I think the reduction in the compensable grams per day of medicinal cannabis from 10 to three grams was a step in the right direction by Veterans Affairs Canada, just because of these harms.

We know that these harms in particular relate to two things. Number one is the content of THC in cannabis. That's tetrahydrocannabinol, which produces the “high” and many of the positive effects but is also related to harm. The other thing that counteracts that is this other cannabinoid, CBD or cannabidiol. Essentially, the ratio of those two dictates safety. The lower the ratio, or the more CBD that's in cannabis of any form, recreational or medicinal, the more it's going to potentially lower the harms.

The other thing I just want to state is that whether folks are getting medicinal cannabis—our veterans who are getting medicinal—or using recreational cannabis, there is going to be a subset of them, probably between 3% and 5%, who develop cannabis use disorder, as we call it in the medical field. The key thing I want to state about that is that it's a treatable disorder. There aren't any medications yet approved for that, but there is a lot of research in treating problematic cannabis use. There are lots of behavioural therapies and talk therapies that are not widely accessible. If our veterans are going to be at risk for developing these disorders, we want to do everything we can to put evidence-based treatments in place so that we can treat problematic cannabis use. It doesn't have to be a psychiatrist or a psychologist. Any willing provider can do that.

In summary—and again, I want to thank you for having me billed to come to speak to you—I think there's tremendous progress that has been made in understanding medicinal cannabis. Now with recreational cannabis, it's very likely that we could see increases in the rates of overall use in the population, including in our veterans. We want to do everything we can to control or limit the amounts of THC because we know that at a certain point it's going to do harm, particularly with developing brains and for people who are at risk or who have existing psychiatric disorders and mental health issues. We have treatments that can work.

Thank you for the time and for having me.

● (1645)

The Chair: Now, it's Mr. James.

Mr. Mark James (Vice-President, GenCanBio Inc.): Thank you.

First of all I want to thank the chair of the committee for giving me the opportunity to speak today. The subject is very close to my heart.

I am a businessman from Halifax, formerly from Fall River, Nova Scotia. I'm a retired RCAF pilot and a former combat arms officer as well. I had a career in the military spanning 35 years. Since then, I've also worked as a first responder in both search and rescue and firefighting.

Over the course of my military career I saw first-hand the mental and physical implications suffered by comrades from PTSD and chronic pain, so this is first-hand.

The bonds we forge in the military continue long after the uniform comes off, and as such, a business venture I became involved in as a co-founder is a company called GenCanBio. GenCanBio is a Nova Scotia company. We're dedicated to pre-clinical research on the interaction of various cannabinoids and terpenes and the efficacy of these ratios on specific conditions.

GenCanBio has been working on and investing in cannabis-related research into PTSD since 2015. Working with the National Research Council of Canada we've developed a high throughput assay to screen these cannabinoid ratios for conditions such as pain and anxiety. GenCanBio has since partnered with an Ontario-based pharmaceutical company called Ethicann for the development of ethical-based drugs based on botanical extracted cannabinoid oils for symptomatologies including PTSD.

Currently, veterans can purchase various forms of cannabis, but the batch-to-batch purity and potency lack the consistency of an approved pharmaceutical. None of my former comrades wants to get high; they want to get better and they want to be productive. GenCanBio and Ethicann believe strongly that smoked medical marijuana will no longer exist shortly. It will be replaced by a standardized, botanically sourced drug that has been subjected to the regulatory scrutiny of Health Canada, the FDA and other regulatory agencies.

Ethicann is currently working with the U.S. Army to develop a clinical protocol for PTSD. We've reached out to Dr. Cyd Courchesne, chief medical officer of Veterans Affairs. We met with her in early December 2018 to discuss PTSD in Canadian veterans and the need for a well-characterized cannabinoid pharmaceutical to treat them.

Dr. Courchesne facilitated for us the outreach to several Canadian PTSD researchers, including the Canadian Institute of Military and Veteran Health Research and the centre of excellence on PTSD and other related mental health conditions.

