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Chair

Mr. David Sweet

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● (1545)

[*English*]

The Chair (Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC)): We'll begin our meeting now. Other members will arrive. I know there has been some delay due to votes.

We have three witnesses here from Veterans Affairs Canada. I also want to tell you that we'll have some time for business at the end of this meeting. I'm concerned because one of the debates about business will be what we'll use for all the contributions for a gift for the clerk. I wonder how long that will take. We'll suspend at 5:15 for committee business, if that pleases the committee.

Right now we'll go to the officials, Darragh Mogan, Brenda MacCormack, and Doug Clorey, from Veterans Affairs Canada.

Do all of you have opening statements, or just one person? Mr. Mogan, you have an opening statement?

I think you know the tradition of the committee. We give you 10 to 15 minutes for an opening statement, and then we'll go by rotation of party for questions.

You may begin.

Mr. Darragh Mogan (Director General, Program and Service Policy Division, Department of Veterans Affairs): Thank you very much, Chair and committee members, for having us here.

My colleagues, Brenda and Doug, will provide an introductory briefing on the new Veterans Charter, as you begin your examination of this. The briefing will be about the policy foundation of the charter, its content, the outcomes we've had to date, and possibly the future.

[*Translation*]

It's a privilege for me to introduce Doug Clorey, Director of Mental Health Policy, and Brenda MacCormack, Director of the New Veterans Charter Program.

[*English*]

Brenda will give a brief oral overview of the deck material that you have been sent. I hope that's been distributed, Mr. Chair. Then Doug will talk briefly about the mental health aspect of it.

So if I can, Mr. Chair, I'll turn this over to Brenda.

Ms. Brenda MacCormack (Director, New Veterans Charter Program, Department of Veterans Affairs): Thank you, Mr. Chair and committee members. I appreciate the opportunity to be here today to provide a brief overview of the new Veterans Charter. We will also provide some information on the mental health context, as well as put the programs into context.

I would like to walk you through a bit of the pre-NVC context and some of the issues we were facing at the time. I will talk about the solutions we arrived at and give you a synopsis of some of the facts and figures at present, now that we are three years in, and talk about the mental health context.

To demonstrate how this works for veterans on the ground, we'll provide you with a few veteran profiles so you can understand the nature of the clients who come before us, then we'll finish with some of the challenges and the opportunities.

In terms of the context of the 1990s and into the early 2000 period, we were seeing an increasing number of Canadian Forces veteran clients. Of course, you are aware that there was an increased operational tempo within the Canadian Forces. We also recognized at that time that we did not really do a lot for families in terms of the services that we offered.

The chart on page 4 gives you a little bit of an outline in terms of the changing demographic and provides you with some insight into the types of client groups we were dealing with. While we were seeing the increased operational tempo with the modern-day veterans, we also were seeing a decline in our traditional vets and an increased need with that group. It created a bit of pressure in terms of the varying needs of client groups.

To put the challenges in some categories, we were seeing CF veterans who were not transitioning successfully out of the military, and we knew the families needed support. We didn't have a holistic, comprehensive, integrated kind of approach to how we were managing transition out of the military and the ongoing success of transitioning CF veterans and their families.

Our response in terms of the programming we had at the time was our ability to offer a disability pension and associated treatment benefits, but there was no income stream into the future. There was no rehabilitation, so really the only mechanism that veterans had to get greater assistance was to be more ill and get more money through a disability pension. Of course, at that time the processing times for disability pensions were lengthy as well, so that compounded the problem of getting to people early.

At that time we were really feeling that our response was inadequate. The problems were not being solved and our liability was increasing, so our solution was to create the suite of programs that has become known as the new Veterans Charter. The investment that we made was to focus on wellness. As you'll see as I go through the programs, that represents the multi-faceted response that really changed the nature of government's response to dealing with this particular group.

Were I to summarize it in a particular phrase, I would say that the new Veterans Charter is meant to respond to individual client needs, to provide services and interventions based on needs, and to provide transitioning members and veterans and their families who are out of the military with opportunity and security.

Another key point is that the focus has been and continues to be trying to achieve a seamless transition from the military. As we go through the programs I'll speak about each of the programs individually, but the programs are intended to work in an integrated fashion. The strength of the programs is in the sum of all of them working together and being responsive to needs. At the time the programs came into being in 2006, the government made a commitment to invest $1 billion in these new programs over the first five years.

Rehabilitation is really the cornerstone of the new Veterans Charter in terms of offering that wellness kind of focus. It's a very comprehensive program that is supported by case management, and the design criteria of this program allow quite a bit of scope in terms of what we offer to clients. It focuses holistically on the client and the family, offers medical services and psycho-social types of supports, as well as vocational.

● (1550)

So the program is not just about getting people back to work, because sometimes that's not possible. It's about improving their quality of life and their functioning at an individual level, community level, and vocational level, if that indeed is appropriate.

There's an accompanying financial benefit package that is part of a dual awards scheme. The financial benefit piece is really about recognizing that there are economic impacts associated with disability, whether they're service-related or career-ending. There's a package of benefits outlined here that's really intended to provide earnings loss benefits for people in rehabilitation, supplementary retirement benefits, and other supports we can perhaps look at in more detail at another briefing.

The disability award is the other part of the economic compensation intended to provide recognition for the impact of service-related disability on the quality of life of the individual. It is a tax-free cash award that's payable based on the level of disability of the individual.

There's also access to health benefits—the public service health care plan—which is really about filling gaps and providing access to that plan for those who would not otherwise be eligible for it.

There's also a job replacement program, which is really a career transition program for folks who are well and who are transitioning out of the military. The package in its entirety is aimed at all of those who are transitioning out of the military, whether they're ill or injured, or whether they choose to leave on their own or they're at a point where they're retiring. So the job placement program is focused on providing career transition types of services that enable them to find employment when they transition to civilian life.

The backdrop of all of this is really case management, which is paramount in helping the client navigate through the system where required, to make sure that the supports are offered at the appropriate time, and to work with the Canadian Forces to ensure that case managers are working in a collaborative fashion as people transition out of the forces, and to continue to work with them as they make that transition.

We've also outlined that there are a number of family supports available through the charter. I won't go into detail on them, but there is a recognition within the charter that the family is paramount in terms of our recognizing their needs and what supports they might require to enable the veteran to make that successful transition, and to maintain that successful transition to civilian life. I've highlighted a few of them on slides 16 and 17.

To date we've assisted close to 13,000 veterans and members and their families. I've outlined some of the program activity pieces, showing how many decisions we've made in particular program areas as well as the favourability rates.

I'll ask Doug now to provide a bit of information on the mental health context, and then we'll just briefly go through a few client scenarios to give you a feel for the program.

● (1555)

Mr. Doug Clorey (Director, Mental Health Policy Directorate, Department of Veterans Affairs): Good afternoon, everyone.

Although this presentation is on the new Veterans Charter, we felt it was important that you have an understanding of the mental health context in which the new Veterans Charter is provided. As I understand, Mr. Chair, there will be a separate briefing on the full mental health strategy of the department within the next few weeks. Hopefully we'll get into a lot more detail there.

Slide 20 speaks about mental health generally within the Canadian context. Essentially, one out of five Canadians lives with a mental health condition during their lifetime.

The second bullet is interesting as well, because in the Canadian context of those who have need of mental health services, only one-third actually access them, so two-thirds don't. That seems to have some effect also in terms of the specific population we serve. The economic impacts are listed there as well. It's a significant cost to the Canadian economy.

In terms of the extent of need for mental health services, you would be familiar with this, I believe. The increased CF participation in military operations, the combat style of missions, and the more frequent deployment of members of the military with less time to recover and recuperate between deployments have all contributed to increased mental health conditions within the military.

