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COMMITTEE

ON

VETERANS AFFAIRS

Tuesday, January 17, 2017

Legislative Committees Office

Canadian Institute for Military and Veteran Health Research
Re: Organization Overview

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VETERANS AFFAIRS COMMITTEE

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Keith Irving
Patricia Arab
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Hon. David Wilson
Hon. Denise Peterson-Rafuse

[David Wilton was replaced by Stephen Gough.]

In Attendance:

Darlene Henry
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESS

Dr. Heidi Cramm,
Interim Co-Scientific Director,
Queens University

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, JANUARY 17, 2017

STANDING COMMITTEE ON VETERANS AFFAIRS

2:00 P.M.

CHAIR
Derek Mombourquette

VICE-CHAIR
Stephen Gough

THE CHAIR: Good afternoon everyone, thank you all for being here. This is the meeting of the Standing Committee on Veterans Affairs. Happy New Year to everyone, I hope everybody had a great break and I look forward to working with everybody on the committee in 2017.

We are receiving a presentation today from the Canadian Institute for Military and Veteran Health Research. Dr. Heidi Cramm is with us and Dr. Cramm, I appreciate you being with us today.

Before we start, please make sure your phones are on mute or vibrate. As we get into the questioning, just a reminder that when you ask your questions, I will recognize Dr. Cramm before you speak, just for our recording.

We'll get started, so the floor is now yours, Dr. Cramm. (Interruption) Oh, actually my fault - we'll start with introductions, starting with Mr. MacLeod.

[The committee members introduced themselves.]

THE CHAIR: Thank you very much everyone. Dr. Cramm, you can begin with your presentation.

DR. HEIDI CRAMM: Thank you very much and thank you to the standing committee for the invitation and the opportunity to speak to the health issues related to military, veterans and families in Canada.

I'll take you through some preliminary information about our organization. To start things off, I guess a little bit about me first; I'm an occupational therapist by training so I've worked with military families in particular, especially through children's mental health services over the years. I also do a fair bit of research on military veteran and family health service access and health issues. I also have done the primary strategy for knowledge translation within the institute. Since last summer I have been Acting Co-Scientific Director. Our founding director, Dr. Alice Aiken, now resides here in Halifax and is now the Dean of Health Professions for Dalhousie so that's where we kind of come from.

The Canadian Institute for Military and Veteran Health Research is a fairly big mouthful so we usually call it CIMVHR. We are physically located - our CIMVHR Central - at Queen's University in Kingston, Ontario. That is our physical location but we represent the pan-Canadian research community.

We came into being really because we have over 700,000 veterans in Canada and only about 25 per cent of those veterans are receiving services through Veterans Affairs. We actually don't have a federal way of sorting out where they all are, so from a surveillance perspective we don't know where all our veterans are at any given time. We have about 90,000 serving members and we have about 70,000 families.

We have a significant need post-conflicts in the 1990s and in the early 2000s. Our military has morphed from peacekeepers to peacemakers to warriors - that's how the Ombudsman refers to the shift. The transition has happened so that our military is very much engaged in active conflict. We didn't have a way, as Canadians, to understand what the health issues were.

We also had a concern that was identified from within the federal government that we didn't have a way to provide that arm's length research that stands separate from and outside of government. The public interest is high and the interest and support for our military is actually at unprecedentedly high levels and the interest in military family impact is similarly rising.

After the conflicts in the Middle East, we see a range of different injuries. What you see through the media, in terms of movies or television - so much of that is based around the American experience. I would just like to note for the record that the American activities around military initiatives are different in the nature of the deployment. What they do, how long they go for, how frequently they go - all of those things are different. They have implications in the extent to which we can generalize the research from the U.S. to the Canadian experience.

We do have complex stages of health in the life course. Some of what we see is some latent impacts. Things that may not be apparent during service or upon release from service may manifest much more specifically after an individual is released from service, and is now separate from any services that might have been provided for the individual had

those issues been identified during service. There is this issue of the latent impact of some of the issues that can emerge through service.

We don't have any kind of typical situation, and we do not understand the impacts on families nearly well enough. In fact, until a couple of years ago, we had virtually no data or health research on the experience of Canadian military veteran families.

We see that the continuity of support, how those transitions take place, and how people are able to access services when they are serving and in the life after service, all remain under high levels of scrutiny within the public. The expectations of our veterans around what should be or could be provided remain publicly debated.

We also have this sense of life course, because the average age of our veterans is quite different from, say, the average age of an American veteran. So we need to understand the life course implications differently, especially when we look at where someone might be in their life course with family expectations.

The issues around reintegration into civilian life can be profound, and people who are ostensibly well can do poorly when they release from service and enter civilian life. We don't historically have a well-developed understanding of what the factors are that allow for a successful transition to go forward. These are some of the issues that have been pressing for CIMVHR.

In 2010, Dr. Alice Aiken and Dr. Stéphanie Bélanger from the Royal Military College of Canada joined together and created this institute through senate approval at Queen's University in partnership with RMC. It's a very young institute; we've only been around since 2010. In that time, we have developed a network of 42 Canadian universities, which is remarkable. We stand alone in a model for collaboration across research institutes and universities. We also have seven international affiliates, and we do have more interest from other international affiliates as well as other Canadian universities.

Combined, we have a force of over 1,000 researchers who are dedicated to researching military-specific, veteran-specific, and family-specific health issues. We also act as the conduit between the academic community and government organizations such as the Department of National Defence and Veterans Affairs Canada. We also are connecting increasingly with international organizations because there are different strengths that different countries have developed through research that we can share and learn from one another more effectively so that we don't all have to start from scratch.

Our vision as an institute is that "The health and well-being of Canadian military personnel, Veterans and their families is maximized through world-class research resulting in evidence-informed practices, policies and programs." Our mission is "To enhance the lives of Canadian military personnel, Veterans and their families by harnessing the national capacity for research."

There is a screenshot there of all the different universities. We're missing our latest university, but we have pan-Canadian representation. In the region here, we do have a fair number of Atlantic provinces represented and increasingly engaged with our mission.