In January 2019, we met with Dr. Alice Aiken, who is the VP of research and innovation, and Sherry Stewart, professor of physiology and neuroscience at Dalhousie University in Halifax, both of whom are very excited to work with us on a clinical protocol for PTSD in conjunction with the U.S. and hopefully the Canadian militaries.

We are thus currently working with several Canadian licensed producers and extractors to develop pharmaceutical-grade APIs—an API is an active pharmaceutical ingredient—that can be formulated for clinical studies on veterans with clinically diagnosed PTSD symptoms. Having the support of Veterans Affairs to offset the cost and timelines of these efforts will greatly benefit Canadian veterans.

In closing, I wish to thank the chair and members of the committee for allowing us to express our views today. We believe and have seen that medical cannabis imparts great quality-of-life benefits to our wounded men and women, but I respectfully submit that there's an alternative and better delivery system for this, one that is more effective, more predictable and more cost-efficient. Working together, this is something we can make happen.

As such, I've included in my speaking notes—I'm not sure whether you received these—letters from the presidents of GenCanBio and Ethicann, with requests to continue this dialogue.

● (1650)

Thank you.

The Chair: Dr. Zacharias.

Dr. Ramesh Zacharias (Medical Director, Hamilton Health Sciences, As an Individual): Mr. Chairman, good afternoon honourable members of the Standing Committee on Veterans Affairs addressing the issue of cannabis use among veterans and its effect on their well-being.

My name is Dr. Ramesh Zacharias. I am an assistant clinical professor in the department of anaesthesia at McMaster University. I'm also the medical director of the Michael G. DeGroote Pain Clinic. I'm also the co-chair of the physician advisory group for the centre for medicinal cannabis research at McMaster University.

It is truly my honour to address the issue of medicinal cannabis use by veterans and the impact on their well-being.

I'm going to frame my presentation around identifying three of the current challenges and propose three opportunities to ensure the safe and effective prescribing of cannabis.

The first challenge is what I call “the cart before the horse”. Since cannabis was legalized on October 17, 2018, the availability of cannabis for medical purposes was instituted prior to our understanding of the efficacy and safety in a variety of conditions. As a consequence, the medical claims are either overly positive or negative. On the one hand, cannabis is being viewed as a panacea with a cure-all for many medical ailments and at the same time, there are those who see legalization as a Pandora's box, the use of which predisposes the public to unknown harms.

I have been involved in prescribing cannabis for over 10 years. I am of the opinion that with the appropriate patient selection, the use of validated screening tools and informed prescribing, cannabis will be a benefit in a number of conditions.

Although anecdotal evidence has highlighted the potential beneficial role of cannabis for symptom management, such as pain, sleep, nightmares, anxiety and PTSD, the research community is far from having a complete understanding of the mechanisms of cannabis use for common health problems faced by Canadian veterans.

Second, in addition to my work at McMaster University and Hamilton Health Sciences, I have been an investigating coroner in the province of Ontario since 2012. Over that time period, I have either been the investigating coroner or the regional supervising coroner investigating over 1,000 cases. Sadly, a number of those were opioid-related deaths.

The majority of education that was provided to physicians with respect to the prescribing of opioids was provided by the pharmaceutical industry, and unfortunately today, the majority of education for health professionals completing medical documentation is once again being provided by the licensed producers.

The third challenge is the way cannabis is currently being prescribed in Canada. My practice involves looking after veterans. Unfortunately, a number of our veterans have received their medical documentation over Skype without actually being seen by a health practitioner in the office. Once the medical documentation was completed and submitted, they were then scheduled for a follow-up appointment in one year. I find it hard to believe that we as a society would support a process for prescribing any treatment for chronic disease over Skype, with a subsequent monitoring one year later.

Having laid out the challenges that we currently face in Canada, I would like to propose three solutions. I do believe we have a great opportunity to make changes in the way cannabis is currently being prescribed.