The last bullet on slide 21 speaks to the results of the 2002 Canadian community health survey, on CF members in particular, which identified the four major categories of mental health condition within the military. In order of prevalence, they are depression, alcohol dependency, social phobia, and PTSD. The interesting thing there is that this is the order in which they occur. PTSD, which is obviously very much in the media these days, is actually fourth in the list of the mental health conditions that are experienced.

In terms of clients within the Department of Veterans Affairs who receive disability benefits as a result of a mental health condition, as of the end of March we had 11,888 who have received a favourable decision for disability benefits associated with a psychiatric condition. That breaks down into roughly 63% CF veterans, of whom 12% continue to serve in the military; 24% war service veterans; and 14% RCMP members, of whom 5% are still serving. It is important to note that our strategy on mental health in the department is not just for the CF veterans; it's also for the older veterans. It scans the whole spectrum of mental health conditions, from those related to service at a younger age to those dealing with dementia, Alzheimer's, and all of those related conditions. We've seen an increase in clients of about 8,000 since March 2003. That represents about 1,500 to 1,600 new clients every year with a psychiatric condition who enter our books.

Of all of these clients, 68% have PTSD. Again, I would recall the previous slide, which showed that two-thirds of all of our clients who come forward do so with PTSD. One of the implications there, and we may wish to speak to it at some point in time, is that PTSD seems to be a condition that members of the military and veterans are more open to coming forward with, as opposed to, say, depression.

The third bullet shows the connection with the new Veterans Charter rehabilitation program. We see that 60% of clients coming into rehabilitation—which is a conservative estimate at this point, and it's probably quite a bit more than that—are coming in with a mental health condition as well. That creates a dynamic and a complexity around rehabilitation that is quite significant.

Slide 23 has the breakdown of the numbers more specifically. Of the 2,591 rehabilitation clients within Veterans Affairs, about 1,600 or so have mental health conditions. So it's a significant percentage of clients with mental health conditions that we are trying to rehabilitate into society.

● (1600)

Slide 24 is a very brief summary of our mental health strategy, which is essentially providing access to or in some cases providing within the department a suite of mental health services and benefits that will assist veterans and their families to regain functioning. It's focused on early intervention. The earlier you are able to intervene with these individuals, the more chances of success of recovering and maintaining and retaining full functionality within one's life.

We're also trying to focus on all aspects of life that support mental health and well-being, which we think is unique within the Veterans Affairs mental health programming. It isn't only about health services through psychiatrists and psychologists and other health professionals, but it's also about providing social support, economic support, physical support in the home, and also dealing with individuals on a one-to-one basis based on the World Health Organization's whole-of-person, whole-of-life perspective. We're also building capacity, exercising leadership in the field of mental health, and doing this in partnership with many others.

I won't go into slide 25 in detail, but it's a sampling of some of the services we provide to assist veterans and their families in regaining their mental health and well-being.

Mr. Darragh Mogan: Mr. Chair, we have a scenario up there. We're beyond the allotted time by a couple of minutes. I don't know whether you want to go through those or just have them there for members to look at as the questions go. I'll leave that to your guidance.

The Chair: What is your timing? Is it another five minutes?

Mr. Darragh Mogan: Another five minutes would be great.

Brenda, do you want to walk us through those scenarios?

Ms. Brenda MacCormack: We've included two or three veteran profiles to demonstrate how the program works on the ground for veterans and demonstrate the needs-based approach in terms of the intervention that's provided. It's very much based on the individual coming forward and what their needs are. You'll see as we go through the profiles that they certainly have varying levels of needs.

The first profile is Justin, who voluntarily released from the military and just needed some career transition, résumé writing type of help. He was able to secure a job he's very pleased with and certainly has provided some very positive feedback in terms of what that program meant to him in transitioning.

The second client, John, was medically released back in 2001. That's five years before the new Veterans Charter came into effect. This particular veteran was quite sick when he came into the program, exhibiting acute symptoms of PTSD, dealing with alcohol, dealing with criminal charges, and marriage stresses, with his wife also being a CF member.

Slide 30 outlines some of the interventions we were able to provide to John in terms of counselling, engaging his family in the plan, providing peer support, and building a trusting relationship. We're beginning to make some headway with this particular client, but I think this demonstrates some of the complexities we're facing. It also demonstrates how clients can come back to the program as many times as they need to. This client would have had some assistance coming out of the military, but he's still struggling, so he will come back and we'll work with him again. At this point, this is a veteran we're continuing to work with. He's still unable to work. We're continuing to help with improving functioning at a family and community level. The marriage certainly remains stressed. Again, that is part of one of the goals we're working on with him, and we'll see over time whether our vocational goals can be achieved.

The last one is Greg. This would be an example of someone who came out of the military with a fairly serious disability back in 1996, being a bilateral amputee, below the knee amputation, but who transitioned well out of the military. He stayed home for a number of years and was the primary caregiver to two young sons. The sons are now in school, and he feels he wants to contribute more to his family situation. We're able to offer those supports to Greg through the programming with some additional prosthesis to allow him to do the work he wants to do and the training that is consistent with what he would like to do in terms of moving forward. He has been very successful and is on his way to a final work term in the marine industry.

Again, this highlights some of the varying levels of need that are presented.

● (1605)

Mr. Darragh Mogan: Mr. Chair, in the scenarios we purposely did not put the amounts of the benefits the individuals received. They're fairly extensive in the latter case, and we can do that; however, we wanted to show what the outcomes of our interventions were compared to what we would have been able to do before the new Veterans Charter, which would have been to give a person a pension, and that would have been it.

That was the purpose of this scenario. Thank you very much for your patience.

The Chair: Thank you very much, Madam MacCormack, Mr. Clorey, and Mr. Mogan.

We'll go to questions now. We'll begin with the Liberal Party and Madam Sgro.

Hon. Judy Sgro (York West, Lib.): Thank you very much, Mr. Chair, and thank you all very much for coming today.

You've given us an enormous amount of material here, and you went through it very quickly. I think probably all of us have a lot of questions. I have to salute you all for the work you've done on this document, because it's very impressive. I think all of us want to ensure that our veterans, the older ones and the younger ones, are receiving the care and respect and assistance they need. I appreciate in particular having the scenarios for Justin, John, and so on to give us a better idea of exactly what you're facing and what kind of support is there.

On the job placement side, when you're trying to assist people to get back into the system, are you able to get preferential treatment from employers for men and women who have been in the service? Do they recognize the individual's qualities and the contributions that he or she has made to our country? Do they get preferential treatment when looking for a job?

Ms. Brenda MacCormack: The job placement program is targeted at those who are voluntarily releasing, people who generally choose to leave. I can say that there's a great deal of interest in the community at large to hire ex-military. I think they're well recognized for the skills they bring and the leadership they can offer. At this time, yes, I think there's certainly lots of interest out there.

Through the changes to the Public Service Employment Act, there are some opportunities as well for those who are medically releasing to have priority access to federal public service jobs. That is absolutely priority access. There's also an opportunity for those who are still in the military—serving members—to apply for government jobs, public service jobs, that are open to that CF population.

Hon. Judy Sgro: Prior to the living charter coming forward, what kinds of services would John or Justin have received?

Ms. Brenda MacCormack: Before the implementation of the new Veterans Charter, they would have received a disability pension if they had a service-related disability. The amount that would have been payable would have been based on their level of disability and any treatment associated with that, and if the disability was minor, it might not be a significant amount. There would be no capacity to provide any kind of an earnings loss stream and no capacity to focus on what kinds of interventions might be required from a rehabilitation perspective to allow them to reintegrate themselves and their families back into civilian life.

For those releasing on a voluntary basis, there was no capacity to have a national approach to finding them jobs that matched the skills they had.

● (1610)

Mr. Darragh Mogan: I might add that there was no support for families. It's different for families now. People have a career in the military, as opposed to the situation at the end of the Second World War, when after three years of service in a civilian army, they went back home.