We work very closely, but again at arm's length from Veterans Affairs Canada as well as National Defence. We have had a significant investment from Health Canada - we are at the beginning of our third year - and the intention of that investment was to develop the research capacity as well as the knowledge translation so we can get the information we have through research into professional associations, policy-makers, and programmers.

We are also in an ongoing way engaging with provincial and territorial governments to ensure that the provincial and civilian governments that are responsible for families and for veterans are also aware of the issues.

I will say that the Canadian public as a whole, and this includes health care providers, are generally unaware that military families are actually serviced by provincial civilian health care systems. Most people assume that the bases are providing those services for families, which is not the case.

We have international links across different regions in the U.S. As you can imagine, the scale of what's happening in the U.S. is so much bigger. To have a sense of that scale, there are more pediatricians in the United States Army than there are in Canada, because in the U.S. families are cared for nationally. That just gives you a sense of the scale.

In the United Kingdom, we work closely with King's College London as well as East Anglia University, and we have partners and developing relationships across these other international links.

We have a four-pillar structure that looks at research, knowledge translation, education, and partnerships and capacity building. To take you through some of the activities across each of these, a big focus of research has been mental health and treatments. Mental health intersects with physical health and rehabilitation, as well, so we could look at things within our network, like low back pain. But we might also look at something like chronic pain and the co-morbidity or co-occurrence of chronic pain with the experience of post-traumatic stress disorder, so those things can go together.

We look at social health and well-being, some of the wellness issues in the social determinants of health that impact on families, for example. Transition issues - the research base on what happens when people leave service and how that goes for people is an ongoing area of international priority. Novel technologies, so when innovations happen - military research has a long-standing international standard of developing technologies because they need to on the battlefield that will later inform the general health of civilians in regular populations. Also, occupational health and health issues related to service, so some of the

occupational exposures, some of the gender differences, and the ethics in treatment as well as moral injuries, which is an up and coming area.

In terms of education we offer a graduate course across our member university sites with a view to growing a pan-Canadian program in military veteran family health. We do have some of our philanthropic partners, such as the Royal Canadian Legion and Wounded Warriors Canada, who support our masters and doctoral scholarships. All of those go out to peer review as a competitive process.

In terms of knowledge translation, I mentioned that for example with families the awareness is quite limited around what service looks like, what the impacts are on the military family, and then what that means in terms of health system access and continuity, for veterans as well as for families.

We can inform policy through our knowledge translation efforts and we are also engaging with a variety of professional health associations, such as the College of Family Physicians of Canada, the Canadian Association of Occupational Therapists, where we are actually working with them to develop a strategy that can begin with figuring out what they need to know first. What we talk about is kind of interest and awareness, kind of priming the pump before we really go to any kind of competency. Defining research directions - I mentioned that civilian clinicians are unaware of some of these issues.

We're really looking to identify who can act on the knowledge and who can influence those who can act on it to get the most impact out of our efforts. I would say that one of the remarkable things about working in this area is that people really believe in our military, veterans, and families, and want to support them. There is a social conscience that goes along with a lot of the researchers who are invested and committed to these areas.

One of the things that we do, and one of our highlights around knowledge translation, is offer an annual conference which is multi-sector. We have a lot of people from government there. We have front-line folks. We have veterans. We have families. We have a lot of researchers. We have very engaged and productive conversations.

About 18 months ago, we also launched the *Journal of Military, Veteran and Family Health*. This is offered through the University of Toronto Press. We have outstripped any reasonable expectation for success at this point. The traction for the journal is quite good, and we're getting more and more international focus around this as well.

We do have a website, and we're very active on social media. One of our more recent initiatives is to have something like social media for researchers, an internal database so people can connect and build research teams. It's intended to be a very collaborative tool.

In terms of partnerships and capacity, we are working with a variety of federal politicians and a lot of universities, getting universities engaged and aware of what we do, and some of these professional associations. We're working with other research institutes and provincial politicians. We've been engaged in a fair bit of international outreach. In fact, the international research community looks to CIMVHR as a model that no one else can replicate. We have the international eye in that regard, because no one else can represent the diversity of issues in the novel way that Dr. Aiken had envisioned.

For researchers themselves, we offer a variety of things. I mentioned the Forum. We also operationalize a contract through Public Works. When the government internally identifies what its research capacity is as well as its research priorities, things that it cannot meet but remain a priority can get pushed into the CIMVHR contract. Then we can operationalize that out within our network so that they can get some of the research done more quickly and feed that back to them so that they can inform policy.

We're also looking at developing things like becoming a research subject repository and being able to have a repository of ongoing research studies so that people can see what people are doing in this space in Canada. We have a lot of people who are very active, but things are ongoing, so you wouldn't necessarily know who is studying a certain thing unless we have a way of profiling that. We hope that that will come this year.

We do have an unprecedented link between the academic community and government, and we can highlight the excellent research that government does as well through our Forum. We provide the opportunity to hear about the research they are doing internally as well. We're also seeing that the work that we are doing has extensions to populations such as first responders. We're looking at being able to respond in a very timely way to the research needs of the federal government around these populations.

In terms of the beneficiaries, we have evidence-informed policies, programming and treatments, and ultimately, the best possible care.

This is an image from our Forum this Fall, in November, where Senator Dallaire presented the Wounded Warriors scholarship for doctoral studies. That is going to be looking at military family cultural competency for health care providers. We're going to have information that's derived from the families as well as from providers on what providers need to be doing and know about to provide effective care for military and veteran families.

Our next event is actually in partnership with the Invictus Games. Invictus Games is Prince Harry's initiative and it is wounded warrior-adapted games for those injured, physically or psychologically, through combat and service. We will actually be working in partnership with Invictus in September this year in Toronto. Thank you.

THE CHAIR: Thank you. We'll open the floor now to questions. Mr. Irving.

KEITH IRVING: Thank you very much for the presentation. I think what I'm hearing underlying your presentation is that we have a large gap in research and understanding of the situation with our veterans. Has that been said loud enough? That's underlying this whole presentation and the need for your organization.

