HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 052 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Wednesday, May 3, 2017

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Chair

Mr. Neil Ellis

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● (1540)

[*English*]

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

Pursuant to Standing Order 108(2) and the motion adopted on February 6, 2017, the committee is resuming its comparative study of services to veterans in other jurisdictions.

In the first hour, from the Workplace Safety and Insurance Board (Ontario), we have John Genise, the executive director, case management. We'll start with 10 minutes and then swing into questions.

We'll turn the floor over to Mr. Genise.

Mr. John Genise (Executive Director, Case Management, Workplace Safety and Insurance Board (Ontario)): Thank you, Mr. Chair, and members of the standing committee.

Thank you very much for giving me the opportunity to speak to you here today. It's something I don't often get to do in my normal duties.

As you said, my name is John Genise. I'm an executive director on case management at the Workplace Safety and Insurance Board and I also reside in Ottawa.

I'll give you a little bit about the WSIB. We're one of the largest organizations of its kind in North America. We provide workplace insurance for more than five million workers and over 300,000 employers across Ontario. Each year we receive an average of 230,000 claims. We collect over $4.5 billion in employer premiums to fund the system and no tax dollars are involved. Relevant to this committee, we registered approximately 3,800 traumatic mental stress claims in 2016 and we are actively managing about 1,300 of those.

In terms of the criteria for entrance into our policies, there are a few. If a designated worker, who is typically a first responder, is diagnosed with post-traumatic stress disorder and meets specific employment criteria, it is presumed to have arisen out of and in the course of their employment, unless the contrary is shown. So we have a presumption clause.

All other workers are entitled to benefits for traumatic mental stress when they experience an acute reaction to a sudden or unexpected traumatic event arising in the course of their employment. A traumatic event may be the result of a criminal act, harassment, or a horrific accident. In all cases, the event must be clearly and precisely identifiable, objectively traumatic, and unexpected in the normal or daily course of the worker's employment or the work environment. The policy considers acute reaction, cumulative effects, and harassment as three types. Now, I'll tell you a little bit about us.

In terms of this committee's areas of interest, I'll speak a little bit about compensation for pain and suffering. The WSIB insurance replaces lost wages, covers health care costs, and helps workers get back to the job safely. We do not financially compensate for pain and suffering. We do have a non-economic loss award, or benefit, for a functional abnormality or loss which results from the injury. It's expressed as a “whole person impairment” as a percentage using a prescribed rating schedule—we use the AMA guide. In 2017, that prescribed amount, the “whole person” base amount, was approximately $59,000. The base amount is then adjusted at the time of the injury, based on the workers age. There's an added adjustment factor for every year that the worker is under the age of 45 and on the other side, we subtract the same adjustment factor for every year that they are over the age of 45.

In terms of short and long-term income replacement, the WSIB pays for loss of earnings, both full or partial, starting with the first day after a work-related injury. Benefits are calculated depending on the date of injury, based on annual wage ceiling. We pay 85% of net average earnings. Loss of earnings benefits continue until the person is no longer impaired by the injury, there's no longer a loss of earnings—perhaps they're back to work—or until age 65, whichever comes first. After 72 months, those benefits are made permanent to age 65. Payments are issued every two weeks and adjusted for inflation annually.

In terms of supplementary support for severely injured veterans—one of your interest areas—our approach is recovery first, access to quality medical care, layered with support for a return to work when appropriate. Workers must have a DSM diagnosis to qualify and we often fund this assessment, even prior to accepting a claim. Often workers don't have the means to get assessed in order to reach the entrance criteria, so we'll pay for that, even if we don't have an allowable claim. Our approach to managing these files is that we have a multidisciplinary team. We have dedicated case managers for these cases, as well as dedicated nurses. We also have dedicated work reintegration specialists and they are in the worker's own community. We also have contracted medical services. We have a dedicated roster of psychiatrists and psychologists across the province in order to expedite care for these clients. We also use the Centre for Addiction and Mental Health, CAMH, for assessment and treatment.

● (1545)

In terms of transition and rehabilitation services, I said earlier that a provider network has been established to assist and provide clinical expert assessment and recommendations to workers in communities across Ontario. This means that we move quickly to get workers treated when needed. For us, return to work is our primary focus. We want to make sure that we restore workers' abilities before we can move forward on these cases.

Work transition specialists are involved early in post-traumatic stress claims, even before the worker is ready to work. We use a collaborative approach in return to work planning, by involving the client, the employer, and the treating physician together to come up with a plan. When workers are able to go back to the workforce, we continue to support them while they are working, and help them to work through their challenges and some of their barriers.

That primarily is my presentation on the four areas that you wanted us to focus on.

I'd be happy to take any of your questions.

The Chair: Thank you.

We'll start with six minutes, Mr. Kitchen.

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

Thank you, Mr. Genise, for being with us today.

As you're aware, at this point we're basically studying comparatively veterans issues in other jurisdictions. Having you here provides an idea of another jurisdiction, not necessarily in another country, but in another jurisdiction that provides services and how you deal with that aspect of it.

I come from Saskatchewan. As a chiropractor there, I have dealt with WCB in Saskatchewan. I'm not familiar with WSIB. I realize that every province has different WCB issues and ways to handle them.

One of the main things they talk about is getting back to pre-accident status. That is the big issue. You touched on it a bit when you talked about return to work and assisting workers in that.

I wonder if you could expand a little more on where you see that role, and maybe you might surmise how you might see that with the veteran population as well.

● (1550)

Mr. John Genise: Our main focus at the WSIB, and I think all across the province, is return to work. However, these cases are particularly challenging because of their nature, so we try to build a strong platform medically to make sure we're going into charted waters. As I said earlier, it is collaborative. We take a slower approach with these than with someone who has a strain, for example because these cases require more care.

We have a number of programs, but primarily it is a slow reintegration into the workforce, and a planned effort. We support our clients with a multidisciplinary team, so there is nursing available for them to work through their medical challenges. We typically have boots on the ground in terms of reintegration with the accident employer. We'll have someone, face to face, do planning with the worker and involve the physician, so together they're working towards employment.

You mentioned the return to pre-accident employment and function. That is the ultimate goal, but we start very slowly and incrementally, particularly on these cases. They are more challenging, and we want to maybe guarantee success by going slow and having a thoughtful plan.

