HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 031 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Thursday, November 17, 2016

Chair

Mr. Neil Ellis

Standing Committee on Veterans Affairs

Thursday, November 17, 2016

● (1535)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): I'd like to call the meeting to order. Pursuant to Standing Order 108(2) and a motion adopted on September 29, the committee resumes its study of mental health and suicide prevention among veterans.

Today we have three different witnesses: from the University of Manitoba, Dr. Sareen, professor of psychiatry; and from the Canadian Institute for Military and Veteran Health Research, Dr. Cramm and Dr. Bélanger, who are both interim co-scientific directors.

We'll start out with the witnesses, with up to 10 minutes each for testimony, and then we will come back to questions.

We will start with the Canadian Institute for Military and Veteran Health Research.

Good afternoon. I'll turn it over to both of you for your 10 minutes.

Dr. Stéphanie Bélanger (Interim Co-Scientific Director, Canadian Institute for Military and Veteran Health Research): Thank you, and good afternoon.

We are here to explain what our research institute can do in the research field for veterans. I'll start with a short background and then Dr. Cramm will carry on with some more specific examples.

The Canadian Institute for Military and Veteran Health Research was founded in 2010 and is now composed of 42 university members, which includes about 1,000 active researchers in military, veteran, and family health. What we do is bring the efforts of all the researchers together so that they can better inform policies and practices. We are here right now to talk about what our researchers do, what they produce, and what they publish to better inform policies and practices as opposed to saying what our own personal research projects are.

It's really important for the institute to ensure the knowledge translation of our products, meaning the publication of it, so that it goes as rapidly as possible from research to practices. For us to participate in parliamentary testimony like this is extremely important.

Because the main topic today is on transition, even though it is a pluri-disciplinary institute, we do have a lot of research that is being produced on the transition from military to veteran, to civilian life. It is a priority area for many university researchers as well as for the government, so we are lucky enough to have government advisers who tell our researchers what their needs are and what they need to know about transitions, and then researchers who can produce, at arm's length, the evidence-based and informed-based data.

Actually just last year there were three research projects that were completed under a contract we have through Public Works with DND and Veterans Affairs Canada. It allowed us to build knowledge around what constitutes a good transition, a successful transition; what mental health might look like during that transition; and what kinds of programs and supports are available during that time. All this has been published and it's on our website.

Right now there is another project that continues to build that knowledge around transition. It's a work-in-progress, and this is where Dr. Cramm could give a bit more detail.

Dr. Heidi Cramm (Interim Co-Scientific Director, Canadian Institute for Military and Veteran Health Research): Thank you.

The project that's currently under way is a study on well-being and military-to-civilian transition. I'm one of the co-principal investigators on that, along with Drs. David Blackburn and Maya Eichler from the Université du Québec en Outaouais and Mount Saint Vincent University in Halifax. This study is a qualitative, in-depth, longitudinal study. This is going to give us, for the first time, that perspective within Canada of what happens as serving members cross into civilian life.

We hope to recruit about 100 members about six months prior to their intended discharge release date, and to be able to follow them for up to two and a half years after that release. This study will really become a critical piece in helping us all understand a little bit better what some of the patterns or factors might be in optimizing a successful transition. Part of that successful transition includes positive mental health and well-being.

Right now we don't have a clear understanding, nationally, around what it is that may or may not create the conditions for successful transition. Some people leave service and we would expect them to do well, but after a period of time they really struggle. Their mental health struggles really emerge in a way that may happen post-release. Maybe they weren't identified prior to release, but it becomes apparent after release. Some of those issues may be contingent upon the reality that it's a significant change in identity, a significant sense of attachment and place. It's very different when you take off the uniform and you're now working to find that same sense of belonging and structure as a civilian. Some of those things may be part of a natural issue, and may not in any way be related to service exposures. We just don't know enough about that in a longitudinal way, so this really will be an important piece as we go forward.

We're just at the stages now where we're about to go into our ethics review for that study. We're looking to kick that off in the spring with full-on recruitment.

One of the biggest challenges we have in Canada to serving veteran health needs really comes from our current inability to identify veterans within health care systems. When serving personnel end their service, their health care transitions from the federal system to the civilian provincial system. Veterans live everywhere across the country, across all provinces and all territories, in urban and rural settings. You can imagine that quite a variety of services might be available in the wide range of what is Canada, but Canada does not have the ability right now to systematically identify where the veterans are, how they use health care services, how their health care needs compare to civilians', and how then, as a result, to understand their needs in order to provide the supports and programs at the right time, in the right place.

Last year, in the *Journal of Military, Veteran and Family Health*, researchers within the CIMVHR network identified, through collaboration with the Institute for Clinical Evaluative Sciences, or ICES, a way to study the health and health service utilization of veterans who re-entered the Canadian public health care system in Ontario between 1990 and 2014. Recognizing that veterans re-enter the system across Canada, we also do know, from some previous work from Veterans Affairs Canada, that about a third of veterans do seem to migrate to Ontario upon release. It is a good sample for us to be able to begin the important work.

Through this study, as they continue their analysis, this group of researchers will be able to give us more information that will inform the diagnostic and treatment patterns related to mental health, as well as to enable those comparisons between veteran and civilian health. Other research that has been published within the *Journal of Military, Veteran and Family Health* suggests that most recently released veterans do, in fact, adjust well, but there do appear to be chronic conditions that are experienced at a much more common rate for veterans.

● (1540)

Dr. Jim Thompson and his colleagues published a review of population studies on the mental health of Canadian Armed Forces veterans and found that veterans who have recently released experience higher rates of mental health issues than the broader Canadian population as well as veterans from previous eras and conflicts. There does seem to be something substantive happening that is different for this cohort of veterans as they are releasing.

Of note as well, we're not alone as a country in struggling to understand transition. We are working on the global stage trying to look to what is understood around military-to-civilian transition experiences and outcomes across countries to be able to compare across the countries, and also to take lessons learned that maybe we can leverage so that we can catalyze the whole structure better and get there faster. Some of those countries include the United Kingdom, the United States, New Zealand, and Australia.

Thank you.

● (1545)

The Chair: Thank you.

Dr. Sareen.

Dr. Jitender Sareen (Professor, Psychiatry, Rady Faculty of Health Sciences, University of Manitoba): Good afternoon, everyone.

I'd like to thank everyone for inviting me to speak and be a witness to the committee. I also appreciate the presentation from Dr. Bélanger and CIMVHR. I think many of the points that were raised are very similar to the things I'm going to say, and I'll add some of my experience.