HEIDI CRAMM: The organization really emerged out of a gap for understanding health issues for military veterans and families, so not only veterans but veterans unto themselves as well as veteran families, serving personnel as well as their families.

KEITH IRVING: The idea that the American experience is different than the Canadian experience - can you expand on that, describe what that is about? I guess falling out of that, it means that U.S. research is not as valid or as informative to the Canadian experience; I think that again is what you are saying. Can you describe that - why the Canadian military and their families are experiencing something quite different than the U.S. military?

HEIDI CRAMM: One of the things we're trying to establish through our international work is to understand the extent to which findings from other countries can be applied to Canada, as well as the extent to which what we understand in Canada can be applied to other countries.

One of the things that happens around the health care system itself in the U.S. that is quite different is that all health care is provided through one mechanism in the federal government in the U.S., so the families don't have to cross jurisdictional boundaries like they would in Canada. We have similar experiences in terms of how frequently military families might move but in Canada they move four times more than their civilian counterparts, often across jurisdictions. If you are living in Nova Scotia and you move to Ontario, you now get a health card that is in Ontario and you have to start all your health relationships again with providers. So if you have any kind of health issue that predates your move, you now have to take that on.

To a large extent that's an individual responsibility so individual families are tasked with having to repeatedly start from scratch: identify health care providers, figure out how things are named and how you access things in a new province because it is different from province to province and that's before you add in any kind of disability or special needs with a child. Then you might also have to do that health care access in the schools and again, those services vary from province to province. You may be going from a province where there are services to a province where there are not services for a specific condition or experience. That does not happen in the U.S.

We are trying very hard to understand what that means for military families. One of the limitations we have is that the health care identifier for military families or veterans has not been identified across provinces and we don't know yet if it can be identifiable. What I mean by that is when you move, there is an agreement across provinces that the 90-

day waiver is removed for you if you are attached to a military family. Somebody who moves from Nova Scotia to Ontario normally would have to wait 90 days, if they are a military family they don't have to.

In Ontario we know that there's an administrative process that allows us to find those families, only the ones that are coming in, not the ones that are already there. We don't know if that's true of the other provinces yet.

What we do know is that when we look at the preliminary data around military family and veterans in Ontario, that there are some unique health needs that are different from the civilian age-match comparators. If you take two people who are the same age, one is civilian and one is a military family or one is a veteran, their health needs may be different, especially around mental health.

THE CHAIR: Mr. Wilson.

HON. DAVID WILSON: I'll kind of continue on that because just recently I've been contacted by a military family who were posted to Halifax and of course the member can go get health care at Stadacona. The challenge was to find a doctor for their four sons and the spouse. Depending on where you live in Nova Scotia, there are doctor shortages and there are significant challenges there and frustrations. It's good that they waived the grace period but if you can't find a doctor, it's a challenge.

Is there any research done on if there is capacity within the military to offer that care, even if it's for a six-month period, until you get established, until you find out maybe more data on physicians who are available in the community? Do you know if that's something that you've looked at or you know that someone has looked at? Is there capacity for the military to offer some kind of - I don't know if you'd call it bridging health services, I guess maybe.

HEIDI CRAMM: I'm not aware of any research in that area. I would say there are partnerships and initiatives underway to enhance or facilitate that process for folks. Calian is working at trying to make the process of family physician access smoother and there have definitely been efforts within the College of Family Physicians of Canada to create a registry for physicians and there has been a lot of activity around strategies such as if you have a military family leave, then you keep that spot for another military family.

I would say a lot of those initiatives or discussions to operationalize those initiatives are well underway. There's a lot of public will towards making that happen.

DAVID WILSON: Thank you for that. I've written to the minister and I'm just waiting for a response. It was right around Christmas so I'll give some grace period to that. I don't know if the government or Veterans Affairs is contemplating that.

Two quick questions to finish up. I would assume that some of the research on that, when you talk about veterans and that - are the RCMP included in that definition of veterans and military families, or is it just solely based on Army, Navy, Air Force members of the military in Canada?

HEIDI CRAMM: Certainly within the contract, it's a federal contract - if they wanted to do that, that's certainly something we would have the capacity to do, we would not exclude that. The difference with the RCMP in comparison to those other agencies is that they don't have a scientific directorate to help define research priorities, so that's something. Veterans Affairs and DND has a directorate that defines what their research needs are. To my knowledge, that is not present in the RCMP and it's also not there in other aspects of first-responder health. When you look at public safety, those things get more complicated because they don't have that structure.

DAVID WILSON: I know there has been a recent report presented in October by the Public Safety and National Security Committee in Ottawa, that talked about the need for a national strategy around PTSD and occupational career or incidences with public safety officers or personnel. There is a whole list - I think there's 16 recommendations.

Could you give us a couple of details on maybe some local research? Are you aware? I know you identified a couple of the universities here in our own province. Are you able to give us a little bit on what is happening here in Nova Scotia, Dr. Cramm?

HEIDI CRAMM: I know Dr. Aiken is keen to work on some of the identifier database so she is into those explorations currently. I personally am involved in a couple of projects with some researchers at Mount Saint Vincent. There are two studies we're currently working on. One has a co-principal investigator, Dr. Deborah Norris. It's a qualitative study that we're looking at the mental health and well-being of families impacted by veteran mental health issues who are transitioning into civilian life.

Dr. Maya Eichler, also at the Mount in a different department - she and I, along with some other folks are looking - it's actually going to be the first longitudinal, qualitative study of veteran transition. We'll follow them from the time about six months before service into at least one or hopefully two data points after service, and really start to get a sense of those critical kind of active ingredients that make for a successful transition because we don't have anything like that yet.

THE CHAIR: Mr. Orrell.