If we can get a worker back to work one day a week or two hours a day, depending upon what the medical needs are, we'll do that, because when workers are outside their normal work environment, they are outside their social environment, their safety net, so to speak. Even integrating them to the workforce in a slow capacity, in any capacity, reaffirms their position in the employment relationship with their peers, with their supervisors. Going slow, oftentimes we find is the way to go.

Mr. Robert Kitchen: Often we've heard throughout our studies that issues of stigma are a big concern in how our veterans are dealing with that transition. Whether it be mental illness, PTSD, or physical injury, whatever capacity it may be, it's the issue of whether that soldier is able to deploy. That's the main focus.

When I have dealt with that as a practitioner, I have often seen people fall through the cracks: Who is taking charge of this? Who is the boss? Is it the MD, the chiropractor, the physical therapist, the nurse? How do you manage to make certain that isn't going to be detrimental to your clients?

Mr. John Genise: Our quarterback, per se, is the case manager. They coordinate all that happens at the workplace, as well as medically. They are the point of contact for the challenges and barriers that exist and how to work through them.

Because we have work transition specialists going to the employment site, they do a collaborative plan with the frontline supervisor and the employee, whatever medical staff the employer would bring, and the union, and they put together a plan. Everyone signs off on that plan so that the expectations for what is to follow are clear to everyone, and therefore so is the accountability.

We do deal with stigma. I'm sure it's not quite the same, but there are probably some common threads in how we handle that. We make the employer accountable for their workplace and for their work culture, and if it's not a good plan for any reason, we won't put someone in harm's way until we're satisfied they are going to be treated with the dignity and respect they are required to receive according to the law of the land. We have the Ministry of Labour to protect that. The accountability is on the employer because that's their workplace, that's their culture. We would hope that frontline supervisors and and their superiors would be supportive of a gradual return to work.

On our system for employers, there is a financial benefit for them in returning someone to work quickly. It's an insurance system, so the longer we pay benefits, the more expensive it is for the employer the longer the worker is off work. There is a financial incentive for employers to make it a good plan, because if it fails, we're going to take the worker out of the work environment and perhaps start over again with them or with another employer, which becomes even more expensive in terms of the insurance model.

● (1555)

The Chair: Thank you.

Mr. Fraser.

Mr. Colin Fraser (West Nova, Lib.): Thank you very much for being here today and for your presentation.

I'm from Nova Scotia where we call it the Workers' Compensation Board of Nova Scotia, but I understand that it's different here in Ontario as it is in other provinces. With regard to the compensation benefits that are paid, can you explain what exactly the economics look like for the worker? Are they getting their full salary? What percentage of their pre-injury salary are they getting?

Mr. John Genise: We take the date of injury as the marker for their earnings: what were they earning at the time of the accident? We take their gross pay over four weeks prior, for the first 12 weeks. We take their gross pay, then we deduct CPP, EI, and income tax. That gives us a net average earnings. Then we pay 85% of net average earnings.

Mr. Colin Fraser: Okay, their income is at 85% of what they would have received had had they not been injured.

Mr. John Genise: Yes.

Mr. Colin Fraser: What is the rationale for 85% rather than the full amount?

Mr. John Genise: That gets into the legislation. I believe part of it is that there are some cost savings for the worker when they are off work, with their not going to work, in terms of transportation and all of the other factors that would be involved in their ability to earn. I believe that is the fundamental factor.

Mr. Colin Fraser: If the worker is able perform some other task or duty or be financially compensated in another fashion while they're on workers' compensation—for example, an at-home business or that sort of thing—does WSIB take that into account in determining whether or not they are eligible?

Mr. John Genise: Their eligibility in terms of our suite of benefits starts when they have an accident on the job that's allowable. Following that, we assess their ability to earn. If they are unable to earn anything, then we will pay them the full amount, 85% of their net...while they are recovering, and we get them into treatment, etc.

We focus on abilities. So, at the very beginning, if the worker is able, it's part of the employer's obligation to offer modified work. If that modified work is at a wage loss, then we will compensate the worker 85% of the net difference. Even if they could work two hours a day, as I explained a little earlier, we would compensate the worker for 85% of the difference.

If the worker were to start a home business, that's a little different because they are taking themselves outside that employer/employee relationship in terms of our claim, and that would indicate to us that the worker has abilities and we'd go back to the employee and say, “If you can work at home, you can work with your employer.” If the employer, for some reason, shuts down or is unable to return someone to their employment, then we'd look at the worker's abilities and opportunities beyond the accident employer. We'd go through an assessment of their abilities to earn outside of the accident employer based on their current skills and abilities. We would then start a rehabilitation program tailored to them in order to maximize their earnings potential, and would support them through the schooling or whatever is required for that. Then we would hopefully place them in a job.

Mr. Colin Fraser: I would imagine there are some cases where it's clear that the person is unable to perform the duties they had in their workplace, and then there are other cases where it's not so clear. Mental health, addictions, and these sorts of things may be not obvious.

Can you give me some idea of how that assessment is made? If there is a disagreement between what the employee is saying they're able to do and what the employer is saying they should be able to do, how is that resolved?

Mr. John Genise: Again, the quarterback, the case manager, is the first person who really takes that issue on. When we first get a file and it's an allowable claim, we do a very thorough assessment of the worker and their abilities, their skills, their barriers, and their medical situation. As well, we do an assessment of the employer and their abilities and history in terms of returning workers to function.

We also have a right to gather all the related medical information with respect to the area of injury, and we facilitate care to make sure that the workers get the best possible treatment early.

We have a very good, sound understanding of what their physical abilities are, typically before we get involved in a return-to-work intervention, so to speak, or before we plan it.

With regard to disputes over that assessment, we try to use the worker's physician's reporting as our primary source of abilities, because the worker has the right to choose their own physician. Where a file or a medical case does not progress as we would expect—for example, in the case of a strain, where there seem to be other things lingering, etc.—then we would employ some of our specialty clinics or preferred providers to give the worker an elevated type of care, for example, a specialist or whoever, and at the same time involve the treating physician so that everyone is roped into the findings.

In the end, we try not to make our decisions based on what the employer says, because they have no idea what the worker's abilities are in or outside the employment. We look at the medical assessment of the worker, and we try to come to an agreement with the worker of what their abilities are—not necessarily their work abilities, but what their abilities are. We then require the employer to try to match their abilities to the workplace.