During this month of November, I also want to appreciate the Canadian Forces and veterans who have served our country, and their families.

For the committee to understand my comments, I'd like to tell you a little about my experience and what I do. I'm a professor and head of psychiatry at the University of Manitoba. Our university is involved with CIMVHR as well. I have worked in the Veterans Affairs operational stress injuries clinic in Winnipeg for the last seven years. I've also done mostly epidemiology research in military mental health for the last ten years and worked in first nations suicide prevention as well.

To move into some of my comments, I'll tell you a little bit about some of the mental health problems and suicidal behaviour; what the prevalence is in the military and veterans; what the common factors are around mental health problems that are general for everyone; and, what some specific factors are that are important to understand for the military and veterans environment. I'll then move into talking about what we are doing well in Canada and then move into a discussion of what we can do better.

As most or all of you are aware, mental health problems and addictions are very common. One in four military or veterans suffers from depression, post-traumatic stress disorder, or alcohol use problems in any one year. That's very,very high; it's 25% of the population. If you can imagine and step back and look at the impact from a family perspective, it really has a broad impact. Recognizing this as well as early interventions are really important.

Suicidal ideation is there in about 4% of the population in the Canadian Forces, so approximately four out of every hundred active military personnel have serious thoughts about suicide. Less than 1% attempt per year. As was mentioned by the previous speakers, veterans, especially during that first year or two, have a slightly higher rate of suicidal ideation. Dr. Thompson did a study of over 3,000 Canadian veterans and showed that the prevalence was around 6%.

Again, the main point is that this is a common issue. Why do mental health problems and suicidal behaviour occur among the military? I think it's really important to remember that the strongest risk factors for mental health problems and suicide are childhood and adult stressful life events. Those occur very commonly in the military population. Early adverse events as well as stressful life events, physical assaults, as well as losses, can occur. Other common factors are also a family history of mental health issues. Physical injuries and physical health issues are also very important. Specifically, financial difficulties and legal problems have also been shown to increase the risk of mental health difficulties and suicidal behaviour. Those are very common.

Things that are known to be protective around mental health difficulties and suicide prevention are community supports, work-place mental health programs, leadership within units, organizational structures. Social supports and peer supports are really important, as are, of course, families, and the understanding of the family of what the member is going through.

● (1550)

As far as military and veteran-specific factors are concerned, there's been controversy around deployment. Deployment in itself does not increase the risk of mental health problems or suicidal behaviour, but if there are high levels of traumatic exposure during a deployment, that can increase the risk of post-traumatic stress, depression, and suicide. I think it's really important to step back. When we look at suicide, the example that I would use is someone who has asthma. Asthma alone is not deadly. But if you have asthma plus someone who has a lot of other physical health issues, that together can lead to mortality.

Similarly in suicide, when we think about suicide, we have to understand that it's not one specific factor that causes suicide. It's the combination of a number of different factors coming together, usually a stressful life event, depression, alcohol, difficulties in the military and transitions, potentially legal difficulties. All those things coming together puts people at much higher risk of making an attempt at suicide or dying by suicide.

In Canada, we've done quite well as far our efforts in trying to address stigma and improve the mental health care for our military and veterans are concerned. I think there's been a lot of effort that has been placed in increasing awareness. There's been investment in peer support. Also, I am going to say that it's really important to have an organization like the Canadian Institute for Military and Veteran Health Research where there can be an arm's-length scientific body, and professors and people can actually do unbiased, arm's-length work in trying to understand mental health problems and physical illnesses and how to improve them.

There are two things that I want to really highlight. One is that we did a study recently that was published in the *Canadian Medical Association Journal* that compared a nationally representative sample of Canadian military to a nationally representative sample of civilians, and we asked this question: if a Canadian active forces member is suicidal, do they get similar rates of service use in the civilian population versus the military? What we showed was that military members have much greater access to mental health services if they are suicidal than the civilian population.

There's still room to improve, and that's what I'm going to talk about next. But I think it's really important to have an understanding that the federal system of providing care to military and veterans around operational stress injuries has done a very important service in improving access to evidence-based care.

If we step back and look at where we can do things better, not just for the military and veterans but in the general population, we have not been able to reduce rates of suicide and suicide deaths in Canada in general. In the U.S. the suicide rates have actually been going up in the military whereas our rates in Canada have relatively stayed stable. I think we have been discussing and thinking about how do we prevent suicide both in the military as well as in the general population.

Let me go into some of where we are in the field. The idea of treating suicidal behaviour up until now has been to treat the underlying mental health problem or addiction. The new evidence suggests that we need to target suicidal ideation and suicide attempts much more directly.

● (1555)

There are specific psychological interventions that can be done, cognitive behaviour therapy that specifically focuses in on suicidal behaviour, and then another type of therapy, called dialectical behaviour therapy, that has also been shown to help people who have made multiple suicide attempts to learn to manage those symptoms. Those are two therapies that are suicide-specific that both the military and veterans systems need to look at and ask how they can implement those.

The second part is that in suicide risk assessment, it's very difficult to tell. If you have someone sitting in front of you, it's very hard to predict at an individual level who is going to make a suicide attempt in the future. There's a huge controversy in the whole suicide field as to which instrument should we use. Most of the instruments that have been tested so far do not predict, do not help a clinician at the individual level. It's very hard to predict behaviour, as all of you know, but to take a specific tool it's difficult.

Nonetheless, if the person is expressing suicidal ideation, specific training that can be done around safety planning, reducing access to lethal means, like guns or large quantities of medications, can actually be helpful.

I could continue for hours, but I'll stop at this point and open it up for questions.

The Chair: Thank you, Dr. Sareen.

We'll start with our first round of six minutes.

Mr. Kitchen.

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

Thanks to all three of you for being with us today. We appreciate your comments and the work that you do, and the work that our researches are doing, in providing services and coming up with ideas that we can use to improve the lives of our veterans and our soldiers.

I'm going to pick your research brain to start off, just because some people may not be aware of how research goes and the actual steps you have to go through in order to come up with a research project. When you come up with an idea, and someone comes with a null hypothesis, and you come up with an ideation on what you're going to do the research on, the researcher comes up with an idea, and they present that presentation to the university or to an ethics committee. Could you go into those steps that researcher has to follow for such a project—nothing specific, but just generally speaking?

Dr. Jitender Sareen: I think one of the key things that is really important is that the research comes from the people. The other presenters talked about qualitative work with people. The ideas really come for me, as a clinician, from sitting with patients and families, and understanding what they're experiencing. From there we come up with an idea, and we write a proposal.