In order to address this issue, one year ago we established a data registry called DataCann. The purpose of it was to gather real-time prospective information on patients using medicinal cannabis. We collect information on their diagnosis for which they have been prescribed medicinal cannabis, but equally important, we use validated tools to assess overall functions: sleep, anxiety, depression, PTSD, as well as the early identification of those who could possibly develop cannabis use disorder.

● (1655)

I believe we have a great opportunity to monitor the effectiveness and safety of cannabis among veterans by having them enrolled in this registry voluntarily. This registry has been funded by the Michael G. DeGroote Pain Clinic, the national institute for pain, at McMaster University and the Centre for Medicinal Cannabis Research. We have received no funding from industry.

The second opportunity we have, if we want to learn from some of the mistakes of the opioid crisis, is that we need to develop Canadian guidelines for the prescribing of cannabis. The first Canadian opioid guidelines were developed 15 years after OxyContin was released. It is extremely important that we create evidence-based guidelines for all health practitioners who are prescribing cannabis. I think it would be important for this committee to encourage CIHR to fund the guideline development.

Finally, the federal government can play a significant role by supporting data collection today, as well as funding much-needed research. We have the infrastructure and a network of outstanding researchers in this country that, when funded appropriately, can give Canada a leading role in informing the dialogue about appropriate use of medical cannabis.

Once again, I would like to thank the chair and this committee for the honour you have given me in presenting to you today on this important topic.

The Chair: Thank you.

We'll begin with five-minute rounds today.

Ms. Wagantall.

Mrs. Cathay Wagantall: Thank you, Chair.

Thanks to all of you for your testimony today. I really appreciate it. I'm very grateful that we were able to hear from you.

Very quickly, on the committee here and as deputy shadow minister for veterans affairs, I talk to a lot of veterans specifically about this issue. In one example of many, a gentleman was bedridden for years. His wife would turn him over, feed him and give him his prescriptions: a thousand pills, pharmaceuticals, per month. Someone said to her, “Look, you have to at least try this.” She was getting the 10 grams before they changed it and would make a suppository, which is not for fun. She gave it to her husband.

The first time she gave it to him, she had an actual conversation with him within a half hour. She had not had one with him for years. Long story short, over time, he continued to improve. She wanted to take him off the pharmaceuticals he was on. She could not get the assistance of a psychologist or a doctor to do that. No one would help her with that step. She did it on her own, which was very frightening, as three of the prescriptions were stronger than opioids. Over time, he eventually walked into his doctor's office. His doctor's jaw hit the floor and he said, “I need to call all of my colleagues together because we need to speak with you.” This is typical, I think, of a lot of things that have been going on without the proper background and research, and without the proper education of our physicians on how to cope with these circumstances.

There are two things that I would like your response on, maybe from Dr. Zacharias first, and then I would ask the others to please come in as well.

How important is this research and that it not be impacted by funding? You say there's no industry funding in the research. I'm concerned that it doesn't become just another method of making a lot of money for pharmaceutical companies, rather than making sure that it's actually serving the way it's supposed to serve and having in place all of those checks and balances that you speak of.

● (1700)

Dr. Ramesh Zacharias: As I think I laid out, we have some challenges today. Part of that is the lack of knowledge among those who are prescribing it and also the lack of research towards understanding what works well. That was the reason we started our data registry: because we wanted to collect information up front on who's getting prescribed and how much, and what's happening to their medications. We track whether their medications are coming down. Has there been a change in what they're using?

Currently, we have 22 clinics across the country. Interestingly enough, 25% of patients on the registry are indigenous patients. We have a number of veterans who are on it, but I believe that now that we're prescribing cannabis to 9,000 veterans in this country, it would be extremely important for their well-being that we track what's actually happening to see whether their symptoms are getting better. There are a lot of stories just like what you told. Unfortunately, I've also seen a lot of disasters with cannabis as well, so I think collecting data in real time would be helpful.

We have a very robust research community in this country. Given the opportunity to fund them, I think they could address specifically the issue of what cannabis will work. I said earlier in my statement that I've been prescribing it for 10 years. In the right patient, with the right monitoring, it would be good.