It might be that they can do only simple filing, but at least we get the worker into the workplace, and that's our goal from the very beginning. As you heard earlier, we see positive collaborative relationships occur when someone gets back into the workplace.

● (1600)

Mr. Colin Fraser: If there is a dispute on a finding of fact that the WSIB has made a determination about the person's abilities that the employee doesn't agree with, is there a mechanism for them to challenge that—

Mr. John Genise: Yes, there is.

Mr. Colin Fraser: —and can you describe it?

Mr. John Genise: Yes, our first mechanism, really, is that typically in those situations we try to get one of our contracted physicians to call or to connect with the treating physician to discuss the findings. We find that dispute resolution technique positive, because when you have a clinician speaking to a clinician versus a government agency talking to a doctor, it doesn't always work out so well in our interest, so we try to get a doctor to talk to a doctor and come up with a plan.

If they completely disagree—the doctor says that this person will never work again, and we say, "Well, based on our physiotherapy findings and our guidelines, we feel this worker would have some abilities"—in the end that is a case where we would make a decision based on the facts and explain it all. There is also an appeal mechanism internally.

The Chair: Thank you.

Ms. Benson.

Ms. Sheri Benson (Saskatoon West, NDP): Thank you, Chair.

And thanks, John, for being here.

I have a couple of questions—two things actually. You talked about first responders and folks who would be dealing with traumatic and very hyper events, and said that those folks have a presumptive clause. I want you to talk about that. That's for a particular group of workers. There is some recognition that their work is different from others.

Could you talk about that a bit?

Mr. John Genise: There was new provincial legislation in 2016 that accepted post-traumatic stress for first responders. Within that bill they gave a list, and there are about 25 of them. I don't have them here today, but you're looking at ambulance drivers, police, emergency personnel, firefighters, so the people who respond to the worst parts of the human condition. Instead of their having to plead their case about their work environment, what we typically look for is that be diagnosed before they gain entrance to that presumption, and that that diagnosis is a DSM-IV diagnosis.

As I said earlier, a good point for you to pay attention to is that if they don't have a diagnosis, because they're just being treated by their family physician, that shouldn't bar them from gaining entrance to us. They're trying to navigate through the system and they're having issues. Life is difficult enough as it is, let alone when you're struggling with what you have, so we will pay for that assessment even though we haven't accepted the claim. We will allow them to get that diagnosis or lack thereof, in order for them to gain entrance to our suite of benefits.

Ms. Sheri Benson: Right. I asked because someone could continue to work in those types of jobs and have experience and have PTSD and not know it.

Mr. John Genise: And not know it—or deal with it under another name. So we want to formalize it. In this legislation we try not to make it difficult for someone to make a claim, to accept their entitlement. That allows us to get to these individuals early and to get them the proper suite of care they require.

Most importantly, it allows us to try to integrate them back to the workplace early, because we all know that the longer you're off work for anything, the harder it is to get back to work. I had two weeks of vacation. I didn't want to come back to work.

● (1605)

Ms. Sheri Benson: Right.

Can you talk about how you make the process of applying for a claim not a barrier to their following through? You sort of mentioned that—

Mr. John Genise: They wouldn't have to prove that the diagnosis they have is related to their employment, because the nature of the employment has already been presumed to have caused, or has had the potential to cause, that type of injury.

Ms. Sheri Benson: The other thing I wanted to ask about was the application process and the paperwork for people accessing WCB—I'm from Saskatchewan, so I'll keep saying WCB.

Is it difficult? Have you had feedback? Have you improved the process? That's often something we hear, not only from veterans, but certainly also from people trying to get access to government services generally.

Mr. John Genise: The requirement under our legislation is that the employer, upon hearing of a worker seeking medical attention or losing time from work, has a legal requirement to report to WSIB. That's the primary channel.

Second, if the employer is non-compliant or doesn't do what he or she is supposed to do, the worker can claim it at any time. If a worker goes to a physician in Ontario or to the emergency department, for example, and says, “I hurt myself at work,” that triggers a responsibility on that health care provider, under the law, to send us a form in which we set up a claim. Then we go to the other parties, the employer in particular, and ask, “Were you aware of this worker seeking medical attention?” We start the ball rolling right there.

That's typically not a large barrier.

Ms. Sheri Benson: Right.

You didn't speak directly to this, and I'm not sure you have the figures close at hand, but how often would people appeal?

I like the process you talked about. If there is a disagreement about someone's abilities, when they need to return to work, or that kind of thing, there's an opportunity to work it out. How often do people appeal? I don't want to call it a success rate. I'm just curious as to how you feel the system is working in some ways.

Mr. John Genise: Ninety-two percent of all our workers get back to meaningful work within 12 months, albeit not always with the accident employer. If they're working for a chip truck and the latter goes out of business, we'll reintegrate them into the workforce in some capacity. We've come a long way.

Where we gain our success is, as I mentioned at the very beginning, in the case management approach. As soon as a case becomes available to us and the worker is off work, we truly do start a planning process that involves the worker and the employer at the very beginning.

We actually have first-day contact. When a case is referred to one of my case managers here in Ottawa, the expectation—although not always applied—is that they are to call both workplace parties and develop a comprehensive plan. That plan might not be a return to work, because we deal with some horrific accidents, but at least a medical plan is put in place. We keep the employer advised of what the plan is and where we're going.

At the very beginning, we develop a relationship with all parties. We are always on the lookout. We do an analysis of barriers and potential problems that have come down the flags, for example, if there is discourse in the workplace or a unionized environment and issues there, or “I don't like my supervisor,” or “I don't have a family doctor.” There are many things that we put into that assessment, and then we try to remove those barriers as we go along.

We try to involve both parties—particularly the worker, because that's our primary contact—with what we're doing and what the plan is, with the understanding that we're working towards recovery and a return to work from the very beginning.

We don't say, “It's tomorrow or Monday”, depending on the circumstances. It might be the next morning or Monday depending on the circumstances, but typically we say, “You broke your leg. Here's the treatment that you have. You're going to see the specialist next Wednesday. I will follow up with you the following Wednesday to make sure you're getting the proper physiotherapy, and I'll discuss your progress with you every two weeks with a view that we're going to try to get you back to your accident employer in some capacity.”

