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Chair

Mr. Rob Anders

Standing Committee on Veterans Affairs

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● (0905)

[*English*]

The Vice-Chair (Mr. Brent St. Denis (Algoma—Manitoulin—Kapuskasing, Lib.)): I would like to call this Thursday, April 19, meeting of the Standing Committee on Veterans Affairs to order.

We're pleased to have with us today Raymond Lalonde and Bryson Guptill.

Mr. Guptill, are you from Ste. Anne's as well?

Mr. Bryson Guptill (Director General, Program and Service Policy Division, Department of Veterans Affairs): No, I'm from the Veterans Affairs office in Charlottetown.

The Vice-Chair (Mr. Brent St. Denis): Welcome to Ottawa. Thank you for helping us as we continue our study of the veterans independence program and health care review. The clerk has explained that you have up to 10 minutes each.

Who is going to go first?

Mr. Bryson Guptill: I'm going to start off by talking a bit about our mental health strategy.

The Vice-Chair (Mr. Brent St. Denis): Okay.

The drill is that after you've each had your turn we'll open it to questions from the members. So if you miss providing something in your presentation, you can import it into an answer to a question if you'd like.

Mr. Guptill, we'll start with you.

Mr. Bryson Guptill: We're very, very pleased to be here to speak before your committee. I'll tell you a little about who we are and why we're here today.

You've had some very impressive presentations from very knowledgeable people on the subject of post-traumatic stress disorder. We'd like to augment some of that information—or certainly try to—and tell you a bit about our mental health strategy.

My role in the department is the director general of program and service policy out of our headquarters in Charlottetown. I'm responsible for some of the policy aspects of the mental health strategy, and I have a director who works for me in that area. He's ill today, so he wasn't able to be with us.

Raymond is operational director for our mental health strategy, and he is responsible for the various clinics we have across the country. As you mentioned, Mr. Chair, Raymond is based out of our operational stress injury centre of expertise in Montreal. He has the knowledge of the day-to-day operational aspects around this issue.

You have a presentation from us. I won't go through all the detailed slides, but I will talk about our mental health strategy.

The department has made a commitment to improve the quality of life of its clients with mental health conditions, and their families, and that's what our mental health strategy is essentially all about. You will hear us talk about operational stress injuries. The term is used to describe a broad range of mental health problems, which include diagnosed medical conditions such as PTSD, but also anxiety disorders, depression, and other conditions that might be less severe but still interfere with daily functioning. PTSD, which you are more familiar with from the presentations that have been made to you, is a psychological response to an experience of intense traumatic events, those that threaten life, making one extremely afraid, helpless, or horrified.

I should point out, and I think other speakers have also pointed out, that although the term “PTSD” we're using now is a fairly new term, this is not unknown in terms of other conflicts. During the American Civil War it was referred to as “soldier's heart”. The First World War often referred to it as “shell shock”, and in the Second World War it was often referred to as “war neurosis”. It was referred to by our American colleagues during the Vietnam war as “combat stress reaction”.

The term “post-traumatic stress disorder” was coined in the 1980s. There's a substantial amount of research that has gone behind the establishment of this particular mental health condition. You've had some clinicians speak to you more specifically about the actual nature of the illness. Raymond and the colleagues he works with in Montreal are our departmental experts on the subject.

If you're following along, the next slide in our deck is number 5. I'm not terribly comfortable with putting this slide in next because it tends to focus your attention on pension conditions. Our approach has evolved in the last few years with the implementation of the new Veterans Charter, and we have many more tools in our tool kit other than simply a disability pension.

In the past, the department has focused on disability pension as a gateway to other benefits, especially benefits that relate to the treatment of things like post-traumatic stress. We no longer have to put people through that gateway process. We now have a suite of wellness programs that allows us to intervene when people have symptoms and deal directly with the medical treatment of their conditions without having to go through a long and complicated process associated with pension adjudication.

● (0910)

Certainly slide number 5 will show you that in spite of the perception perhaps, Veterans Affairs is a department with a reducing number of clients. The overall number of clients has gone up steadily over the late 1990s and into the 2000s, with the forecast numbers projected to drop off. But we haven't actually seen a decline in our work yet, and that's not likely to happen with the increased operational stress and tempo that is being experienced with Canadian troops abroad.

You will see from that slide that the proportion of clients who make up our veteran population has increasingly become Canadian Forces clients as our older veteran clients pass away. That trend is also expected to continue.

Many people perhaps lose sight of the average age on release. This is something that the new Veterans Charter was about. The average age of a CF member on release is 36. That's quite a young age to be thinking about a disability pension and being disabled for life. I think it's quite appropriate that we have done a lot more than issue pensions to these younger veterans who are suffering from conditions such as PTSD.

Having said that, the interventions are still there. We now have 10,000 clients who have been pensioned or who are receiving disability awards for a psychiatric condition. There are 63% of them who have conditions labelled post-traumatic stress disorder. That number has increased quite dramatically over the last five years. Slide number 7 illustrates the number of people who have been pensioned for psychiatric conditions in the last number of years.

The next slide highlights those people who have been specifically pensioned with post-traumatic stress disorder. I say pensioned, but I should say that since last year, younger CF members are now able to get a disability award, which is a lump sum payment, treatment, and monthly benefits by virtue of rehabilitation that they undertake as part of their case management.

As I mentioned, we now have a much more comprehensive approach to case manage members. We provide a very broad suite of wellness programs to help them back into civilian life and to recover as quickly as possible.

The next slide, committee members, focuses on where the favourable decisions for PTSD are located in our offices across the country. I should tell you that the five offices where we have the most clients are in Edmonton, Quebec, Montreal, Halifax, and Calgary. We have clinics, and our colleagues in the Department of National Defence have clinics, for the treatment of post-traumatic stress disorder and other occupational stress injuries in these areas. Part of the budget measure is to expand our number of clinics across the country. We are putting even more focus on this issue in the next few months and years.

If you look at slide number 10, the deployments the military is facing result in serious and dramatic human suffering. This human suffering is the type you see in the newspapers and on television almost every day, but it is also a much more subtle form of disablement that comes from mental health conditions such as PTSD.

The other thing that's quite evident from the research and the work we are doing is that in general there is a lack of capacity in Canada to deal with mental health issues. That is why we focus a lot of our efforts in two areas. One is to establish a legislative and regulatory framework that gives us the tools, as I mentioned, to actually intervene and provide the treatment that is necessary for these folks. The second thing is to provide facilities where they can be treated. That is what these occupational stress injury clinics are all about.

● (0915)

I'm now on slide 12, if you're following, and I'm talking a bit about our response. Veterans Affairs Canada has launched an aggressive approach to try to deal with people suffering from these operational stress injuries. We've established a mental health strategy. This strategy was developed and launched a number of years ago, but we have put a lot more resources into it in the last couple of years, and we envisage, as I mentioned, putting substantially more resources into it in the years ahead.

The components of the strategy, on slide 13, are providing a comprehensive continuum of mental health services and policies, to build our capacity in the department to deal with these issues, and to provide leadership, not just leadership in Canada but leadership outside the country. We've sponsored a number of international symposia on this subject, and we're working in collaboration with many of our colleagues in the health care field in Canada and also internationally.

In terms of a comprehensive continuum of mental health services, we are focusing on more health promotion, assessment, and treatment for people who are suffering from these conditions, and we have a very comprehensive case management scheme under our new Veterans Charter that allows us to deal very actively with cases.

I'll move quickly through the next few slides and then conclude and answer your questions.

I mentioned the capacity-building we're doing. We're focusing on establishing these new clinics, five that we've already established and five more that were announced in the recent budget. We're providing leadership in terms of research in this area, and we'd be happy at some future date, if you have interest, to talk to you more about some of our research, the research that's taking place at Ste. Anne's and also across the country with some of our research capacities. And my research colleague who works with me, Dr. David Pedlar—we can talk to you more, if you have interest, about the collaborative partnerships we have.

That summarizes the major issues we wanted to highlight for you this morning. I'd be happy to answer any questions you have on the policy aspects, and I'll direct questions on some of the operational issues to my colleague, Raymond.

Thanks very much.

The Vice-Chair (Mr. Brent St. Denis): Thank you. Is it "Dr." Guptill?

Mr. Bryson Guptill: No. There are a number of doctors in my family, but I am not one of them.

The Vice-Chair (Mr. Brent St. Denis): I just wanted to address you correctly. Thank you, Mr. Guptill.

Monsieur Lalonde, please.

[*Translation*]

Mr. Raymond Lalonde (Director, National Centre for Operational Stress Injuries, Ste. Anne's Hospital, Department of Veterans Affairs): Good morning. I'm pleased to be here today to testify before your committee. I had the opportunity of meeting some of you during your visit to St. Anne's Hospital, last year in November.

Today, you'll have an opportunity to get a better understanding of what the department does when it comes to mental health and issues surrounding operational stress injuries. I won't rehash the presentation, because a number of points have to do with our role at St. Anne's Hospital. I would however like to talk a little about the Department of Veterans Affairs' National Centre for Operational Stress Injuries, what we do, and the plans we have to improve our services.