EDDIE ORRELL: Thank you for the presentation. Just continuing on with Mr. Wilson's questions, with the number of tragedies that have happened over the last number of years, especially recently in Nova Scotia with the PTSD - has your research been able to develop any specific policies that would aim towards treatment or making strides in figuring out what or who or when or why this may affect? Have you been able to use that,

if there are any initiatives policy-wise, to persuade levels of government - all levels of government - to hopefully look at a veteran when they're released, to provide those services no matter where they go in the province?

That's not to say a cookie-cutter type of role but health care people, if a veteran comes in and identifies themselves as a veteran and they're showing some signs of that, could go to your office and say this is what we'd like to see you try to do with each of these. I guess that's my question.

HEIDI CRAMM: I think there are a few things that may speak to this. The research itself doesn't directly develop the policy but we do develop recommendations that could inform policy that we could feed back to government.

There's another local initiative here that actually came out of some of the recognized issues for mental health stigma, health service access for children in Nova Scotia. It's coming out of the Strongest Families Institute. The initiative is headed up by Pat McGrath and Dr. Patricia Lingley-Pottie. What they have done is create a telephone-based, accessible coaching service for families that are experiencing mental health issues. That service is available regardless of where you live, by phone, and can support people in a stigma-free way.

The evidence has been extraordinarily promising, and countries like Vietnam are looking at adopting it. It has won all kinds of awards for social innovation, locally in Nova Scotia and beyond. That structure has been piloted within military family services for some military families to see if we can support continuity of services to support military families to provide mental health services to their children. But we also see that a model like that could be developed - if we had funding, we could develop that model further to support families living with PTSD. That's the first priority for us.

I have been working with Dr. Pottie to try to develop funding mechanisms to make that happen because we recognize that access to services, the timeliness of services, and the stigma-free aspect of service access are critical for families.

I think many of you will have seen the interview on CBC last week that the Linfords did. The Linfords are a couple - he's a retired officer and they, along with Dr. Tim Black out of the University of Victoria, have been funded through Wounded Warriors Canada to develop COPE, which is Couples Overcoming PTSD Everyday. They are into the evaluation and research around this to try to make an impact.

The Linfords, who have been living with PTSD for quite a number of years, really emphasize that although PTSD affects an individual, it impacts the family significantly. A lot of the research that we've done that looks at PTSD and the impacts on the family really suggests that those are very significant impacts.

The problem becomes that the health service system recognizes the individual who has PTSD as the target of care. It's a problem because one of the biggest predictors for recovery from PTSD is social support. If you have a family that ends up mirroring some of the PTSD themselves from trying to cope with that scenario in a day-to-day way, then they also need support to be able to provide the social support to the individual who is diagnosed with PTSD for anybody to do better. Right now, we don't have the research on that, but what we do have is evidence that is really pushing us all toward family-centred PTSD intervention, which does not currently exist.

THE CHAIR: Ms. Arab.

PATRICIA ARAB: We spend a lot of time, and this is generally the conversation around mental health and mental illness, talking about the aftereffects of a crisis. What research is happening about preventive mental health, so not waiting for a crisis? You have people who are enlisting in the service, and you have families that are going to be impacted by what their loved one sees and returns with, and their lives are going to change. Is any research being done on the benefits of preventive mental health?

HEIDI CRAMM: Yes. This is not out in print yet because it was presented in an oral plenary at our recent Forum for our Banting Award winner. The Canadian Armed Forces selects the research that has the biggest impact in a given year. This past year, Denise Fikretoglu actually presented research evidence on how the Road to Mental Readiness initiatives that the Canadian Armed Forces has been rolling out over the past number of years are definitely having an impact on members. Members are actually doing better than civilians at being able to recognize the need for mental health services. We are seeing an impact, and it's very promising.

PATRICIA ARAB: Having that knowledge, what emphasis are your universities and your researchers putting on developing - again, we use the words "cookie cutter," and we know that there is no such thing as a cookie cutter plan. What emphasis is being put in research on giving these families and these individuals the tools that they need so that, if there is an escalation of a mental illness or a trauma, they are better prepared to deal with it or just better able to transition in healthy and productive ways? What specific research is being done for that?

HEIDI CRAMM: In terms of the interventions, I would say that from the family perspective, we're not there yet because we're still trying to map out what the issues are within the Canadian context. We can't put the interventions in place prematurely until we understand the issues. Right now, I would say people are trying to balance that dance between needing to put something in place and not knowing yet what works best or why.

One of the things that we know is that well-intentioned programming isn't always effective programming. If it's not research-informed, it may just be something that is provided but doesn't actually help. We're trying to develop the evidence as quickly as we

can, recognizing that some of the things that may exist already could be generalized perhaps to military families or veteran experiences, but the funding to do the research is pretty limited. So within the community, based on the funding that is available, there's a lot of activity but we're not at the intervention stage I would say. But that's a developmental process in a field of research as well.

THE CHAIR: Mr. MacLeod.

HON. ALFIE MACLEOD: Thank you very much for your presentation. Some of the numbers you use have just blown me away here, especially the one about the pediatrics. It's quite amazing when you listen to that and hear it.

Based on the geography of our country which is so huge, I'm just wondering if your research has identified any area or province where the mental health challenges are greater within the military. As we know, over 10 per cent of Nova Scotia's population are involved with the Armed Forces in one way or another. I'm really curious if you can identify geographically where the greatest needs are through the research you have been doing.

HEIDI CRAMM: I'm not aware of a geographic capacity to do that at this point. Once we get more of the provinces online with being able to look at the health identifiers within the bigger data, the hope is that we will be able to make some of these comparisons.

One of the things that's an exciting addition is that IBM has pledged now $12 million for a CIMVHR advanced analytics initiative to create the capacity to look at some of that big data, but we have to identify what's available first. All of those have policy implications for even privacy, what data is available and how to look at it. All these things are under way, those discussions. Then we will have to look at that from a province-to-province perspective.

What it has told us in Ontario is that we can identify the regions where the density of veterans is higher and then we can inform the local health authorities that there are a greater number of veterans in their catchment area so that they can provide veteran-specific service programming. In that regard, at a provincial level, in Ontario we're able to have those conversations.