We lay the plan out at the beginning and we adjust the plan as we go along if things change medically. That's our approach.

The Chair: Thank you.

Ms. Lockhart.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you, Mr. Chair.

Thank you, Mr. Genise, for appearing today.

As you know, we're trying to compare the suite of services provided by VAC with many other jurisdictions'. One thing we have talked about quite a bit is the services offered by Veterans Affairs in the hope of helping people transition to different types of work. Do you offer such services for transition, and what services are included there?

● (1610)

Mr. John Genise: Yes, we have work transition services. Their primary role is reintegration into the accident employer, where the worker was injured, but that doesn't always occur for a variety of reasons. After we've exhausted work with the accident employer, then we go to the worker's abilities outside the workplace they were working in. Again, it's a collaborative process in terms of planning. We do a detailed assessment of what their vocational characteristics are, what their skills and abilities are from the past. We try to use whatever skills they might have had in the past to formulate a plan with them.

We make that collaborative because of the success factor. If the worker feels engaged and they feel that yes, that's a plan, that they're interested in computers, for example, then we will try, within the scope of our entitlements, to get them into the field they want to go into. Now, if I want to become a helicopter pilot, that might not be appropriate. But we try to tailor it based on their earnings, because our plan is to mitigate their wage loss. So if you are a low-wage earner, and you no longer work with your employer, the plan might not be as fulsome. But if you are a high-wage earner and you can't go back to work with your employer, and you have limited skills, we'd probably spend more time trying to maximize your earnings potential outside of the accident employer.

But it's a plan that's developed with the worker, not the employer, in this case, because they're out of the picture, so to speak, and the medical community is involved in terms of the worker's abilities and strengths and weaknesses. We'll transition them through that plan. It could be going to school; it could be short, on-the-job training or whatever; but we involve them in that transition.

Mrs. Alaina Lockhart: When you say it could be school, do your services extend to paying for tuition and education programs?

Mr. John Genise: Yes.

Mrs. Alaina Lockhart: At what level? Are there caps? Are there time frames?

Mr. John Genise: We have all levels. We look for success, so we do a job market analysis of where employability is in Ontario and within the worker's geographic region. It has to be a viable plan. Many factors go into it in terms of workers' vocational characteristics. If they are approaching retirement and really have no interest in starting a new field and haven't been to school in many years, it may not be the best plan. So we involve them in that planning. For example, if they are relatively young and have just started in their career and are now unable to continue because of their workplace accident and their impairment, then depending on their earnings, we would put together a plan for them that might be more fulsome, depending on their earnings at the time.

Mrs. Alaina Lockhart: Do you extend any services to the families of those who are injured?

Mr. John Genise: That's not part of our suite of packages. I know we have survivor benefits for workers who have been killed on the job. But in terms of the workers and their families, no, we wouldn't typically get involved in that.

Mrs. Alaina Lockhart: Okay. I think that with Veterans Affairs, part of reason is that we recognize that families are—

Mr. John Genise: Absolutely, yes.

Mrs. Alaina Lockhart: —part of the recovery and the transition, so I just wanted to check on that.

What would you say your biggest challenge is in delivering your services?

Mr. John Genise: I'll just stick to the stress and traumatic portion of it, because we have a large population of different types of claims.

Stigma is one. We found that access to medical care within the worker's community is quite difficult. Not everyone lives in Ottawa or Toronto. We had difficulty even getting a baseline assessment. Of course, you can see what I'm talking about: we need that assessment to build on and go.

We took it upon ourselves, and we're a larger insurer, so we have a little bit of opportunity to use our size. We have just been developing a provider network within the worker's community. We have a roster of psychologists and psychiatrists specifically for these cases.

It was a challenge with the medical community for sure. We've overcome that. We're trying to overcome that by facilitating care within the community.

Return to work is very difficult in most of these cases. There are so many factors, from transportation to and from work—again we talked a little bit about stigma—to cognitive load, and being able to manage screens. The other part of it is maybe the employer's reluctance, the front-line supervisor's reluctance or lack of understanding of what's required.

As to how we overcome some of that, again, at the very beginning, we try to do a fulsome plan, including even education of the workplace parties who are on the ground to say what the worker's abilities are. They can only work for two hours at time. They're going to need an hour of downtime. If we have a good plan upfront and the people understand the reasons for it, we have a better chance of success.

The last couple of things are these. We have a dedicated team for these cases alone. They have that economy of scale of working with people who have those challenges. It's not a claim for a back, then post-traumatic stress—you know what I mean—then a leg injury. They deal specifically with these cases, so we are able to skill them up in terms of how to communicate, including that they not take the typical responses you get from someone at face value. Maybe there are other things going on. They have a breadth of understanding, and we try to incorporate that.

● (1615)

Mrs. Alaina Lockhart: Do you mean that you have a case worker who dealt with, I don't know, back injuries?

Mr. John Genise: Yes, dedicated to those.

Mrs. Alaina Lockhart: You would have back injury case workers?

Mr. John Genise: We have it for certain specialties. For this one we do. We have some others. We have a shoulder team here in Ottawa. We have some areas that are particularly medically complex, and we find it to our advantage to have people who are skilled with that.

It's the same with the dedication of the nurses. They're very helpful in our care of workers with post-traumatic stress disorder. They are kind of the liaison or the intermediary between the medical community and the worker. Oftentimes they don't understand what's asked of them in term of their doctors.

I think I'm talking a little too much. First time, probably last time.

The Chair: Thank you.

Mr. Bratina.

Everybody has a lot of questions for you.

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

We've been talking about service delivery and the complexity of applications. How do you evaluate how well you're doing? It's probably not by what's printed in the media, because, like most of us, it's only the difficult things that show up publicly.

What about your evaluation? How well do you think you're doing?

Mr. John Genise: We have a macro and micro type of approach. The macro level is our overall success, as I told you, in terms of return-to-work rates. Return to work is really our game. First of all, it's the worker's functioning, but it's return to work—and that's meaningful return to work. One of our primary measurements as an organization is do we get workers back to work? Is it meaningful work? Does it stick? A return to your normal life is paramount. That's one of our primary measurements.