They don't have a home to go back to, so we need to support the families that have been moving from base to base and have experienced deployments of people overseas in increasingly risky operations. We didn't have any capacity to support them, and we do now.

We were offering the case management service primarily to traditional veterans and not to the modern veterans, and the modern veterans with severe disabilities really need that kind of help. A number of things that were both benefits and services didn't exist before the charter, and they exist now. Of course, our mental health capacity has been greatly strengthened as well.

Hon. Judy Sgro: With respect to the issue of mental health, we were talking a lot about PTSD and the new clinics and services that are being made available. At one point, many of those services would have been referred to as mental health services. What is the difference between mental health services and PTSD? Are they not similar?

Mr. Doug Clorey: PTSD is one of many mental health conditions. When we speak of mental health services we're talking about services that address a variety of mental health conditions, PTSD being one, but also depression, anxiety disorders, social phobia, any of those. The operational stress injury clinics focus on all the operational stress injuries. So it could be any of those, but it tends to be primarily post-traumatic stress disorder.

Hon. Judy Sgro: Even though we are in 2009, we still haven't got over the stigma when you talk about mental health, especially for men and women coming from the military. We all know they've had a horrific experience, especially our younger men and women. For them to go to a clinic for PTSD I would think would be a much more acceptable and an easier transition for them to say they're experiencing various things and get help, rather than 20 years ago, or 10 years ago, going and saying there's a mental health condition there. Are you paying some real sensitivity to those issues of wording and terminology?

Mr. Doug Clorey: Absolutely. We speak of operational stress injuries exactly for that reason. It was understood that to talk about mental illness within the military had such a large stigma that individuals would not come forward to access treatment or any other services. So DND coined the term "operational stress injury" so there was an understanding it was related to operations; it was like any other injury, physical or mental: it's an injury and it was related to the stress related to the operations. Just that nomenclature has gone a long way, especially within the military and the veteran community, to reduce the stigma associated with mental illness and to allow people to come forward to receive the services they require.

Hon. Judy Sgro: Are the men and women in the reserves entitled to all these services as well?

Mr. Darragh Mogan: Yes, there's no distinction.

Hon. Judy Sgro: There's no distinction.

Mr. Darragh Mogan: Being reserve service, the difficulty of course is finding them, because they can come and go at will. That's the challenge, to make sure that when they leave the military.... We offer a transition interview to anyone who is leaving the military, but if you don't come back for a second or third contract when you're on reserve we don't see you again. That's a real challenge. We have a special initiative on outreach to reservists because we believe there's a hidden problem there in terms of transition to civilian life that we need to track better than we have.

The Chair: Thank you, Mr. Mogan.

Thank you, Madam Sgro. It's seven and a half minutes.

Monsieur André.

[*Translation*]

Mr. Guy André (Berthier—Maskinongé, BQ): Good afternoon.

I have a few questions. With regard to trauma and operational stress. Have you developed, through years of research, ways of further preventing operational stress in the people we send on military missions?

With the new charter, we see that you have developed rehabilitation programs to help veterans with operational stress. What results have you achieved?

We're talking about mental health problems. Are there any other mental health problems found among former military members apart from operational stress? What are those types of diseases? In Quebec, how do you cooperate, for example, with the CLSCs, which provide front-line services?

I know very well that stakeholders have expertise with regard to certain mental illnesses, but others have less. Do you provide training for specialists, caseworkers, psychologists through health facilities in Quebec and Canada to enable those professionals to provide services to these people near where they live?

We talk about people in rural areas who often have to travel very far to access services. What are you doing in that regard? Do you have any projects to improve the quality of services for those persons?

● (1615)

[*English*]

Mr. Doug Clorey: I will start. There are many questions here.

In terms of preventing operational stress injuries, your first question, one of the findings in research is that the best way to prevent, if you can prevent, is to build resilience so you have an opportunity to be more prepared for what you are going to deal with. Very often where we find ourselves in Veterans Affairs is very much downstream, where the opportunity to prevent the operational stress injury is not there because it has already occurred. I cannot speak for the Department of National Defence, but I know they are working very hard at trying to build resilience in the members of the military so they are better prepared to deal with what they have to deal with and hence to avoid some of the operational stress injuries that occur, we hope.

The other area of prevention is education. Here we are doing quite a lot in terms of building awareness, as are the Canadian Forces, to reduce stigma, to get across the idea that a mental health injury is an injury, just like a physical injury, and it needs to be approached in a very similar way in terms of approaching various agencies for services, treatment, and whatever benefits are required.

The second question, on success in terms of rehabilitation, Brenda may wish to speak to. The approach we take in Veterans Affairs is that recovery is possible and that recovery should be the norm. So we approach the delivery of services as if there will be a recovery at the end.

Our statistics are really not that sound at this point, in terms of lifetime projections. How successful have we been over the lifetime of an individual? That's really hard to tell. But the approach we use is that the individual will be able to recover, and we work toward that end.

In terms of other mental health problems, yes, what we see in veterans is reflective of the general Canadian population. We will see all kinds of mental health problems, some of which are related to operations and some of which are not. So it's not unusual for us to see that.

In terms of collaborating with local agencies, as in the province of Quebec, we very much try to do that, primarily with our district offices. We also work very closely with our operational stress injury clinics to reach out to these agencies to provide education awareness training. In fact, there are four functions of the operational stress injury clinics that may be of interest. The first is to provide a comprehensive assessment to individuals; the second is to treat, where it's appropriate; the third is to reach out to providers in the local communities, like the ones you've mentioned; and the fourth is to conduct research.

It's very important for us to reach out to service providers in the community, because these operational stress injury clinics provide only a temporary service. Eventually the individuals will return home, return to the local community, and will need to rely on local service providers in the community. So part of the job is to reach out to them so they are able to provide the kinds of services that are required.

Have I addressed most of your questions?

● (1620)

[*Translation*]

Mr. Guy André: I have a question as well. You talked about resilience as a way to somewhat prevent operational stress.

I know that, when people are in the armed forces, they undergo physical examinations to determine whether they are able to take part in military missions. Is any vigilance exercised with regard to the psychological side?

As you know, some people are more prone to develop operational stress than others. Is any screening work really being done?

[*English*]

Mr. Doug Clorey: Again, this question would be better directed to the Department of National Defence, but I do know they screen in their recruitment phase, both physically and psychologically, and they screen before and after deployments. But you would need to ask the Canadian Forces themselves the details of that. Part of the role is to be able to build that resilience so individuals are able to deal with what they're going to encounter in missions.

The Chair: Thank you, Mr. Clorey.

Thank you, Mr. André. That's seven and a half minutes as well.

Go ahead, Mr. Stoffer, for five minutes.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you very much, Mr. Chairman.

Thank you all for coming today.

Your presentation says your traditional veteran clients are diminishing by about 5,000 each year, but that's your client base. Correct me if I'm wrong: the reality is that we lose a lot more who are not your client base. Is that correct? Thank you.

As you know, the government made a promise in September of last year regarding the allied veterans promise. I wonder if you could tell us approximately when we may be able to see that promise completed in terms of any direction you may have been given.

Also, I assume most of the decisions you've outlined on page 19 are VRAB decisions. Am I correct?

Mr. Darragh Mogan: Actually, most of them would be primary decisions. Some would go to appeal, but it would be a relatively small number.

Mr. Peter Stoffer: Okay.

Would you have a figure on how many people have applied and been turned down a first time? Of course on the letter it says you always have an appeal, but they may not appeal, because they're of the generation that understands that if the government says no the first time, they figure there's no hope. Do you have a figure for how many of those people wouldn't have appealed in that process?