In 2002, we announced the official opening of the trauma clinic at St. Anne's Hospital, where we have now begun to treat young members of the Forces suffering from post-traumatic stress disorder, or PTSD. The department then broadened St. Anne's Hospital's mandate, and that of the clinic, to make it a national centre responsible not only for providing services, but also for developing programs, promoting clinical practices for the treatment of mental health problems, for research and enhanced access to services nation-wide, including health care and treatment services for our clients. That gives you an idea of the broad mandate of the National Centre for Operational Stress Injuries.

In order to carry out this mandate, one of our roles is to enhance access to clinical care. So the clinics we developed and which will be set up following the budget announcement, will become part of a pan-Canadian network of clinics available to veterans, and members of the Canadian forces and of the RCMP. These clinics will work hand-in-hand with similar Canadian Forces' clinics called OSI centres. These are ultra specialized clinics that assess and treat people with complex mental health problems related to operational stress, including PTSD.

These clinics should be able to treat about 1,200 to 1,300 patients across Canada. Clinics will be set up in every region of Canada. The overall network may include up to 15 clinics. The Department of Veterans Affairs currently has five operational clinics, and the Department of National Defence also has five in military bases throughout Canada. So, we'd like to increase the total number of clinics with the addition of five more. These are ultra specialized clinics, meaning that they don't provide all the health care services our clients may need.

When our clients suffer from mental health problems, they have access, just like every Canadian, to the public health care service. They also have access to clinical services, therapeutic services provided by psychologists, and specialized community social workers. These are services that we pay for. With the network of clinics, they'll enjoy access to a network of specialists working in multidisciplinary teams, including psychologists, psychiatrists, social workers and nurses. In addition to these health care professionals, the team may also include general practitioners, occupational therapists, and substance abuse counsellors. Our clinics rely therefore on a multidisciplinary team which works across the spectrum of disciplines. In other words, the whole team of professionals contributes to the assessment, treatment plan and care provided, based on the particular needs of the client.

● (0920)

These clinics specialize in assessment and treatment, but they're also mandated to work with community service providers, both public and private, in order to refer people to the appropriate professionals in the community—as I said earlier, not every client is treated in our clinics—broadening the knowledge-base of community health care workers, teaching best practices in the care of the people suffering from mental health disorders related to operational stress, and providing expert opinions to facilitate a collaborative approach with people in the community when it comes to treatment plans and the provision of services.

Our vision is to ensure that all our clients needing an initial assessment, or ongoing assessment due to the complexity of their problems or in absence of positive outcomes, have access to such. We offer clinical care at St. Anne's Hospital, but there's a whole array of complementary services provided by peer helpers. Bryson referred to these earlier.

The Operational Stress Injury Social Support Program, called OSISS in English, whose representatives you've met, I believe, provides services to people who have had mental health disorders and post-traumatic stress, and who offer support. We also provide the services of clinical care co-ordinators. These are people in the community who are available, and who are there to work more closely with the client in the community to ensure that there is no interruption in the services they receive. When a client suffering from an acute disorder out of hospital, after spending time in emergency and two or three weeks in a psychiatric wing, we want to ensure that there is some sort of follow-up to the health care that has already been provided. So these people are available to work with clients at Veterans Affairs' district offices, and also to work with the various community service providers, peer helpers, and with our specialized clinics to ensure these various levels of service are coordinated, that clients go to their appointments, that there is some sort of follow-up, sometimes daily, so that clients take their medication and know that the next step will be treatment in the community.

When you came to St. Anne's Hospital, one of the questions raised was about the beds we have for veterans. This question is often raised by the media, and you asked about it also when you came to visit. I'd like to point out that the beds we have at St. Anne's Hospital are not the only beds available to veterans suffering from operational stress. These beds are specially designed for a particular type of program, but we also have access to beds in private clinics throughout Canada. There are currently five clinics with programs developed at the request of Veterans Affairs Canada and the Canadian Forces. These are specialized programs lasting up to 60 days for people suffering from both post-traumatic stress and substance abuse problems,wich can be up to 75% of the total. We have a sufficient number of beds—there are beds in virtually every region of Canada, and these beds are available to veterans suffering from these disorders.

We also have access to some clinics' programs. In at least one specialized clinic, there's a program which provides an adequate number of beds. So, the beds at St. Anne's Hospital are beds designed for a specific stabilization program, and we're currently conducting a needs-based assessment to increase the total number of beds throughout Canada. We are still looking at this whole issue.

That completes my opening remarks. I would welcome any questions you may have.

● (0925)

The Vice-Chair (Mr. Brent St. Denis): Thank you, Mr. Lalonde.

[*English*]

We'll proceed to questions.

Ms. Guarnieri, for seven minutes, please.

Hon. Albina Guarnieri (Mississauga East—Cooksville, Lib.): Thank you, Mr. Chair.

[*Translation*]

I'd like to wish Mr. Lalonde a warm welcome.

[*English*]

I certainly want to take the opportunity to commend you for the difficult and challenging work that you and the staff at Ste. Anne's are doing for veterans, and in particular for those suffering from operational stress injuries. I'm certainly aware of the good work that Mr. Guptill does in his division. I know you're certainly up to the challenges ahead.

I've had the privilege of visiting Ste. Anne's on many occasions, and I've really seen a dedicated team of professionals who do their utmost for our veterans. That is fortunate, because it seems certain that we will be seeing a large increase in cases over the next number of years.

Mr. Guptill, you referred to the upcoming challenges. I wonder if you could provide the committee with the volume of cases you are planning for as a result of our Afghanistan mission. As I recall from the Gulf War, we had several hundred veterans being diagnosed with operational stress injuries. Obviously, the Gulf War had a relatively short duration with a limited number of soldiers involved on the ground. The Kandahar mission, of course, is significantly different. It's set to last at least another three years and involves many rotations of thousands of soldiers. So I wonder what the volume of cases is that you're projecting you'll handle. And how many years of treatment do you think the average veteran might require? Have you done projections to that effect?

Mr. Bryson Guptill: Thank you for that question. It's a good question.

We don't have a direct number that we've been forecasting in terms of the number of clients who would specifically have these occupational stress conditions. What I can tell you, and I think it is important to think about, is that the number of clients we've received who are going through our disability award process has decreased dramatically since we brought in the new Veterans Charter. We had forecast, in this year, that about 5,000 clients would go through our disability award program, and the number is dramatically less than that. I can't tell you exactly what it is off the top of my head.

That is indicative, I think, of what we've accomplished under the new charter in the sense that people are now coming in for rehabilitation and treatment as opposed to focusing purely on the financial benefit that was available and which is still is available under the disability pension and now the disability award. In fact, the number of people who are coming through the rehab gateway is bang on the number we had forecast, and that number is somewhere in the order of 2,000.

So although the tempo of operational stress injuries has increased dramatically as a result of deployments like Afghanistan, it is similar enough in nature to have client numbers that are pretty much along the lines of what we had forecast at the time of going forward with the new Veterans Charter.

I sense that we'll be much better equipped to deal with people suffering from occupational stress injuries as a result of the recent announcement under the budget of about $9 million to be dedicated to the establishment of new occupational stress injury clinics across the country and another $13.7 million to help the department deal with clients who are suffering from mental health and in fact physical health conditions.

More specifically, the casualties we're experiencing in Afghanistan, and in particular the number of people who have died in Afghanistan, have been dramatically higher than what anyone would have projected. I don't want to downplay that in any way. But there certainly is enough capacity in our forecast to deal with the financial aspects associated with that. We have in fact been tooling up to deal with people who are suffering from mental and physical problems related to those deployments.

● (0930)

Hon. Albina Guarnieri: It's certainly good to hear that the new Veterans Charter is working the way it was meant to, and I always knew that my department, my former department—Freudian slip—would never mislead me in their forecasts.

On another current matter, on Monday, the Minister of Health mentioned the OSI clinics in the context of the challenges and the stress faced by military children. I wonder if you could confirm whether you are expanding any counselling for the children of currently serving forces personnel.

Mr. Bryson Guptill: That's a tricky question, as you know, in the sense that—

Let me answer it in this way. One of the features of the new Veterans Charter that I think is very important is that the wellness programs we provided under the new charter also extended to families. This was quite a new approach for the Government of Canada.

We are now able to provide counselling to families of veterans, and can do so in a much more aggressive fashion, if I can call it that. We don't have to wait until people have received a pension entitlement in order to deal with their families. That's given us a tool in our toolbox that we didn't previously have, and it's very useful.

That said, our legislation still refers primarily to the treatment of families of veterans. People who are still serving are not the responsibility of Veterans Affairs, as you would know. Rather, they are a responsibility of the Department of National Defence. The Department of National Defence prides itself on preparing for counselling the families of people who are deployed, preparing the families for all sorts of ideas about what the members themselves are going to face.

There was a bit of attention a few weeks ago given to how much DND is doing and how much the Province of Ontario is doing in some particular areas. I was pleased to read in the media, as I'm sure many of you were, that this issue has now been resolved in the sense that Ontario and the Department of National Defence have sorted out a way to provide more proactive assistance to families.