In our laboratory we utilize Statistics Canada collected datasets that are nationally representative. Basically, our laboratory goes in and gets approvals from Stats Canada to be able to anonymously analyze a large sample so that we can understand, in 8,000 service members, the risk of suicidal ideation and the factors. We get that approval, we do the analysis in Statistics Canada datasets, and then we publish them in journals.

I think The Canadian Institute for Military and Veteran Health Research is also very important. We present at conferences, learn from each other, develop networks, and try to engage patients and families in making sure that the questions are relevant to Canadians.

● (1600)

Mr. Robert Kitchen: Thank you.

Dr. Cramm, I'm going to add a little bit to it and ask you maybe to comment more. My understanding is that while Dr. Sareen might be doing more epidemiological studies, you might be dealing with actual subjects. When you're dealing with subjects, and you're looking at issues such as consent, and informed consent, and the steps you have to follow through to make sure that project is done, I'm wondering if you could explain to us what sort of information has to be provided for that informed consent and what sort of documentation you would need to support that.

Dr. Heidi Cramm: Absolutely. Thank you.

Certainly Dr. Sareen does some very big data analysis in some of these population-based epidemiological studies, and that is a very different kind of research, because we don't have a lab when we do qualitative research. Once we have a proposal, once we have funding to actually do the study, then we can proceed. Part of the operationalization of a project involves ethical clearance. You have to have a scientifically sound design, and it has to be approved at the university level for any potential ethical concern. If there are multiple university researchers involved in a particular project, we actually have to go through multiple university research ethics boards.

For the study that I mentioned, we actually have to go through three different university research ethics boards to get approval before we can even begin to move forward with the recruitment process. Part of the evaluation at the ethics review board level involves looking at a letter of information so that people have informed consent. They find out what the study is about, how their information will be used, who will have access to the information they are providing, how it will be recorded, and whether they have rights to stop if they feel uncomfortable. All those kinds of things are outlined. The tri-council guidelines on ethics must be followed by all of the academic university researchers, and so the ethical review boards give an extraordinarily granular review of all documents, including what questions we intend to ask, what the samples are, whether there is undue burden on the sample, or whether we place anyone at any kind of enhanced risk. All of those things are considered at the university level, and often by multiple sites. That is before we can even begin the recruitment process.

Mr. Robert Kitchen: What would happen if it were determined throughout that study that those steps weren't followed?

Dr. Heidi Cramm: The protocols are in place so that we know that there is a plan. If there is an adverse event and something does happen, there is an entire reporting structure within the universities. Those things are often there for lab-based events, but most of it, from a qualitative end, is more around...and by lab-based I mean more biological science lab-based adverse events, to report a structure that way if there is an adverse event report. But there are processes and balances and checks in place within ethics, and all researchers are trained around the ethical guidelines and their duty to report anything that deviates from the protocol that's been agreed upon.

Mr. Robert Kitchen: Great.

Thank you very much.

The Chair: Next we'll go to Mr. Poissant, who is going to split his time with Mr. Eyolfson.

[*Translation*]

Mr. Jean-Claude Poissant (La Prairie, Lib.): Thank you, Mr. Chair.

I would like to thank the witnesses for their brief. It was very interesting.

Earlier, I noted that you mention in your study that the suicide rate among veterans is higher in the United States than in Canada.

So my question is whether you have compared the situation with other countries. If those countries are doing some things better than we are to help veterans, how could we benefit from it?

● (1605)

[*English*]

Dr. Jitender Sareen: I can address that. I haven't looked recently at the other countries concerning suicide rates. I know that in the U. S., suicide rates have been going up in the military, and there has been quite a bit of concern, but I don't have an answer for you about other countries. I can look into that.

[*Translation*]

Mr. Jean-Claude Poissant: Thank you.

Was any follow-up done in your study with families who have lost a loved one to suicide? We know that it has major repercussions on them.

[*English*]

Dr. Jitender Sareen: Those studies we haven't done. This is a very important area, and going back to the previous question around the ethics and the impact of that on families, it's a huge piece. We haven't gone into that area. I'm not sure if the other researchers have.

That is a very important point. I think it is really important to look at suicide attempts and suicides to really understand what happened specifically, and what are the lessons learned with regard to quality improvement and trying to improve the system.

[*Translation*]

Mr. Jean-Claude Poissant: Thank you.

That's it for me.

[*English*]

The Chair: Mr. Eyolfson.

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

Jitender, it's good to see you again.

Just for background, we went to medical school together.

An hon. member: Just like every witness.

Voices: Oh, oh!

Mr. Doug Eyolfson: Well, lots of them, yes.

There was a witness at our last meeting, Jitender, who I also went to med school with.

The Chair: That was an awfully big classroom.

Mr. Doug Eyolfson: It was a big classroom, yes.

An hon. member: Did you graduate?

Voices: Oh, oh!

The Chair: Okay, your time is up now....

Mr. Doug Eyolfson: Thank you.

We've talked about how VAC does have systems to identify homeless veterans and those at risk, and we know that although there's a big interplay between homelessness and mental illness, they don't always go together. Not every person with a mental illness becomes homeless, but there are ones who are particularly at risk for becoming homeless.

To any of you, could you make suggestions so that VAC could identify the veterans who are at risk of becoming homeless through either financial or mental health issues that could be dealt with before it gets to that point?

The Chair: Dr. Cramm.

Dr. Heidi Cramm: I think research around homelessness generally has demonstrated that there is a complexity in that prediction as well. Being able to identify who is most at risk is not a straightforward process. There may be indicators of certain things related to precarious employment and the insecurity of housing that may precipitate things, but there's also a parallel issue related to a sense of disengagement and disenfranchisement so that some people may actually elect to pursue a state of homelessness rather than fall into homelessness. It is not a homogeneous group.

Dr. Jitender Sareen: I would echo those comments. The transition period is really, as was said by the speakers, the important phase for the member to figure out their identity. They come from the military system, where they have access to a range of services. Trying to bridge that gap is really important around identity, financial stress, and as well relationship stress. One of the members I saw was developing suicidal ideation because he was afraid of becoming homeless due to financial losses that he was having during a divorce. We really spent a lot of time working together on trying to help him sort out his financial situation, because his concern was that he was going to become homeless. This is a member who I was seeing at an OSI clinic. We know that financial stress puts people at risk for depression as well as suicidal behaviour, and homelessness is of course a very important issue.