Also, the Royal Canadian Legion has written all of us and has indicated concerns on the living charter in terms of the lump sum payment. That possibly could be looked at. Some veterans are asking for a lifelong pension instead. I wonder if you could address that issue.

Also, I have two people in my riding—in Dartmouth, actually—who went through psychiatric treatment. They were both determined to be cleared, but their children were denied further assistance because the parents were no longer receiving psychiatric help. Since the parents were no longer receiving psychiatric help, that help was cut off for their children. We've heard in testimony that PTSD and symptoms of that nature could be transferrable, but unfortunately their children were denied further assistance in that regard.

The other concern I'm getting in fair numbers relates to asbestos on ships. I have about a dozen cases on my desk from across the country of people who were denied asbestosis claims. We know now that there was asbestos on the ships in the 1940s and 1950s.

There is also the matter of hearing loss. As you know, after the court case a few years ago, DVA was forced to go back and contact all those people who had claimed hearing loss and were denied. I wonder if you can tell us how that process is going and whether it is almost finished.

Last but not least are the hospitals. As you know, the hospitals under DVA—which are now provincially run, except for Ste. Anne's—are for World War II and Korean veterans. What are the plans for those hospitals when the vast majority of those individuals have passed on? Do you plan to open them up for more modern-day veterans, or what would be the proposed plan in that regard?

Thank you very much. I have more, but I'll be cut off very soon. Thank you.

● (1625)

Mr. Darragh Mogan: I'll attempt to answer some of those, Mr. Chair, if I can.

With regard to the question you raised about allied veterans, your question of course requires a political answer, as you know—what, when, and under what circumstances—but it's fair to say, I think, that everybody is interested in helping these individuals as soon as possible, so there is a certain heightened awareness there.

With regard to the percentage of appeals that are required and successful, we'll submit that information to you, Mr. Chair. I don't want to speculate on that.

Mr. Peter Stoffer: I understand.

Mr. Darragh Mogan: That's understood? All right.

With regard to the lump sum versus the annuity or the return of the pension, to an extent it depends on who is asking, because some people want the lump sum paid out as an annuity, which is a possibility if it's invested properly, but you've got to be careful when you're investing these days, as we all know.

Whether we would return to paying out pensions, which by their very nature grow if you can demonstrate a greater illness, apart from a policy point of view, that can and does, I think, run counter to the wellness approach. So I'm not optimistic that there is going to be revision back to the old pension days, but I am quite convinced that there is a ministerial commitment that improvements in the charter are going to be considered as soon as possible.

Mr. Chair, Mr. Stoffer asked about the children of veterans who were receiving psychiatric help, and the veterans recovered and the children didn't. We'd have to look at those cases. I think we have the authority to continue to help those children, so maybe I could get names at the break. We'll have a look at that.

With regard to asbestosis on ships, we're aware of that concern and we're looking into it. I can't give a progress update now, but I can submit one if you wish.

With regard to hearing loss, we certainly are trying to revise our policy in line with the Federal Court of Appeal decision. We are looking back to provide disability benefit decisions in line with the court decision. That policy should be released quite soon.

The Chair: Mr. Stoffer, I have to say that I was already getting some concerns from this end of the table about the long list of questions you delivered, and we're over the five minutes now, so....

Mr. Peter Stoffer: Five?

The Chair: Yes, that's the rotation.

All right, it's now Ms. O'Neill-Gordon, for seven minutes.

Mrs. Tilly O'Neill-Gordon (Miramichi, CPC): Thank you, Mr. Chairman.

And I want to thank the presenters for being with us this afternoon.

My first question is probably just one that I was thinking about. As we know, as we went through all that information, there's certainly a lot of information to be dealt with and to be digested, and I was just wondering this. Is there a means by which the veterans are given a way to understand all they have coming to them and what they deserve to have and what is out there for them and their families?

Ms. Brenda MacCormack: Yes, there is, certainly.

We have a comprehensive outreach strategy we've implemented, which includes taking advantage of every opportunity we have to provide briefings to members while they are still in service and veterans groups while they are out. At SCAN seminars and any general kinds of meetings, we take that opportunity.

We also have a speakers network formed of VAC employees across the country who take opportunities to visit bases and provide information at any opportunity. We have a VAC presence on 17 bases and wings across the country, and we continue to augment that presence as we go forward. That provides an opportunity on a one-on-one basis to impart that kind of information.

Mrs. Tilly O'Neill-Gordon: That is good to know, because there is so much to comprehend, and some of these veterans and their families could overlook some of the things that are available.

Yes?

Ms. Brenda MacCormack: I was just going to indicate, as well, that we also provide a transition interview to all releasing members, as they transition out. So again, that's another checkpoint for us to provide the information. We also have the opportunity to publish in a lot of CF publications, which again affords us the occasion to convey the information about the programs.

Mrs. Tilly O'Neill-Gordon: Good.

Can you provide us with the advantages and a comparison of the disability award versus a monthly disability pension?

Ms. Brenda MacCormack: The new Veterans Charter, as I've mentioned, is really about a very comprehensive approach to meeting the needs of veterans and their families. To make a comparison between a disability pension and the disability award, per se, is probably not a fair comparison. What we really ought to compare is the disability pension and then the entire suite of programs that now is there, which offers security and opportunity and really is targeted at wellness, investing money in terms of achieving wellness types of outcomes, and offering people security and opportunity—the security, really, of knowing those programs are there if something does occur.

So it's much more comprehensive in terms of its approach, and it's based on principles that are very consistent with a modern approach to management of disability.

● (1630)

Mrs. Tilly O'Neill-Gordon: Okay.

How long has this charter been in place?

Ms. Brenda MacCormack: The charter was implemented in April 2006, so we're really just three years in. That's new, in terms of our government programming, so I think we still have a lot to learn in terms of what kinds of outcomes we're going to achieve with what's here. It's an excellent package that we have, in terms of moving forward, and as Darragh mentioned, there's been a government commitment that it's a living charter. So we'll continue to evaluate outcomes, evaluate the programs, and consider options in terms of responding to emerging needs as they occur.

Mrs. Tilly O'Neill-Gordon: Yes. Well, I'm happy to see our government has put this in place and it's working so well, because certainly everyone loves our veterans, that's for sure.

Thank you.

The Chair: There are three more minutes remaining, if someone else has a question.

Mr. Phil McColeman (Brant, CPC): I will, Mr. Chair.

I want to extend my appreciation for your time here today in meeting with us.

Is PTSD more common among traditional veterans or newer veterans?

Mr. Doug Clorey: If you had asked me that several years ago, I would have probably told you that it's much more prevalent in CF veterans. I'm not so sure that's the case any more. It's interesting to see, as war service veterans reach a certain point in their lives, that they start to reflect back on their lives, as we probably all will do at some point, and it seems that as they do that, they start bringing up some of the traumas that occurred when they were younger and that have been repressed for up to 60-plus years.

In fact, there was a study in Australia on Korean veterans. It was really quite astonishing how many Korean veterans, 60 years after the fact, who had apparently lived very successful lives, what one would call very stable lives, and had families, reached a point in their lives where they started to reflect back, and suddenly all these symptoms started to show up and they became clinically diagnosed with PTSD.

So I'm not sure, to answer your question, but I do think what is happening is that there is greater data now, which shows that PTSD, within the military, can show up at any time, either very early on or 60-plus years later.

Mr. Phil McColeman: So it can happen at any time. If you wouldn't mind, I'd like to understand more: what are the major symptoms you see in these folks?

Mr. Doug Clorey: As for what we see, I'm not a clinician, so—

Mr. Phil McColeman: No, that's fine.

Mr. Doug Clorey: —that said, we see a reliving of the experience. When they start exhibiting symptoms of PTSD, these individuals start reliving what they've experienced, very often with great anxiety.