Underneath that, we have a lot of checks and balances along the way. You heard me say that we plan at the very beginning. We have a system that requires first day contact. We assess the quality of those plans and the timeliness of them. We listen to phone calls of our planning discussions with our clients, in terms of their quality.

At the macro level we're looking at how the case is managed from all angles. We want to make sure there's a fulsome plan in place, that there are milestones. If the plan has changed, that's okay, but is there rationale for it?

We're pretty on the ground when it comes to how we manage individual cases. We also have the macro view of how we measure our success.

Mr. Bob Bratina: The point you make is interesting from our perspective, because you want to get them back to work, and one of the big concerns we have is the veterans' loss of their career. Sometimes they feel, unfairly, “Just give me another chance and a little more therapy, and I could still do whatever.” That seems to be the a complexity of the situation—the transition from the regular armed forces to the veterans—and we're trying to work on that.

One of the issues that would come into play would be that you have contracted physicians—a roster of people—and I'm guessing some people will say, “He's there to make sure you save money by getting me back to work”, or something like that. You understand?

● (1620)

Mr. John Genise: Yes.

It's not really my area, but we have a very elaborate FRP process, where they bid. There's a whole structure around how doctors are chosen, their credentials, etc. We try to align ourselves with some of the major treating facilities in the province. I mentioned CAMH, which is the centre of mental health in Toronto. That's our primary assessor for post-traumatic stress disorder. They do everything. So it's not just us. We're in Toronto Western hospital; we have most of the significant players in the medical field, and we buy time from them.

I'll give you an example of a worker who had a very significant ankle injury, whom we sent to Toronto to one of our specialty clinics. He said, “You're going to send me down to your doctor.” He sat in the chair beside one of the Toronto Raptors, who was going to see the same doctor. You know what I mean? It's not like we're buying our own doctor. It's like, “If it's good enough for the Toronto Raptors, maybe it's good enough for me.” We try not to segregate our own doctors to our own population, but we try to get the ones out in the community who are recognized.

In some areas, in smaller communities, it's difficult, but we expect our clients to travel if we can't get it in their own locale.

Mr. Bob Bratina: Another issue we've seen with veterans is dealing with the complexities of the application and so on. Has that been worked out to your satisfaction, in your world?

Mr. John Genise: We make it pretty easy. We don't make assumptions about the channel by which a client wants to use to come to us. It's easy to say everything is e-formula, etc., but most people don't have a printer or a computer, so we try to have a number of delivery channels. You can even start a claim with us by phone. We'll have someone there to take all the information down. We try to take that part of the stress away as much as we can. You can come to our office and sit down with someone to set up a claim. Typically the employer does, but we try to remove that administrative burden and get to the facts, so that we can move on with recovery and then return to work.

Mr. Bob Bratina: Do you have an investigative component to your service?

Mr. John Genise: It's light. It's more for the collection of information. If a worker comes to us and says they were injured in 2012 and their employer never reported it—they reported it to them and went to the hospital, but the hospital didn't...and there are gaps—then we'll send an investigator out to gather all the information.

We're not looking for false claims. That's not what investigations are for. We look for the facts of the case, and we make decisions based on what we find.

Mr. Bob Bratina: When I was doing a little research, a fraud case cropped up.

Mr. John Genise: That's part of society, and we manage our cases as we go along. If there are irregularities in the medical.... If the doctor says the worker has abilities, and the worker says they really can't drive anymore but the employer says they see them driving around, then we take steps. But it's not a large part of our work.

Mr. Bob Bratina: Thank you.

The Chair: Mr. Brassard.

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

Yesterday I had an opportunity to sit in on a Veterans Review and Appeal Board hearing. What was interesting to me, after talking to the appeal board members afterwards, was the issue of record-keeping. Oftentimes, injuries happen and illnesses happen, and they aren't reported to the employer. I guess I'm picking up a bit on where Mr. Bratina was going.

From a WSIB standpoint, what's an ideal situation for an employee and an employer in terms of keeping records? Are there best practices? Are there issues where you guide your employers? Maybe you can just speak to that a little as well.

Mr. John Genise: Under our Occupational Health and Safety Act, which is not under the guides of the Workplace Safety and Insurance Board but the Ministry of Labour, if there's an incident at work, it must be recorded. In terms of retention of that incident, I'm not familiar with that exactly, but I'm suggesting it's five years, five to seven years, in terms of record-keeping.

That's not really where we get most of our claims in terms of that type of claim. We require an employer to report to us within three days of learning of lost time or of health care. There's an obligation on the employer. If the employer doesn't do that, we look at what the medical treatment was. In terms of medical records and the requirement for a physician in Ontario to keep medical records, I believe it's 10 years. I'm sure I can be corrected on that. The community at large retains much of this information, which suggests that if it's not with us, it will be out there for us by the time someone claims for it.

● (1625)

Mr. John Brassard: You also said that you would do investigations as well. Would that be to fill in the gaps?

Mr. John Genise: Yes.

Mr. John Brassard: Would that be any claims that come forward where perhaps there isn't record-keeping?

Mr. John Genise: Yes. Periodically we have to go back in time and piece together what occurred on the day of the alleged event. The worker will say that a witness was their co-worker at the time and that his name is so-and-so. He might not be working for the employer anymore, but that might be a linchpin for us to allow that claim. We'll send an investigator out to the employer to find that last record for that co-worker. We'll piece together the story as best we can based on the facts given to us.

Mr. John Brassard: The other thing I want to bring up is the issue of modified work programs. There is case law about an employer's duty to accommodate. I think you mentioned that if an employee doesn't return after a year, there is a 7% likelihood that they may not come back to work at all. Within the military system and the Canadian Forces, there are issues of modified work. How forceful is the WSIB, in working not just with the employer but with the employees as well, in ensuring that there is a modified work program in place to get employees back to work, whether it's returning them to their job or to other positions?

Mr. John Genise: It's embedded in our legislation that both parties have a requirement to co-operate in the return-to-work planning. The employer has an obligation, once they hear what a worker's abilities are, to review their workplace to determine what jobs and duties could be offered to that employee. The worker has an obligation, under our legislation, to co-operate in that return-to-work planning, so from the get-go, the expectation is there.