The other thing I'm going to remind the committee about is the “housing first” project that was led by the Mental Health Commission of Canada. In that project, people dealing with mental health problems and homelessness were randomized to get housing first and then support. That project was quite successful, and there were homeless veterans within that sample. We looked at that data; I can provide that.

There's that transition period when there are identity issues and financial issues, as well as potentially relationship issues, that can really put the person at risk. It's hard to predict who is going to be at risk, but knowing that's a vulnerable period, a public health approach might be important to look at it to ask how we can reduce the distress during that time period.

● (1610)

The Chair: Thank you.

Ms. Mathyssen.

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

Thank you to our witnesses. We truly appreciate your expertise, and are relying on the information we receive to come up with something that is important and truly works to serve our veterans and their families.

Dr. Cramm, you said you're engaged in research, and you're working with subjects who six months before they leave will be followed throughout for two and a half years past their release. What's the criteria for choosing the individuals? Is it random, or are you looking at the state of their mental health? What goes into that choice?

Dr. Heidi Cramm: For that particular study we're trying to understand a diversity of experiences. We want to be able to have an open recruitment to see, during a period of time, who will be releasing from service. Then people can elect to join the study, recognizing it's going to be a commitment to the two and a half years with three different interview points. We will aim to have some representation across categories like the service element. Right now our plan is to be able to recruit the majority who will be coming from the army because that would represent the population. The next largest group would also be the navy and air force. We will also make sure we are capturing the experience of those who participated in the armed forces as reservists.

We want to be able to understand a variety of experiences, within the study. We'll have some categorization across things like the region of the country they are releasing from. We have to make sure that different experiences around language are represented in terms of English or French. We need to make sure that males and females are represented as well. It will depend on who is releasing within a given time frame, because if you have three-year study, you only have so many people whom you can expect to be releasing during a given time frame. We will look at about 100 of them, planning of course that we may lose some of them over the course of the study. Continued engagement in longitudinal studies is hard to maintain.

● (1615)

Ms. Irene Mathyssen: Thank you.

Dr. Sareen, you said there's a predisposition to mental health problems in some individuals, depending on some of their experiences and stresses in their lives. One of the things we heard from General Hugh MacKay is that there is no pre-screening of new recruits regarding their mental health. I'm wondering if it's even possible. Would it be a reliable test or measure to do this pre-screening, or is it even advisable?

Dr. Jitender Sareen: We have discussed this quite a bit. Right now the field says there is no reliable measure or screening process. Again, it's such a common...mental health problems, if you look across 25% of the population, if you started screening people out, there wouldn't be enough people for the military.

I think this is an important area, maybe looking more deeply into that recruitment phase to really carefully understand both the vulnerabilities and the mental health training. I think the military's doing R2MR, and there's a range of different ways to build resilience, but I think it's important to have the arm's-length evaluation of that training and also to look at both time points, the recruitment phase as well as the transition out of the military phase. It would be important to review the literature in those two areas and figure out the best practices as well as look at potential interventions. I know that—

Ms. Irene Mathyssen: I was going to ask another question, but please finish.

Dr. Jitender Sareen: I think right now there is no screening process that is suggested around the world, that I'm aware of, to say people aren't eligible to be part of the military, unless they have a very serious psychotic illness; that's the only thing that I think would be a problem.

Ms. Irene Mathyssen: Thank you.

I don't know whether you or Dr. Cramm can answer this next question. Are the services that are currently offered by DND and VAC suitable to really effectively address the mental health needs of CF members and veterans? Are the current services working? Are they adequate?

The Chair: Dr. Cramm, you can start, but we'll have to limit it to you. We're down to the last few seconds on this question. Please make your answer concise.

Dr. Heidi Cramm: I can tell you that last year one of the contract research studies was an environmental scan of all the programs that are available, within the CAF, within Veterans Affairs, and also within the community. There was some high-level analysis done as well across different countries to see how they might compare. The purpose of that study was not to determine the effectiveness but more to map the field and look at how those things are, how they're represented, and who they're targeted to.

The Chair: Thank you.

Mr. Bratina.

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

Dr. Cramm, it's good to see you again. We had a good conversation with the occupational therapists presentation, and I know you have done work in transition to the civilian workforce. On that one, could you describe the mental or emotional issues around someone leaving the training and the job opportunity or the service of an active military person versus the great unknown of what they're entering in post-military service?

Dr. Heidi Cramm: Absolutely. Thank you, and certainly my training as a mental health occupational therapist really informs this perspective as well. We do know that when you have someone who's in active service, there's a great deal of structure that goes along with that particular way of life. A lot of decisions are made for you on when you wake up, where you go, what you do, where you live. If you're told that this is where you're going to be living next, you know you have three months to make that happen.

So you go from a period of time when a lot of things are externally structured for you to that great unknown, where now the time use can actually be quite a challenge to people in their mental health and well-being. You think you have all this time available to you and isn't that great, but in fact, it can be quite detrimental to positive mental health. If you have too much time on your hands, it can be very difficult to fill any of it in a meaningful way. So if you combine that, in terms of time use, with the sense of meaning and purpose....

People sign up for the military because they believe in something. They have an identity that's recognizable. People can look at you in uniform, and that means something to them about who you are and what you're bringing to bear in your day to day. But if you're just in your civilian clothes, you could be involved in any number of different kinds of jobs or contributions to society. You don't have that same kind of face value recognition around what your identity brings. You potentially have a compromised sense of your meaning, identity, and purpose. You have some difficulties potentially in how you're structuring your time, and then your sense of belonging gets quite disrupted as well. You have this very tight family of other serving members, and this is also true for military families. There's an identity of being a military service member or being a military family. We can't say the same for a veteran family or for a veteran. It's not nearly the same, and many veterans—we see this from the United Kingdom example—don't even identify themselves as veterans because they don't see themselves as veterans: they see themselves as ex-service members. Veterans to them are people who have served in combat in World War II or Korea.

So that sense of identity is quite a real issue. We know that if we can support people through the transition so that they continue to be living lives worth living, as we say in occupational therapy, then that can really support people's mental health transition and general quality of life.

● (1620)

Mr. Bob Bratina: On recruiting the cohort, I'm curious to know whether a veteran in Bienfait, Saskatchewan, would have similar or different issues in a large urban area like Vancouver or Montreal. Would you include that kind of diversity in your cohort?

Dr. Heidi Cramm: This is one of the challenges to that recruitment process. When we're recruiting people, when they're still in service, we don't actually know yet where they're going to be moving to. They may be serving in Meaford but they may return to Grand Falls, Newfoundland. We don't know where people are going to end up.

