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Chair

Mr. David Sweet

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● (1105)

[*English*]

The Chair (Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC)): Good morning, ladies and gentlemen. *Bienvenue à tous*. Welcome to the 14th meeting on a review of the new Veterans Charter.

Our witnesses have given me the nod to say they're ready, so I will introduce them briefly.

I believe Madam MacCormack will make the opening remarks. She's a director of rehabilitation. Janice Burke is the acting director of mental health. Jane Hicks is the acting director of operational direction and guidance.

Now we'll allow Madam MacCormack to make her opening remarks. I think you're familiar with how the committee works after that. We'll go through the rounds of questions.

I would like to point out that Mr. Vincent's request was fulfilled. You have samples of application forms for benefits in your packages, as well as the decks that the witnesses will be using.

Madam MacCormack.

Ms. Brenda MacCormack (Director, Rehabilitation, Department of Veterans Affairs): Thank you.

Mr. Chair and committee members, my name is Brenda MacCormack and I'm the director of rehabilitations at Veterans Affairs Canada.

It's my pleasure to appear before you again today with my colleagues: Janice Burke, the director of mental health; and Jane Hicks, the director of operational direction and guidance.

You heard from other colleagues last week on the disability and income support programs. We are here today to talk about rehabilitation, career transition services, and mental health.

As you requested last week, Mr. Chair, we provided a presentation in advance, including four case scenarios. We gave the clerk hard copies for distribution today as well. I'll be referring to that presentation in my remarks, and we'll be happy to walk through those case scenarios in more detail if members wish.

We have been following your committee's study closely and have noted one important question that is arising: is there anything really new with the new Veterans Charter? So I'd like to start by responding to that question for you today, from the perspective of the rehabilitation program.

First, a veteran doesn't need to be receiving a disability benefit to be able to get rehabilitation services. This is new and critically important to making sure veterans and their families get services early, which I know you've heard before is essential to success. We don't have to wait for a disability award to be approved, which can sometimes be a lengthy process and can delay getting someone into rehabilitation services.

Secondly, we can now provide economic support while the client is in rehabilitation. We could not do that under the Pension Act. We could provide disability pensions, but in many cases there would certainly not be sufficient income to allow the person to undertake rehabilitation. As my colleagues emphasized last week, having an appropriate level of financial support at the time it's needed is critical to achieving successful rehabilitation outcomes.

Third, we now have the authority in legislation to help veterans who are not eligible for SISIP because they were not medically released from the military, or perhaps were medically released a number of years ago and are once again experiencing challenges. I know many of you are concerned about this group of veterans who were falling through the cracks before the new Veterans Charter. I want to be clear that these veterans could not before, and still cannot, receive services from SISIP because they were not medically released, or they may have been released quite some time ago and have emerging challenges.

VAC is now able to help them get back on their feet. An example of Ron, starting on page 17 of the presentation deck we've provided, shows how we might do that.

I know your committee has also heard about veterans who start showing signs of post-traumatic stress disorder ten years after leaving the military. The new Veterans Charter was designed to help these people as well, no matter when the disability manifests itself. In fact, one-third of our clients currently in the rehabilitation program have been out of the forces for at least eight years.

Fourth, we now have the authority in legislation to provide rehabilitation to spouses and survivors if the veteran is unable to participate. As you'll see in the Paul case scenario, starting on page 22 of the presentation deck, this is vital to helping restore the family's earnings capacity. You'll note that Paul's wife Kelly can now pursue a nursing degree and get the support she needs to be successful. Kelly and the children can access counselling in their own right—and I'll speak more about our mental health services in a moment. This example of Paul shows the shift to seeing the veteran as part of a family and a community, not an individual in isolation.

● (1110)

[*Translation*]

Now, we can take a more holistic approach to the treatment and support required for disabilities that hinder successful reintegration. Previously, under the Pension Act, we could provide health care services only in cases where veterans were receiving a disability pension.

On page 27 of the presentation, we have André's case scenario, which is based on the example that Mr. Vincent asked us to examine. André lost his right arm and three fingers on his left hand as a result of an IED. Of course, André will receive psychotherapy, occupational therapy and prosthetic care, among other services, but we can also support André by offering him driver training to help him overcome his anxiety, which resulted from his traumatic experience. If he experiences depression such that it becomes a barrier to him, that can also be taken into account to achieve the objectives set out in his rehabilitation plan.

We can go beyond treating just the amputations. Under the New Veterans Charter, our medical and psycho-social programming is much broader than our traditional treatment programs. It allows us to meet the specific needs of a younger population making the transition to civilian life.

[*English*]

The rehabilitation program recognizes that injured and ill CF members and veterans are committed to getting well. They want to engage in treatment, establish goals for themselves, and accept their own roles in their health and treatment. It's premised on a more holistic and integrated approach that focuses on the goal of independence and return to active engagement in family, work, and community.

Clients in the rehabilitation program receive individualized case management. What does this mean? It means that case managers sit down with the client and their family, assess needs, develop goals and intervention strategies in collaboration with health professionals, and help them transition to VAC services, benefits, and programs, as well as community resources.

The committee requested examples of our approval forms, which we have provided. I want to stress that we don't just give these forms to veterans and abandon them. The case manager can help the client and family every step of the way, advising them as required, including gathering evidence.

Mr. Oliphant commented earlier this week that CF members experience a significant cultural shift when they're released from the military. We recognize that as well. That's why case management begins prior to release from the military, in collaboration with CF case managers, to ease them through that transition and provide support as early as possible.

The 19 integrated personnel support centres set up across the country are playing a vital role in making sure that CF members and their families are aware of the full range of benefits and services available to them, and that they can get all the information and help from both DND and VAC in one place.

As you'll see on page nine of our presentation, 50% of clients entering our rehabilitation program have an identified mental health condition. So to support the new Veterans Charter we have also invested in mental health supports. We have a comprehensive mental health strategy based on four pillars: providing a continuum of services, building capacity across the country, showing leadership through research, and nurturing partnerships.

Our strategy is based on a whole-person approach that recognizes the impact of personal, physical, social, economic, and health circumstances on mental health. The objective is to promote wellbeing, symptom reduction, recovery, community integration, and enhanced quality of life.

Our network of ten operational stress injury clinics across the country and the operational stress injury support program, or OSISS, as it's better known, are key to reaching out to potential clients battling the stigma associated with mental health conditions, and helping people get support and treatment.

Serving members and veterans of both the CF and the RCMP and their families can receive services. Over 2,700 people have been helped by our OSI clinics, which is more than 20% of our total number of clients receiving disability benefits for mental health conditions.

The final topic I'd like to touch on today is VAC's career transition services. Whereas SISIP and our rehabilitation program are focused on those with health difficulties, the career transition services target those who are voluntarily leaving the forces, both regular and reserve. It offers practical advice and help in finding suitable civilian employment. There are three key services: job-search training workshops, individual career counselling, and job-finding assistance. This program can begin while the member is still in service. This is a new benefit under the new Veterans Charter.

In summary, we are now able to help a wide variety of clients in a wide variety of circumstances. So whether it's someone who has a minor injury but is unable to pursue his or her occupation, or someone who is releasing from the Canadian Forces after suffering a catastrophic injury, the new Veterans Charter can help, proportionate to the level of assistance each one of them needs.

Thank you for the opportunity to appear before you today. We look forward to responding to your questions.

Merci.

● (1115)

The Chair: Thank you, Madam MacCormack.

We will go to our first round of questions.

Seven minutes, Mr. Oliphant.

Mr. Robert Oliphant (Don Valley West, Lib.): Thank you.

I want to focus on spouses, partners, and family members for a moment. I put an order paper question in on this regarding what percentage of veterans' spouses, partners, and family members who were eligible to receive rehab services availed themselves of those services. Veterans Affairs has told me that 11% of eligible spouses and family members have actually availed themselves of your services.

Do you have an understanding of why that would be? Why would 89% of eligible spouses not avail themselves of that? Have you done studies on that?