Mrs. Cathay Wagantall: Maybe, Dr. Lucas, you could respond to this.

In my province there is one doctor who would prescribe at the time that this individual was getting the help because they weren't prepared. Even if we get through all this research, what kind of a timeline are we looking at in terms of this being able to be handled with confidence by our physicians?

Mr. Philippe Lucas: I think there is encouraging news in that area. I've been working on this for over 20 years. I can remember when I knew all the doctors prescribing cannabis in Canada. You could count them on two hands. The latest report from Health Canada, from September, suggests over 18,000 physicians across Canada have prescribed cannabis at least once. That's a quarter of all physicians across Canada. Under those circumstances, it's hard not to think of medical cannabis as, in many ways, being a blockbuster treatment.

I completely agree that this is not the right treatment for all patients under all conditions. There are vulnerable populations out there, be they youth, women who may be pregnant or people with a predisposition for psychosis or schizophrenia, and of course we believe there should be some tracking to ensure the safety of those patients. It's one of the reasons that Tilray and patient groups have been advocating for pharmacy-based access to medical cannabis so that patients can get the benefit of a health care provider and get their advice as they pick up their cannabis, rather than just simply having it sent directly to the door, as is the case under the current system.

Licensed producers would love not to have to fund clinical research anymore. It's an expensive endeavour. That's why very few of us are doing it right now. There are 130 licensed producers in Canada. Only a couple of them are funding phase two or phase three clinical-style research. If the funding was available through the federal government, we'd be more than happy to make that available.

I also want to point out that like any clinical research project with academic affiliation, these studies have gone through rigorous ethics reviews, both via Health Canada and the academic institutions where they're taking place. In regard to our PTSD study, that would be the University of British Columbia. To mitigate any conflict of interest associated with funding or otherwise, we're completely separated from the data gathering, data analysis, associated with those studies. This is a very common practice, and we want to ensure that the data we collect is as independent as possible so that we can learn about the benefits and harms associated with medical cannabis.

Mrs. Cathay Wagantall: Thank you.

Do I have more time?

The Chair: No. Thank you.

Mr. Eyolfson.

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

Thank you to all the witnesses for coming.

I come from a medical background. I'm an emergency physician. I practised for 20 years. Coincidentally, Dr. Zacharias, I'm married to an anaesthetist.

I was glad to hear what you've been saying because I felt the same, although I was a supporter of legalizing for the recreational because I think the harms of the previous regimen were greatly outdoing the benefits. I was trying to find good medical evidence for it. I agree, some witnesses have said cannabis, in large part, although it has some use, has been more a triumph of marketing over science. I'm glad to hear you say that we need better evidence. We need a good, strong system because we want to do no harm, as the first part of the Hippocratic oath says.

I also really like your idea of a registry so that people who are having it prescribed can be tracked. I think that's a very good idea too. I think that's a good way we can get some research done.

Of the evidence that is there, what evidence do you know of on the use of cannabis for either pain or anxiety secondary to PTSD? What is the evidence that you're aware of on the benefits versus the harms in them, Tony?

● (1705)

Dr. Tony P. George: That's a very important question. Cannabis affects on anxiety is somewhat indeterminate, whether it be within the context of PTSD or independent of that: generalized anxiety, panic anxiety, etc.

The preponderance of the studies has been not well-done one-time assessments, what we call cross-sectional, but generally those have been somewhat mixed. There are very few prospective studies whether of THC cannabis or CBD-rich cannabis. I think that's where we await the results of properly done clinical trials. Again, it's somewhat indeterminate, and what I worry a little about are anecdotal reports that might get overblown. That's why we need to do rigorous evidence-based studies. Whether it's academic investigators in universities or licensed producers, someone has to do this research and do it with rigour and transparency. Then we'll know the truth.

It has great potential, but let's get the facts behind it or not.

Mr. Doug Eyolfson: Okay.

Dr. Zacharias.