They start to look at separating themselves in safe places. Very often, you will find individuals with PTSD who cannot live in a home, in a traditional kind of setting. They have nightmares, sleep disturbances so that they can't sleep, paranoia, and very often depression. It tends to be a combination of a variety of symptoms that could in their own right be considered mental health conditions.

That is the complexity around PTSD, because it's kind of an amalgamation of a whole series of mental health conditions all rolled into one.

The Chair: Thank you, Mr. McColeman.

Thank you, Mr. Clorey.

Now we'll go on to the Liberal Party, with Mr. Andrews, for five minutes.

● (1635)

Mr. Scott Andrews (Avalon, Lib.): Thank you, Mr. Chair.

Thank you for coming in today.

I'd just like to get into the new Veterans Charter a little bit, get your understanding, and pick your brain a little on moving forward and where we go. Tilly just asked the question; it's been three years now and it's working well. How often would you suggest that you make changes to the charter?

Mr. Darragh Mogan: It may be less a matter of frequency, although if you look at the original Veterans Charter between 1946 and 1953, I think there were three separate periods when that was amended and changed. By the time of the Korean War, there was a statute passed called the Veterans Benefit Act, which added to the World War II Veterans Charter.

To answer your question, though, we try to focus on the wellness and the successful transition to civilian life, with the benefits and services that are there, and allow experience, plus a formal evaluation that we're now undergoing for the new Veterans Charter, to identify gaps. We've already identified some gaps in family support. We're doing this with a large advisory group called the New Veterans Charter Advisory Group, which we just met with today.

On the degree of economic support while someone's on rehabilitation, the question may be, for instance, is it adequate to ask a family of four to survive on 75% of a private's salary for two years while a private is going through rehabilitation? It's better than what was there pre-charter, but it may not be a reasonable thing to ask someone to do. In other words, you may be setting individuals up for failure by not providing an adequate amount of income support while they're going through rehabilitation.

The other area, then, in addition to family services, is the mental health area. We've made extensive progress within existing authority, but I think it's pretty imperative to look at gaps in that area.

As to timing, when we have the information that's there and when the government of the day is satisfied that it's ready to move and has the resources, that's when the movement will be there. We want to build, as I think anybody would want to build, a fairly strong consensus among modern veterans that we've identified where the gaps are. The foundation of the new Veterans Charter is solid, but we've identified where the key gaps are and we can fill them in a timely fashion.

Mr. Scott Andrews: Did you say you have a group right now within the department reviewing the charter?

Mr. Darragh Mogan: We have a group right now called the New Veterans Charter Advisory Group, which is made up of veterans organizations, experts in the area of disability management, and psychological care. It is providing guidance of a professional nature to the government on the experience of the new Veterans Charter and changes that may be needed.

That's certainly not the only area where we're going to draw evidence, but it's one of the key ones where you get a mixture of veterans advocacy groups with a lot of experience and a mixture of academics and health professionals.

Mr. Scott Andrews: Do they have a timeframe for their reporting?

Mr. Darragh Mogan: They'll be reporting some time this year on their deliberations. That will be a public report, and I'm sure your committee will be interested in talking to members of that group, and they're more than willing to be here, I think.

Mr. Scott Andrews: Is that the only group you have reviewing it right now?

Mr. Darragh Mogan: We have a formal evaluation done by our evaluation directorate, which steps outside the current frame and looks at the overall outcomes and effectiveness of the program. It also tries to answer the question that was already asked about whether it is the right trade-off between a disability pension and disability award in terms of investing in wellness? That's a broad two-year evaluation. It was a commitment when there was all-party agreement on this, that this would occur within the first two or three years.

Mr. Scott Andrews: And what is the timeframe on that?

Mr. Darragh Mogan: The first stage of that will be finished this year. It's a two-year one, so it will be done in about 18 months to two years.

Mr. Scott Andrews: Will that be a public document?

Mr. Darragh Mogan: It is a document for your use here and for the public.

Mr. Scott Andrews: I'm just getting to slide 35, where you've looked at some ways to amend. I don't know if you want to elaborate on any of these in particular, but I'm curious about the needs-based policy review. Are you identifying something there now that is not needs-based? What's the thinking behind reviewing that?

Mr. Darragh Mogan: I think when we look at pre-charter, it will give you a bit better context for considering that. We had run programs—for example, the disability pension program was an entitlement-based program. In other words, if you had the disability you got this much money; it didn't matter whether you needed it; you just got it; it was a compensatory program. That was the only program we had, so our policy framework for helping somebody was all entitlement-based. What would happen—it wasn't the intention it would happen—over time is the only way you could get more money or more support was to show that you were more ill. If you were more ill you could certainly get that, but you didn't want a system in place that encouraged that. So we had a number of policies that were entitlement-based rather than wellness and needs-based.

So what we are attempting to do is revise as many policies as we can, especially those focused on the modern veteran, to make sure we're responding to the need and not creating a financial dependency that inadvertently encourages illness. That was the policy foundation of the new Veterans Charter. It's not by any means a way of saying there are going to be benefits denied to individuals. In fact, some benefits will be offered to individuals who have greater need, which we haven't been able to do up until now.

● (1640)

The Chair: Thank you, Mr. Mogan.

Thank you, Mr. Andrews. You're well over the five minutes there, but I think by your questions you've identified a pool of witnesses who we'll want to call before the committee during our own review of the charter that's scheduled.

To the Conservative Party, Mr. Lobb, for five minutes please.

Mr. Ben Lobb (Huron—Bruce, CPC): Good afternoon, and thank you for coming.

I would like to say that in the riding I represent, Huron—Bruce, there is a large number of troops who are current members of the forces, and it's reassuring to know about the veterans programs that are there, the new charter that's there, to take care of them in time of need and time of transition. So I know they'll be well served in the future.

Under the rehabilitation, what I found very interesting was on slide 10. I really like the idea of the case managers not only working with the client but working with the families and the extended families. I just wondered if you could broaden that out a little bit and give us an idea of where that idea came from and the kinds of successes we're seeing with that. I can imagine that is a very successful strategy.

Ms. Brenda MacCormack: Rehabilitation, by its very nature, is about working with an individual and their family, and certainly recognizing that the family needs to be part and parcel of any kind of rehabilitation moving forward.

Case management provides that kind of stabilizing influence, that one point of contact, where the case manager can work with their client, work with external community resources, work with professionals involved in the care of the veteran and the family, and help them navigate through the system, advocate for them in times when that is necessary, help them establish goals, and help them determine what kinds of intervention need to be in place to get them help. That personal relationship with the case manager is paramount.

In terms of working with the family, it's certainly recognized that when we have some of the complex veterans health needs we see before us, families—children and spouses—will be impacted because of the very nature, in particular, of the mental health types of impacts.

To achieve that comprehensive, integrated kind of approach that the rehabilitation program provides, case management is the means by which we do that.

Mr. Ben Lobb: Again, it is impressive, the numerous references in your report on mental health, dealing with that straight on, and dealing with any addiction issues that may lie therein.

On the rehabilitation front, many of us are from rural Canada. I represent a rural riding. Could you give me a sense of how that care works for people in rural communities and how that outreach works and develops?

Ms. Brenda MacCormack: In terms of the actual service provision, we certainly have capacity across the country to engage service providers, whether they're providing medical care or psychological counselling. I think you've had a good appreciation from Mr. Clorey around the importance of the infrastructure he's helping to build so we have the mental health capacity to work with these clients, whether it's counselling, family counselling, social work.

There is a capacity through the provider network across the country. As well, we have a national contract with a vocational rehabilitation provider who has access to clients, provides services all across the country, and if necessary will travel to assess clients and provide them the services they need.

● (1645)

Mr. Darragh Mogan: I'll add that it would be misleading to suggest we're going to have as many services available in Tobermory as we have in London. I think you know that.