Ms. Brenda MacCormack: I have to admit I'm not familiar with the stat of 11%, but....

Mr. Robert Oliphant: It's from your department and you're the director.

Ms. Brenda MacCormack: We have the capacity to offer rehabilitation services to families and spouses in their own right when the veteran himself can't participate in the rehabilitation. In that case they can partake in training and all the vocational components. There is also capacity for the spouses and children to participate in treatment when that's required to meet the goals of the rehabilitation program.

Mr. Robert Oliphant: I understand the program. My concern is that 89% of those who are eligible don't avail themselves. So I'm wondering, what is your outreach program, what is your analysis? And what are your case management workers doing to make sure that spouses actually understand what they can get? What systems do you have to make sure that it doesn't just go through perhaps a mentally ill, multi-disabled veteran to get to his or her spouse? Are there programs that you are doing to actually promote this?

Ms. Brenda MacCormack: Yes. The point that you raise in terms of outreach and communicating the programs and having them understood by our clients and their families is one we have done some work on but we need to do more.

Jane, from the operational guidance perspective, can offer some particulars around what we're doing on the outreach piece, and maybe speak a little bit about case managers and how they link with families and make them aware of services.

Ms. Jane Hicks (Acting Director, Operational Direction and Guidance, Department of Veterans Affairs): Certainly case managers will contact family members to find out if in fact they are eligible or are interested in the benefits and services through the rehab program, and ensure they understand them. Often if it's an ill or a disabled member. However, they do have to go through the member. But what they will do is seek the permission of the member to go to the family or speak to the family, because we try with the rehab to have a comprehensive.... It's all about the family and the member and how they work with the family.

Sometimes the member does not want us to do so, and we have to respect that. But certainly the case managers work with the family. There are a variety of supports in place for family. We have OSISS, the OSISS family peer support program if the families require assistance. So there are a variety of services.

In some instances family members often have their own careers as well and don't require the assistance of the rehab program and are coping well. It all depends on the individual circumstances of the family.

Ms. Brenda MacCormack: And just in terms of outreach generally, I think I stated that we do need to do more. I think that's clear. We are aware there are many who don't understand the benefits that are available, so we do have an outreach strategy that is looking at who we need to be speaking with. We do transition interviews. We do a number of briefings within CF environments before they go on deployment, when they come back, during second-career transition workshops. Again, the message may not be landing at the time because maybe it's just not a message that is relevant to them at that time.

We also do briefings at family resource centres, and we've found that to be very valuable, because the more the spouses and families know, the more likely they are to avail themselves of services.

We do publishing in the CF *Maple Leaf*, as well as our own newsletter, called *Salute!*, which reaches 260,000 on a regular basis. We've had some publications as well in *Canadian Family Physician*, a quarterly kind of publication where we can write articles from a VAC perspective that touch on the kinds of issues that you're raising.

● (1120)

Mr. Robert Oliphant: My concern is that less than 3% of spouses and families eligible for vocational rehab are availing themselves, so 97% aren't getting there. That tells me there's a systemic problem.

So my hope is that the department will listen to its own numbers and really recognize that there is a problem of either geographical isolation or mental isolation or something is not working.

Ms. Brenda MacCormack: Yes. Thank you.

Mr. Robert Oliphant: I want to move on.

With respect to the disability award lump sum payments—and I don't know whether this actually falls under rehabilitation—financial counselling is available for families, but only 1% of veterans who are eligible for financial counselling actually avail themselves, and 99% of veterans don't take the opportunity for advice. It's sort of a similar problem.

Ms. Brenda MacCormack: Yes. In that particular instance we are doing some follow-up with disability award recipients to just have some discussions with them about the disability award. And one of the questions we'll be asking them will be “Did you access financial advice, and was it enough to assist you in managing the money?” That client contact is beginning as we speak, and the results of that should be available some time over the summer.

What were you going to say?

Ms. Jane Hicks: I was just going to say also that with some preliminary contact we have had with veterans, there are a number of institutions that offer financial advice free of charge, so they don't take Veterans Affairs up. They may go to the institution they're comfortable with, such as their own bank or whoever they're dealing with in managing their funds.

Ms. Brenda MacCormack: Yes, and that has been offered.

Mr. Robert Oliphant: In your case management, have you been in touch with the Association of Occupational Therapists and availed yourselves of their professional expertise in case management?

Ms. Brenda MacCormack: I can start by saying that we have a regular, ongoing relationship with the Canadian Association of Occupational Therapists and liaise in looking at best practice. They also play a very important role in mental health, and in rehabilitation in particular. So yes, we have a linkage and in fact have a speaking engagement at their upcoming national meeting.

Mr. Robert Oliphant: Is Elizabeth Taylor advocating for a more formal relationship?

Ms. Brenda MacCormack: Yes.

Ms. Janice Burke (Acting Director, Mental Health, Department of Veterans Affairs): Let me add that we have about 2,000 service providers registered across the country around mental health, and a large majority of them are occupational therapists as well.

The Chair: Thank you.

Thank you, Mr. Oliphant.

[*Translation*]

Now, it is over to Mr. Vincent for seven minutes.

Mr. Robert Vincent (Shefford, BQ): Good morning.

In your presentation, you talked about an individual with an amputated right arm below the elbow and three amputated fingers on his left hand. It says that the person received his disability award of 100%. Last week, however, we received another document describing someone who became a paraplegic as a result of a spinal cord injury, but that person did not receive a disability award of 100%. The first person received $260,843 in 2008. Is that how much he would have received under the new charter?

[*English*]

Ms. Brenda MacCormack: No. For a disability award under the new charter we are using the same rules that we were using under the disability pension. The terms by which they become eligible for a disability award are the same. How we would assess level of disability is the same as well.

There is an assessment instrument called the table of disabilities that provides guidance in terms of looking at functional capacity and how it impacts upon one's ability to do something. In this particular case, if he was right-handed, that would have an impact.

[*Translation*]

Mr. Robert Vincent: In a case where the person has an amputated arm and three missing fingers on the other hand, what percentage of the disability award do they get?

● (1125)

[*English*]

Ms. Brenda MacCormack: It's 100%.

[*Translation*]

Mr. Robert Vincent: So 100%.

A quadriplegic would not receive 100%, but someone else with only an amputated arm would receive 100%. Is that right?

[*English*]

Ms. Brenda MacCormack: I don't have the particular details around the case that was discussed last week, but I would be surprised to find that someone is—

[*Translation*]

Mr. Robert Vincent: It is in the document submitted by the department.

[*English*]

Ms. Brenda MacCormack: We have a case here, and it is 100%. So there was an error in last week's presentation; I guess that is what is being pointed out. I think in the presentation a week ago, perhaps it was listed at something less than 100%. In this particular case, which is that of Antonio, it is 100% as well.

[*Translation*]

Mr. Robert Vincent: I am trying to understand how you calculate the percentage of the disability award. For a quadriplegic, it is 100%. For someone with an amputated arm below the elbow, it is also 100%. For an amputated leg, again it is 100%. The way I see it, everyone gets 100%.

[*English*]

Ms. Brenda MacCormack: In terms of how the disability is assessed, a table of disabilities is used that looks at how the disability affects one's ability to function. But in legislation there is a 100% cap on the amount that can be payable.

Someone can reach 100%, and different people can have different profiles and be at 100%. We've heard the criticism from a number of different groups that it doesn't seem fair that someone who is a bilateral amputee gets 100%, and someone who loses one arm and three digits gets 100%, and someone who loses three limbs gets 100%. I think some of the financial benefits in place are intended to recognize that. But it's certainly been a criticism we've heard and have been listening to: are there other means of financial compensation that should be given in those kinds of circumstances? In legislation, the cap is 100%.

[*Translation*]

Mr. Robert Vincent: So there are no preset criteria? That means it is left to the discretion of the employee assessing the file to determine whether the person gets 100%, 50% or 25%. Who determines the percentage? How do they make that determination without any preset criteria? You just said there are no preset criteria and that you find it a bit discriminatory that a quadriplegic and someone with an amputated arm receive the same amount.