Many people will attempt to get their final posting close to where they want to retire, but that's not true for everyone. So we don't have a way, necessarily, of predicting it. Sometimes people themselves don't, because they're also in the process, in that last six months before they're ending their service, of trying to map out what they're going to do next: whether they're going to have a second career, and implications like what their spouse might need to be doing for her or his career.

It's not a straightforward issue, but we do expect to be able to identify some of those patterns or trajectories across that time frame.

Mr. Bob Bratina: Do I have time left?

The Chair: You have one minute and 20 seconds.

Mr. Bob Bratina: Dr. Sareen, on the question of suicide, typically does a suicide event, an attempt and so on, come after a lengthy period of some sort of continuum of behaviour, or does it often happen suddenly? Is there anything you can say about that?

Dr. Jitender Sareen: I think there's usually a suicide attempt before, and often there's suffering for a period before someone attempts. Sometimes, if there's alcohol involved, there can be impulsive events. The strongest evidence around suicide prevention is around restricting lethal means—for example, access to firearms like hunting rifles, and access to large quantities of medications. Those are two, really, that have been shown to have quite a bit of evidence.

I think most people suffer for a long time, but if there is alcohol involved, sometimes it's quite impulsive when that event occurs.

● (1625)

Mr. Bob Bratina: So it would be fair to say, just as a brief summation, that there is an opportunity for intervention, identifying an issue, if we work hard at it.

Dr. Jitender Sareen: I completely agree with you.

The Chair: Thank you.

Go ahead, Ms. Lockhart.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you very much for being here as researchers, because we've heard a lot of anecdotal information.

I actually have a couple of studies here, one from you, Dr. Sareen, "Combat and peacekeeping operations in relation to prevalence of mental disorders and perceived need for mental health care". I'm wondering if that one could be submitted to the committee as part of this report.

Dr. Jitender Sareen: Yes. I was going to ask the question. We have some recent studies that we have done and some of the latest around suicide prevention that I would like to submit to the committee, but I just didn't have a chance to do it before the meeting.

Is it okay if I submit a couple of key papers?

The Chair: Excellent. If there are any papers or any questions you want to further elaborate on, either of you, please send them to the clerk, and the clerk will distribute them to the committee.

Mrs. Alaina Lockhart: I just had an opportunity to read through some of them. I think the information will be very good for our study, so thank you for that.

You mentioned in your testimony, Dr. Sareen, that military suicide rates have stabilized. Do we have any data on the rates of suicide amongst veterans?

Dr. Jitender Sareen: Yes. I haven't reviewed the latest, but I do think there's been a small increase in both the army's suicide rates and in the veterans. I'd have to double-check that.

The important thing is that the number of suicides is quite small, so it's hard to have a significant change, but I know there has been a small increase.

Mrs. Alaina Lockhart: Is that something that's tracked well enough that you can get the numbers?

Dr. Jitender Sareen: I will look into it and get back to you.

Mrs. Alaina Lockhart: Okay. Thank you very much.

You also mentioned that there are other treatment methods that should be looked at. Are they specific to PTSD or are they for all mental health? Could you expand on that a little bit for us?

Dr. Jitender Sareen: Yes. I think the area that the operational stress injury clinics have done a really great job in is to increase the availability of PTSD-related treatments as well as other emotion-regulation skills. More recently, in the last few years, there's been an emphasis on cognitive behaviour therapy for suicide. That has been shown in American military samples to actually reduce future suicide attempts. If someone's made a suicide attempt, targeting the risk and protective factors in a psychological intervention has been shown in a randomized trial to reduce future suicide attempts. We think it's important for our military and veteran clinics to really look at those new treatments.

The second piece is safety planning. For most clinicians, and this is not just military veterans but all of us, when we see a person who's thinking about suicide, there are new ways that you can actually try to do an assessment and try to reduce the risk in that moment. Again, I can give some of that information back, but it's a suicide assessment intervention and safety planning, which includes helping the person bring out things they want to work on that would help them live, and really focusing in on, if they have access to lethal means, trying to remove those, as well as talking about social support. Those specific interventions are what they're saying we should be implementing across the system as the latest suicide prevention methods .

● (1630)

Mrs. Alaina Lockhart: Did you say those are now being used in the U.S., but they're not best practices yet here in Canada? Is that right?

Dr. Jitender Sareen: They're not being used in the U.S. either. This is just new, new “hot off the press” kind of evidence. A new randomized trial that was done two years ago showed that this specific intervention actually had reductions. But clinical practice hasn't changed yet, and that's what I think is really important to work toward.

Mrs. Alaina Lockhart: Okay.

Again, from the research you did, you said you studied 8,441 active military personnel. You said the conservative estimate would be that approximately 15% of the sample would be considered in need of mental health services.

Do you have a “non”-conservative estimate?

A voice: Liberal.

Mrs. Alaina Lockhart: Yes: a liberal one, perhaps...?

Voices: Oh, oh!

Mrs. Alaina Lockhart: Sorry, I couldn't resist.

Dr. Jitender Sareen: In that study, and that was 2002, the liberal estimate was 31%. That included diagnoses, people who were diagnosed by a structured interview, as well as people who were receiving services, as well as people who perceived a need for care. When we looked at the whole, from a self-perceived need for care, seeking care, and meeting diagnosis, that number was 31%.

Mrs. Alaina Lockhart: Thank you.

The Chair: Ms. Wagantall.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you very much for being here and for the expertise you bring. I don't have a lot of background, obviously, in this whole area of research, and it's so crucial for us to understand, even as a committee, how best to make recommendations and encourage changes in our systems here.

Dr. Cramm, with your research on transition to civilian life, you mentioned government advisers. I haven't read your reports or anything. What role did those advisers come from? What were the parameters and what did they do specifically to set up these trials?

Dr. Heidi Cramm: That particular study is part of a funding relationship we have here, at the Canadian Institute for Military and Veteran Health Research, where the government can actually internally define; so the research directorate within Veterans Affairs Canada looks at its strategic priorities and its needs for research, and it looks at what it can manage internally and what it can't. Those things can get outsourced through a contract that we provide, and those go out to tender, essentially.

What happens is that instead of it just being a tender process it's actually a peer review process. Research teams will apply for a given contract, and then our college of peer reviewers here at the institute will review them. Then the best study proposed, with the most rigorous design and the best mix of expertise, will end up doing a particular task contract. There's already a fair bit of definition around what the study needs to look like to meet some of the policy needs within the scientific directorate at Veterans Affairs in that case.