Certainly one challenge—and this is something that you would have experienced previously, as minister—is that we don't also want to abandon military families or have them ghettoized in such a way that they can only get benefits or attention from the federal government. The provincial government has certain responsibilities for families as well. We want to make sure that this is a comprehensive approach that has everyone helping, and it's my sense that the provinces want to do that too.

● (0935)

The Vice-Chair (Mr. Brent St. Denis): Thank you.

Monsieur Perron, for seven minutes, please.

[*Translation*]

Mr. Gilles-A. Perron (Rivière-des-Mille-Îles, BQ): Good morning, Raymond. I take the liberty of calling you Raymond because we once had occasion to have a smoke together.

I'd ask you Mr. Guptill and Mr. Lalonde to not answer as if you were politicians but to get to the crux of the issue as quickly as possible.

I'm concerned about youth services. Clearly excellent service is provided to young people living in and around the major urban centres such as Montreal, Quebec City, Toronto, Edmonton and Vancouver. But what is being done for our young people in the far reaches of Abitibi, Medicine Hat and Elliott Lake? This is a problem.

The reason I use the example of Abitibi is because I come from that area. You are very familiar with this region of Quebec. Flying from Montreal to Rouyn-Noranda costs more than going from Montreal to France. It takes at least eight hours by car to go from Montreal to Rouyn-Noranda. So a young person from Abitibi can't go to Montreal for medical treatment and come home all in the space of one day. And yet, these people are entitled to these services.

Here's my suggestion, and I'd like you to comment on it. In your statement, you said that some psychologists work with you in some cities and towns. Why don't we know about them? I'd like to have a list of these offices.

When Dr. Biron made her presentation before us, she said that the majority of Quebec's psychologists, and those from elsewhere in Canada, know little or nothing about the problems associated with post-traumatic stress, that they need better training, and so on and so forth. She acknowledged that the plan that I'm putting forward made sense, that is to hire a psychologist or two on contract so that they can look after people in these regions and also make it know that the service exists.

You need to bear in mind that young people suffering from post-traumatic stress disorder are basically ashamed to admit that they have mental health issues. People are macho and tough when they are in the army. Asking for help with some sort of psychological disorder is a lot harder than seeking treatment when you need your hand or arm amputated or you suffer from some other physical problem.

Could you elaborate on your plan for the country's regions?

[*English*]

Mr. Bryson Guptill: Let me start by trying to answer your question in a more general way. Then I'll ask Raymond to deal specifically with some of the issues you've raised as they relate to regions in Quebec.

You've touched on the important issue that many of the folks suffering from some of these conditions are not located in Calgary, Edmonton, Ottawa, or even Quebec City. They're often located in more rural areas, and because of the nature of the illness they often retreat from society and go to even more isolated locales. So this is a challenge for us, there's no doubt about it.

Let me say initially that there is a shortage of people in Canada who have the right kinds of skills to deal with people with operational stress injuries. We recognize that, and in our new Veterans Charter we have an ability to provide treatment to these people. The treatment is a quasi-statutory right, so it's not restricted by any specific budget limitations. We can draw on the services on the basis of need, in other words. But we do find that there are shortages of skill sets, and that's why we've had to focus some of our attention on these areas where we've established a critical mass and clinics.

I'll give you an example from Calgary, because I was at our Calgary clinic just a few weeks ago. They are treating some people in the Calgary clinic who are living in some very isolated areas of Alberta. In some instances they've made the trek into the clinic, and in other cases they're dealing with people on a distance basis by phone and other means. They have been providing counselling to people.

Often the difficulty has been getting the message out. My colleague Raymond will talk a little bit about our peer support programs. But in the Calgary situation we were advised by the people who run the clinic that the most effective way to reach out to some of these people is to have former members of the forces, who are peers of these individuals, do outreach for some of them. They go to them in these remote communities and encourage them to come in for treatment.

I think we've established enough critical mass, and the expansion of a number of clinics will help us deal even more effectively with this. But there are certainly areas of the country, and the Quebec north shore is an area that comes to mind, where—

● (0940)

[*Translation*]

Mr. Gilles-A. Perron: And what about in New Brunswick?

[*English*]

Mr. Bryson Guptill: It's the same thing.

Raymond do you want to—

The Vice-Chair (Mr. Brent St. Denis): Please make it a short answer.

[*Translation*]

Mr. Raymond Lalonde: Not all psychologists are able to provide services to veterans. Criteria have been developed based on experience and education. There is a plan being currently developed in order to improve the training programs offered to these service providers. In fact, on May 7, 8 and 9, we'll be holding a national symposium on operational stress injuries in Montreal. Researchers, clinicians, health service managers and presenters from the United States and Canada, people who are leaders in their field, will be present. Training programs are being developed.

Mr. Gilles-A. Perron: Is this training being provided in conjunction with the association of psychologists?

Mr. Raymond Lalonde: Training courses are being developed at our centre of expertise. We work with clinicians in various clinics, and in conjunction with National Defence. We're developing programs with the National Centre for PTSD at the USDVA. It's not the training programs themselves that are a problem, but rather the way they are being delivered to service providers. They can be delivered in many ways. There is a conference. Each clinic is responsible for giving training sessions in its region. There are 10 of them; and there will be a variety of people involved.

[*English*]

The Vice-Chair (Mr. Brent St. Denis): Monsieur Lalonde, you can have a chance to come back to that.

Gilles, you will have a chance in another moment.

Mr. Stoffer is next, please, for five minutes.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you, Mr. Chair, and thank you, gentlemen, for appearing before us today.

In slide 4 you talk about PTSD as a psychological response to an intense traumatic event. Sometimes I worry that if the Liberals or Conservatives ever form a majority government, I would have political traumatic stress disorder.

The reason I say that is I've talked to doctors in Halifax who say PTSD can also be a string of minor events that are accumulated over a long period of time, not necessarily an intense—like fire or death or something, but little things that accumulate and because they were never dealt with in a proper manner or discussed and given proper treatment or advice or peer advice, for lack of a better term, they build up. All of a sudden, these little things all become one big one and blow up. So I'd like your comment on that.

In *The Hill Times* you probably saw the story of Louise Richard, and I'd like to read into the record what she said. This is about the fact that the modern-day veterans, she's claiming, do not have access to federal government health care facilities. Here's what she says:

> "PTSD and other disorders that are related to military service require a suite of expertise in order to deal with those ailments," says Sean Bruyea, a former Canadian Air Force intelligence officer who is also suffering from a service-related disability. "So pawning us off on a civilian institution that may not necessarily have any expertise whatsoever in caring for military-related injuries sounds like a complete abandonment of their responsibility for the care, treatment and rehabilitation of all disabled veterans."

The article goes on to say that DVA believes that sometimes community hospitals or facilities closer to the home of the veteran are probably just as suitable for them in that regard.

I'm wondering how you would respond to the first comment and what you would respond to Louise Richard and Sean Bruyea in terms of their concerns about not having access to Perley, Ste. Anne's, etc.

● (0945)

Mr. Bryson Guptill: I'm not a clinician in this field, but I can tell you from what I've read and from what clinicians have told me that PTSD can certainly result from a number of different types of events. I don't think our definition or our medical advice around people with PTSD conditions would constrain any very broad acceptance of a series of events as leading potentially to PTSD. I think you can see from the numbers we presented that the number of people who are diagnosed with the condition have increased rapidly in the department.

But I want to emphasize that under the new Veterans Charter we are now able to deal with these people and treat them as a result of a very quick examination by people on the front line in our 32 offices across the country. Area counsellors in our offices now are able to assess the need for rehabilitation and start people in the treatment program without the requirement to put people through a very complex, quasi-judicial adjudicative process.

I also think that what Louise Richard was being quoted as saying is quite true, that there is a lack of capacity across the country in the diagnosis and treatment of PTSD and other occupational stress injuries, and that's why we've tried to establish this network of clinics where there is a critical mass of expertise.

I'd like to deal specifically with Mr. Bruyea's allegation that we don't have the right kind of response in place. I don't accept that, and I don't accept it for a number of important reasons. If you look at where people have wanted to receive the treatment—and this comes back in part to Mr. Perron's point—it's unlikely that people who are suffering from PTSD or other occupational stress injuries or other illnesses related to recent deployments are going to want to be treated in a geriatric hospital that Veterans Affairs Canada might have operated after World War II. That's what these contract facilities are all about, these nursing homes where we provide contract beds.

What we've been doing with the younger veterans, and I think this is the appropriate thing, is giving them a lot more choices about where they're treated in communities, and we are able to draw on the expertise that has developed across the country where there is capacity to deal with the specific types of illnesses these people are suffering from.

I should point out that there's been about an 80% increase in the occupation of what we call community beds across the country in the last couple of years, and yet the people who are in what we call our contract beds...the use of those contract beds over time has been diminishing quite dramatically.

So I think if you look at the choices younger veterans are making, if they have to go into a nursing home kind of setting or a setting where they are getting treatment, they'll often want to get the treatment closer to where they live rather than in the departmental facilities we occupy in very limited places across the country.