[*English*]

Ms. Janice Burke: I could maybe respond a little bit.

The table of disabilities is on a website. It's available to clients. That's the tool that's used, and it shows very comprehensive criteria around how we assess disabilities. It ranges from 0% to 100%, depending on the type of disability. It focuses on loss of function, the ability to do activities of daily living, which is different for different people. It also looks at the quality-of-life impact. There are very comprehensive criteria for that. It's the pension adjudicators who determine the level of assessment.

What I would suggest, if there is interest in understanding a little more about how the table is applied— because it is very comprehensive, very transparent, and we've worked on it quite a bit to explain it to clients, but also to make it available to the public so that they can understand how we arrive at our assessments—you might see some value in our taking you through some cases, if you like—

[*Translation*]

Mr. Robert Vincent: Thank you.

My other question has to do with the same document. On page 30, it reads: "Under the Pension Act, André would have received...", but "would have received" does not mean that he would receive a disability pension of $2,831 per month, plus a grade 3 monthly exceptional incapacity allowance of $846. What I want to know is what kind of pension someone like André will receive as a result of the bodily injuries he sustained. How much will he get? To my mind, "would have received" does not mean it is the amount he received. I want to know how much he will receive every month, after his amputation, for the rest of his life. How much will he receive?

● (1130)

[*English*]

Ms. Brenda MacCormack: Under the new Veterans Charter he would have received the disability award, which is the amount that's listed at the 100% rate, the $276,000. In addition to that, he will receive the earnings loss benefit, which is calculated at 75% of the income he was earning at the time of release from the military. That's the income he would continue to receive. So it is based on his rank at the time he was leaving the service.

If he goes back to work, the veteran's loss benefit would then be discontinued. He would receive significant rehabilitation. We would hopefully help him achieve independence and get him back to living independently in the community, with the knowledge that he would continue to get ongoing support.

The Chair: That's all the time. It is way over, Mr. Vincent; I'm sorry.

Mr. Stoffer, you have five minutes.

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

Thank you, folks, for coming today.

We'll go back to André for a second. He receives his lump sum award of $260,000, and on page 30 this document says he would also receive a disability pension of $2,800 and change. Is that correct?

Ms. Brenda MacCormack: The comparison we were asked for is what he would receive now under the new Veterans Charter and what would he have received in the old scheme. You've been hearing a lot about the question "What would I have received if we had maintained the disability pension scheme and associated benefits?" My understanding is that your interest is in drawing those comparisons from a client perspective.

Mr. Peter Stoffer: He receives $260,000.

Ms. Brenda MacCormack: That's correct.

Mr. Peter Stoffer: What else does he receive financially—not in terms of support, but as a monthly payment?

Ms. Brenda MacCormack: On a monthly payment he will receive an earnings loss benefit.

Mr. Peter Stoffer: And what would that be?

Ms. Brenda MacCormack: It will be based on his salary at the time of release. The minimum amount we would pay on would be for a senior private, who makes $46,000 a year, so he would be getting 75% of that. Again, the goal is to get him back into—

Mr. Peter Stoffer: Right, and he receives that until 65. It's not for life.

Ms. Brenda MacCormack: He would receive that until 65 if he were unable to work. If he is able to work and is able to be independent, then he would not continue to receive it.

Mr. Peter Stoffer: If he's unable to go back to work, and he continues to receive this until 65, what happens after 65?

Ms. Brenda MacCormack: At age 65, he may well at that time be eligible for a permanent impairment allowance under the new Veterans Charter. He would also receive supplementary retirement.

Mr. Peter Stoffer: You said "he may be"?

Ms. Brenda MacCormack: Again, it's based on level of disability.

Mr. Peter Stoffer: But he's lost his arm and three fingers.

Ms. Brenda MacCormack: Yes, and I would expect that this would progress. If he's unable to work, I would expect that his disability would be progressing over time. The permanent impairment allowance would be an allowance that's available for life. It has three grade levels, and the amounts payable range between $500 and $1,500 a month. This would be the only payment that would continue after age 65.

As well, he would then be able to avail himself of the general benefits that are available to the Canadian public. As I mentioned, the supplementary retirement benefit would be payable at age 65, which represents 2% of the gross earnings loss that he was eligible for over his....

Mr. Peter Stoffer: The unfortunate part is that André would receive the 75% at the senior private's level, as you've indicated. But if he were going to spend 25 or 30 years in a career in the military, there's a high probability he could have become a sergeant, lieutenant, or captain. But there's no pro-rating of that, and that's what we've heard is the major flaw within this: it doesn't give indexing for the possible advancement that most people in the military achieve. So there's a snag there.

You've obviously heard and read a lot of the testimony from people who come before us—the Legion and other individuals. They have been, I'll put it mildly, extremely critical of the new Veterans Charter. You may not agree with everything they're saying, and maybe they have misconceived some things, but they can't all be wrong. I'd like you to tell us what cracks or crevices you notice in the new Veterans Charter. And have you had the opportunity to tell your superiors within DVA that these are the problems you're seeing?

Surely clients must be calling you and asking what's going on here. When you see these cracks—and obviously a lot of it is legislative changes, there's no question, which you obviously have no authority over—do you have the right to advise your superiors, ADMs, and deputy ministers, that this is a continuing problem and that we need to address it? Have you noticed any flaws yourself with the new Veterans Charter compared with the old system? If you did, have you had the opportunity to forward those concerns to Suzanne Tining or the minister himself or, for example, to your ADMs?

● (1135)

Ms. Brenda MacCormack: I would start by saying that absolutely I have the opportunity to raise concerns and do analysis and listen to what's being said and form my own opinion based on that analysis and communicate it. Of course, that work is currently ongoing.

As you know, we've had a number of reports tabled by special committees: the new Veterans Charter advisory group, the special needs advisory group. These groups are comprised of not only stakeholders, with representatives from the Legion and other veterans organizations, but also experts in the field of rehabilitation, disability management, and occupational therapy.

We've certainly been listening to them. My experience to date has been similar to what Monsieur Vincent was pointing out, in terms of whether we're doing enough for those who have catastrophic injuries. Does it make sense to give the same amount to those individuals, and are we giving them enough to support them over their lifetime? As you pointed out, if we're paying someone at the level of a senior private, is that enough to sustain them over their lifetime?

I think the answer is yes, I certainly have that opportunity, but I firmly believe that the package that is there is a good package. It has a firm foundation, it's based on the right principles, and it's heavily weighted in terms of the research base that supports it. That's not to say that there shouldn't be some building on it to address gaps, but that analysis is ongoing.

Ms. Janice Burke: In terms of our mental health clients, or clients who suffer from mental illness or PTSD, depression, or anxiety, I have to add—again, I've been working with the department for quite a number of years—I have seen the old system. I have seen our mental health clients struggle. I have seen them focus solely on compensation and I have seen a system like that really promotes illness.

What I'm seeing in the new Veterans Charter, in terms of the programs it offers, it offers hope to these individuals. I don't know if you can put a price tag on that, but it gets them to look positively at the future in terms of employment, which we could not do before with the old system. It also allows us to treat these people more holistically.

I don't know if you've seen the statistics, but we have over a thousand clients who have served in Afghanistan, who have mental health conditions, not necessarily related to Afghanistan but they've had multiple deployments. Fifty percent of these people are still serving. We have not seen anything, I don't think, compared to what we are going to be seeing coming to us in the future, perhaps after 2011.

I'm glad we have the new Veterans Charter programs in place to deal with that. If we did not, I don't know what we would be dealing with today.

The Chair: Thank you very much, Madam Burke.

At the rate we're going, Mr. Stoffer, you'll probably have another round.

Now on to Mr. Lobb for seven minutes.

Mr. Ben Lobb (Huron—Bruce, CPC): Ms. Burke, that's a good segue into the question I was going to ask you, so that was timely.