That doesn't always work, so we have collaborative planing. As I said at the very beginning, in any contentious case, one where we haven't had someone go back to work already, we'll get a work transition specialist or a return-to-work specialist to the job site, with both parties, to commence that planning. In terms of how forceful we are, with the co-operation provision, they have no choice. You have to come to the meeting. If you don't, we'll find you. If the worker says they're not interested at all, we'll say that if there's a job offered and we determine it to be good, then their benefits will be affected, because they're not co-operating and the job is custom-made for the type of accident or injury they had.

If the employer is not compliant, we have some means with which to find them, but we will also continue to pay the worker and perhaps go in a separate direction. Again, this is an insurance system, so they're paying more money because they have not had the wherewithal to bring their workers back to work.

In terms of how forceful we are, once there are abilities, there is a press for us to get the worker back to successful work. We're not looking for modified jobs that are pretend or—

Mr. John Brassard: They're meaningful.

Mr. John Genise: They're meaningful. That's why we have the on-the-job planning right there that's signed off on by everyone. Everyone knows what the duties are, and the hours, the responsibilities, and the barriers, and what the problems are. It's a form of about six pages or so that they fill out on the job with all parties to make sure it's comprehensive.

Mr. John Brassard: Thank you, John.

The Chair: Mr. Eyolfson.

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

Thank you for coming, Mr. Genise.

In regard to the PTSD presumption clause for first responders, does this also apply to health care professionals such as nurses or physicians, say, for whom they're really starting to recognize that PTSD is an issue in these kinds of workplaces?

Mr. John Genise: Not at this time.

Mr. Doug Eyolfson: Okay. Is that being looked at or investigated?

Mr. John Genise: Yes. It is being looked at.

Mr. Doug Eyolfson: Okay.

Mr. John Genise: The government is looking at legislation to expand the roster of jobs. I believe that nurses are part of that expansion.

● (1630)

Mr. Doug Eyolfson: Thank you.

You might have touched on this. What is the process for determining a PTSD claim? If you have someone claiming PTSD in an unrelated field, such as a factory worker who's been injured in an explosion, say, or if there's no physical injury but there's a claim of PTSD because other people were hurt or whatever, what would be the process for compensating a person for PTSD?

Mr. John Genise: We still go down the same channels. I'm going to consult my notes, because there are three specific criteria that we look at.

First of all, we're looking for an event—typically a significant event—that's clearly and precisely identifiable and wasn't cumulative, but was typically traumatic and outside the normal course of their duties. Again, we're looking for the DSM diagnosis, to make sure there is a diagnosis behind that.

If a worker has significant traumatic physical injuries, we often accept the related psychological component. It could be as the result of an explosion or whatever. It's all together. We will accept that as part of their entitlement, again using the DSM-III diagnosis as our requirement for permanent benefits on that.

Mr. Doug Eyolfson: Yes, for sure, but if there's no physical injury?

Mr. John Genise: If there's no physical injury?

Mr. Doug Eyolfson: Yes. Say, for instance, that the explosion occurred and the factory worker was standing next to the person killed in the explosion and claims PTSD.

Mr. John Genise: Yes. That would meet the criteria. Even if they weren't physically injured themselves, but they were in a horrific event—for example, being a driver on the subway when someone jumps on the tracks, etc.—we would again go through the basics. Was this normal for them? Was there an identifiable event? Did they seek medical attention within a reasonable amount of time? Is there a medical connection? Obviously in this case, there would be. They would gain entrance to that policy.

Mr. Doug Eyolfson: Thank you.

You touched on the fact that some people in certain locations might not have access to a regular MD. I practised emergency medicine for 20 years, and that was a challenge we sometimes had. We'd see someone in the emergency department who was injured, and we'd write down what was going on, but there would have to be some ongoing medical care and ongoing evaluation.

Let's say the patient didn't have a family doctor. They sometimes would write us letters, repeatedly, saying, “He doesn't have a family doctor, so can you assess his return to work?” We'd say, “Well, we don't do that in the emergency department.”

What kinds of delays do you have? In terms of what you can provide, how timely is the regular medical care and follow-up that someone needs? You said that you have some means of plugging in people in these cases.

Mr. John Genise: Yes. You have a couple of things there. One is in terms of how we.... It's common, unfortunately, that many people don't have a family physician in the traditional sense, but we accept very different forms of health care, such as physiotherapists, and chiropractors.... There's a whole list of health care providers that report to us. We use their reports. As has been mentioned, we also have the nurse consultant as part of that team. They will help to facilitate this for workers who need a family physician for that follow-up. They will work with the client to try to get them a family doctor within their community.

In terms of us facilitating care, it varies depending on the nature of the injury, etc., and the type of treatment. I talked about the roster of psychologists and psychiatrists. I believe the standard is two weeks. We expect, as part of the contract, to get one of our clients seen within two weeks. That's expedited care for sure.

Mr. Doug Eyolfson: Thank you.

The challenge I had in Manitoba—perhaps this doesn't occur in Ontario, and maybe there are different government guidelines—is that sometimes we would have a patient with a psychiatric issue and we'd want to refer them to a psychiatrist as an outpatient. Psychiatrists were generally very reluctant to take on someone as a regular patient if they did not also have a family doctor, because what would happen, then, is that the psychiatrist would be put on the hook, as it were, for all the ongoing medical care for this person. They'd be the only doctor on record for them.

Do you ever have that problem? Are you aware of that problem occurring in Ontario when you're referring someone for psychiatric care who doesn't also have a family doctor?

Mr. John Genise: I'm familiar with that challenge. There are a variety of challenges around a psychologist treating anyone, particularly someone who's injured. If, for example, the extent of our entitlement is limited, the psychologist has a duty to continue to treat this individual, perhaps without our funding it. I know there are challenges around psychologists and psychiatrists in terms of the treatment and their carriage of clients as we move through. I am familiar with that.

● (1635)

Mr. Doug Eyolfson: All right. Thank you.

Mr. John Genise: I don't have a comprehensive answer other than that.

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

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

Thank you again.

Dr. Eyolfson asked a lot of the questions I had, so I'll take a little bit of a different bent.

I realize that you don't really deal with clients who are trained to leave nobody behind, who learn to take a bullet for their comrade. That's a bit of a different mindset when you're dealing with this.