What we do have are itinerant counsellors who are trained case managers. We do have the national contract Brenda referred to, and we do have a network of voluntary and professional suppliers in the area. We will not ignore someone who is a reservist or someone who lives in Tobermory who's having a struggle with transition. We will not ignore them. We may not be able to supply the service independently to them, as we could in London or Chatham or places of that nature, but they will not be ignored and they will not be asked to leave their environment in order to get service.

Mr. Doug Clorey: If I could add to that, on the mental health side, the committee may be interested in knowing we are aggressively pursuing a tele-mental-health network so we can link some of these individuals in local communities through the tele-health network that may exist there to our operational stress injury clinics.

The Chair: That's pretty well it, Mr. Lobb.

Now we'll go to the Bloc Québécois

Monsieur Gaudet.

[*Translation*]

Mr. Roger Gaudet (Montcalm, BQ): Thank you, Mr. Chairman.

Going back to the chart on page 4, could you explain that chart to me, which shows numbers of traditional veterans, survivors, modern veterans and members of the RCMP?

Are traditional members, veterans receiving a pension, or are they survivors?

An hon. member: Yes.

Mr. Roger Gaudet: That's what I wanted to know. Traditional veterans don't receive pensions. Do all those people receive a pension?

[*English*]

Ms. Brenda MacCormack: Everyone reflected in this chart is receiving services from Veterans Affairs. In the case of traditional veterans, it would primarily be a disability pension. In the case of modern veterans, it would be a mix of those who had received disability pensions prior to the new Veterans Charter coming into force. And disability awards would be for the balance, after the new Veterans Charter. It would also include recipients of the veterans independence program.

[*Translation*]

Mr. Roger Gaudet: If I understand correctly, all those people receive services or pensions. Is that correct?

[*English*]

Ms. Brenda MacCormack: Yes.

[*Translation*]

Mr. Roger Gaudet: Thank you.

Here's my second question: at what point do soldiers become veterans? That kind of question has never been asked, and it intrigues me.

[*English*]

Mr. Darragh Mogan: The accepted definition of a veteran is someone who has gone through basic training and has been honourably discharged. That's the definition of a veteran. It's for recognition purposes. It's not for benefit purposes. There are other eligibility requirements to receive benefits, such as disability awards and the new Veterans Charter. But you're a veteran if you've served Canada, went through basic training, and have been honourably discharged.

A lot of people are veterans and don't realize it. To be recognized as a veteran is extremely important in terms of a person's well-being. Many modern veterans have told us that after they left the service, they didn't feel recognized. And when you don't feel recognized for something you've put your life on the line for, it can't have a very salutary effect on your mental health or your transition to civilian life.

Your question is very important. There are lots of implications to the answer.

[*Translation*]

Mr. Roger Gaudet: I have another question. The example that comes to mind is that of the lieutenant who loses a leg in Afghanistan. Has he become a veteran or is he still working for the Department of National Defence? Does he receive a veteran's disability pension? Perhaps he can work at the same time; I don't know. I want to know how all that works.

[*English*]

Ms. Brenda MacCormack: All of the case examples we've gone though here are of veterans who actually have been released from the service. But if we take the scenario of a member who's currently serving and was injured in Afghanistan, what happens is that we receive notification when this kind of injury occurs, and we have a casualty protocol and we make contact with that veteran and the family to make ourselves known to them. The charter provides capacity to pay the disability award while the member is still serving. And that is really the commencement of our relationship with that member and his family. Then we will work with them as necessary, depending on how seriously injured the member is and whether they are able to return to their job in the military, or whether they end up transitioning out of the military. So it's a very collaborative kind of effort if the member ends up transitioning out.

● (1650)

Mr. Doug Clorey: But to answer your question more directly, they are not considered veterans while they continue to be employed within the Canadian Forces. They have to be released in order to be considered veterans.

[*Translation*]

Mr. Roger Gaudet: All right.

So they receive a pension and they're still working, let's say, for the Department of National Defence, for the armed forces, and are not considered veterans, but they receive a pension.

Are they veterans or employees of the Department of National Defence? I'm not talking about their salary, but about a pension received because they have lost a leg or two.

[*English*]

Mr. Doug Clorey: The actual pension would be provided by Veterans Affairs while they continue to serve in the military, but they would not be considered a veteran until they're released.

[*Translation*]

Mr. Roger Gaudet: Veterans.

Mr. Doug Clorey: That's correct.

Mr. Roger Gaudet: Thank you, Mr. Chairman.

[*English*]

The Chair: Merci, Monsieur Gaudet.

We'll go over to the Conservative Party now. Mr. Clarke, for five minutes.

Mr. Rob Clarke (Desnethé—Missinippi—Churchill River, CPC): Thank you, Mr. Chair.

I thank the witnesses for coming.

I have to apologize. I had a previous meeting, so I missed part of your presentation. I do apologize.

I'm quite interested in veterans affairs. I served in the RCMP for 18 years and I retired as a sergeant.

There are a lot of RCMP veterans now who have served overseas. They serve their country. They serve in their homeland. I've seen a lot of members suffer from post-traumatic stress disorder. For the NCO, say, in charge of a detachment, the onus was on the detachment commander or an NCO to make recommendations to the appropriate health services to look at possible symptoms if a member was dealing with post-traumatic stress disorder.

Now, I'm just curious. In regard to the Department of Veterans Affairs and its policy, when did the RCMP become included in the mandate for post-traumatic stress disorder, or just basically added to Veterans Affairs?

Mr. Darragh Mogan: The Royal Canadian Mounted Police have been clients of Veterans Affairs since 1949, so it's a longstanding relationship.

With respect to the specific issue of mental health challenges among the RCMP, they're beginning to realize that it's an important factor, and you as a former police officer would know just how traumatic some of the events are that the Royal Canadian Mounted Police constables have to deal with, whether they're overseas or here, but particularly overseas. They want to be part of our mental health strategy so they can get help from our operational stress injury clinics, and they're increasingly using our OSISS peer support coordination function for helping individuals cope on a day-to-day basis for people who have gone through that kind of traumatic event. It's a peer-based mental health non-clinical, non-therapeutic type of support. The RCMP are engaged in both the OSI clinics and in the peer support network we've developed.

Mr. Rob Clarke: You mentioned the clinics. The RCMP have access to the full gamut of services provided by Veterans Affairs. Where are these clinics?

Mr. Doug Clorey: We have ten clinics that actually complement the five DND operational trauma and stress support centres. So there are essentially 15 points of service between Veterans Affairs and the Department of National Defence. Going from west to east, there is one in each of Vancouver, Edmonton, Calgary, Winnipeg, London, Ottawa, Montreal, Quebec City, and Fredericton, and there's actually a residential program out of Ste. Anne's Centre in Montreal that will complement the tenth clinic. So those are our locations.

Mr. Rob Clarke: How long is the program at the residential clinic you just mentioned there, for the rehabilitation or the mechanisms to deal with the everyday stress of post-traumatic stress? Is there a duration?

Mr. Doug Clorey: All of our operational stress injury clinics, with the exception of the one that will offer a residential program, are out-patient services. Clients simply come in and receive services and leave. The residential treatment program will be a program of eight weeks' duration, and it will also include participation of family members as well, so it's a fairly significant initiative on the part of the department. It will be operated out of Ste. Anne's Hospital.

● (1655)

Mr. Rob Clarke: For the eight-week program, how many beds are in that facility? How many people can attend? How many allotments are there overall at Ste. Anne's?

Mr. Doug Clorey: I don't have an answer to that, but I can get it to you.

Mr. Rob Clarke: Okay. Thank you.

The Chair: Thank you, Mr. Clarke.

There's one more spot right now for the Conservative Party.

Mr. Kerr, you have five minutes.

Mr. Greg Kerr (West Nova, CPC): Thank you very much for being here. You certainly are taking the questions away quickly.