● (0950)

The Vice-Chair (Mr. Brent St. Denis): Very briefly, Peter, if you're following up....

Mr. Peter Stoffer: I'll wait until the next time.

The Vice-Chair (Mr. Brent St. Denis): Thank you, Peter.

Mrs. Hinton, please, for seven minutes.

Mrs. Betty Hinton (Kamloops—Thompson—Cariboo, CPC): Thank you.

I'm going to share my time with Mr. Shipley, but I guess that will depend on the length of the answers.

I think you would agree that it's pretty obvious to any Canadian that there has been a lack of health care providers, whether that's doctors, nurses, or psychiatrists—anyone to do with post-traumatic stress disorder. There has been a lack of these health care workers for over a decade. I was actually quite impressed; I think I heard you say 32 working clinicians. That's very impressive.

It is also interesting that we've had this problem for so many years. You were referring to “shell shock” from the Second World War, and “combat stress reaction” is what you were saying it was called in the United States. I think we've come quite a long way in helping people.

But one of the things I noticed in your chart was the number of RCMP officers. I'm assuming that's the third column.

Mr. Bryson Guptill: Yes.

Mrs. Betty Hinton: That's a pretty dramatic jump from 2005 to 2007. I'm not doing the math properly, but it's almost a 50% increase. I wonder if you could discuss the RCMP portion a bit. Obviously these are all stress-related injuries.

The other question is that you've given us charts on clients with a favourable decision for the condition of PTSD, but could you provide some background on the number of clients who have not received favourable decisions? I'll let you answer that first.

Mr. Bryson Guptill: In terms of the favourable versus unfavourable, we thought you'd be interested in seeing the number of cases that we have approved. I can't tell you right now what the numbers would be in terms of unfavourable. In general, the favourable rate for these kinds of conditions is around 50%. It has been like that for many years. But we could provide more specific information on that.

I've forgotten your first question.

Mrs. Betty Hinton: My first question was my surprise at the number of RCMP and the more than 50% increase in cases. These RCMP officers are serving in Canadian cities, I am assuming, and not in war zones, so I was really quite shocked to see that kind of a dramatic increase.

Mr. Bryson Guptill: I think the percentage increase in RCMP members is very similar to the increase for younger CF members. As you would know, the RCMP is eligible to receive the same kinds of interventions from the department, for the same sorts of conditions, in terms of disability awards or disability pensions.

There has been deployment of RCMP members to some of these war zones, and a number of RCMP members are serving in areas of conflict. I'm thinking about Haiti, for example, as a recent one. The response by RCMP members has been much the same. We've been encouraging the RCMP to take advantage of some of the wellness programs that are available under the new Veterans Charter.

The committee may not be aware that although they avail themselves of disability awards and pensions under Veterans Affairs programming, the RCMP don't actually have eligibility for those programs under Veterans Affairs legislation. They get it by virtue of RCMP legislation and regulations. They haven't yet modified their legislation to take advantage of the full benefits available under the Veterans Charter. We think they could probably benefit significantly if they were to do that. The wellness programs that are now available to National Defence members, Canadian Forces members, are not yet available to members of the RCMP, but this is by choice. The RCMP hasn't taken that step yet.

Mrs. Betty Hinton: One final question was regarding the issue that was raised with mental health issues in children of families. We obviously have bases in Ontario, but we have bases in other parts of the country as well, where there has been the same type of loss. Has there been any other provincial government that has been reluctant to do their part, as a provincial government, or is this unique to Ontario?

● (0955)

Mr. Bryson Guptill: I haven't heard of other provinces being reluctant. We've been talking, for example, about recent deployments, and some of the recent fatalities in Afghanistan were from Atlantic Canada. We've been briefed very thoroughly by our colleagues in National Defence about missionary work that they are undertaking with provincial health officials to help them get ready for people returning from deployments, especially in Halifax, at the VG, and from Gagetown, for example.

The reports our DND colleagues are giving us are that they've been getting very enthusiastic endorsement from the provincial government to welcome these folks back if they have treatment needs. So I'd be surprised to hear of similar situations, but it certainly could happen.

Mrs. Betty Hinton: I'm not sure how much time I have.

The Vice-Chair (Mr. Brent St. Denis): Well, you're at six minutes now.

Mrs. Betty Hinton: Well, then, I'll make a closing remark.

I just want to tell both of you how grateful I am, as a Canadian citizen, that you do the job that you do. I recognize that you're doing it under very difficult circumstances, with a shortage of personnel, and that things seem to be moving along as well as could be expected under the circumstances. But I just thank you very much for the job that we do for our veterans, and I appreciate your showing up today at this hearing.

Thank you.

Mr. Bryson Guptill: I appreciate it.

The Vice-Chair (Mr. Brent St. Denis): Okay, thank you.

Now, Bev, are you going to wait for your—

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): I'll wait.

The Vice-Chair (Mr. Brent St. Denis): Yes, because your full turn will come up here shortly.

Mrs. Betty Hinton: He doesn't want 30 seconds?

The Vice-Chair (Mr. Brent St. Denis): Well, we'll add it.

Thanks, Betty.

Roger Valley, please.

Mr. Roger Valley (Kenora, Lib.): Thank you.

Thank you for the information.

I have a quick question for Mr. Lalonde. You mentioned that the beds at Ste. Anne's are for PTSD. You mentioned five other clinics across the country. I missed them when you listed them.

Could you tell us what areas these are going to go into?

Mr. Raymond Lalonde: I'm sorry, I missed your question.

Mr. Roger Valley: The beds in Ste. Anne's are slated for PTSD, a lot of them. You've mentioned five other clinics across the country that are going to have beds for—

Mr. Raymond Lalonde: That's not exactly what—maybe I should clarify.

We have five clinics, actually. These are out-patient clinics. We have one in Ste. Anne, which is a departmental clinic. We have MOUs with four provinces for our clinics in Quebec; in London, Ontario; in Winnipeg; and in Calgary. We're looking to open other clinics in Fredericton, Ottawa, and Edmonton, and there's another one that we still need to find a location for. There will also be, for sure, a clinic in B.C., which will complement the five out-patient clinics that DND, the Canadian Forces, has. These are out-patient, ultra-specialized clinics.

We have beds with private providers for the co-morbid PTSD program and substantive use. We have two clinics providing that in B.C., two in Ontario, and one in Quebec, and one provides that program on an out-patient basis in Halifax. So there are six clinics providing that co-morbid program.

Mr. Roger Valley: The two in Ontario are where?

Mr. Raymond Lalonde: In Homewood and Bellwood, around Toronto. And there's Edgewood, in Nanaimo. So there are six together.

We have beds in Ste. Anne's for a specific program called the stabilization program, and we're looking at how we could expand that program.

The problem we have, related maybe to the question you raised earlier, Mr. Stoffer, is that balance between critical mass—to have experts dedicated to people with military background—and the fact that people are scattered across the country. As you were saying, the balance we need is to have integrated services.

We'll have 15 clinics across the country—ultra-specialized. We'll have service providers. We also have private providers providing specialized services. It's a balance between both. We need a balance between specialized services and access in the community to service providers and public health services. We're trying to meet the balance between all of these services.

● (1000)

Mr. Roger Valley: Thank you.

I have a question for Mr. Guptill.

Slide 11, on lack of capacity—I don't lay this at anybody's door, but I think a lot of the problems are from some of the provincial boundaries we have—the portability of health care.

Very quickly, because I have a question and I don't want to run out of time here, I'm personally going to the issue.

My daughter is graduating in three weeks as a psychiatric nurse. A huge class in Brandon, Manitoba, is graduating; none of them is allowed to come east and work. They can only work in the west. In Ontario you have to become an RN and then you specialize. It takes two to three years longer. These people are actually being bid on right now to travel all across the west, because for one thing they can't get any doctors. So psychiatric nurses are providing services that doctors would normally do because there are no doctors either. You have a huge challenge in the capacity.

I would very much like Mr. Perron to deal with the rural part of Canada. My riding is one of the largest in Canada, the Kenora riding. Even in your district offices, if you look, there are 11 in southern Ontario. Then you go 1,000 miles from North Bay to Winnipeg; there's one office in between and that's in Thunder Bay.

I want to know, when somebody has to visit a clinic, has to go to one of these contract beds, service is provided wherever they go, but what kinds of supports are in place for the families now? You mentioned families in the charter. Do we have the support? Say a spouse has to take him in or a child has to take their father or their mother in? What kind of support is there when the family tries to look after this person? They may have to travel hundreds of miles. Do we have some kind of support network there for them?

The Vice-Chair (Mr. Brent St. Denis): Thank you, Roger.

Go ahead.

Mr. Bryson Guptill: That's a good question. I have to say that we do have support. The families can get support. In particular, I'll go back to the example I gave in the Calgary area. The clinic there gave me some specific examples of how they treat the families of veterans. One of the issues they highlighted for us was that they can't provide treatment to the family unless the veteran is also getting treatment. I will come back to the issue that Mr. Perron raised. Sometimes these veterans, especially in isolated areas, are reluctant to come forward. So what we've been working on is to develop a policy work-around that allows us to determine whether or not the veteran is likely suffering from a condition. If so, then we will provide treatment to the family. So we're working out some of the bugs in this area. I think it's a good approach. I think we have the tools we need, and those tools are available to us as a result of this new piece of legislation we have.