We're also able to look at if there's an increased need or an increased access rate for mental health services for those who recently release. We don't know if that's because they didn't access while they were in or if they're experiencing mental health issues now that they're out. We don't yet know that part of it, so there needs to be that big data piece and there needs to be that human interaction interview-based where we understand people's experiences. We need a lot of different methods to be able to get the full picture.

ALFIE MACLEOD: I guess my question is really quite simple. What is it that we in the Province of Nova Scotia could do to help make your work easier to help that huge percentage of our population that has a military background, and their families?

HEIDI CRAMM: In terms of a Nova Scotia perspective, I think the health care identifier issues are significant and pretty transformative in giving us information that would allow us to really understand what the experience of Nova Scotian veterans and families might be. That's under the purview of the province rather than the federal jurisdiction for military members. That's where a lot of these things start.

From there, we can understand some of these patterns of need and the unmet need as well. I think the health identifier issue is vital and that's layers of government that that will require.

ALFIE MACLEOD: The other thing that I think is a big concern for a lot of us is it's great when you're in downtown Halifax and there's all kinds of services. There was a recent tragedy in this province and - I am certainly no expert at this, but part of it may or may not have been the location of where the individual was and the ability to obtain services. I'm wondering in what you are trying to achieve, is there any consideration into how we tackle that problem where so many people are not in the centres of population but they're spread right across provinces, like our own, which has vast areas where we don't even have Internet connection in some places?

I think the problem you identified is very significant and the challenges of meeting that are significant. I'm really curious as to what we in this committee and what our province can do to help people in rural areas tackle and be as successful as they can be in what's going on. I know that's a loaded question.

HEIDI CRAMM: I think these kinds of system access issues are true for many veterans across Canada because veterans go everywhere. They don't just stay in the place where their last posting was, they return to their home communities. Many of them are rural, many of them are remote, many of them are not. They're home communities where they have the historic kind of family networks to draw upon. In that regard I think a lot of veterans are in similar situations.

We also know that some bases are much more separated from other more urban centres than, say, you know the base in Toronto you would never know there is a military population but if you're in Gagetown, you know there's a military population, for example. This is where something like the Strongest Families initiative came from, is recognizing exactly these issues, and that's why it's telephone-based rather than Internet-based. If you have a phone, you can access the service and it doesn't matter what time of day it is. That's the kind of model that I think holds the most accessibility to impact people in their day-to-day, those types of outreach models.

If we centralize all the services so people have to come in, if you're a family living with PTSD, then it would be very hard to drive in to Halifax to have an appointment for an hour. That would be extremely difficult to do, just given the uncertainty and the variation from day to day on what that can look like in a family, so wouldn't it be great if you could pick up the phone and access that service?

THE CHAIR: Mr. Jessome.

BEN JESSOME: You made reference to a social network of sorts. I'm just wondering if you can provide a little more information. Is the platform established? Who does it incorporate? What capacity is there within it? What is its purpose, and if it's already functional and on the go, then what type of buy-in do you have? How many people, for example, would be participating in this network?

HEIDI CRAMM: The UNIWeb is what it's called. Proximify developed it and it's functioning at a number of different Canadian universities with kind of their internal networking. What we're doing is using it across our network, across our 42 universities. We are in the early stages of getting people to put their data in.

Ideally we would have all the researchers so they can upload all their research interests, their publications, so that if you wanted to do intervention research and you wanted to develop a team, you could find out who in Canada is doing that. It's really meant to help mobilize some of that collaboration and team development.

One of the things that CIMVHR has done, historically when researchers apply to the contract - say the call for a particular project, a research task, goes out to the network, and then research teams will apply for peer review so it will be evaluated. There have been a number of times when the peer reviews have come back and said well this team here, from Queens, ranks equally with the team from Mount Saint Vincent, so why don't we see if we can actually get them to work together? In fact, that's how I started working with Drs. Norris and Eichler.

That's a completely novel approach because with all the other funding, you either get it or you don't. We recognize that you have different strengths and maybe you can combine together, so the synergy that can happen through that kind of research team-building becomes really profound because now we have social scientists at the Mount and health scientists at Queens working together so you have this very comprehensive, balanced team.

BEN JESSOME: I guess you're still in the research phase that won't ever stop. I wasn't clear initially on whether this was a platform for researchers or for military veterans themselves, so thank you for that clarification.

THE CHAIR: Did you want to comment on that, Dr. Cramm?

HEIDI CRAMM: Yes, please. One of the things we want to do in our work plan for this year is to develop a repository for research projects that are currently ongoing, as well as a research participant repository, so that if you're someone who has an experience that you would like to have represented through research, you can submit your information to the repository and then researchers can query that repository to see who's out there. That can then allow us, as researchers, to do the research that much more effectively and efficiently because we will already have people from all over Canada so we can have that representation of urban and rural and east and west and central and French. We can have that.

That is an infrastructure issue that we're in a growth period of. We're at the beginning stages, but that's certainly an identified need for us to really do a good job at doing the research well but in a timely way. Right now recruitment takes an incredible amount of time.

THE CHAIR: Mr. Wilson.

DAVID WILSON: You mentioned the Strongest Families program and it's an amazing program. I've worked with that and was very proud to support it when we were in government. Knowing how important it is to de-escalate maybe a situation that a family finds themselves in, instead of maybe having to call the law enforcement or go to an ER.

I'm just wondering if there's any data or research on the benefits of peer-to-peer support. I ask this because I support an organization called Tema Conter Memorial Trust. They have a 1-800 number that first responders, correctional officers, can call and speak to a peer - not that they're a trained physician or counsellor, but they do go through some training. It has been something offered through that organization to try to hopefully get people to support the need. They have a whole list - if you're calling from Nova Scotia, you should go here, and if it's an emergency call 911.

Is there anything that shows there's benefit to that? I know that often it could be used beneficially for certain circumstances but if it has escalated beyond a point where maybe a peer could intervene - is there any research being done on the benefits of at least having that as one little component of a suite of services potentially that's offered to Canadians, to Nova Scotians, especially if you're in a province where there are people in rural communities? Just making an initial call could help or maybe alleviate that escalating to a more dramatic event down the road.