You have likely read or been briefed on most of the testimony that has been made on this study. There has been a tremendous focus on lump sum and the earning loss benefit and the pension and the debate about the who, what, where, when, why, and what was the best thing. Certainly Veterans Affairs is committed to a wellness model, and the thing I think we haven't hit on so much is the rehabilitation side, some of the significant costs incurred in providing rehabilitation.

I wonder if you could just tell the committee a little more about the wide variety and a bit about the costs involved, and the case of Ron, in your briefing package, who receives a modest amount, but who would receive a tremendous amount of services on the side.

Ms. Janice Burke: I would leave it to Brenda to talk about the costs associated with rehabilitation, but in terms of the mental health supports for our clients, with the new Veterans Charter, obviously the rehabilitation piece is key, because that's what provides the holistic approach to treating their conditions. Before, we would focus on that psychiatric condition. We are seeing clients in our system now with a combination of chronic pain, addictions, and psychological disorders. The new Veterans Charter, the rehabilitation piece, allows us to treat that holistically, whereas before we would not have. If you're talking mental health, I don't know what the program is costing us, but we also have our operational stress injury clinics across the country that can now do more than ever. We did have them prior to the new Veterans Charter, but because of the new Veterans Charter these clinics can now expand and do more than they ever could for these clients who have mental health conditions.

We have a host of other programs. We've got over 2,000 service providers who specialize in mental health registered across the country. We have over 200 clinical care managers who provide the daily contact with their clients with mental health issues. We have our peer support program across the country, volunteers who provide social support and peer support to our clients. We haven't costed all the components, but I can tell you, from my perspective, we now have a system that deals with the majority of the determinants of health, which we did not have before, and I think that's what makes these programs more advantageous for clients with mental health conditions.

In terms of costs....

● (1140)

Ms. Brenda MacCormack: We have provided some information in the deck regarding costs, which looks at expenditures of $12.8 million over the time period the benefits have been in place. When you're looking at those costs, it's important to understand these are new costs, over and above treatment that would have been provided in the old scheme.

I want to touch a bit on the difference in the nature of the treatment that was and is available. In the previous scheme we were able to provide medical treatment—physiotherapy, and those kinds of benefits—to an individual who had a disability pension. But we were only able to do that after they were in receipt of a disability pension, which sometimes meant they were waiting for six months or a year to get a pension that would enable the treatment. It was a benefit-driven type of system, where if they asked for the treatment and the doctor said they could have it, they would get it.

The way the system works now is much more proactive in terms of looking at what the person's needs are. The case manager is always involved with someone who is in rehabilitation. There is a multi-disciplinary group treating the client that the case manager liaises with. We're not just bound to treat the pensionable condition—for example, if someone has other types of health conditions that are creating barriers and that are interacting with the primary condition, we'll treat that as well. In the case of André, for example, if he is experiencing some depressive symptoms, some coping symptoms, we can help with that. We're not just going to provide him with what he needs for the amputation.

Mr. Ben Lobb: Another comment I've heard is that it is sometimes a little cumbersome, and the veterans aren't quite happy with how long it takes to begin receiving services. On the delivery side, I'm wondering if you could tell the committee what initiatives you have to cut red tape to be able to deliver the services in a quicker manner to the veterans.

Ms. Jane Hicks: Certainly. There has been quite a bit lately. One of the initiatives in the past month is that we have increased authority to the case manager so they can make decisions immediately. They don't have to rely on their client service team managers or other authorities. We've delegated authorities within the regions so they can make decisions in a more timely fashion.

We are trying to ensure that people are trained and up to speed and comfortable with some of the cases we see, as they are very complex. We are making sure they have the resources in place to assist them with these cases. In some of the offices across the country we have access to clinical care managers who can provide assistance to the case managers. We have regional rehabilitation officers. There's an increased access to resources. There have been improvements in resources, and certainly the caseloads.

There's work under way in the district offices to enhance the capacity of our case managers so their caseloads are lower than what they had been previously in order to give them more time to make decisions.

● (1145)

The Chair: Thank you, Madam Hicks and Mr. Lobb.

We will now go on to Madam Sgro, for five minutes.

Hon. Judy Sgro (York West, Lib.): Thank you very much for coming this morning.

As always, everyone coming before us represents the department extremely well. I think your care and compassion always comes across. Yet it continues to concern many of us about what I think is the department's desire to satisfy the needs and so on. We continue to hear of other problems. What we are trying to do here is find ways to correct those problems.

When we look at Antonio's situation, or Ron's, or any of the others, you think, how could anybody complain about this? They get a lump sum and then they get these monthly benefits. Why should anyone be complaining? Yet there are still lots of issues.

Before the charter, what would any of these cases have received as a lump sum payment compared to what any of them receive today? If you look at Antonio, and he gets $260,000, what would that lump sum payment have been before the charter for that kind of injury of loss of limbs?

Ms. Brenda MacCormack: In the previous scheme, it was not a lump sum payment that was paid; it would have been a monthly disability pension. In some cases there would have been specific kinds of allowances, depending on the nature of disability. From that perspective we didn't have large lump sum payments, except in cases where there was some retroactivity and we needed to catch up on the payment. That would be the time we would grant a lump sum. The other time would be when they were small amounts of money. Those were the only lump sums that would be given.

Hon. Judy Sgro: Pre-charter, Antonio would have received exactly what he's receiving now, more or less, $2,000 or whatever the number is per month.

Ms. Brenda MacCormack: No, pre-charter he's not.... We're looking at the comparisons, and this goes back to Mr. Stoffer's question. The comparison here is of what he would receive now under the new Veterans Charter with what he would have received as a financial stream under the legacy disability pension system, if you're just looking at the financial pieces.

Hon. Judy Sgro: But we did not have a lump sum payment previously.

Ms. Brenda MacCormack: No. That is correct.

What the new Veterans Charter essentially does is set up an entirely new rehabilitation support scheme. As part of setting up all these rehabilitation supports and approaching the question in such a different capacity, you have to think about the compensation scheme that goes along with it. When you are thinking about disability management principles, there is a basic premise that you can't pay people more money to stay at home than to go to work. You have to strike the balance with providing enough of a financial benefits stream that people can live with dignity and be supported, or in cases where they can go back to work, that they have an incentive to go back to work. Trying to strike that balance is pretty important.

All of the wellness programs are there, and then the financial stream is twofold. One is the lump sum—the disability award, which is recognizing some of the non-economic impacts of disability; it's quality-of-life factors, those kinds of components. Then there's the second set of benefits, which includes the earnings loss benefit, a permanent impairment allowance, the supplementary retirement benefit. That is the ongoing, monthly financial stream, which continues to be available. What is different is that it's based on their salary and is payable to them while they're participating in the rehabilitation program, or if they are unable to work, is payable to them until age 65.

Hon. Judy Sgro: But there is no escalating clause in it, given the fact they are not moving forward. How many of the vets ever ultimately achieve employment?

Ms. Brenda MacCormack: It's early days. We have probably close to 3,500 clients currently in the program. We've had about 500 complete the program. So it is early to be looking at what kinds of outcomes we're achieving, but we have some early information that is telling us that a large percentage of people, when they complete the program, are getting employment.

I want to also point out that rehabilitation is not just about getting people jobs. It's also about improving their capacity to function in their family units, in their community, and if possible in their jobs. We will over time have better information about what kinds of outcomes we're achieving. We give people surveys when they enter the program, when they leave the program, and then two years out. We're looking at areas such as what their health status is when they're coming in, what their employment status is, what kind of financial resources they have, how they are integrated into their community, and whether they feel recognized for their service. Those are all pieces that we'll be measuring over time to look at what the impact has been, but we're certainly seeing, in early days, that we're having significantly positive impacts on mental health in particular. We have a number of individual cases that I've personally seen in which the kinds of outcomes we have been able to achieve are extraordinary—people with mental health conditions, which Janice spoke so eloquently about, who did not have hope in the past and now have it. They have the opportunity.