The Vice-Chair (Mr. Brent St. Denis): Thank you very much, Mr. Guptill.

Monsieur Ouellet, please.

[*Translation*]

Mr. Christian Ouellet (Brome—Missisquoi, BQ): Thank you, Mr. Chair.

Mr. Guptill, you said that there was a lack of expertise and a lack of identification capacity. What staff do you need in order to permanently stabilize your clients?

[*English*]

Mr. Bryson Guptill: As I said, we have the tools that allow us to respond appropriately. We sometimes have challenges in recruiting people. I'll give you another example that I recently ran into where I had a psychologist in one of our clinics talking to me. This chap was actually a psychiatrist. In the community he was treating a lot of different types of cases and was very overworked. When he came into our clinic he was able to focus specifically on folks with these occupational stress injuries. He said to me that it was such a relief for him to be able to focus on clients with specific needs and not to have to spread himself so thinly, as he would in the general health care system.

That was nice for me to hear as an employee of Veterans Affairs, but it reminds me of the challenge we have, because these resources don't come cheaply. We also have difficulty attracting some of these folks, and we have difficulty holding on to them. So it's a constant balance for us. I think we have the tools and the resources now to deal with it, but it will always be a challenge, because, in general—and this is not news to this committee—we don't have enough resources to deal with mental health problems in the country, so we're constantly having to recruit.

● (1005)

[*Translation*]

Mr. Christian Ouellet: Mr. Lalonde, earlier you said that your institute provides ultra-specialized health care services. If you compare your care to that provided by regular hospitals, would you say that the quality is better, worse or the same?

Mr. Raymond Lalonde: In the public hospital system, there is the same classification of services, that is primary care, emergency services and walk-in clinics. There are also secondary services, for example when somebody is referred to a cardiologist, etc.

There are also ultra-specialized services, such as child psychiatry, brain surgery, and so on. These are highly specialized clinics. There are ultra-specialized clinics for people suffering from anorexia.

Thes services are comparable. There are highly specialized services in the province which are comparable, but we cannot say that our services are better than any other services provided.

Mr. Christian Ouellet: So these services are of similar quality.

Mr. Raymond Lalonde: The quality of the services is the same, but they are specialized and deal with operational stress problems, and our clinicians also take into account the military culture.

Mr. Christian Ouellet: Could you talk about the support you get. What about the hospital buildings, for example at the hospital in Sainte-Anne-de-Bellevue, which was built 90 years ago and renovated 40 years ago.

Mr. Raymond Lalonde: It's currently being renovated.

Mr. Christian Ouellet: Are the needs of people with mental health problems being met?

Mr. Raymond Lalonde: The facilities are fine. The main problem is access to treatments. The other problem is with people who live in the regions; that's a major issue. People need to be able to actually go and get health care, ask for help, and we must be in a position to provide the best of services possible.

That's why I refer to a balance between high specialized services, the public network services and those offered by community providers. It's about working together. Part of our clinics' mandate is to work hand-in-hand with people in the community so that they can be supported in the work they do.

Take the example of a client from Abitibi seen at Sainte-Anne's hospital who then returns home. When this person re-enters the community after six months of treatment, we want to make sure the general practitioner or the psychologist in Abitibi is able to contact our specialists to discuss the treatment program. This collaborative approach between the various stakeholders is extremely important, much more than the facilities themselves.

Mr. Christian Ouellet: Thank you.

[*English*]

The Vice-Chair (Mr. Brent St. Denis): Thank you, Christian.

We'll go to Bev Shipley. We'll give you a couple of extra minutes because you missed a few—I mean a couple of extra seconds.

Mr. Bev Shipley: Thank you very much, Mr. Chairman.

Mr. Lalonde, I want to thank you for welcoming us last fall, I believe it was, to Ste. Anne's Hospital. For me, it was a first time, and I very much have a great respect and appreciation for what you're doing.

Mr. Guptill, thank you for coming today and for the work that you, through the Department of Veterans Affairs, are doing.

I think everyone around this table is looking to the goal of better treatment and what we can do to facilitate veterans, which leads to my first question.

If I go to slide 10, just to comment at the start of this, clearly in anything we do, any time we can have early analysis and early diagnosis, prevention is the opportunity that we need to be seeking, and we obviously need to have things in place so that we can do that to the best extent we can.

I would see that this is what we're doing now. We are doing pre-screening before they go into deployment, returning as they come out, and doing some screening trying to detect—correct me if I'm wrong—when something is not as stable, that we can actually go in and start to work with individuals. Doing that saves anxieties, and I think there's likely quite a close connection between high anxiety and post-traumatic stress disorder.

On page 10 you talk about the delays in seeking treatment. I'm hoping that when you say that that some of these pre-screening things have taken that stigma away, that really we aren't in the same situation today as we were yesterday—yesterday being in the past.

I'm concerned about the last four bullets, because if these are in any chronological order, then where the condition starts to work on an alcohol dependency, obviously that rolls down if they have a job, and it leads to family violence and sometimes breakups, and then the ultimate, the worst scenario is that they have suicidal tendencies.

It takes me back to my first comment, about early diagnosis and prevention. Are those in an order, and are you dealing with those in an order to activate the early diagnosis and prevention as much as you can?

● (1010)

Mr. Bryson Guptill: They aren't in any particular order, but they do show the magnitude of the problem. Something called the Canadian community health survey was carried out by Statistics Canada recently, and that survey indicated that the most common mental disorder of people who are serving in the military is major depression, followed by alcoholism. Social phobia was third, and PTSD was fourth.

So there are some significant issues that need to be dealt with, and all the research has shown, and all the work that we've been doing emphasizes this, that early intervention is the key. So it's very important for us when we start to see people from the military who are coming to the Department of Veterans Affairs with issues that we be able to deal with these people on a very, very rapid basis, because the faster you intervene, the sooner you get people back on their feet again.

Mr. Bev Shipley: I don't want to interrupt, but I don't want to run out of time, because I have a couple of other questions.

On the records that come from DND, then, if there were a circumstance where there was a notice of alcohol dependency at the DND area, at the post-deployment part when they return, is that triggered early so that you know there's already a hint of an issue?

Mr. Bryson Guptill: We're working very closely with DND during the transition phase. So while people are still serving, they're the responsibility of DND's case managers, but if DND notices that someone has some serious issues and they're going to be transitioning out of the force, then they contact us and we get involved.

The analogy we like to use is two hands on the baton. For a while, both of us are case-managing, and then as someone makes the transition out of service into civilian life, we're there to help out.

We're doing that in a whole lot more comprehensive way than we were previously, because remember, under our old legislation we had to focus entirely on whether a person was suffering from a disability that we can call a pensioned condition, and then once we'd gone through that adjudicative process we could start dealing with them. Now we can deal with these issues at the same time. So they can apply for a disability award, but at the same time, with our front-line offices—to come back to Mrs. Hinton's point—the 31 or 32 offices across the country, we can have our area counsellors dealing with that person right away, talking to them and their family members, making a judgment that they seem to have some issue that relates to their military service, even without defining it, and start putting them into a treatment program.

Mr. Bev Shipley: I don't know if Mr. Lalonde has anything to add.

Mr. Raymond Lalonde: I think early intervention or prevention is really a key factor that helps improve the outcomes. DND has put a lot of work and effort on this, and we have to realize that someone who comes back from Afghanistan with PTSD will not become a Veterans Affairs client the day after. He may be treated by the Canadian Forces for a year or two before we see him, so we work in collaboration with them at that point. We share our best practices. We work in clinical programs with them so that there's continuity of treatment when they're released and they don't, the day they're released, come and get services with us that are so different from what they're receiving that there is discontinuity. We really work together on that front too.

● (1015)

Mr. Bev Shipley: Thank you.

The Vice-Chair (Mr. Brent St. Denis): We're going to come back to you, Bev. There will be a chance for everybody.

Mr. Roger Valley is next.

Mr. Roger Valley: I want to go back and deal with some of the rural issues again. It's my penchant, coming from where I live. I'm always concerned about the lack of services in my riding and other large ridings that don't have big populations. On top of being from a riding that's spread out over one-third of Ontario, I serve 41 reserves. Of those, 21 are fly-in reserves, meaning they're in northern Ontario. Some of them are 500 miles from the end of the road, so there are a lot of challenges to get services out there. We also know we can't expect the level of service that is in many communities. When I asked earlier, I got the impression that Mr. Lalonde had part of an answer to some of the comments I made.

Mr. Guptill, I don't think I phrased my question correctly. I'll give you a specific example. Somebody travels 400 miles to get to one of these sites that is going to provide the service, and they're brought by their family member, or whoever is bringing them. I was thinking more of family services putting them up in a hotel, along the line that we're actually supporting them, or is there a house that houses these people? How does the family—? Generally, these veterans from the Second World War are elderly people who may have very limited resources in my riding and in these areas.