Mrs. Cathay Wagantall: Thank you.

What I think I'm hearing, too, is that it's much more difficult to track our veterans, obviously, than the armed forces, where you have a very structured situation and so many control variables. When you look at the database that I can only imagine exists with our Canadian Armed Forces, and then with VAC, we're finding a need to be able to have more of a transition of that information along with the veterans.

Would that be helpful? I think of 600,000 veterans, and 100,000 of them need help from VAC. Then there are the more serious cases, which are really the ones that we have to deal with, who need a case manager and have really serious issues. Would it not be helpful to have that information available even in those big-picture formats, and then be able to peg these veterans, in some way, as they're coming out, to realize where they are similar and where they may end up having these issues more than others?

● (1635)

Dr. Heidi Cramm: There are two parts to that. One is that there is a lot of activity across the Canadian Armed Forces and Veterans Affairs to close that seam, to improve that handover, to give that warm handshake. That's a very active initiative, with a lot of different invested parties within government working hard to make that happen. I'm not saying that it's there yet, but there's a lot of activity around that.

On the other end of it, when you have people who are leaving the military because they already have an identified mental health issue, and they are having a medical release as a result of this mental health issue, often we know where they are in that first two years. They get connected directly in with Veterans Affairs, with the joint personnel support units. We know where those go.

In fact the people who have the mental issues, who are identified prior to releasing service, may not be the ones we are most worried about. It may be the people who are releasing because they have a mental health issue that hasn't been identified and they aren't ready to address it. They may elect to leave service and try to manage it on their own, and they decompensate over that release period of the first two years. They may go out into nothing. They are not obligated to register with Veterans Affairs Canada, so they may not have a link in where Veterans Affairs can even provide them services, and the services may not be related to their military service, their issues.

It's complicated on that end. We do have concern that we're missing a number of people moving through the system who aren't already identified or whose issues emerge after release. A longitudinal study will hopefully give us more information about some of those patterns of trajectories as people move through the release period.

Mrs. Cathay Wagantall: So it would be beneficial then. We've also talked here about some kind of positive recognition that our veterans can carry with them that enables us to stay in touch with them, once they are released, in some way that isn't demanding on them. It would be an opportunity to be able to track them, to ensure that we're in touch and are able to ensure that they're receiving the care they need as they make that transition and perhaps can't manage what they thought they could on their own.

Dr. Heidi Cramm: Credibly, yes, the idea of a registry for veterans...and if that could be tied to some of their anonymized health data so that we're able to understand the health needs and issues and health utilization patterns for veterans, because they may not be all defined at the point of release. Some of these things do emerge. We know that in the case of people who have post-traumatic stress disorder, some of those things may take a significant amount of time to present at a level of symptomology that's impacting daily function and must be dealt with. That can happen five, seven years after someone releases. We have to be flexible in our understanding of how those things can evolve.

Mrs. Cathay Wagantall: Thank you.

Dr. Sareen, you're shaking your head. Are you agreeing or is there something else you would like to add?

Dr. Jitender Sareen: I just like to shake my head.

The Chair: Go ahead, please, but it will have to be a short answer.

Dr. Jitender Sareen: Yes. There is some literature that I didn't get into that basically describes what you're saying: caring contact. If someone has made a suicide attempt, having a letter from the institution that says, “We're thinking about you”, and there's no expectation to contact VAC, has shown in randomized trials to reduce suicide deaths. We've been talking about caring texts. Outreach is a really important piece, but how you implement that in a system is important.

I didn't want to get into that, but because you were describing it, I thought it was important for you to know that there is evidence behind that.

Mrs. Cathay Wagantall: Thank you.

The Chair: That's great, thank you.

Go ahead, Mr. Fraser.

Mr. Colin Fraser (West Nova, Lib.): Thank you very much, Mr. Chair.

Thank you so much for testifying today. It's actually very helpful, and I appreciate the expertise.

Dr. Sareen, I have a very general question. When we're undertaking this study on mental health and suicide prevention, it's important that we understand terminology. I wonder if you can help me understand what suicide ideation actually is, the levels of severity that it undertakes, and how it's recognized.

● (1640)

Dr. Jitender Sareen: Regarding suicidal ideation, a question that is usually asked is, “Have you thought seriously about taking your own life?” When we present these kinds of numbers, that's a question that's asked in a mental health survey. But when you're sitting with individuals clinically, it's really important to get into the details of trying to understand. When did they last have those kinds of thoughts? Is it something they've been thinking about for a number of months? What triggers them, what brings up those thoughts? And then getting into even more detail, it's to try to really understand if the person has actually come close to attempting. Have they actually made preparations, or figured out whether they would use a gun or pills?

When we think about suicidal ideation, that's one level. Concerning whether someone has made an attempt, there has been controversy in the field about whether it was a serious suicide attempt or a self-harm where there was not an intent to die. What we know at this time is that people who self-harm, whether they say they're intending to die or not, are at risk for later attempts. That's another level, to say how lethal the attempt was. That's a gradation of going from thinking about suicide, planning it, to attempting. A number of scales actually measure the depth and severity of suicidal behaviour.

Mr. Colin Fraser: With regard to suicidal ideation and regarding the intervention that may be required, then, is there any difference between armed forces members or veterans going through a transitional phase, who have suicidal ideation, and somebody who is an ordinary person?

Dr. Jitender Sareen: I don't think there is specifically a different intervention, but as has been discussed, a transition period is so challenging around identity, financial stress, and sometimes relationship stress that it's really important to try to help, if there is a depression, to treat the depression, and if there are alcohol difficulties, to try to reduce that. But it's really important to understand the person in the context of their family, as well as how they're trying to leave the system. It requires both individual help and advocacy, and also working to try to ensure that the family understands what's happening, and to help through the financial issues as well.

The only thing I would add is that it's a very similar issue when you have youth who have mental health difficulties and who are then transitioning into adulthood. Our youth mental health systems have usually both the individual and a family, and there is a lot more attention to the whole system. But when they become an adult it's like they're on their own, and we've been advocating that the transition period between youth and adult is similarly a challenging part, so it's important to understand that.

Mr. Colin Fraser: Thank you.

Dr. Cramm, in your comments on the project you've undertaken for the study on well-being during the transitional phase, you said that obviously the goal is to optimize a successful transition. I wonder if you can comment, then, on how we know whether a transition is successful and what that looks like in your mind.