Dr. Ramesh Zacharias: There's moderate evidence of benefit in spasticity disorders and patients with MS. There's moderate evidence in chronic pain. There's weak evidence in anxiety, as well as sleep disorders. In educating people on prescribing, we have to be concerned that there are some red flags where you can see real challenges. Those are patients who have schizophrenia and bipolar disorder.

Part of the education that's required is to be able to bring that information out. Huge credit should be given to the Ontario Medical Association. Last October, they retained our research institute and we created the fundamentals of cannabis, module one, and a second one on pharmacokinetics and dynamics. They were distributed to the 36,000 doctors in Ontario. It's that kind of information that needs to be disseminated. Developing these education modules was funded by the OMA.

I think we're making very good progress, as has been reflected. We now have probably one in four physicians prescribing it. My only point is this: Are they prescribing it appropriately? That's the challenge that we need to address.

Mr. Doug Eyolfson: Thank you.

I believe that's my time.

The Chair: Mr. Johns, you have five minutes.

Mr. Gord Johns: Thank you.

I'll start with Mr. James. Thank you for your testimony. Thanks to all of the witnesses for your testimony.

You talked about some of the barriers for veterans accessing cannabis, and you talked about some of the alternative and beneficial.... Could you elaborate a little more about that? As a former veteran yourself and in terms of the barriers, can you talk about the importance of how we remove those barriers for veterans so they can access medicinal marijuana, and how that ties into opioid use? We see a lot of veterans who have been given prescriptions for opioids and pharmaceuticals—and we're seeing that shift over to cannabis as well—but it's important that veterans actually have that choice in their well-being and in their healing journey.

● (1710)

Mr. Mark James: Right. I didn't really speak about the barriers for veterans obtaining it. There are any number of ways that veterans can obtain cannabis.

First of all, from a doctor's perspective—I'm not a clinician and I'm not a physician—it just seems to me it would be very difficult for me as a physician to prescribe something that is impossible to dose properly. I have no idea what type of marijuana will be bought, what batch it will come from, how big a cigarette you're going to roll or how big a puff you'll take.

We're advocating moving towards a pharmaceutical product that is not smoked. We're talking more about a delivery system. We're talking about doing the research to get the right ratio of cannabinoids and terpenes into the pharmaceutical-grade product, and being able to administer it through a pill, a sublingual or skin patch, or that type of delivery system.

Mr. Gord Johns: Dr. Zacharias, maybe you can elaborate on what Mr. James said in terms of the different types of progress that we've seen in science. Is Canada working with Australia or the U.S. in terms of the development of cannabis and different alternative methods of ingestion?

Dr. Ramesh Zacharias: I'm not sure who's working with whom, but I do know that there are various initiatives today to look at different delivery models. The folks from Tilray can probably address that better than me. I am aware of the initiatives. I'm just not closely tied to it.

Mr. Gord Johns: Okay. Do you want to elaborate, Philippe?

Mr. Philippe Lucas: Tilray is involved in six clinical trials right now. I'm in Australia to meet with our team that's working on chemotherapy-induced nausea and vomiting. It's a capsule form of ingestion. It's worth mentioning that Tilray produces pharmaceutical-grade cannabis extract products, both as drops and as capsules, with a known dependable standardized source of THC and CBD from one batch to the next. This is as pharmaceutical grade as you're going to find. I'm pleased that patients are switching away from smoking and vaporization of cannabis more and more and our data clearly shows that they're moving toward the oral ingestion of higher CBD products.

I've recently been co-author of a paper looking specifically at cannabis and anxiety, which was published in the Journal of Psychiatric Research. The primary author of that study is Michael Van Ameringen from the DeGroote institute at McMaster. It's based on cross-sectional data, from the largest patient survey to take place in Canada at that time at 2,132 responses.

What we found was that over half of the patients cited a mental health condition as their reason for using medical cannabis—or at least as a symptom they were treating with medical cannabis—and for those who cited anxiety specifically, 92% reported that cannabis improved their symptoms. Nearly half reported replacing a non-psychiatric drug—opioids or other drugs—and about 46% reported replacing a psychiatric medicine with medical cannabis.