I know it may not be in place now, but you mentioned the charter, and we're talking about providing for the families. That's the kind of drive I was getting at there.

Mr. Bryson Guptill: We have a provision for something we call medical travel. It allows us to pay for people to travel to medical appointments, and that would be available for someone who's receiving this sort of treatment, so we have a way of dealing with that.

Mr. Roger Valley: Mr. Lalonde, did you want to answer part of that question?

Mr. Raymond Lalonde: If that person needs to be accompanied, we will pay for the travel for the person when there is a medical requirement for the person to be accompanied to go to a treatment. For example, we had a client in southern Ontario going to the PTSD program in Nanaimo. It depends on the need. The thing is that the clients don't choose where they go. If there is an adequate provider close to their community, we would pay for travel to go to that provider, but if the client comes from Ontario to Ste. Anne, to the stabilization beds, we would finance the travel for the person who accompanies that client to the facility when there's a medical requirement to be accompanied.

Mr. Roger Valley: Thank you.

We also never had an opportunity to discuss some of the comments I made on the challenges that have faced Canada for decades over the portability of health care and professionals who travel from one jurisdiction to the next. I didn't mean to say my daughter couldn't work in the rest of Canada east, but I know she can't work in Ontario. She can maybe work in Quebec or somewhere else.

I know this area is outside Veterans Affairs, but the federal government has to somehow deal with the issue with the provinces to get portability in health care. Do you see that as a restriction to some of the access you have to professionals?

Mr. Bryson Guptill: I think it's a good point, and it's not just in the area that you mentioned. My daughter is working on her PhD in occupational therapy. In some areas the rules are different for some parts of the country. This is not unusual, I think, in some medical professions, but it is from time to time a problem and needs to be dealt with. We haven't run into it as a significant problem, but if it were to be a problem, I think we have the tools to allow us to deal with it.

Mr. Raymond Lalonde: We will have to look at that one, because we're looking at telemental health as a means to provide services in the remote communities. We have a project on the table with the Alberta Mental Health Board in Calgary. Our west side clinic would provide telemental health through their clinic. If we have a clinic, for example, in Fredericton for Atlantic Canada, and we would want that clinic to provide telemental health services to Newfoundland, we would need to address those issues in the future. But telemental health is a way we're looking at to provide service in remote areas.

● (1020)

Mr. Roger Valley: Just quickly, before my colleague cuts me off, the only good thing about my daughter not being able to come east is that she was going to evaluate me, but she can't do that in Ontario.

I want to point out again, and I don't want to make it trivial in any way, that with our shortage of mental health workers across Canada, we're putting.... The level of strain they're under now, because there are not enough out there, is just being multiplied by situations like the one I mentioned. My daughter will work at a level that she's not supposed to. She's supposed to be a psychiatric nurse who works with patients and brings them up so the professional psychiatrist or the counsellor can deal with them. But that's not happening, because there are no doctors out there for these issues.

So on top of a tough situation, it will get worse, unless we somehow deal with some of the shortage and capacity issues we have in Canada.

Thank you.

The Vice-Chair (Mr. Brent St. Denis): Thank you.

We'll go to David Sweet.

Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC): Thank you, Mr. Chairman.

Thank you for coming.

If you look at the blues, and you mentioned that you were familiar with some of the testimony, my area of questioning has always been about our capability to—how would I say it?—prepare the soldier prior to going into an area.

Are we spending money at Veterans Affairs ourselves for research, or is most of the money going to clinical services right now?

Mr. Bryson Guptill: We spend a significant amount of money researching this field. I'd have to say that probably the vast majority of the dollars the department spends is for the treatment of actual veterans. We do have a small research group headed up by very competent people, I believe.

We've been able to access research that's being carried out in other jurisdictions as well, and we benefit significantly from that research. Our director of research, David Pedlar—I mentioned the name earlier—tells me, for example, that he's able to benefit from the research that's going on in the U.S. because of some of the committees he takes part in. We have an international group that compares best practices and research findings. The U.S., for example, spends about $2 billion a year on researching this and related issues. So we do get access to a lot of good findings that way.

Mr. David Sweet: Is there pre-screening going on now, prior to a soldier going into an area of conflict, to discriminate between those who would be able to well survive a traumatic experience so they don't end up with PTSD and those who'd be more vulnerable to having a traumatic situation become a mental disorder?

Mr. Bryson Guptill: This is a good question and one that probably is more appropriately directed to our colleagues in National Defence. I have gone over some of the testimony, and I've noticed that some of the folks who have appeared before you have indicated, and they've indicated it to us as well, that there is pre-screening that goes on.

I think one of the debates that was going on before your committee previously was about how effective that pre-screening is and whether pre-screening can actually identify when people might suffer from these sorts of illnesses. I think the jury, in some way, is still out on that, but there is an effort within the military to make sure that troops are being trained and are getting the right kind of training before they go out to a deployment.

Mr. David Sweet: Are you aware, in this $2 billion worth of research going on in the United States, and of course in the whole global community as well, if there is a focus on developing a better capability for screening?

Second, do you know of any research going on right now on how to actually prepare a person? In one aspect, we're talking about discriminating between those who have the capability of dealing with stress.... I can't even think of how you might do it, but would there be some programs in which you could actually expose someone to stressful situations in order to desensitize them to a future traumatic consequence?

Mr. Bryson Guptill: Yes. I think because of the nature of what some of our troops are doing you wouldn't want to desensitize them too much, but certainly the evidence we've heard is that pre-deployment training is a very big asset in terms of getting the troops ready for what they might encounter when they are deployed. Absolutely.

● (1025)

Mr. David Sweet: Okay. So there was substantial research going on at that time.

Mr. Bryson Guptill: Absolutely.

Mr. David Sweet: Are we operationally testing to see if some of these best practices and this kind of research in this area are working for our people?

Mr. Bryson Guptill: In terms of pre-deployment training, that's something DND is focusing on. We've been working with them, but they would be better equipped to answer your questions, I think.

Mr. David Sweet: I have a last quick question.

Everybody is concerned about the capacity issue. Is there an awareness in our public post-secondary institutions as well as in the recruiting centres at DND of the need? Is there a high-level campaign going on to try to steer people who are interested in a psychological medical career to go into this line of clinical work?

Mr. Bryson Guptill: I'm not really equipped to talk much about that, but you may want to get some colleagues from DND. We've had a presentation by Rakesh Jetley, I believe. He's a psychiatrist with DND who gives a very powerful presentation on what DND is doing to prepare troops and also what they're doing to increase their expertise in these psychiatric areas.

Mr. David Sweet: Mr. Chairman, it would be good to have that person as a witness sometime.

The Vice-Chair (Mr. Brent St. Denis): I understand from the clerk that at the next meeting we'll have DND.

Mr. David Sweet: Brilliant.

Thank you very much.

The Vice-Chair (Mr. Brent St. Denis): Thank you, David.

Mr. Stoffer, please.

Mr. Peter Stoffer: Thank you once again.

Sir, on the situation at Petawawa, I was glad to see Ontario and the federal government get together and resolve that issue, but it took an ombudsman's report and media attention to do that. You said earlier that you didn't want a situation — and I believe the term was to "ghettoize" this particular concern. I'm not sure if that's the word I would use.

When I look at a military base, I look at it as having a separate identity. The men and women who serve our country are prepared to pay the ultimate sacrifice, and the families on those military bases are prepared to have their mom or dad do that. When they suffer concerns, I don't think we should be playing ping-pong or bat-the-ball because it's someone else's jurisdiction.

This is a military component, and I have always believed that the federal government should be responsible for their concerns. I know this isn't your issue to address, but I would hope that in the future we don't have places like Shearwater, Esquimalt, Borden, Valcartier, or any more reports of that in the future, and that the federal government would take its responsibility. And I would hope that if provincial facilities are there, they would work closely before we had another ombudsman's report. I'm glad to see that you're correct in that the situation was resolved.

Going back to Louise Richard again, the headline of the article says: “New veterans not entitled to Canada's federal government's healthcare facilities”. Is that a true headline?

Mr. Bryson Guptill: I wouldn't say the headline is true. We've been trying to make sure that the Canadian Forces veterans get the best care possible. We also want to make sure we have the right kinds of tools to deal with their needs. There are a significant number of younger Canadian Forces veterans who haven't availed themselves of the provisions of the new wellness programs, and I would encourage them to do that.

In terms of the treatment they can receive, I think we can provide the best treatment possible. In terms of the facilities where they can receive that treatment, the point I was trying to make earlier is that we would like to make sure that they're getting access not just to federally funded facilities. As you know, we only operate one hospital in Canada, so all the facilities we have are in collaboration with provincial governments. It's not just federal facilities but also provincial ones, and we are willing to pay for whatever the care happens to be.

Mr. Peter Stoffer: If Louise Richard wishes to go to the Perley to have treatment, if she wishes to go to the Perley specifically, if she requests that, would she have access to that?

Mr. Bryson Guptill: I can't comment specifically about Ms. Richard's case.