I'd like to talk a bit about transition. Ms. Lockhart talked a little about transition. If we're assuming that we have someone who can't return to work, and now they're going from being a worker to, if I can use these words, “civilian life”, does the WSIB assist them in any way in that transition? Besides the monetary part that you might pay out, do you provide any assistance in that transition process?

Mr. John Genise: Well, we are already civilians, so if you're injured on the job in Ontario, you are already a civilian; you're not within the military. Maybe I'd look at it from a different perspective. My lens is employment and employers, so who's the employer here? I guess in this case, it's the government.

Mr. Robert Kitchen: So you'd be looking more at the employer?

Mr. John Genise: I would look at the government and say if you can't work in this department of the government or you can't work on this line at GM, then why can't you work on this other line at GM? GM is paying the cost for this claim, so if you can't build tires, then maybe you can fix the radio. But it's up to you to decide how you manage your business.

Mr. Robert Kitchen: I'm not necessarily asking you to respond for the military. I'm just asking you whether, if there is a construction worker who can't go back to work and you are basically saying he is unable to return to work, there is a process through which you would assist him as he transitions? We've talked about education and things like that. There's that opportunity, but besides that, are there any services you might provide, such as counselling?

Mr. John Genise: Yes, there's employment counselling and planning, but we're always working on the rehabilitation side, in terms of their going back to work, and goal setting. We collaboratively set a goal. For example, if it's not going to work with their employer, if they have shut down and the worker can't go back to work in construction, now what are we going to do? What are their interests? We try to involve them. That's part of the transition. We try to involve them in the planning, so they feel that they're part of it and have a say in their own direction. There are also employment services with counselling and exploration. We assess their skills, abilities, and interests, and we provide them with their own data for them to choose their way, so to speak, rather than just giving it to them.

Mr. Robert Kitchen: Sure.

If you were dealing with a client with PTSD and the doctor prescribed medical marijuana for them, who would pay for that?

Mr. John Genise: It would not be the WSIB of Ontario.

Mr. Robert Kitchen: It wouldn't be the WSIB?

Mr. John Genise: No.

Mr. Robert Kitchen: Can you answer why?

Mr. John Genise: Well, it's not within our drug formulary. It is our medical opinion and our legal opinion that there's no proof that it is effective in the treatment of our injuries. That's our stand right now.

Mr. Robert Kitchen: As I mentioned earlier, there are differences between provincial WCBs or WSIBs. Have you put together any sort of chart that we might be able to access to see the differences among Nova Scotia, Manitoba, Quebec...?

Mr. John Genise: Is this for post-traumatic stress in particular?

● (1640)

Mr. Robert Kitchen: Just in general in your whole....

Mr. John Genise: In the whole compensation system?

Mr. Robert Kitchen: Yes, the whole system.

Mr. John Genise: We do connect regularly. We have an association of compensation boards across Canada. Yes, we would have that.

Mr. Robert Kitchen: You would have a flow chart on it that we might be able to access?

Mr. John Genise: Someone would, yes. I'm sure I could find it or get someone to do it. Yes.

The Chair: Thank you.

Ms. Benson.

Ms. Sheri Benson: I have a couple of things.

You talked a bit about how a treatment plan that included medical marijuana wouldn't be part of an acceptable treatment, from your perspective. When you started to look at PTSD more than in the past —as we all did—the corporation must have had to start to be more open to different or alternative therapies. I wondered if you want to comment on the processes inside the organization when you start to look at something like this that's—I'm going to use air quotes here —“new”. We know it isn't new, but it is new for institutions, governments, and insurance companies to look at PTSD and its effects on folks.

Mr. John Genise: You know, I'm not overly familiar with that part of our large organization.

Ms. Sheri Benson: Sure.

Mr. John Genise: I do know that there's a certain amount of rigour around anything we do with respect to our drug formulary and what's accepted or not. We look at research, and I know that there's a department that specifically drills into it.

On medical marijuana, I've seen some discussion around that and where the world is going, so to speak, but we're sticking to the clinical evidence so far and the top research says about whether it really makes a difference or not. That's where we are right now.

Ms. Sheri Benson: Right.

When we're talking about PTSD and people accessing psychiatric or psychological services, those therapists would be in charge of the kinds of therapies that people could have—

Mr. John Genise: Yes.

Ms. Sheri Benson: —so they could be open to something when someone is having a difficulty and something isn't working. They would continue to work, depending on the trauma, depending on the event, and they would leave that to—

Mr. John Genise: Right, of course. They would follow a treatment plan, but we won't necessarily pay for the drug.

Ms. Sheri Benson: Right. Got it.

This is probably an issue for a lot of government programs, including Veterans Affairs, but you mentioned that the corporation would fund an assessment even before someone is maybe eligible for your program. I wondered if you could share with us how that works.

Mr. John Genise: Okay. I'm not overly familiar with that. I know that it's a nuance for this type of injury and—

Ms. Sheri Benson: That's right.

Mr. John Genise: —it's not the norm, but since this legislation came to us in 2016, it was recognized in this program that many of the clients who wanted to apply didn't meet the standard of having that diagnosis. They couldn't. They had been treated by their family physician for a year and the mark hadn't been achieved, so in order for us to facilitate the administration of the claim quickly, particularly for cases on that list of first responders, we thought it was.... We already know that they are in harm's way, so to speak, when it comes to this type of injury, so we would facilitate that care. They would call us. We would say, “Here's a preferred provider in your region.” We would give them their claim number, and we would be billed directly for that assessment.

Again, we're trying to include rather than exclude in this scenario, because we already know that they work in that environment. We're just trying to make sure that they are trying to meet the threshold of impairment, so to speak, so that we can take them in and help them.

Ms. Sheri Benson: Thank you.

The Chair: Thank you.

That ends our time today. I would like to ask the committee, with consent, if—

Mr. John Brassard: Mr. Chair...?

The Chair: Yes?

Mr. John Brassard: Mr. Chair, I'm not sure whether it's a point of order or a point of personal privilege, but if you'll indulge me, I have information that I think is beneficial to the rest of the committee.

Yesterday I came across a story on a news wire that speaks about a research study to assist Canadian Armed Forces members and veterans to transition into civilian life. The news release said about $570,000 is going to be spent for funding and program research. There are quotes from the minister. There are quotes from members of the New Brunswick government.