Dr. Heidi Cramm: That's not a simple question to answer, because that's been the subject of some international debate around what exactly that looks like. There's quite a bit of perspective around a successful outcome being equated with the experience of well-being and whether well-being is a proxy for success. A lot of social determinants appear to need to be in place to promote the experience of health and wellness.

Unfortunately, we're trying to in some ways define, through our pattern analysis of people's experiences, what different kinds of success might look like. I think that will emerge. It's not going to be the same for everybody, depending on where you start and what kinds of resources you have available to you. If you choose to re-engage in paid work or what have you, some of these outcomes can look different. I think it will be a by-product of the study to help better answer that question.

● (1645)

Mr. Colin Fraser: You may have mentioned this, so forgive me if I'm asking you to repeat yourself, but is the study itself going to be broadly done, showing people with different access to resources in rural versus urban and various locations across the country, to know what that looks like for people in different situations?

Dr. Heidi Cramm: Yes. The recruitment process will become embedded within the Canadian Armed Forces release process. People will become aware of the study, and they can elect to release at that time. For many people, if they're medically releasing, they would have a date well in advance of their six months. For people who have been in service for 20 years, they can elect to go within 30 days. There are different amounts of lead time before that release date comes in. If you're a reservist, you don't release; you do not renew your contract. This is where we talk about when you're ending your service, because not everyone is going to be releasing from regular forces.

Mr. Colin Fraser: Thank you both very much for your help.

The Chair: That's great. Thank you.

Mr. Brassard, you're next.

Mr. John Brassard (Barrie—Innisfil, CPC): Thank you, Mr. Chair.

You'll be glad to know that Dr. Sareen and I did not go to medical school together.

Voices: Oh, oh!

The Chair: But you went to fire college together.

Mr. John Brassard: I'm not sure: have you ever done that, Dr. Sareen...?

Thank you both for being here. We are having an absolutely fascinating discussion today.

In the context of any of the research done by either of you, have you ever come across any instances of the impact that battlefield medication has had on the development of OSI or PTSD symptoms or the heightening of a preconditioned diagnosed or undiagnosed mental health issue?

The question is to both of you.

Dr. Jitender Sareen: I haven't seen literature on that particular piece. That's not an area I'm familiar with.

Mr. John Brassard: Thank you.

Dr. Cramm.

Dr. Heidi Cramm: I'm not aware of any research literature that would inform a response to that.

Mr. John Brassard: Okay. Thank you.

I also want to pick up on something that Mr. Bratina picked up on earlier with respect to that transition. One of the things we've been hearing consistently over the course of the last week is the loss of identity, the loss of structure. Dr. Cramm referred to that.

Are there studies to show or compare the impact that has on the mental health of our veterans and our forces personnel as they transition into civilian life compared to others who have served—more specifically, police, fire, EMS? We've heard in the past that there are similar impacts on them. What are the comparables, if there are any, to our DND personnel and those who transition from the emergency services?

Dr. Jitender Sareen: I'm pretty sure a study hasn't been done on that. Again, we just don't have enough funding for mental health research. I think it's really important to remember that most of the time we're not guided by evidence, and it's really important to invest in that.

I think identity, especially when you have a young veteran, is a very important issue. For someone who is struggling with PTSD and depression and is released on a medical leave, trying to figure out what they're going to do in their 20s and 30s is very challenging.

I haven't seen literature that's directly compared other police to veterans. I'm not sure if Dr. Cramm has.

● (1650)

Dr. Heidi Cramm: I haven't seen that directly. I will speak a bit on the first responder research basis, because we do have a fairly heterogeneous representation of research. There's much more research on police than there would be on fire, for example. Even within that group of first responders, it's difficult to understand their experiences.

There are some intersections between those who are releasing from the military and who then go on to do a public safety position as a second career. That's not an uncommon experience. Again, these are areas that are newer and that have not received a lot of research funding, so we have a lot of work to do there as well.

Mr. John Brassard: Dr. Sareen, you spoke about investing in the pursuit of this evidence. As far as the Canadian Institute for Military and Veteran Health Research is concerned, what is your funding on a yearly basis? What do you receive in grants and funding?

Dr. Jitender Sareen: I'm not sure what CIMVHR receives. I guess I'm talking broadly about the field of suicide. What we're trying to do is suicide prevention around the world. This is not a criticism of Canada. It's around the world. We have very limited evidence around suicide prevention. The article I'm going to submit is a two-page editorial that says we need to do these things while we look for evidence.

If we're trying to change suicide attempts and suicide deaths, you really need large, randomized trials or pretty strong investments. If you look at other health conditions like cancer and HIV, strong investments in research have turned HIV from a deadly disease into a chronic health condition, and that's through discovery.

Suicide rates have not changed in Canada and the U.S. If we want to change those rates, we really need to have good, strong evidence and investment in research.

Mr. John Brassard: Ms. Cramm, can you answer the question for me as well?

The Chair: We're short on time, so please make it a concise answer.

Dr. Heidi Cramm: Certainly.

Health Canada has invested $5 million over five years in the institute to develop its capacity to harness research to inform these issues. That does not directly fund research. That is to fund the development of the research ecosystem across Canada. The contracts come through Public Works grants. Those funds vary from year to year, depending on what is released up the chain from government. We don't directly fund, as an institute, research projects. Our researchers within our network are competing for grants to do all of this work.

The Chair: Thank you.

Ms. Mathyssen.

Ms. Irene Mathyssen: Thank you, Mr. Chair.

I wonder if perhaps both of you might attempt to answer my question. Sexual assault or trauma in the military can be a significant cause of PTSD or other mental health issues. We had Brigadier-General Hugh MacKay, surgeon general of the Canadian Armed Forces, testify before this committee last Tuesday. He said that PTSD or other mental health issues resulting from sexual assault or trauma of military members are not considered operational stress injuries. Could you comment on how that perspective might well impact the mental health of a CF member who was assaulted and injured while on duty serving with the military?

● (1655)

Dr. Jitender Sareen: I wasn't aware that it was not considered an operational stress injury. Over the course of the time that I've worked at our OSI clinic, we see members, and we provide treatment. I wasn't aware of that piece.

Dr. Heidi Cramm: I would echo Dr. Sareen's comments. I'm not aware of that distinction.

Ms. Irene Mathyssen: Is it detrimental, or could it be detrimental, in terms of how the victim responds to being told, no, this hasn't anything to do with your service but it's something else over on the side? I'm wondering if you have any thoughts on that.

Dr. Jitender Sareen: I think that certainly can have an impact. For someone who has gone through a sexual assault, not having support is a really important piece. But I wasn't aware of that piece.