Mr. Peter Stoffer: Let me put it another way without being specific. If a modern-day veteran suffering from PTSD has various ailments and recovery time and they wish to go to the Perley—for whatever reason, they feel psychologically or physically better at the Perley—would they have access to the Perley?

● (1030)

Mr. Bryson Guptill: They would have access—

Mr. Peter Stoffer: It's a yes or no question.

Mr. Bryson Guptill: The answer is yes. But let me try to describe to you what happens at Perley.

Perley is basically a nursing home. It's largely reserved for people who are suffering from dementia. Most of the patients there are 85 years old. There is a wing in Perley that is a community wing. It has 200 beds. The veterans wing has 250 beds.

If a Canadian Forces member were deemed, through an assessment process...and this is important, that it be through an assessment process. So if they were deemed to need, as a result of their rehabilitation need, nursing home care, under the new veterans legislation they could get the care at Perley.

Mr. Peter Stoffer: Thank you.

The Vice-Chair (Mr. Brent St. Denis): Thank you, Peter.

Bev, I think you wanted to continue.

Mr. Bev Shipley: Yes. I may not take all my time.

I'm so encouraged to hear—and I would encourage you still, as a Canadian organization, to spend the time and resources, to partner our money with those in research and development in other countries. I don't think we can emphasize enough the significance of not tripping over top of one another's research but benefiting from the research that has been done in partnership.

I want to touch base on the clinics. I think a number of things have happened over the years and are unfolding now. A number of things are coming on stream for the veteran, with the Charter of Rights, the ombudsman, a bill of rights, and looking at the health care of veterans. The emphasis is on helping them in terms of early diagnosis and prevention from getting into serious situations.

As Mr. Valley and others mentioned with regard to these clinics, what about the specialists? What about the GPs? What about the staff for these clinics? Where are we at in terms of the follow-through, so that it's not taking us partway and then not having the specialist at the final stages to do the proper treatment?

Mr. Bryson Guptill: As I mentioned earlier, we have the ability now to hire those individuals as we need them.

Mr. Bev Shipley: Are they available?

Mr. Bryson Guptill: We have been able to get them, yes. I'm not saying it's been an easy task. I think the challenge is still there.

One of my concerns is that if we hire these resources, generally they come out of the community they're in. Once they become dedicated to us, they're not available to the community any longer. So there has to be a capacity to backfill for them too.

So we haven't run into difficulties where we haven't been able to find the resources, but it is an ongoing challenge. There's a shortage of resources across the country.

Mr. Bev Shipley: When you pull them from a community, what is the reaction in that community? Maybe some of these specialists have the sense that this is where they actually want to be, for whatever reason. It may be because of their commitment to their country, to the veterans, to our armed forces people, and that's credible.

I would suspect that in a community there's a lot of respect for that, for a specialist who takes that stand. The other side, of course, is that it likely creates a vacuum within that community. How do you deal with that?

Mr. Raymond Lalonde: If I may, we deal with it by asking our clinics, our specialists, to give back to the community in support, in providing training and education, and working with them in dealing with the clients we have in a community.

So there is some give and take. We take for our clients, but we want to ensure that....

One of my mandates is to increase the knowledge and awareness around treating trauma and operational stress injuries. This benefits the whole community afterward.

Mr. Bev Shipley: What you're trying to do, then, is to generate a win-win within a community and for the veterans.

I have another question. How closely related are anxiety disorders and PTSD?

● (1035)

Mr. Raymond Lalonde: PTSD is a diagnosis where some of the symptoms are intrusion thoughts—the thoughts are coming back, and you have avoidance. With an operational stress injury, it's not only a trauma that can cause a condition to develop.

As Bryson was saying earlier, the most common mental health problem in the Canadian Forces is depression. Anxiety and depression are specific diagnoses that may be related to just the stress of being in operation. If you're there and you're away from your family, etc., and you're always nervous and you develop depression, we call those operational stress injuries. PTSD is a trauma that has its own set of criteria and symptoms associated with it.

Mr. Bev Shipley: And I guess at the end—

The Vice-Chair (Mr. Brent St. Denis): Please wind up.

Mr. Bev Shipley: Obviously we're looking to not only deal with PTSD, but other operational stress injuries that occur. You don't have to give us this now, but in terms of moving ahead to next steps for us to make the improvement, I would be looking, and I think the committee would be looking, for some direct recommendations to follow through on.

The Vice-Chair (Mr. Brent St. Denis): Thank you, Bev.

Mr. Bev Shipley: That's just a question to be left.

Thanks.

The Vice-Chair (Mr. Brent St. Denis): Gilles Perron, please.

[*Translation*]

Mr. Gilles-A. Perron: I'm going to ask a couple of short questions and I'd like short answers.

Raymond, what's the waiting time for an appointment at Quebec City's Emergency Hospital Centre?

Mr. Raymond Lalonde: At Quebec City's Emergency Hospital Centre, well, I don't know.

Mr. Gilles-A. Perron: If I said to you it was over a year, would you believe me? It is unacceptable.

Secondly, on the front lines, why isn't Quebec's CLSC network being used for diagnostic purposes or why isn't somebody like Pascale Brillon offering training, for example? It's available, the infrastructure is there. It would cost less than it would to build another centre.

I'm going to give you another example. Let's say that there's a person from Lac Saint-Jean who has to take the bus to go to the Emergency Hospital Centre in Quebec City regularly. That's unacceptable. There aren't 100,000 cases in Lac Saint-Jean, there may be 10. In Abitibi, there are perhaps seven or eight, maybe a dozen in the Bois-Francs, in the Sherbrooke region.

We really must find a way of starting the diagnostic process in the local communities. We have the tools we need in Quebec. Why don't you meet with people from the association of psychologists, the CLSCs, and others? We have the tools and the infrastructure; what we need to do is use them.

Mr. Raymond Lalonde: When you talked about the Emergency Hospital Centre, what were you referring to? Were you talking about our clinic in Quebec City?

Mr. Gilles-A. Perron: Yes, the Quebec City clinic.

Mr. Raymond Lalonde: No, the waiting time isn't a year.

Mr. Gilles-A. Perron: The waiting time is one year.

Denis Boucher is on the waiting list. He has an appointment in the last week of May, but he's been waiting for a year.

Mr. Raymond Lalonde: There have been problems with staffing changes at the clinic. Our objective with the OSI clinics is to provide appointments with a maximum wait of 15 working days. We're currently holding discussions with clinic staff to increase resources so that we can meet this objective.

Secondly, it clearly isn't our goal to treat everybody at the clinic. However, when it comes to assessments and for some period of time, it may indeed be that the best place for treatment is the clinic because we have an interdisciplinary team. But we do want the majority of our clients to be cared for in the community so that they don't have to travel.

That's why we want to work with service providers in the Lac Saint-Jean region, for example. We want to increase their knowledge base through interaction with professionals at our clinics so that patients only come to the clinic to get a proper assessment or when the treatment requires an interdisciplinary team, including psychologists and psychiatrists, for example.

Mr. Gilles-A. Perron: I agree with you. You play the same role as the Cardiology Institute in Montreal.

Mr. Raymond Lalonde: Exactly.

Mr. Gilles-A. Perron: I agree with you there, but you have to get a foot in the door in order to get treatment, and that can take a very long time. That's unacceptable.

Mr. Raymond Lalonde: We have a plan to address that, and our goal is that no one will have to wait more than 15 working days to get an initial appointment at our clinics.

● (1040)

Mr. Gilles-A. Perron: I have another concern which, I know, has nothing to do with your system. I'd like to know what needs to be done to prevent post-traumatic stress disorder. Ms. Brillon and Mr. Guay, who appeared before the committee, told us that this was possible. I am sure you've met them, they have patients who are in the military and also patients at Ste. Anne's Hospital.

I find it regretable that Ms. LeBeau came and told us that National Defence will give our young troops a three and a half-hour training course on post-traumatic stress disorders before they leave for Afghanistan in August. These young people don't even know the disorder exists.

And yet, his booklist the various symptoms, so people can self-diagnose and realize they might have a problem. Why isn't this being taught, why isn't there more training given at National Defence? Is anyone putting pressure on you to do this? One of you said earlier that the faster someone is treated, the better their chance of success. So it follows that victims of PTSD should be treated on the front line, in the theatre.

Mr. Raymond Lalonde: Obviously we're not experts when it comes to National Defence's programs and services, but what I can tell you is that National Defence is working hard to identify unstable people, including people who may suffer from mental health issues as a result of family or personal problems, for example. It won't help the Canadian Forces if you send troops away on a mission who are likely to become chronically ill and may be forced to leave the Canadian Forces. One of the problems force members have talked about is that often they are so eager to go on a mission that they won't necessarily talk about all their problems. There's also a taboo associated with mental health issues, not to mention troops' desire to do their duty as part of these missions.

Mr. Gilles-A. Perron: I believe you. In Valcartier, the second floor, where the psychologists' office is located, is nicknamed the stairwell of shame.

The Vice-Chair (Mr. Brent St. Denis): They're good questions, Gilles.

Mr. Gilles-A. Perron: Thank you.

[*English*]

The Vice-Chair (Mr. Brent St. Denis): Thank you, Raymond.