It's hard to measure the value of that opportunity. If you're giving the right services by the right people at the right point in time, you can have a tremendous impact on someone's life. This is the piece that is maybe not being talked about enough. It's not necessarily well understood, and we haven't seen as many public results as we will see in the future.

If Janice....

● (1150)

Ms. Janice Burke: Let me add to that. As Brenda indicated earlier, about one-third of the folks in the rehabilitation program have been released for longer than eight years. When you consider that 50% of them have mental health conditions—in fact, up to 75% of them are struggling with mental health, though they may not have full-blown mental illness—we're dealing with a group of veterans who did not have the benefit of early intervention. Because of that, we're dealing with a lot of addictions and chronic pain types of disorder, on top of the psychological conditions.

It is a very complex group of clients we are dealing with in the rehabilitation program. Had we had the opportunity to get that earlier intervention, I think you would probably be seeing different results or perhaps shorter periods of time in the rehab program. This is important to consider and to understand. These are not veterans just released from the service who have had the benefit of early intervention that we're seeing now, in defence. These are folks who have been out for a number of years and are coming back, and they are seeing hope. They are seeing light at the end of the tunnel. That's why these programs are so important to support.

The Chair: Thank you, Madam Burke and Madam Sgro.

Now we go on to Mr. McColeman for five minutes.

Mr. Phil McColeman (Brant, CPC): I thank you as well for being here and for clarifying certain areas.

There has been a number batted around in this committee from various people, that case managers have been involved in as many as 800 or 900 cases at a time. Is this a manageable number? How often do interactions occur with those veterans for someone who's managing that number? I guess the ultimate question is, are more staff needed?

Ms. Jane Hicks: In terms of the number of case-managed clients per case manager, at one stage it was a high number, as you have mentioned. There's been quite a bit of work in the last year or two to enhance the capacity. We've determined that an acceptable case load for this type of client is 40 to 60 clients per case manager, especially those with complex needs. There's work underway right now, and we've achieved it in a number of instances, whereby case managers only have that. We've reallocated work within offices or within regions so that case managers have much lower client bases.

Mr. Phil McColeman: Just so I'm very clear on what you've just said to me, you're telling me, then, that at one time it could have been as many as 600 to 800 cases for one case manager?

Ms. Jane Hicks: When we say that, we're speaking of all clients. That does not necessarily mean case-managed clients. We would have clients who, for example, would require no services. They might be getting a disability pension but would have no contact with the department other than that; they were fully functional. There would be some who would be survivors or widows. So it was the whole client base.

Mr. Phil McColeman: Just to interrupt, as a business description, I would call these active and inactive files.

Ms. Jane Hicks: Absolutely.

Mr. Phil McColeman: So you're lumping inactive files with active files.

Ms. Jane Hicks: It was everything together.

● (1155)

Mr. Phil McColeman: I guess the point, and I want some verification of it, is that this was an area that obviously needed some attention, and the department has given attention to reducing the case loads.

Ms. Jane Hicks: Absolutely.

Mr. Phil McColeman: Good.

Another area that has been brought up is the red tape area, the area of the forms you have brought today. I've previewed some of these. I know there has to be some degree of red tape and, I suppose, qualification documents and information provided, and they seem pretty straightforward to me. Then again, we've been hearing from certain people that this is an onerous task to ask some of these veterans to do. If they came to you with, let's say, this application for disability benefits form—I think it's about six pages—and said, “I'm really not able to get that completed”, would you offer them assistance to get it completed?

Ms. Jane Hicks: Absolutely. They have a choice of the types of assistance they would receive. They can call us, and a pension officer can assist them and walk them through the process. They could go to an office anywhere in the country and could visit with a pension officer or pension assistant who would assist them in completing that form. The Royal Canadian Legion also has legion service officers who provide assistance and prepare pension applications with members.

Mr. Phil McColeman: At one point in time, some indications were given and some expressions voiced at this committee that certain veterans, when approaching Veterans Affairs, are not treated with respect and dignity. That's a pretty scathing comment, in my mind. It's been testified here; it's on the record.

This is directly opposite to what I experienced when I was at Veterans Affairs in Charlottetown. I was amazed at the amount of care and technique and strategy there was to give the veterans all the respect and dignity they deserved, as well as the benefit of the doubt in any matters that concerned borderline questions about whether there was a disability or not. In comparison with other models that I suppose are similar, I would say it erred on the side of generosity, and, as I said, granted respect and dignity.

What's your reaction to that comment having been made?

Ms. Jane Hicks: I'm disappointed, because as a former director of a district office, certainly if there are examples of that, we would deal with them very quickly, because we do bend over backwards to assist veterans. We recognize that veterans who come to us need our assistance. Some of them have very complex and very challenging issues, and we do what we can to assist them. Sometimes we have veterans who are very ill, who are very angry, and it's very difficult to work with them, so I can understand how some may have an impression such as that. But, again, we try to work with them and their providers and what not to ensure that they're getting the benefits and services they need.

The Chair: Thank you, Madam Hicks.

Thank you, Mr. McColeman.

[*Translation*]

It is now over to Mr. André for five minutes.

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

My question will deal with three different things. I will put them to you, and then you can answer. I will be quick because I do not have much time.

On one hand, you have a good assessment table for evaluating the needs of veterans, but the process has some grey areas. As you know full well, certain cases are contested. Some cases are contentious. Take, for example, someone who, 10 years after leaving the Canadian Forces, notices some back pain. He may not necessarily have undergone a medical evaluation while he was in the Canadian Forces. As you know, cases like that are typical. After some ten years, the person comes back and says that their back pain stems from something they did while on a Canadian Navy ship. That kind of case is contentious.

I would like to know the percentage of those cases. We are aware of certain cases in which the person has been fighting a long time for a disability pension. Now, they have to go up against the entire system to get a disability pension. Those are specific cases. What can be done to settle those cases. How do you assess them?

On the other hand, I want to talk about the lump sum payment and financial advice. As you know, prior to 2006, there used to be the monthly pension payable for life. The new charter sets out lump sum payments and a disability pension of 75%, which is a different amount. I am not sure whether you can give me a ballpark figure, but let's take the example of a 25-year-old who receives a payment of $260,000 and invests it according to the financial advice he gets. You know that there have been some serious complaints: in some cases, 22- and 23-year-olds had spent all their money after two or three years. I have a 21-year-old son, and I do not think I would hand over a large chuck of money to him at his age—let us be clear.

In cases where young people seek financial advice, how do you assess those amounts? With an estimated amount of $260,000, which is the maximum, how do you determine the specific income until the age of 65, for example? Also, would the person not have received a larger amount before 2006, as opposed to the lump sump assessment? I would like to hear your thoughts on that.

Furthermore, last week, we heard from an individual who had suffered from post-traumatic stress. What struck me—and I used to do case work—was the lack of support for natural caregivers, such as his spouse, as well as the lack of information. Obviously, it requires a certain level of confidentiality, an agreement, because the case is ongoing. That being said, there can still be an agreement with the client to at least provide more support to the natural caregiver, in other words, the wife living with the person suffering from post-traumatic stress.

I was also struck by some of the things she said: she had not had much contact with the Department of Veterans Affairs regarding the situation, she had not received much information and she felt as if she had been left out in the cold. And she had discovered that her husband was a bit different because of his mental health problem.

I would like you to answer those three questions, please.

● (1200)

[*English*]

Ms. Brenda MacCormack: I'll start, and I'll invite my colleagues, and hopefully I'll hit on some of the points that you're raising.

In terms of the first question, on individuals who leave the services, who perhaps didn't have an issue and didn't perhaps have medical evidence on the record, what we can do in terms of dealing with those cases now is we can absolutely offer them rehabilitation services. That's one piece that was not there before, where somebody left and they didn't have problems at the time—they perhaps didn't medically release. If that person comes forward now with a back condition, they will be eligible for the rehabilitation program. The eligibility gateway is quite generous in terms of recognizing types of conditions like back conditions that are occurring. We will immediately admit them into the rehabilitation program.