HEIDI CRAMM: Certainly the research on peer support from CIPSRT, which is the Canadian Institute for Public Safety Research and Treatment - that was the institute that you referenced from the parliamentary recommendations from October.

We've been working with the University of Regina in a sister-institute model because a lot of what we have found and what we know and our network itself could be

leveraged to scale the first responder and public safety research landscape as well. They had put out in September what they called the blue paper, which looked at the evidence for peer support programs, and they were not able to state that there is evidence to support those types of programs. That's not to say there isn't, and that's an important distinction. They didn't find that there is negative research, but there is not evidence to support it at this time. They're really trying to develop the evidence on peer support broadly.

I know from some of my own work on firefighters and PTSD that there is some concern that peer support programs are not understood well enough to identify what circumstances are appropriate and what types of peer support and critical incident debriefing situations could look like. I would say the jury is not in on what works when for whom and why, broadly.

The OSISS program, which is run in partnership with Veterans Affairs Canada - it's the operational stress injury. "Operational stress injury" is the term that the government uses to talk about the psychological and emotional injuries that might be acquired through service, which may include PTSD, depression, alcohol use, and those types of things. In fact, depression, anxiety, and substance use far outstrip the experience of PTSD; I think that's important to note as well. I know we don't hear about that in the media nearly as much, but alcohol, substance use, depression, and anxiety are much bigger issues for our military and veteran community than PTSD is in Canada. OSISS, which is the Operational Stress Injury Support Service, offer peer support as well, and they also offer it for families. That's available nationally. I would say it's available. I haven't seen what the evidence is to support it, but many people will report it as helpful.

THE CHAIR: Mr. Irving.

KEITH IRVING: This has been very interesting for me, realizing that we're really lacking the evidence to know how to change public policy or where to use our resources most effectively. What is really underscored here is the importance of this first step of getting the research done and the information to inform public policy.

That leads me to my question, which I don't think you've touched on: how is this research funded? You mentioned a CIMVHR contract. Maybe you could explain that in the context of where the funding is coming from. Is it sadly underfunded? Are there ways to increase funding if needed? Can you explain how it's structured, where research money comes from?

HEIDI CRAMM: Research money is hard to come by. If I were to apply to the Canadian Institutes of Health Research, I would have somewhere between a 7 per cent and 12 per cent chance of having my research funded. That's what the research funding landscape looks like for health scientists; that's broadly.

KEITH IRVING: Where does that money come from in that pot that you're getting a 7 per cent chance? Is this government money?

HEIDI CRAMM: That's federal government money, and that's to the broad health science community.

For military, veteran, and family research, what we see is a scientific directorate within Defence, within Canadian Armed Forces, and within Veterans Affairs where they do research internally. They also have a way to identify what their priorities are and whether or not they have the internal capacity to meet it. If they have priorities that they require timely research on, they can then put it through what we generally refer to as the contract. It's a contract with Public Works Canada. We will operationalize these calls that are government priorities to our academic communities. It's a much more specialized pot of money but it's also a government-identified priority pot.

As a researcher, if I said okay, those are really important things and I want to participate in that but what I'd really like to do is this thing over here, I have to be able to find someone who will fund that. That's either going to be a foundation, a government, some kind of philanthropic organization or it's going to be through the highly competitive grant competition where you are in with everybody else and you have between a 7 per cent and 12 per cent chance of getting something. Really I wouldn't even say, depending on where you are in your career, it may not even be that high.

KEITH IRVING: Do you feel that D&D understands the research void that really needs to be filled? I think what the Canadian public is saying is there is urgency for us to begin to address these issues but of course the beginning of addressing those issues is funding the research. Does D&D understand the need to support more research to deal with these issues that are in the public eye that we're all concerned with?

HEIDI CRAMM: It would be hard for me to say what D&D does and doesn't understand per se. I can say they have invested significant amounts of funding into research priorities that they are unable to meet. The collaborative engagement with the CIMVHR network is extraordinarily strong, I can say all of those things.

To date what we have, what we call the pilot contract, was $2.5 million of research funding and then what we are currently in right now is an estimated $11 million contract. That contract will end - its current end date is March 2019 so just two years away. This funding would need to be extended for some of these projects to continue. I would say the research community is working as fast as they can, given the available funding. Researchers are driven by funding because they have to have funding for their research so they will do research where they can get funding. If they can't get it here, they will have to find a different branch of research to do because they are required to get funding from somewhere to do their research.

THE CHAIR: Mr. MacLeod.

ALFIE MACLEOD: My question is a little bit along the same lines because it sounds to me like you've had a very good success rate to date in the research you are doing and where it is taking us and the need that is out there that has identified that research needs to be done.

I'm wondering, pretty similar to what Keith was asking - in two years' time the funding runs out, so is there anything that this committee can do to help push the idea? I think there was a request somewhere along the line for $5 million over five years to keep this research going because the importance of it, from a novice's point of view anyway, is quite large. I'm just trying to figure out what it is that our committee can do because we've all got this special desire to help the veterans. We're one of the few provinces that even has a Veterans Affairs Committee.

I guess I'm kind of wondering what it is we can do to help you to keep on doing what you are doing to help them. How about that for a roundabout question? I mean the reality is I think the work you are doing is so important that there must be something that we, as a group, can do to help continue that on.

HEIDI CRAMM: Thank you for your comments. I think we're always looking for a more permanent funding base for CIMVHR to function but also the individual research activities also need that funding so this is where those conversations around this as a priority would certainly be helpful.

ALFIE MACLEOD: If CIMVHR is looked to be a very solid project with adequate supports, would it be fair to say that it would be a little bit easier for researchers to get funding to help support what CIMVHR is dong? I don't know if I've put that in the right context. If there's a strong core that the research over here is helping, does that make it easier to get research money?