Anybody who knows me—and I think this is important for all members of this committee as well—knows how much I hate wasting time on studies. The study that we did back in 2016, in which we made recommendations to the government on transitional aspects of medically releasing CAF members, was presented to the House of Commons in December. Since 2007, ten reports have been presented to the House of Commons and to various governments. In fact, in 2014, there was the following report, “The Transition to Civilian Life of Veterans”, of a study done by the Senate of Canada. In 2016, the report “Support to Military Families in Transition” was done by the veterans ombudsman. In 2016, the well-known defence ombudsman report on successfully transitioning was presented to Parliament, and, of course, there's the report that this committee did.

I realize, Mr. Chair, that I came to the committee in the middle of that report. I think you spent four or five months coming up with 18 or 19 recommendations on how we can ease the transition from military life into civilian life. Some of those recommendations were well received not just by the defence ombudsman but also by the veterans ombudsman in subsequent conversations that we had.

With regard to this new report, the department proposes that the study be completed and presented to Parliament in 2019. I don't understand, after all the work this committee did, all of the studies that have been done over the years of Parliament and all of the reports that have been presented to various governments, the previous government included, why there's a need for another report. I guess, in order to qualify my privilege, I would say why did we waste our time if the intent of the department was to do another report?

I want to bring that up to committee members, because I think it is important. It certainly shocked the hell out of me when I read yesterday that another study on transition is going to be done after all of the previous studies have been done and that the report is not expected until 2019, which means, I think it would be safe for one to presume, that nothing is going to get done to help in the transition from military life to civilian life among those who served in the military until at least that time, whereas all of these recommendations have been made in the past.

I am compelled to bring that up to the committee, because I know we worked very hard. We came up with, I think, terrific recommendations. Many of them were endorsed by not just the defence ombudsman but also the veterans ombudsman. We need to get on with this. We need to fix things, not just study things over and over again.

That's my point, Mr. Chair.

● (1645)

The Chair: I think Ms. Lockhart had her hand up.

Mrs. Alaina Lockhart: As the first order of business, I'd like to respond to that.

Have we finished with the witness? Can we dismiss our witness?

Mr. John Brassard: Were we not done?

The Chair: No.

That's okay. We'll come back to that.

I'd like to thank you for coming today.

With the permission of the committee, the analyst would like to ask a question of the witness if that's okay. I see a consensus here.

It'll be short.

Mr. Jean-Rodrigue Paré (Committee Researcher): It's just to have something on the record.

I know that part-time reservists from the Canadian Forces who get injured can elect to file a claim with Veterans Affairs Canada or with the compensation board in each province. In that case, that would mean that the Canadian Forces are the employer.

Do you have many claims of that type and can you say something about the process involved?

Mr. John Genise: They would be considered civilian, I believe, and that's why they gain entrance to our legislation. We do have claims. I've dealt with some myself.

Mr. Jean-Rodrigue Paré: That's because they are federal employees.

Mr. John Genise: We would treat the employer as we would treat anyone else. There's an agreement that wherever the worker is injured, the laws of that province, regardless of whether or not the employer is federal, would take precedence. We require the same thing from the accident employer, the federal government in this case.

It's not been my experience that we fine the federal government for a lack of co-operation, whereas perhaps with other employers, small ones, we would. We still have the return-to-work meetings. We still do the case planning. We treat it as any other case.

We're involved in return-to-work planning with the federal government in those type of claims. Some of the ones I've witnessed have been quite significant. There are challenges, though, in dealing with those cases, with some of the intricacies of a collective agreement, or with the management of those cases with, I believe, Health Canada. There are some steps that are outside of our norms in reintegrating someone back to the workplace. There are different areas of Health Canada that have some jurisdictional parts to it.

However, our approach is the same. We just keep going and look for the same goal as long as we can.

● (1650)

The Chair: Thank you.

On behalf of the committee, I would like to thank you for coming today and for all the service to our men and women.

That will wrap up the questioning of this panel.

We will suspend and come back—

Mr. Colin Fraser: Mr. Chair, before we move in camera, Ms. Lockhart would like to respond to the point of privilege.

The Chair: I can do that now, or suspend and come back and do it.

Okay, I'll give you the floor.

Mrs. Alaina Lockhart: Thank you, Mr. Brassard, for bringing this up.

Shaping Purpose was one of our witnesses during the service delivery study we did.

They talked to us about the work they were doing. They had private sponsors at the time, those being Saint John Shipbuilding, as they mention here, and the Desjardins group.

They felt at the time that their work would be very relevant to our recommendations in respect of the transition of veterans. This isn't a government release. I have actually referred to their testimony several times since then, because the work they were doing sounded very much in line with what we were recommending.

Mr. John Brassard: If I could briefly respond to that, I'm not discounting the work that they're capable of doing, Ms. Lockhart. The fact is that there have been numerous recommendations in the past on how to deal with transitioning. Some of them are very simplistic ones, as the defence ombudsman testified here: low-hanging fruit opportunities.

My concern is that we're going to waste another two years, and I say that loosely. We're going to push this off for another two years when the problem of veterans transitioning from active service into civilian life is a very real problem now.

It's a very real problem, Mr. Chair, because we've heard numerous testimonies that have told us what a problem it is.

That's the issue that I have with this.

Thank you.

Mrs. Alaina Lockhart: Mr. Brassard, I'm not sure why you would sense this to be pushing it off. The work they're doing is actually with those who are transitioning, and the program they have is in response to some of the recommendations we've made. They're putting transitioning veterans through the program to see if helping them to determine their purpose going forward would be beneficial in the transition.

I don't see anything else being put on hold, but I would say that testing out one of the recommendations we made is a positive step.

The Chair: Okay.

Mr. Eyolfson.

Mr. Doug Eyolfson: Yes, I just want to add to that.

I'm looking at the news release on this, and this is an independent organization that is doing this study; it's not the government. How this in any way, shape, or form either delays or invalidates any of the work that we did, I don't know. This is a completely independent issue that's come up.

I understand your perspective that there's urgency to getting this done, and I agree with you. There is urgency to getting this done, but how does this have any effect on the work that we did? This is an independent organization that's decided to do this research. We have no control over them and we're not participating in this. They've decided to do this study.

● (1655)

The Chair: With that, I would like to suspend. Again, thank you for being here.

We'll take five minutes and come back. Thank you.

[*Proceedings continue in camera*]

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