[*Translation*]

Mr. Guy André: Is it automatic?

[*English*]

Ms. Brenda MacCormack: If they have a need and it's related to service.... In the case of backs, we know that in mental health conditions those kinds of musculoskeletal conditions will receive rehabilitation because we recognize that link with service. So we can right away begin to treat them, provide them with whatever they need in terms of medical treatment, whatever they might need in terms of social supports or tools to help them deal with their issue. Perhaps they're having a lot of pain; they need to have pain management skills.

[*Translation*]

Mr. Guy André: It can be an amount for disability, for example.

[*English*]

Ms. Brenda MacCormack: Pardon?

[*Translation*]

Mr. Guy André: It can be an amount for disability.

[*English*]

Ms. Brenda MacCormack: What I'm talking about first is the rehabilitation program.

The Chair: Excuse me, Madam MacCormack.

Mr. André, we're already at six minutes.

[*Translation*]

Mr. Guy André: Okay.

[*English*]

The Chair: The questions are kind of stacked, so I'm allowing the witnesses to finish. If we kick them along, we'll be okay.

Ms. Brenda MacCormack: All right, I'll go very quickly.

I guess the key point here is that we can offer the individual rehabilitation and we don't need to have a disability award or a disability pension for us to do that.

With respect to the lump sum amount and the concerns about mismanagement, those are concerns that we've heard. We've listened to them. We're currently doing a survey of clients who have received disability awards to understand how they're coping with it. We do believe this is a very important issue; it's a very important problem. It probably is affecting a fairly constrained number of clients, but we have to get to the bottom of that, understand how many clients it is impacting on. The financial advice is really important; case management is very important. That's an area that continues to be of focus for us.

In terms of your comment of the lack of support for spouses and caregivers, I think we touched on it earlier in terms of the importance of having people aware of the nature of the services. As we ramp up our outreach efforts, we will do more in that area. The new Veterans Charter offers significantly more for families than we could ever do in the past. We don't just treat an individual veteran as an individual any more. We look at how they function in their family and what kinds of barriers might be existing in the family in terms of having that individual move forward. We can probably do better in terms of making the programs better known, and we will continue to do that. Certainly there is significantly more there now, and they're actively engaged. In the example of rehabilitation, they would be actively engaged with the rehabilitation program, with the case manager, and children may also be....

● (1205)

Ms. Jane Hicks: Under the old system it was particularly difficult to meet the needs of the family. It was mainly focused on the veteran, and that's where you get into the challenges of how do we get benefits and services for the family, for the children. It doesn't fit with the system and the treatment that we have. With the new Veterans Charter there's so much more flexibility, and I think it's much better with respect to families and children.

The Chair: Thank you very much.

Mr. Kerr, for five minutes.

Mr. Greg Kerr (West Nova, CPC): Thank you, Mr. Chair.

Welcome here today. I think you've given some very concise, very important information.

I want to start by saying I'd probably disagree with where Mr. Stoffer came from on a couple of things. I want to make it clear why. Ever since we started this review I've gone back to the department to try to dig into what's going on, what's happening, and so on. I've become more of a believer in the charter, with its flaws, with the changes needed. I think it's fair to say we had people in here as witnesses who had individual problems with government, with the department, or it may have been with the politicians themselves. It was people who just simply said "We want to get back before the charter", and so on.

What I understand is the whole point is the change in direction the former government put in place, which we all endorse, and that is, go away simply from the money and look at the long-term benefits and treatment and support for the individual and the families. They've answered a lot of that, particularly on the mental health side, on some of these things that just would not have been addressed that are being addressed today. I just want to get on there. I think we have a job ahead of us, but I think it's fully on us to ask, "How do we strengthen the charter? How do we make it better?"

Having said that, I know there are some legitimate complaints, and you are or we are addressing some of them. I guess the point is we know that one of the complaints we've heard is that government has not reacted to some of the recommendations coming in. Again, that's not your job so much as it is the minister's and the government's to do it.

If the recommendations that have come through from the review committee were in place—the big 16 we're talking about—what difference would that make in the kind of service you could provide?

Ms. Brenda MacCormack: I think the recommendations we've seen coming out of the various parties have been fairly wide-ranging in terms of what they're looking at. They're indicating gaps in terms of those with catastrophic injuries, whether the financial stream is adequate over time, whether we're providing enough support to families, whether we're using health professionals adequately. There's really a great deal of good information there, and I think there are a couple of ways we're dealing with that.

There are certain recommendations we can look at now to strengthen what we do within the current authority we have, some of the red-tape issues Jane talked about, strengthening case management, making sure our staff are well trained, trying to reduce and simplify. So there are many. The other one is maximizing the authorities we currently have in terms of providing services to families. All of that is under way and will take some time.

Then the remaining gaps or remaining recommendations we do need to look at and assess what kind of an impact they would have in terms of the overall scheme. I'm a firm believer that we've built the right foundation, that we have the right principles. Whatever changes we're making and whatever recommendations we're dealing with need to respect the fundamental foundation that's been built, because it is very much built on current practice, and the most available research, and is strongly supported by academics and experts in the field of disability across multiple kinds of jurisdictions. So I think we would have to make that a priority.

Again, it will not be for us to decide, obviously. It will be a decision of government in terms of what might occur.

● (1210)

Ms. Janice Burke: Yes, and I certainly could add to that. Again, it's going to be a decision of the minister at the end of the day. As you know, in terms of what we can do for families, particularly on the mental health piece and health care, the provinces have the jurisdiction for health care for families. I believe we have maximized to the extent possible what we can do under our current authorities and under the current jurisdictions we have.

I really want to add to that to give you a picture of the landscape across the country in terms of mental health. It is problematic. I think you could say it's a fragmented system right now for people who are living in the provinces and communities. I think the stats are that two out of every three adults who require mental health help are not getting it. I think it's three out of every four children who require mental health supports are not getting them either. So there is a real crisis across the country in terms of mental health, which we hope the Mental Health Commission of Canada will help address in terms of its national strategy. Until we can build that capacity at the provincial and community level for families, we probably have maximized to the extent we can, certainly at the federal level.

Mr. Greg Kerr: Do I have a little time left?

The Chair: No, you're all out. Sorry, Mr. Kerr.

Thank you, Madam Burke. That was an issue we faced when we did the study in the 39th Parliament on PTSD: there's simply not a lot of incoming graduates in psychiatry, psychology, and counselling.

Now to Madam Crombie for five minutes.

Mrs. Bonnie Crombie (Mississauga—Streetsville, Lib.): Thank you, Mr. Chairman.

Ms. MacCormack, I guess I'm going to bring up an issue that's already been addressed by a few people because it's so important. I had the opportunity on Saturday evening to speak to the Polish Combatants Association in Toronto. They were honouring an organization called Wounded Warrior. Are you familiar with this organization and the kind of work it does?

Ms. Brenda MacCormack: I've heard of it.

Mrs. Bonnie Crombie: The executive director pulled me aside after she heard I was sitting on the veterans affairs committee, of course, and wanted to address the issue of the lump sum payment. In fact she asked if she might come to our committee herself to make a representation. They have some very serious concerns. Her son, as well, is in the armed forces. He was injured in Afghanistan and just came home.

The ability of the newer veterans—or especially the older veterans—to manage the lump sum benefits has been an ongoing issue. I wonder if you might want to address that. We have heard in testimony from witness after witness that they preferred the old system of the monthly pension benefits rather than the lump sum payment. Since it's supposed to be a living document, isn't there any way we could accommodate this overwhelming cry from every single witness that they prefer the old system with respect to the pension benefits?

Ms. Brenda MacCormack: At this point, I don't think we have enough evidence to understand how widespread the problem is, which is why we've undertaken a review. We'll contact all disability award recipients to understand the extent of the problem and how they have dealt with it. We have a number of current strategies in place to try to mitigate the problem. I certainly have heard the criticisms. I think our challenge right now is to really understand just how big the problem is. Is it fairly contained in terms of affecting just certain individuals?