HEIDI CRAMM: One of the things we're most mindful of is the sustainability of the institute. We have a student engagement strategy as well now that we're operationalizing because we need to grow more researchers to be able to do this work. The amount of work that is out there outstrips the current capacity for the research to be done in a timely way.

We're at once trying to grow the research, like the up and comers, and Wounded Warriors and the Legion have been fantastic at supporting a master's and a doctoral scholarship in that regard and really to help showcase that. We have CIMVHR central - what it costs to run the institute itself - and then the research activities of the researchers across the country. Those are the folks looking for increased funding opportunities so they can find the funds to do their work.

Increasing the reciprocity of those conversations across government and CIMVHR around the things researchers are identifying as next steps within their bodies of research - if we had ways to feed that back to government as they set their priorities, I think that could be useful as well. Currently what we have is government determining what those priorities are for the academic community to meet.

As we engage in our different projects, then we can identify what some of those next steps could be that might be different from what the government would see from their internal lens. I think those discussions, that reciprocity - CIMVHR is positioned to help mediate those conversations to help those along, but I think we're getting there in our development.

THE CHAIR: Mr. Jessome.

BEN JESSOME: I think you might have sort of answered my question but I'll just clarify. Does CIMVHR have a branch of the organization - evidently you are here today to communicate directly to elected officials, but is there a team or individuals within your organization that are charged to do that in an ongoing way? You ask if there is a way to help explain the priorities of CIMVHR, because you're saying the government sets the priorities. I'm thinking here it's the cart before the horse type of thing - the research drives the priorities, but if the research isn't there, how are you supposed to set the priorities? Is there an active arm of your organization - they probably would be called lobbyists otherwise but I don't really see it as a lobbying sort of thing, more of just an open forum for your folks to create that to-do list?

HEIDI CRAMM: I would say the government relations aspect is certainly part of our Health Canada mandate to develop, especially at the provincial and territorial levels because we do have really strong relations at the federal level. That's one-third of our stream, so we have military and we have those federal relations, but then we're working on the veteran and the family which are all provincial and territorial, so the government relations is a big part of that.

What we're aiming to do is to develop some regional leadership within our network, to be able to do that more locally. That's part of our kind of developmental process in this phase of CIMVHR's development.

BEN JESSOME: I'm going to shift gears if that's all right. You talked about the lack of information specifically around transition services or a successful transition. You've probably done some form of an assessment on why there's such a great barrier between accessing that information and getting it. Why is it so difficult to get that information on transition services? What are you folks doing to recommend a breakthrough or to achieve a breakthrough?

HEIDI CRAMM: The issue around transition is definitely complicated. I do know that within government, it has been a huge priority for them to do what they're calling closing the seam. It's both ends working together to try to figure out what this soft handshake might be - a warm soft kind of transfer.

The internal research had looked at folks who are identified as having medical release issues. They might be the high-risk group. More recent internal research suggests that maybe those are the ones where we generally know what their needs are, and those needs are set up for them as they transition.

What we don't know is, for the people who for lots of reasons are not either identified as having any kind of need, or willing to explore being identified as having any kind of need prior to release from service - what does it look like for them? There are some folks who, when they are released, would elect to not access services through Veterans Affairs regardless of their appropriateness. There is a cohort of folk who maybe don't want to access the services for personal reasons. We only have about 25 per cent of veterans accessing services through Veterans Affairs, so we don't really know what's happening with the other 75 per cent.

I would say there's a lot of activity around transition and identity. Your sense of yourself is as a soldier, as a warrior, and then you're no longer in uniform. You've been a military family for 25 years, and now you're a veteran family. For lots of people, it's a difficult transition.

This longitudinal study, we're just in the applying for ethics stage. It's a longitudinal study, so it's going to be two and a half or three years before we really have answers around what some of these things are that make for a successful transition.

I would say internationally, there is no consensus around what constitutes a successful transition.

BEN JESSOME: You've indicated that two years down the road, we'll come to another crossroads. In the interim, is the goal to spend that full two years developing the research and creating a set of recommendations with that end date in mind? Or is it something that will be more real-time as things develop?

HEIDI CRAMM: With the longitudinal study, what we'll have is about 100 people whom we'll interview in in-depth qualitative interviews. It's a lot of data about their sense of how the transition is going to go. We'll have that about six months before they release, and then we'll connect with them again about six to nine months after they release and look at what that means. We have a sense of what they think, and once we start to see how it's going, we can start to have a sense of what some of the patterns and trajectories might be.

As soon as we have that information, we'll be presenting it at academic conferences. We'll be talking to government. We'll be writing up our papers as soon as we can get the work done. But it does take time. If we have the mechanisms to communicate and the relationships to communicate as that stuff is coming online for us with the analysis, then we can start to impact policy and programming earlier. That's where these two studies that I'm currently involved in that are funded by Veterans Affairs, one is looking at the experience of the families and the needs of the families around mental health and transition, that will be done sometime over the summer. We're going to be interviewing about 30 families for that. There has been a huge interest.

Our recruitment, I don't anticipate us having big problems for recruitment. That will also then inform in parallel what we look at for the veterans themselves. You can see how Veterans Affairs is trying to kind of patch different perspectives together so it's almost like at the centre of something and you have this wedge that gives you one perspective on what you're seeing but until you have all the different wedges you can't really see what the centre looks like, so we're all just trying to get our pieces done. It's a very complicated process for folks.

THE CHAIR: That concludes the list that I have. Did you have any questions anybody? The final question to Mr. Orrell.

EDDIE ORRELL: To continue on my first question, we're talking about the research with PTSD and so on and so forth. A veteran who returns to Nova Scotia, for example - 10 per cent of our population is military here in Nova Scotia. A huge rural area, a lot of areas where employment is way down, none, health care is suffering from lack of doctors and lack of mental health professionals, support groups would be very limited.