Right now, it's clear that we do need more data. We need clinical trials to get more information on this, so that's why we've moved forward with a PTSD study and we'll soon be announcing a study specifically looking at other mental health conditions with medical cannabis.

I agree that more data needs to be gathered, but right now, what we do know is that over half of the patients in Canada are citing that a mental health condition is being treated with medical cannabis. We feel based on that—and certainly with the reports that we're getting from veterans—the government needs to keep supporting that use to ensure cost is not an obstacle to access and to ensure the taxation is removed, so that it's available when needed. That's why pharmacy-based access is so important.

The Chair: Thank you.

Mr. Samson, you have five minutes.

Mr. Darrell Samson: Thank you very much, all four of you, for your presentations. Thank you very much for your patience. I understand it's such an important topic and your information is crucial to our study, so I thank you again for your patience concerning that.

As my colleague mentioned, it is sometimes difficult when we have testimony from individuals who are clearly able to articulate how it's helping them and their family, but then the other side of the coin is that we don't have the research to support it or we're saying so far we know it helps MS, it helps certain pieces, but it's.... I seem to be getting the notion that it's more of a one-to-one basis because you need to understand your patient as well.

Can a couple of you comment on that, please?

● (1715)

Dr. Ramesh Zacharias: Do you want to go first?

Mr. Philippe Lucas: I was just going to comment that almost everything we know about medical cannabis right now, we first found out through patient experiences. I've been working with patients for 20 years and when I started working with them in 1999, we didn't know anything about medical cannabis in the treatment of pain. We knew nothing about CBD being effective in the treatment of seizure disorder or pediatric epilepsy. We knew nothing about medical cannabis and its use for PTSD. Everything that we've learned about this, we've learned from patient experiences and, frankly, science is just trying to catch up now to that patient experience.

Sometimes, I get concerned when we start talking about this level of evidence as simply anecdotal. An anecdote would be if I said to you that my sister's husband said he cured his ingrown toenail with a cannabis tincture. It's very different when we have thousands of Canadian patients citing a specific level of efficacy or finding that they're getting relief from this kind of treatment, so as a social researcher, we cull that community to find evidence.

We need more research, obviously. We're eager to work with the government and academic institutions to do more research, but I get concerned, as I'm sure most physicians would be, when we start dismissing that patient experience. It's exactly what you're saying, Mr. Samson. We need to listen to the patients first and understand their stories and that can help guide the science down the road.

Mr. Darrell Samson: Thank you.

Maybe one physician can share their feedback on that.

Dr. Ramesh Zacharias: Go ahead, Tony, if you want.

Dr. Tony P. George: I'm listening to this and I completely agree with what patients are saying. On the other hand, we want to make sure that what people are saying is supported by the facts.

I'll give you an example.

In the mental health field, anecdotes and some preliminary studies have suggested anti-anxiety, antidepressant effects of cannabis. These include studies on veterans mostly coming from the U.S.

One thing you have to realize is that someone who uses cannabis every day is likely physically dependent on it, and when they're not using it they go through withdrawal, which can masquerade as anxiety, depression and mood instability, and using cannabis can merely reverse those withdrawal symptoms. Doing rigorous, well-controlled studies is the only way to prove the case once and for all.

I love to listen to what my patients are saying. I love to be able to follow up and try to ensure that we optimize the treatment, but I also want to be a little skeptical about the kinds of things I'm hearing until I see well-controlled studies.

Mr. Darrell Samson: Yes, but the testimony is helping us get the information we need to analyze and get the bigger picture.

Some groups believe that using cannabis for medical purposes can help reduce the use of other types of medications, such as opioids and benzodiazepines. Do you have any comments on that?

Mr. Philippe Lucas: It's actually my specialty area of research. I've been publishing on a phenomenon known as cannabis substitution effect for the last 12 years or so.

We have right now a longitudinal study taking place in 21 medical clinics across five provinces that is gathering data over a 12-month period on the impact of medical cannabis on more than 2,100 patients, with data points at baseline, one month, three months and six months, and it includes a very detailed prescription drug inventory.