Until we have more information that's actually evidence-based and that actually reflects the total population, I think it's really difficult to know the solutions. Certainly it's an issue that's on our minds and that we're looking at. There have been other suggestions in terms of what we might do, such as having structured settlements and paying out over a longer period of time. But I don't think we're at the point yet where we have enough information to get to a solution.

● (1215)

Mrs. Bonnie Crombie: Ms. MacCormack, I just want to interject quickly, because I didn't get the opportunity. There has not been one witness who has come here to tell us that they prefer the lump sum settlement over the monthly pension—not one.

Ms. Jane Hicks: There are examples we've seen of people who have been really wise with their money. They've bought a home or have made a down payment or have paid off their debts. We have examples, and we don't hear about them. We always hear about those who are.... That's why I think it's important to have more evidence. The survey we're going to be doing in the next little while to determine what people have done with their disability awards will be a statistically sound study, and I think we'll have some more information to support or negate.

Mrs. Bonnie Crombie: Well, we do look forward to it. We do hear about those people who go out and buy a home and buy a car, and then they don't have any money to live on to pay their expenses.

Let's move on.

I want to go back to the issue of the catastrophically injured. What percentage of veterans are catastrophically injured?

Ms. Brenda MacCormack: I guess it depends on how you define that, but it's a fairly small percentage overall that would fit into that category. It certainly would be fewer than 10%.

Mrs. Bonnie Crombie: Let's go over again what is offered to those who are catastrophically injured.

Ms. Brenda MacCormack: Under the new Veterans Charter, those who suffer catastrophic injury would get the lump sum disability award at 100%. They also would be entitled to the monthly financial stream, which is the earnings loss benefit, if they can't work to age 65. They would be entitled to a permanent impairment allowance of between $500 and $1,500, which, again, would be indexed over time. At age 65 they would be entitled to a supplementary retirement benefit, which is 2% of the gross earnings loss benefit that was payable.

Just to touch a little bit on your earlier point, I think when people say that they prefer the disability pension over the disability award, I think we need to understand better why they're saying that. There is the mismanagement issue, but there is also the challenge of having people understand the program and the opportunities here. In my own personal experience, I can say that having talked to a number of veterans, and to members of the forces, for that matter, once you sit down and have an opportunity to explain to them what these programs are, what they offer over time, and how they might impact them, they come away with a different impression. Maybe they're not saying that the old system was better. The old system was broken. We had lots of evidence that told us it wasn't working.

Mrs. Bonnie Crombie: Just briefly, where I wanted to go with this was that we heard repeatedly, as well, that the attendant allowance was really important. I wonder if you might want to talk about that. And obviously, there was groundskeeping. They had access to those kinds of benefits previously that they don't have any more. We heard from witnesses that they would like to see those reinstated.

Ms. Brenda MacCormack: The groundskeeping services you're referring to would be available under the veterans independence program. That program remains available to Canadian Forces veterans under this scheme. Any of those benefits that were available previously are still available. So that may simply be a misunderstanding.

Mrs. Bonnie Crombie: What about the attendants allowance?

Ms. Brenda MacCormack: The attendants allowance was a benefit that was available under the Pension Act. Again, it was payable at various grade levels, and it was intended to help people with housekeeping and with personal care, if they needed it. It was a monthly allowance, tax-free, that supplemented the monthly income.

I think that looking at what kind of help was available in the past will be helpful in terms of looking at where we need to make some changes. Some of those services can be provided now under the veterans independence program. Some are under rehabilitation programs, if they're needed.

This charter is about investing in and providing the services people need at the time they need them, which research tell us has the biggest impact in terms of positive health outcomes. But it is a culture change. It represents a significant culture change not only for our veterans and members of the Forces but for our staff and employees as well.

We still have more work to do to achieve the full potential of the new Veterans Charter. And when we combine that challenge with the fact that we have some communication issues in terms of people not understanding the charter, it makes it even more challenging. But I think that's certainly part of the solution.

The Chair: Thank you, Madam MacCormack.

Now to move on to Mr. Casson for five minutes.

Mr. Rick Casson (Lethbridge, CPC): Thank you, Mr. Chair, and I thank my colleagues for this opportunity.

I want to address my questions to Ms. Burke, to deal with the mental health aspect here. I think at the same time that the Veterans Affairs committee was looking at PTSD, we were doing a study at National Defence on quality of life focusing on PTSD, and there were a number of revealing things that came out of that. I was glad to hear you mention the families because a lot of the witnesses who came with us came with a family member for support, and there were all varying degrees of stress or trauma from quite mild to very severe.

Some of the things that came forward were that if you were in the regular force and you were close to where your unit was stationed, you had more opportunity for treatment. If you were reserves and you were far away from where your unit or any of your colleagues was, it became harder to get service. There is an urban-rural split, it seemed, just generally; you mentioned that in Canada alone, just the general population, getting help for mental health issues.

So I certainly hope that some of these issues have been addressed. Maybe you can address that, and the fact that PTSD sometimes is not apparent for quite a while, and then the addictions and the instability in the family and the inability to work and cope with people around you start to appear. So you may leave the forces and you may sign something to say you feel good, you're young, you're ten feet tall and bulletproof, nothing is going to bother you, and then months later you collapse.

So I'd like you to talk a bit about what has been put in place—maybe not so much with the Veterans Charter, but try to relate it to that if you can—for these types of folks.

● (1220)

Ms. Janice Burke: Thank you.

Actually, as you indicated, on the impact on families in terms of people with mental illness, it's recognized that it doesn't just impact the individual, it's the whole family, and the whole family needs to be part of the solution and be part of the planning too. So I think it's recognized that that's an issue.

When you talk about the rural-urban split, about 33% of our clients with mental health conditions live in rural areas, and the remainder are obviously urban. So that is creating a challenge not only for our department. Other federal departments have clients in rural areas, and the same with the provinces and communities. So what we're doing is we're implementing tele-mental health, for an example. We have that in most of our clinics across the country. We have ten clinics. We also have now providers who have come on board with tele-mental health, and we've done a few pilots and we find that that's helping. Through the pilots, we found that the clients are actually benefiting from it. It's probably the health professionals who don't feel as comfortable utilizing that capability, but we are doing things like that.

I don't know if you know this about our OSI clinics, which I think is just fantastic: they do spend time in the communities going to different providers and putting on conferences to share the knowledge and transfer the knowledge around how to treat people who have PTSD and their families. So we're doing a lot of work in that area. We also have peer support people who do travel to the rural areas, obviously, and provide support to families, and to veterans as well, who have mental health conditions. So that's happening. And we do have the VAC assistance line, which they can call 24/7 if they're struggling, if they need some assistance. So that is available as well for the people in the rural areas.

But it is an issue, and it's interesting that you raise it, because we are starting a pilot in Newfoundland. We thought it was a good place to start because of its vast geography and the fact that a lot of their clients—more than the national average—live in rural areas. We're working with the province, with communities, and with other federal partners to see how we can better support people who live in rural areas. It will be interesting to see what comes out of that that would have applicability across the country. So we are certainly doing more around that.

Your second question was around mental health...? I should have taken notes and I didn't. I was too intrigued by your questions.

Mr. Rick Casson: It was just the family aspect. I think you've addressed most of it.

It's going to be interesting to see the results of this survey you're taking on how this lump sum money is being handled and who's benefiting and in what way, because it is a number one issue. People just pick that and they don't like it. To see some of the other numbers that go along with that, that's interesting.

To wrap up—

The Chair: You have to get to your question quickly, Mr. Casson.

Mr. Rick Casson: Okay.

Do you work with family resource centres, and how important are they to the whole issue?