Such a high percentage of our population being military - I'll use Atlantic Provinces as much as Nova Scotia - there are six research universities here doing research military-wise. Would it be beneficial for them to be doing area-specific research? I would think that a veteran coming out of the Armed Forces who did two tours of duty, 10 years, and is either now damaged because he has PTSD or whatever, who would have a job coming out, would probably be more equipped to cope or would have some support in the job with different people and/or doctors that would come in the area. Is that research specific to a certain area, even to say rural areas because the city would have that access and have the jobs and so on. Is the research being done specifically to a certain area, I guess is my question.

HEIDI CRAMM: I'm not aware of research being done around the role of like a secondary job or career after transition specifically being done. I think there is lots of evidence that suggests it would be useful, especially when you look at meaning, purpose, identity, all the things that make life worth living. If you had all that when you were in uniform and you no longer have those things, you don't have the structure as well, then those also can complicate day-to-day life.

I think there are some initiatives, again not research but like Prince's Operation Entrepreneur, that look at trying to bridge folks into jobs. Certainly in the U.S. we have some great examples of boot camp models to prepare people, doing small businesses, how to get themselves going in a place even if they have to define what that job might look like because there may not be a job to go to.

There are some examples of some models even within Canada where they are having some success, but I don't know what the research around those initiatives looks like.

EDDIE ORRELL: I guess what I'm saying is with the high volume of veterans and military people in our province, should we not maybe be funding some of that research through our provincial government, through maybe our Veterans Affairs office that we have here because we have the only Veterans Affairs Committees that happen.

My question would be, should we not be preparing an individual for discharge the day they enter the Forces - is there any research done on this? They're looking at, hopefully, 30 or 40 years in the military, and they'll be fine. But if somewhere along the way, all of a sudden they're done, and we haven't done any preparation up until then - should we not start that the day they enter? Is there any research to say that that would be beneficial or not beneficial?

HEIDI CRAMM: I'm not aware of any research that said that would be beneficial. I have heard many people in uniform say that it's essential to prepare for release when you start and to have those kinds of trajectories - the different ways that you might release and when - as part of your planning around positioning yourself well so that when you do release for whatever reason, you're able to transition to something that is meaningful to you. That is certainly there.

Some of the models for transitioning into different kinds of work would look at how to translate - and some of this has to do then with the civilian community's capacity to understand the translation of how the skills acquired - not just the technical skills but the skills and experiences acquired through military service - actually can shine in a civilian type of job.

Depending upon what your trade is, what your occupation is, within the military, those things may be more or less accessible to the public. If you're infantry, it may not inherently make sense what that looks like in downtown Halifax or in Sackville. But that's not to say that the skills that you develop as a worker don't translate aside from the technical skills that you would acquire. Those things could flow. There's significant expertise in work research at Dalhousie, so it would be developing that area. But again, it's a funding-dependent phenomenon.

THE CHAIR: That concludes our questions. Dr. Cramm, I just want to give you a few moments for any closing comments.

HEIDI CRAMM: I had mentioned that the research from the U.S. may be significantly different. I would put that out there in terms of families but also age of service and PTSD rates. PTSD rates, as they're reported out of the U.S., are significantly higher than what we know to be in Canada.

One of the sad things that can happen from circumstances, as you're working through here in Nova Scotia, is that the stigma associated with mental health can be reinforced. We do see a fair bit of stereotypes around PTSD that are concerning for all the families who live with PTSD and how they access services. There is some concern from the research community that the portrayal of those with PTSD where circumstances end tragically, which is a minority of cases - clearly they are sad and very tragic, but that is not representative of the population of veterans. We also have to be careful not to presume that all veterans have PTSD because they do not. A minority of veterans would have PTSD. We have to be very careful around making those presumptions and over-generalizing to the entire veteran population.

We also have to be careful about how PTSD is represented because it can stigmatize folks from seeking service as well as their families. If I give you the example of two females - it's very heteronormative because most of the family literature presumes that families are the male serving member, and the female is married to the member. This is not representative of families generally and it's not representative necessarily of Canadian military families.

The example typically is that there is a male serving member, there is a female spouse and there's a couple of kids. Let's say that you, as a female spouse, work in an office and the office right next to you, both of you have spouses with significant health issues. One of them has cancer, one of them has PTSD. The worker who has a spouse who has cancer can post, this is my husband's cancer treatment regimen, this is when you can expect me to have additional need, this is when you can expect me to maybe not be doing so well. The spouse with PTSD can't make that plan, they can't lay that out in any kind of structured or anticipatory way. They are also not talking about it at work because that stigma is still quite heavy so you are not putting a calendar of your husband's PTSD treatment on the door of your office or your cubicle. But you might if your spouse has cancer so people know what is going on so you don't have to talk about it.

There's a substantive difference when you are living with someone who has mental health issues that may not be very predictable and may be disruptive to the family when they are acute. Many people can recover very successfully with PTSD. Social support is the critical part that allows people to get better.

I think it's trying to be very mindful of what we perpetuate when we talk about these kinds of issues without that.

THE CHAIR: Thank you, Dr. Cramm, and thank you to all the committee members for this very important discussion. We're going to take a five-minute recess and then we will come back together as a committee to finish off the rest of the business on the agenda. Again, thank you very much for spending the afternoon with us.

[3:27 p.m. The committee recessed.]

[3:33 p.m. The committee reconvened.]

THE CHAIR: We're now moving into committee business. We had some correspondence, the follow-up correspondence from the Nova Scotia Health Authority, July 5, 2016, the three-month update on the new agreement with VAC regarding Camp Hill Veterans Memorial Building. Is everybody okay with that information?

The second item on the agenda is to sign the report of the Standing Committee on Veterans Affairs for 2016, so we need everybody's signature. We can pass that around. If we can do that now it would be great.

Right now we are scheduled for our next meeting to be Tuesday, February 21st, from 2:00 p.m. to 4:00 p.m. It is the Legion Service Bureau Network, Royal Canadian Legion, Nova Scotia Nunavut Command.

That concludes our business. Thanks folks and I want to thank everybody for the discussion today, it was a great discussion. As always with the committee, everybody asks great questions and it was really great.

We are adjourned, thank you very much.

[The committee adjourned at 3:34 p.m.]