What we see is a significant reduction in opioid use. About 30% of this patient population was using opioids at baseline. That reduces to 14% at six months, and the average dose of opioids from baseline to six months is reduced by 74%.

In light of the opioid overdose crisis that Canada and all of North America is facing, which is now starting to impact the rest of the world, it's hard to look at data like this without thinking that medical cannabis can play a role, if a limited role, in at least reducing the public health impacts of opioids on Canadian society and society elsewhere.

● (1720)

The Chair: Mr. Bratina, please take five minutes.

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

I have to say I'm becoming confused, because we're hearing two sides of a very important story. Having heard Mr. Lucas just speak about the survey they're doing, Mr. Zacharias, tell me how that stands up to the clinical research you would be used to doing.

Dr. Ramesh Zacharias: When we have looked at the literature published so far—and I haven't looked at the literature that has just come out on sleep and anxiety—the evidence we have seen would be moderate for certain conditions and weak for others. Over time, I think part of the challenge is going to be selecting what patients you're prescribing these drugs for. If somebody has anxiety and also has bipolar disorder and possibly schizophrenia, you're going to see a huge difference from what you would see in somebody who just has anxiety.

The veteran population is quite interesting. From 2000 to 2005 I was looking after military personnel, and from 2012 to now—seven years—I've been looking after veterans. It's a completely different population from non-veterans in terms of the comorbidities and the challenges they've had being in theatre. They're a completely different group.

Part of the reason we wanted to separate the data collection is that things that might apply to the general public may be different. I still maintain what I shared earlier. I think the information isn't absolutely clear at the present time. The fog is lifting, and over time, we will have a better idea.

I think the dialogue between industry, which has been funding some of the projects, and the federal government will be quite different five years from now from what it is today, but it won't be any different if we don't learn the lessons from our mistakes in the past.

Mr. Bob Bratina: How long has cannabis been under scrutiny at the DeGroote clinic?

Dr. Ramesh Zacharias: I've been the medical director at the clinic since 2012. My practice has been around pain for 14 years now, mostly chronic pain. I can tell you it's very rare today for a patient to come looking for opioids. The most common drug they're looking for is cannabis. There has been a tremendous shift in what they're looking at.

I can speak only to my own experience. I've been prescribing it for over 10 years now. I have seen the benefits, but I'm also going to tell you I have seen some challenges, including in veterans.

Mr. Bob Bratina: Mr. James, you've had experience as a pilot and as a first responder. Do the comments regarding veterans as a separate group in terms of our discussion sit well with you?

Mr. Mark James: Not particularly. When you look at first responders, you look at police officers, you look at.... There have also been cases we've seen in the press of people who were exposed to very graphic evidence at trials. If the right clinical research is done, it will be applicable to patients across the board.

Indications such as the anxiolytic properties of cannabis are one thing, but pain and CINV, for instance, are different indications, and I believe they will require different formulations to address.

The Chair: You have 50 seconds.

Mr. Bob Bratina: Mr. George, what's the effect of cannabis on the body? Do we have the full picture of everything that happens from the ingestion of cannabis?

Dr. Tony P. George: That's a great question.

We're still learning. We probably know much more about its effects on the brain. We do know that many of the components in tobacco are also in cannabis, including some potential carcinogens. That's why I like hearing this discussion about alternatives to smoking. We can isolate the therapeutic components to truly understand that and get rid of some of those that are potentially harmful.

As has been said, we still have a lot to learn to understand the effects of cannabis, which is a mixture, on the body.

● (1725)

Mr. Bob Bratina: Thank you.

The Chair: Thank you.

Mr. Kitchen, we'll end with you. You have five minutes.

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

Thank you all for being here.

In many ways we're in a bit of a pickle. I agree with you, Dr. Zacharias. In your opening statement you said we've put the cart before the horse. The reality is that we have no guidelines, no standards, no prescription levels. We don't know how often it should be taken, whether it should be taken in pill form, how much should be taken and for how long. That's a challenge.