Ms. Irene Mathyssen: I was surprised by it myself. I thought, by virtue of the fact that young men and women are in a military situation that might make them vulnerable, it would be regarded as something connected with their service. I appreciate your response.

You did say that it is very important for family support in the case of mental health issues. I wonder how we can better support the families who are caring for CF members or veterans who have OSI, who are dealing with mental health issues.

The Chair: This question is for both of you, but you'll have to give very concise answers, please.

Dr. Heidi Cramm: I've done a fair bit of work around the evidence for this. I think this echos back to the need to move toward a family-centred model of service delivery. As [*Technical difficulty—editor*] when they come in for mental health services, there is a primary referral. That's the name on the referral. That's what gets all of the remuneration going. This is how people get paid to deliver the service. But it happens...in the context that there is a secondary client, and that is whatever your social support is—typically your family, as a child. This is how it functions, because people exist in these systems.

Social support is one of the biggest predictors of people doing well in the context of living with mental health issues, so the idea that we would provide a service to someone who has something like PTSD, without supporting the family to support the person who has PTSD, is counterintuitive.

The Chair: Thank you.

Go ahead, Dr. Sareen.

Dr. Jitender Sareen: I would completely echo that. We've developed cognitive behaviour therapy classes at our site, where we educate both clients and family members in learning the CBT skills that are important in managing depression and anxiety. The family members really appreciate being involved in learning some of the skills we're teaching. There is evidence around engaging the family members in PTSD treatment. Especially in suicide and suicide attempts, it is really important to engage family members.

Ms. Irene Mathyssen: Thank you.

The Chair: That's great. Thank you.

That concludes our time for witnesses today. We'd like to give you both a couple of minutes, if you want to wrap up.

We'll start with Dr. Cramm.

Dr. Heidi Cramm: Thank you very much, and thanks to all the members for their interest in these areas. There is a lot happening in the field of military and veteran family health, so it is very important to have these conversations, because we're learning more all the time.

The family piece is one that can't be overemphasized, because it really is critical to everyone's success. So many people who struggle with mental health receive the service after their family disintegrates, and the family disintegration is actually the impetus for the beginning of the mental health process. I believe we can do better at supporting families to support people, so that things do not have to deteriorate to the extent they often do. It takes a lot of different stakeholders working collaboratively to really effect these changes, because no one group in this space can really make these changes happen.

Thank you.

The Chair: Thank you.

Go ahead, Dr. Sareen.

● (1700)

Dr. Jitender Sareen: Thank you so much again for inviting me to speak.

There are two things I want to be specific on. One is that it's really important to review suicide systematically to see what specific issues are occurring and what the intervention points are. There are general suicide intervention strategies, but during the transition period there really needs to be a systematic look taken at suicide attempts and suicide deaths over 100 or 200 consecutive cases to say, okay, how can we reduce these? That kind of work would be helpful.

The second piece is media contagion. The media can increase the risk of contagion of suicide through media reports about suicide. We have been working with the military as well as journalists to really remind people about safe reporting around suicide. I can send you some of the literature on that as well.

Thank you.

The Chair: Great.

On behalf of the committee, I would like to thank both of you for testifying. Please relay our thanks to Dr. Bélanger, who had to take off a little earlier.

If there's any contact information or any other information you need to give to the committee, you can give it to the clerk and the clerk will distribute it to the committee.

On behalf of the committee, I would like to thank both of you for all that you do and have done for our men and women, and for taking time out of your busy day to testify in front of us. Thank you very much.

We will now recess for about two minutes and go into committee business.

Thank you.

[*Proceedings continue in camera*]

Published under the authority of the Speaker of the House of Commons

SPEAKER'S PERMISSION

Reproduction of the proceedings of the House of Commons and its Committees, in whole or in part and in any medium, is hereby permitted provided that the reproduction is accurate and is not presented as official. This permission does not extend to reproduction, distribution or use for commercial purpose of financial gain. Reproduction or use outside this permission or without authorization may be treated as copyright infringement in accordance with the *Copyright Act*. Authorization may be obtained on written application to the Office of the Speaker of the House of Commons.

Reproduction in accordance with this permission does not constitute publication under the authority of the House of Commons. The absolute privilege that applies to the proceedings of the House of Commons does not extend to these permitted reproductions. Where a reproduction includes briefs to a Committee of the House of Commons, authorization for reproduction may be required from the authors in accordance with the *Copyright Act*.

Nothing in this permission abrogates or derogates from the privileges, powers, immunities and rights of the House of Commons and its Committees. For greater certainty, this permission does not affect the prohibition against impeaching or questioning the proceedings of the House of Commons in courts or otherwise. The House of Commons retains the right and privilege to find users in contempt of Parliament if a reproduction or use is not in accordance with this permission.

Also available on the Parliament of Canada Web Site at the following address: http://www.parl.gc.ca

Publié en conformité de l'autorité du Président de la Chambre des communes

PERMISSION DU PRÉSIDENT

Il est permis de reproduire les délibérations de la Chambre et de ses comités, en tout ou en partie, sur n'importe quel support, pourvu que la reproduction soit exacte et qu'elle ne soit pas présentée comme version officielle. Il n'est toutefois pas permis de reproduire, de distribuer ou d'utiliser les délibérations à des fins commerciales visant la réalisation d'un profit financier. Toute reproduction ou utilisation non permise ou non formellement autorisée peut être considérée comme une violation du droit d'auteur aux termes de la *Loi sur le droit d'auteur*. Une autorisation formelle peut être obtenue sur présentation d'une demande écrite au Bureau du Président de la Chambre.

La reproduction conforme à la présente permission ne constitue pas une publication sous l'autorité de la Chambre. Le privilège absolu qui s'applique aux délibérations de la Chambre ne s'étend pas aux reproductions permises. Lorsqu'une reproduction comprend des mémoires présentés à un comité de la Chambre, il peut être nécessaire d'obtenir de leurs auteurs l'autorisation de les reproduire, conformément à la *Loi sur le droit d'auteur*.

La présente permission ne porte pas atteinte aux privilèges, pouvoirs, immunités et droits de la Chambre et de ses comités. Il est entendu que cette permission ne touche pas l'interdiction de contester ou de mettre en cause les délibérations de la Chambre devant les tribunaux ou autrement. La Chambre conserve le droit et le privilège de déclarer l'utilisateur coupable d'outrage au Parlement lorsque la reproduction ou l'utilisation n'est pas conforme à la présente permission.

Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante : http://www.parl.gc.ca