I was interested when you talked about the national review that was done. I'm referring to the Canadian community health survey. I'd like to know a little more about that, because I'm sure that's not just for veterans. That was done for a whole number of reasons. Can you give us some detail on when it was done and when it will be updated, how we participate, I guess, overall in it, and how it's accessed when it's finished? I know it was referred to quite often, so I'm just wondering.

Mr. Doug Clorey: I can give you some general information. I don't have all the details with me here. Hopefully, we can do that when we have a more detailed presentation on the mental health strategy.

It was conducted in 2002, and it was a general community health survey conducted by Statistics Canada. Part of it had a Canadian Forces supplement, which was directed towards—and I don't have the exact numbers of CF members, but a significant percentage of Canadian Forces members—the mental health of Canadian Forces members in particular. It was out of that CF supplement that those four priorities that I mentioned earlier came.

Mr. Greg Kerr: When do you expect that will be updated or done again?

Mr. Doug Clorey: I don't have any information on that at all. That's essentially pursued by Statistics Canada.

A voice: We can get that information.

Mr. Greg Kerr: Okay.

When you started off, Mr. Clorey, you were talking about whether there was a stigma. I know Judy was raising the question. It's something that comes up and you hear about it. As a matter of fact, my friend was talking about the RCMP, and I remember being involved several years ago where all you were hearing about was stress leave for RCMP officers. There was nothing about treatment or going somewhere else, just that they were off duty.

Are we making progress on those stigma issues in terms of depression, or alcohol dependency particularly? I'm not so sure I understand as much about the social phobia that was referred to. Do you sense that, not just with Veterans Affairs but in terms of delivery, we making progress in breaking through that stigma part?

Mr. Doug Clorey: As I mentioned earlier, I think we're making progress in terms of the stigma associated with post-traumatic stress disorder, and that's reflected in the number of clients we have. In terms of depression, I'm not so sure, and that's reflective generally of Canadian society. There is still significant stigma around the whole notion that depression is a clinical condition that requires the same kind of assistance as any other kind of medical condition. The attitude still continues to be a “get over it” type of approach.

There's probably some movement, but it's not as significant in terms of the veteran community as it has been with post-traumatic stress disorder.

Mr. Greg Kerr: Okay. And that would be typical within the society dealing with the issue, would it not?

Mr. Doug Clorey: Correct.

Mr. Darragh Mogan: The only additional comment I would make is that I think in the military there is more of a recognition that operational tempo and the nature of the deployments can bring about things, some of which are very natural responses to very unnatural circumstances, and some of which are very unnatural responses to unnatural circumstances, and they need to deal with it. Witness the fact that both organizations have made a strong commitment in the mental health area. Witness the fact that the number of individuals who come to us for disability benefits has come up from 5,000 ten years ago to 14,000 now, or 11,000 or 12,000. So I think it's kind of coming out of its shell.

The other thing that has a very strong influence, frankly, is the lack of research on things that you can't see. So all the research that all countries do tends to go to the physical injuries, and thank God that happens. But there's a whole range of research or a whole range of things that we don't know about mental well-being and mental illness that will be uncovered when the stigma leaves the research community as well. So it's still something we have to deal with. Nevertheless, these people are coming to us, and we have to respond.

● (1700)

Mr. Doug Clorey: As just a final comment on that, I find it disturbing that we're not making more movement in this area, because the World Health Organization indicates that by 2010, I believe, or in the neighbourhood of 2015, it will be the second leading cause of disability in the world next to heart disease. We just don't seem to be moving fast enough to address that.

Mr. Greg Kerr: And there is a massive cost, of course, to the economy as well. We're going to get a chance another day to pursue some of this, but I really think it's something we have to talk more about, not just within a departmental context but in a public context, so I appreciate that.

Thank you.

The Chair: Thank you, Mr. Kerr.

Just to clarify, because the answers were from two individuals, you are saying that the number one issue is depression.

A voice: Yes.

The Chair: Thank you very much.

Now we'll go to Mr. Stoffer.

Maybe a maximum of three questions at once would be good, sir.

Mr. Peter Stoffer: I have three questions, actually. The first one is on the hospitals. What is the long-term plan for the hospitals when the vast majority of World War II and Korean veterans have passed on?

Also, in Nova Scotia, the 1-866 number for veterans shuts down at 4:30 and they are told to call back the next day. I wonder if that can all be changed and transferred over to handle calls across the country. It's frustrating. The people who answer the phones during the regular business hours are very good, but the problem is that if you call after a certain time, you're told to call back.

The other issue is that you had indicated—and we're quite aware of this, Doug—the fact that there are many people within DND collecting a DVA pension. Could you please tell us how many of them could be doing so, and are they part of this statistical information that you've given us? If you don't have the number, maybe you could send it to us later. It seems rather ironic that they're not veterans, which is understandable, but they do receive the DVA pension. So it would be interesting to know how many of them are, and are they part of your statistical information?

That should do it for now. I have many more questions, but the chair will cut me off, I'm sure.

Mr. Darragh Mogan: I'll answer the first two, and maybe Doug can answer the third for Mr. Stoffer.

On the long-term-care plan for our hospitals, Veterans Affairs created these hospitals in the absence of any alternative in the community. Right now there are about 250,000 to 260,000 nursing home beds in Canada that weren't there at the end of World War II. The long-term-care response at the end of World War II was a stop-gap measure—and a very important one, by the way.

Now the older veterans are sort of voting with their feet and wanting more and more to stay in the community. Our long-term plan for these facilities—even for the modern veteran, because it's so important for long-term care to be close to family and home—is to emphasize and support individuals staying close to home in existing Canadian nursing homes. Over time, our plan is to specialize the care and services offered in the contract beds we now have for the older veterans that they can't get in the community—primarily respite care, and then geriatric care.

I think we could give the committee a longer briefing on our long-term-care strategy, but in summary that's the direction in which we're proposing to go. Even the traditional veterans want to stay close to the community. For instance, they don't want to go to Sunnybrook Hospital if they live in Barrie, Ontario, because they'll never see their families again.

Adding eligibility for Canadian Forces veterans is a political decision that will have to be considered in time.

Regarding the 1-800 number, I'll have to check about the availability. It seems to me those service hours are meant to be longer, but we'll have to get back to the committee on that.

Mr. Peter Stoffer: On the hospital issue, you indicated they want to stay longer in their homes, but in Halifax there's quite a waiting list, and there's a three-tier process to get in. If you're absolutely correct that most of the veterans want to stay near their homes, why would we have such a massive waiting list to get into one facility and a three-tier process to get in? In reality, there simply are not enough nursing homes in areas like Atlantic Canada to facilitate that.

Correct me if I'm wrong, but you didn't say the hospitals may not have a long-term future 20 years from now, but I hope that's not what you're indicating. Ste. Anne's does a wonderful job in Quebec, as does Camp Hill and others, even though they're provincially run and federally funded. I would hate to see the demise of those institutions if we go to more community-based ones. There's nothing wrong with community-based hospitals for those who want them, but the reality is the vast majority of veterans I talk to on a regular basis love Camp Hill. They would love to be able to get into Camp Hill, but they can't because of the eligibility restrictions.

● (1705)

Mr. Darragh Mogan: That's probably true, but I can't comment on whether those eligibility criteria are going to change. I can tell you that when you give veterans in Nova Scotia a choice between staying in Eastern Passage or going into Camp Hill, they'll stay in Eastern Passage. It's the absence of choice rather than the presence of something else, so we're working on increasing the number of choices.

We will get back to you on the 1-800 number and the availability of service.

Doug, do you want to comment?

Mr. Doug Clorey: If I understood you correctly, you were asking how many clients of Veterans Affairs who receive disability benefits are still serving in the Canadian Forces.