Now, the only outstanding request for questions is from Roger, for a very short one. Anybody else?

Okay, Roger, for a short one, and then we're going to suspend for a minute while we thank the witnesses.

Mr. Roger Valley: Thank you, and I'll be very quick.

Slide 16 talks about leadership. We know governments come and go. In fact, we're going to change this one out shortly, but we want to —

[*Translation*]

Mr. Gilles-A. Perron: We don't engage in politics here.

[*English*]

Mr. Roger Valley: You mentioned the collaboration with the World Health Organization. I want to know who's leading in the world on your mental health strategy. Who's leading in the world? Who can we learn from? Are we there? Are we close?

Mr. Bryson Guptill: It's a difficult question to answer as to who's ahead. There's a lot of research in this field. Certainly in terms of the volume or the amount of money spent, the U.S. is leading the pack in the research. They probably have more people diagnosed with PTSD as all the other countries together. There's been research going on in the U.K. as well. They've taken a slightly different tack. Australia has a lot of research going on in this area.

We have a subgroup of our overall collaborative work with the western countries, the western allies, to share some research in this area. As I mentioned, Dr. Pedlar is the person who actually deals with this and could speak to your committee at some point if you wanted more details.

Mr. Roger Valley: Thank you.

The Vice-Chair (Mr. Brent St. Denis): Thank you very much, Mr. Guptill and Mr. Lalonde. You've helped us immensely today. No doubt our interim report on this matter, which we're going to be discussing in the near future, will be greatly influenced by your assistance today. So thank you.

With that, we'll take a one-minute suspension while our witnesses leave their chairs before we go to the other business. Betty has asked during that minute suspension to make a presentation. Apparently she would like Gilles and Roger to pay attention.

● _____ (Pause) _____ ●

The Vice-Chair (Mr. Brent St. Denis): We have a motion submitted by me. I'm not going to speak to the motion. It's self-evident, so we'll give Betty first dibs.

● (1045)

Mrs. Betty Hinton: I don't need to have first dibs. I just want to get in the line.

The Vice-Chair (Mr. Brent St. Denis): Okay. Perhaps Roger can go ahead, and then Betty, and if we don't finish it, because we have to be out of here for the next committee, it'll be on the list with Betty's motion and Peter's next week.

Okay, Roger.

Mr. Roger Valley: I'll be very quick, considering I'm speaking on behalf of you.

We don't want to talk too much about the frustration of finding out that some of our work has been circumvented. The fact is you've sent a very clear message here to the minister: give us some direction, give us some guidance on some of the issues you mentioned, one, two, three, and four. We want our work to be taken very seriously at committee. We don't want to be upstaged in any way. We also realize the Prime Minister has the prerogative to do things, but let's be serious. If the committee is going to do work, let's do our work, and this motion will give us some direction from the minister.

Thank you.

The Vice-Chair (Mr. Brent St. Denis): Betty.

Mrs. Betty Hinton: The first thing I would ask is why are we asking for direction from the minister when it's this committee's work? We don't need direction from the minister to do the job we have been given by Parliament at committee, so I don't accept that part of it.

There are four points here, but I think the third is the only important one for this committee. Is the minister or the government open to suggestions, including adding enforcement measures to a posted statement of rights? Obviously the government is open. This committee has yet to finish its report, which I believe is very important for us to do.

There's always room to improve anything, so I'm not going to vote against this motion; there's no reason to vote against it. But the question I'm asking you very clearly is, why are we asking for the minister's advice when this is the committee's mandate?

The Vice-Chair (Mr. Brent St. Denis): David.

Mr. David Sweet: I agree. Let's finish it now. I mentioned earlier that I felt concerned about the process, that we're to make recommendations as far as legality. We had the legal people in here and had some good testimony about it. We had a full discussion about scheduling, importance, and everything. This delays the bill of rights by sending that and waiting for a response or our recommendations on that to the minister.

Mr. St. Denis, I will support the motion.

[*Translation*]

The Vice-Chair (Mr. Brent St. Denis): Would anyone else like to speak?

[*English*]

Roger.

Mr. Roger Valley: Thank you. The last thing we want to do is become redundant. We know that the committee can give all the advice it wants, but the Prime Minister has made it clear what he wants on this, so who is he going to listen to? Is the government prepared to give the bill legal standing? I think we need to know.

● (1050)

The Vice-Chair (Mr. Brent St. Denis): Are there any other comments or questions?

Then I guess I can ask if there is unanimous consent to adopt the motion.

(Motion agreed to [See *Minutes of Proceedings*])

The Vice-Chair (Mr. Brent St. Denis): The motion is adopted, and Mr. Anders will be instructed to send a letter.

Gilles.

[*Translation*]

Mr. Gilles-A. Perron: I have two questions to ask Ms. Hinton. When will the vote on the report tabled in the House take place? And has the department started thinking about a bill, or drafting a bill, in relation to the ombudsman's report?

[*English*]

Mrs. Betty Hinton: I'm very flattered that you think I have all these powers, Gilles, but I don't.

Mr. Gilles-A. Perron: You have the right ears.

Mrs. Betty Hinton: Those are questions you will have to ask the House leader regarding tabling—or the minister himself. I certainly can't answer them for you.

Mr. Gilles-A. Perron: But did you check with your leader if he has an idea? I'll check with my leader.

The Vice-Chair (Mr. Brent St. Denis): When the Prime Minister announced the bill of rights and the ombudsman at Vimy, did he refer to the ombudsman having a legislative element or not?

Maybe I could add that to Gilles' question and leave it with you.

Peter.

Mr. Peter Stoffer: I gave the clerk a notice of motion for the next time we appear. It's that this committee ask the Department of Veterans Affairs officials to appear before us to give us an update on the status of the department's health care review.

I read the papers periodically, and I hear that the department has an ongoing health care review. I would like to know where they're at. If they announce it tomorrow while we're going through this again, I don't think we in opposition, or even yourselves, would like to be usurped in any way. So maybe just let us know if they are in the middle of it, near the end, or at the beginning.

The Vice-Chair (Mr. Brent St. Denis): Betty.

Mrs. Betty Hinton: If they weren't looking at this health care review they wouldn't be doing their job, so obviously they're supposed to be looking at it.

Mr. Peter Stoffer: I disagree.

Mrs. Betty Hinton: If you'll let me finish, both the government and the department are waiting for this committee to hear its witnesses and make recommendations.

The more things get in between that happening—and I'm not faulting any of these. PTSD is a very important subject, all of these things are very important, and I know they're important to all veterans. But if we don't move forward and get moving on that health care review, we'll be doing a disservice to veterans. The House is only going to sit from now until the middle of May. We have only seven or eight weeks left, so we need to move forward.

Mr. Roger Valley: Is something coming up in the middle of May that we don't know about?

Mrs. Betty Hinton: It's eight weeks. We have a break in there, and then usually we go to the middle of June.

Mr. Roger Valley: Sorry, I was trying to—

Mrs. Betty Hinton: Were you trying to be funny?

Mr. Roger Valley: No, I'm following David Sweet over there.

Mr. Peter Stoffer: Then I would give this advice to Madam Hinton. Gerald Lefebvre, who's the spokesperson for Mr. Thompson, said, and I quote, “until we have completed the full health care review”. It doesn't say until we work in collaboration with the veterans affairs committee. The thing is it says “until we have completed”. Who's “we”?

If they're waiting for us to give them recommendations, then they should say that, because in the paper it says very clearly "until we have completed the full health care review".

Mrs. Betty Hinton: Peter, we agreed as a committee at the very beginning of this that we were going to study the health care issue and we were going to make recommendations.

Mr. Peter Stoffer: Right.

Mrs. Betty Hinton: So when he's using "we" in his sentence—I mean, I didn't say those words.

Mr. Peter Stoffer: No, he said them.

Mrs. Betty Hinton: I know. He said those words. My assumption is that he's referring to the royal "we", if you will—all of us. So he's waiting for input, and this committee has yet to begin on the health care review.

Mr. Peter Stoffer: Would it be possible then, if it's the will of the committee not to have the officials here, to have a letter from them stating where they're at? Are they near completion? It would be nice to have the department say, "We're waiting for the committee's recommendation before we make our final summation." That would be nice to hear.

Mrs. Betty Hinton: All right. I'll take that message back. I think it's an unspoken assumption on the part of the department that they understand this committee is going to be looking into the health care review. They're waiting for us to do that to give them our recommendations.

Mr. Peter Stoffer: And I agree, but the thing is I thought it was an unspoken thing, too, that they would wait until we completed our bill of rights recommendations.

Mrs. Betty Hinton: Peter, if you're more comfortable having everything spelled out for you, I'll do that for you. I'd be happy to.

● (1055)

Mr. Peter Stoffer: That would be great.

Thank you.

The Vice-Chair (Mr. Brent St. Denis): Are you going to hold your motion pending Betty's response?

Mr. Peter Stoffer: That is correct.

The Vice-Chair (Mr. Brent St. Denis): So we're just going to withdraw that motion for the time being.

Is there anything else?

Thank you very much, colleagues.

The meeting is adjourned.

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