It's a big challenge for us, because we've heard lots of testimony from veterans and from family members who've come in and said, for example, that they have their spouse back after dealing issues of PTSD, etc.

Dr. Zacharias, you made comments about opioids and how there is some indication or some link along those lines. We don't have research today. We can have anecdotal research, but ultimately the best research is an RCT. That's the only way we're going to know where we need to be on this. That's a challenge, because that research takes years to come up with.

How do we do that without falling into, as you indicated, Dr. Zacharias, the challenges we've seen with opioids and the side effects we had from their prescription?

Dr. Ramesh Zacharias: I think it's been said: Don't let what you don't know today keep you from doing what you do know today. We do know that there's a safe and effective way of prescribing these products. While we might not have every issue identified, we know there's a way of prescribing it and monitoring people well to be able to identify early those who are going to have problems.

This is where the guidelines, I think, will be helpful. As I said, with opioids, Canada did not create its first guidelines until 15 years after OxyContin was released. I hope that's not going to be the case with cannabis. One of the recommendations I would really like to see this committee adopt is encouraging the CIHR to fund the creation of the guidelines.

In the interim, it's a safe product in the right hands for the right patient, so if you can educate people to know their products well, which ones work, but more importantly, when you are starting to see signs of complications.... I've seen that in veterans who I've had in clinics. Early on you will identify that they're taking the wrong combination or they're taking too much of one product and not the other.

As I said, I've been prescribing it for 10 years. I believe it's safe as long as you screen people and, more importantly, monitor them. You can't prescribe this product and then see them in a year. You and I would never agree to an endocrinologist seeing a diabetic patient, prescribing insulin and then saying, “I'll see you in a year.” That would not be good medicine.

I'm seeing that the way we're prescribing—and most of the veterans tell me this—is that they get their appointment and the next appointment is scheduled for a year later.

Mr. Robert Kitchen: I was a regulator before for the chiropractic profession.

Doing things over the phone without seeing that patient's face up front is a huge issue, as you mentioned about Skype. How do you do it without assessing that patient and knowing them?

Dr. Ramesh Zacharias: I agree with you. I think you can monitor people once you have prescribed it.

Distance is an issue with some of the veterans. They have decided not to live in metropolitan areas—and I completely understand their choice—but I think you can use various technologies to monitor them.

My issue is how they were prescribed and the fact that they were left alone for a year. That's what they have reported to me.

● (1730)

Mr. Robert Kitchen: Thank you.

Dr. Lucas.

Mr. Philippe Lucas: Thank you so much.

I just want to point out that UBC is doing a phase two randomized clinical trial on medical cannabis as a treatment for PTSD, looking at two different preparations or combinations of THC and THC and CBD. That research is ongoing.

But do you know what? Even when that study is done, we're not going to have all the answers. Ultimately, science is not about an absolute yes or no, or right or wrong. It's about the weight of evidence. Right now the weight of evidence is that medical cannabis, while not the perfect treatment for all patients under all conditions, is relatively safer than opioids. It's relatively safer than the use of benzodiazepines by any objective measure that's been done academically.

Additionally, the use of medical cannabis seems to reduce the use of opioids. Also, interestingly enough, and particularly relevant to veterans, it reduces the use of alcohol and illicit substances as well on an ad-hoc basis.

With all of that in mind, I think that all we can do right now is to keep supporting that patient experience when it comes to veterans who are using it for PTSD, continue to do the research and increase the amount of funding and support we get for research. We can all hope that, through all of that, we'll have a better understanding next year and the year after that than we have right now.

Certainly the wrong thing to do right now would be to cut off veterans who are finding benefit from this and whose families are finding benefit from the use of medical cannabis. I really urge this committee to keep this in mind as it's making decisions based on this testimony today.

The Chair: Thank you.

That ends our time for witness testimony today.

On behalf of the committee, I'd like to thank the witnesses today for their patience and their testimony.

That adjourns the meeting.