I don't have the figure for all our clients, but of the 11,888 clients who have psychiatric conditions, 1,369 are still serving. They would be included in our statistics.

The Chair: Thank you, Mr. Clorey and Mr. Stoffer.

Now we'll go to Mr. Andrews for five minutes.

Mr. Scott Andrews: Thank you, Mr. Chair.

I don't think I'm going to use my full five minutes, but I do have a couple of questions.

We're talking about reviewing the charter. The charter has been in place for three years and it is a living document. Could I get a little history on the charter, as somebody who is new to it? How long was your department in the planning process of putting the charter in place? How much time and work went into getting the charter ready?

Mr. Darragh Mogan: That's a fair question.

In terms of getting the evidence base for the conversion, as it were, from an entitlement to a needs-based or a wellness approach, we started the first studies in 1999. We did a study of the needs of Canadian Forces veterans themselves, and we asked them what their requirements were, and it was no surprise. We also began to look at what was happening with the anecdotal evidence and the increase in our pension claims and what the outcomes were for these individuals.

It became quite apparent when we started talking to the experts—and we had what was called a Canadian Forces Advisory Council, whose members were academics and practitioners. When we put the scenarios and the research we had gathered to them, they said, “Listen, you're inadvertently encouraging illness here with your sole response from a pension program. You don't mean to, and the veterans themselves don't mean to do that, but the only way you can create an income stream is to have more pension, so you get reassessed and get higher and higher rates, and what's happening is you're not investing early enough and you're not investing in wellness with a rehabilitation program.”

That's a summary version of where we went. That took about four and a half years of research to get the case to put to government. And all parties agreed with the evidence and all parties agreed with the response, which is very heartening for us. But there was quite a lead-up, in terms of research, in terms of getting the evidentiary base that justified the change and justified a rather large investment of almost $1 billion over five years in the front end.

Mr. Scott Andrews: Okay. So from 1999, five years of research and development, to 2005-2006, and then now this is where we are today. Okay.

Here's the second question. I'm looking at your chart on page 19, and I have just a couple of questions about the number of disability awards and applications.

The numbers we're seeing here are from three years of applications. Is that correct?

Ms. Brenda MacCormack: That's correct.

Mr. Scott Andrews: Okay.

And the 60% favourability, is that on the applications received?

Ms. Brenda MacCormack: That is on the applications where we have rendered decisions, so that would be on the 20,712, for example, on the disability awards.

Mr. Scott Andrews: Okay. So the pending, the 7,000 or just under, the 6,500, where decisions haven't been made, they're in the process of being—

Ms. Brenda MacCormack: They're in the process. They may have been withdrawn, but most of them would still be in some stage of process.

Mr. Scott Andrews: How long would an individual be waiting for a decision?

Ms. Brenda MacCormack: It varies, depending on the nature of the claim. But we do have service standards, and for a disability claim the service standard is 24 weeks from the time of the application until completion of the decision.

● (1710)

Mr. Scott Andrews: Okay.

On the favourability rate of the application—the 40% of the applications that get turned down—do you have any statistics on those 40%? Are a number of them similar applications that are from similar veterans or veterans who are looking for a similar type of disability? Is there a chunk of those that are being turned down for a particular reason? I'm looking for just a little bit of in-depth to that 40%.

Ms. Brenda MacCormack: There are probably a number of reasons why they might be turned down. I think it's fair to say there are certain conditions that are more likely to be accepted than others, because we know there's more prevalence of those types of illnesses or disabilities coming out of the military context. The adjudication process itself is a quasi-judicial process, so I think it's fair to say it requires some due diligence. There is requirement to obtain the evidence and look at the evidence and make sure we're giving good service to those who are applying to the program.

Mr. Scott Andrews: Looking at the ones that are turned down, is there a chunk of them being turned down for a specific reason? Is there a glaring number there that are being rejected because they don't fit X, Y, or Z?

Mr. Darragh Mogan: Well, it could very well be this. There has to be a causal relationship to military service, so if that causal relationship can't be established from medical records and military service, it's more difficult to get an approval than if it were clear that you fell off a tank and broke your arm. So the 60% rate may not sound high, but it's higher than for most workers compensation and higher than for most of our colleagues in the U.S. and the U.K., because we have the benefit-of-the-doubt principle, which in law is the most generous principle you can have. The other is balance of probabilities, where you have to have more probabilities for yes than no.

So in terms of analyzing individual ones that have been turned down, it's principally the absence of associative evidence that it was related to military service. And it has to be.

Mr. Scott Andrews: Would it be possible to send to the committee some statistics on that 40%?

Mr. Darragh Mogan: Yes. We'll try to get you some information through the chair.

The Chair: Perhaps you could break it down into the different categories.

Thank you, Mr. Mogan, and thank you, Mr. Andrews.

We need to move on to some committee business, but first I have a couple of questions myself.

Am I correct that you said 24 weeks was the service standard for a decision on an application?

A witness: Yes.

The Chair: Is that standard going to be reviewed in and of itself?

Mr. Darragh Mogan: Yes. We'd certainly like to shorten that from what it is, but it's down from 10 or 11 years ago, when it was 18 months. We had a very burdensome process, in my view, that we changed.

It's constantly under evaluation to ensure that when the medical evidence is clear, you have a report from a physician, you have an incident in the military, and you have the individual presenting, they should be dealt with very quickly. There are some obvious disabilities that are going to be related to military service—musculoskeletal and others—that shouldn't have the same level of attention and therefore take the same amount of time as others.

So that process is being undergone in our program management group.

The Chair: Mr. Mogan, is this 24 weeks strictly for pension? It's not for other services, is it?

Mr. Darragh Mogan: No. The new Veterans Charter programs are meant to respond very quickly. You don't have to have a pension in your hand to get them. Early intervention is key, so we're looking at shortening those turnaround times. We haven't quite gotten there yet, but they're to be quite a bit shorter than 24 weeks.

The Chair: That's good to know about the differentiation, and about the diminishment of the time as well.

This will be just a simple question. It has to do with page 4 of your colour power-point presentation. I notice that on the projection side of the chart, there's a darkening of the lines. Is that simply the colour copier that went awry, or does that darkening of the lines mean anything?

Mr. Darragh Mogan: No, there's not a secret code there, Mr. Chair. We just ran out of ink.

The Chair: Okay. I just thought maybe that was the probability of error or something like that.

Mr. Darragh Mogan: We don't make errors in the public service, sir, I'm sorry.

Voices: Oh, oh!

The Chair: I'm very sorry.

In terms of tele-health, are you asking specific questions as far as getting feedback on service? We always see clinical therapy as one-on-one in an office. Is there a high level of satisfaction with that? Is it close to the same kind of effectiveness?

Do you understand where I'm coming from? I'm wondering if we have a handle on how effective that is compared to someone actually travelling to an office and being with a counsellor, psychologist, psychiatrist.

● (1715)

Mr. Doug Clorey: I can speak to the tele-mental-health side of things, which is what you may be referring to.

The Chair: Yes.

Mr. Doug Clorey: We're still early days in this. In the department we've conducted three pilot projects, at this point, to ensure that we know what we're getting into when we enter the tele-mental-health field.

It is a field that is available in all the provinces of Canada, but it is tricky. You need to be able to create all of the safeguards around the intervention in an environment where the individuals are not physically present.

We did conduct a pilot project in Newfoundland, one in Calgary, and one recently in Fredericton, to develop the protocols to ensure that when we implement this fully across the department, we have the assurances that the interventions will unfold as they should, with the appropriate safeguards at both ends.

The Chair: Good. Thank you very much.

Thank you to all of you. We appreciate your answers. We've also learned some lessons, on our next study, of the witnesses we need to have.

We'll take a break and then go in camera for committee business.

[*Proceedings continue in camera*]

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