Ms. Janice Burke: Absolutely, they are key. As a matter of fact, just in Mental Health Week,which we celebrated not too long ago, one of the things we did was to involve the family military centres in joining up with the district offices with their peer support program with DND around the mental health area. So we're very connected with the military family resource centres. Their primary role is to provide services to the military families, but really, they don't turn people away, so they are seeing our veteran families. They are absolutely key. It's a wonderful support to families, and they rally a lot of support in the communities. They educate communities around the needs of families too, so it's a fantastic organization for families.

● (1225)

Mr. Rick Casson: Thank you.

Thank you, Mr. Chair.

The Chair: Thank you very much, Mr. Casson and Madam Burke.

We'll move to Mr. Stoffer, for five minutes.

Mr. Peter Stoffer: Thank you, Mr. Chairman.

Folks, you had talked about the survey you are doing. I was wondering if you could ask the department if we could have a copy of that survey for our committee and what kinds of questions you're asking, so we can see how that's going on.

Also, you talked repeatedly about families. Of the four forms you have here, on two of the forms you ask the veterans if they are married, and on the other two you don't. On the application for earnings loss benefits and on the rehabilitation program and vocational assistance you don't ask the person if they're married, and yet you talked about families being very important. Why wouldn't you ask on these forms if that person is married with children?

Ms. Brenda MacCormack: That's a good observation. I will certainly take a look at that in terms of rehabilitation.

Mr. Peter Stoffer: Yes, it doesn't say it anywhere on here.

The other one here....

First of all, Mr. McColeman talked about the benefit of doubt clause being applied in some cases. Of all the VRAB decisions that come on my desk that I have seen on veterans I've worked on for the last 12 years, I have yet to see the benefit of doubt clause applied to any VRAB decision that I have ever worked on. Where it happens I don't know, because they constantly ask. You have to have new medical information in order to do this. But that's not necessarily Veterans Charter stuff. That's a bone I have to pick with them.

But here we talk about the complication of the forms. Now just picture this: you're in a LAV and six of your buddies are killed, two are severely injured, and you're injured. You have PTSD like we couldn't comprehend. You're now asked to fill out this form within 120 days, it says. We've heard testimony that sometimes the forms sit on a table for months. They just can't touch it. They don't want to go near it.

The first question is, why the 120-day limit?

Secondly, a lot of veterans say that every single member of Parliament uses them for photo ops—and that includes us, too—and say they're the greatest Canadians, and everything else. Yet on the bottom of this declaration, and I don't even have to do this for my mortgage or a line of credit or anything else that I get to do, it says, “I declare that the information provided here is, to the best of my knowledge, true and complete and knowing that it has the same force and effect as if made under oath.”

The veterans I've talked to who have to fill out a form of this nature ask why they are being treated with suspicion. This is how they think because of their mental state. They're heroes of Canada, yet when they fill out a form seeking assistance it's like it's made under oath. It's like they're under suspicion. This is part of the problem these forms have.

And by the way, I can fill out these forms, but if I had a severe disability, as my friend Rick Casson had to fill out.... It says to fill out section D, F, G, or D, E, G. A person under mental strain is going to have great difficulty doing that. Plus, you say attach this form, attach that form, do this, do that. A guy's got to go through hoops to fill out this document. This is not simplistic enough, and I'm being frank and honest.

For a person who is mentally stable, this is not a problem. This is just a process and you do it and on you go. But for someone suffering, and their family is suffering, this is not helpful, even if someone is on the phone walking you through it. So as a suggestion to you, is there any way these forms can be looked at to simplify them and to put the trust back into the veteran? The veteran is not applying for something they don't think they deserve. They're applying because they believe they deserve this.

So if you could comment on that, it would be greatly appreciated. These two forms over here are fairly straightforward, but these two over here for the lost benefits and for the rehabilitation program, I would definitely include families and children on that. And also, there should be a form here asking if this information can be released to your family. It doesn't say that. But I'll just leave that with you.

Thank you.

Ms. Brenda MacCormack: Thank you for your comments on the form. I think they're very helpful.

Your point about how potential applicants might perceive some of the language that's there is an important one, in terms of certifying that it was made under oath. Essentially what that statement is about is that whatever is there is taken at face value, taken as the truth, and there's no additional looking to try to support it. But I think your comment in terms of how that's perceived is an important one.

The 120-day issue is in legislation. That's why that is there currently.

In terms of somebody experiencing some mental or psychological issues, these are exactly the clients we would expect to be helping with. If someone is transitioning out of the military, and if we look at what we have set up in the integrated personnel support centres where you have everyone there working together for the client, we should know about that client and about his psychological issues long before he has to fill out an application form. That would be part of the transition process. That would not be a form that we would be giving that person individually to take home. We would be filling it out with them, telling them they're eligible for the program, and putting those services in place before they leave the services.

There certainly are a lot of supports there to assist them. Maybe they're not as aware of those supports as they need to be and maybe we could do better in terms of reaching out and making sure they are.

● (1230)

Ms. Jane Hicks: In terms of the 120 days, certainly for someone who can't fill it out or is not well, there is flexibility to consider that application well beyond the 120 days.

Ms. Brenda MacCormack: Absolutely, that discretion is there.

Mr. Peter Stoffer: Thank you very much.

Ms. Janice Burke: In response to your question, there is activity under way to streamline. That has been recognized, I think, even through our peer support coordinators who work with people who have PTSD. As you've indicated, it's a struggle sometimes to get up out of bed, never mind having to complete forms.

That is an area that's being looked at in terms of how we can streamline. There are certain legal requirements for forms in terms of accountabilities and authorities and that kind of thing. We're looking at ways in which it can be streamlined so that better support can be given to people who are not in the right place in terms of completing it and the assistance that can be provided.

The Chair: Thank you.

Because it's germane to this very subject, I have a quick question, if the committee will indulge me.

When someone is catastrophically physically injured, there's an officer assigned to that person's case. Is that correct? If someone is catastrophically injured with post-traumatic stress disorder, is that the case as well?

Ms. Jane Hicks: Yes. For anyone with a severe injury, there would be an assisting officer from the military assigned, as well as a case manager from Veterans Affairs.

The Chair: I was speaking directly to Mr. Stoffer's point. In the case where it's obvious that the person is going to be severely affected, they would have somebody shadowing them right away.

Ms. Jane Hicks: Yes.

The Chair: Very good. Thank you.

We'll now go to Mr. Mayes and Mr. Tweed, who are going to share five minutes.

Mr. Colin Mayes (Okanagan—Shuswap, CPC): Thank you, Mr. Chair.

I was here when our government decided to go forward with the charter a number of years ago. It's good to be here now and hear that it has given you the tools to do your job better and provide that care.

I really do appreciate the deck that you provided. Obviously, those are the facts.

The one challenge that I see is the buy-in of the veteran. You have to have a willing client. I'd just like to hear a few words about that. There are people who unfortunately, maybe through their experiences, have a hard time fitting in and wanting to take that help. Could you give me an overview as to the number of clients to whom that happens and what you do to try to get them into the system?

Ms. Janice Burke: I could probably start.

In terms of particularly clients who have mental health conditions, who are transitioning out of the military, I think it's fair to say that most of these folks would prefer to remain in the military. It's partly perhaps because of their illness as well, but there is a lack of trust, maybe, in the system, that the system can work for them. That's why we have our peer support coordinators working with them.

That's very powerful, because it's people who have been through similar experiences that they have. It's people who have struggled, but they sought help and they got treatment. They got the services through perhaps the new Veterans Charter or through the counselling through the clinics, and they got the support for their family.

They work with them. They listen, they assess, they try to refer, and that's the objective, to get people into the programs that can help.

We are finding that it is significant and it is helping these folks. But there's no question that we have to recognize that there is sometimes anger in terms of leaving the military, and there is distrust.

So we need to work with them. It's a complex process to transition people from military to civilian life, and it takes time.

● (1235)

Ms. Jane Hicks: As Brenda mentioned earlier, it's a big cultural shift, a big change. The old system was about money and treatment and the new system is about wellness, outcomes, and quality of life. It's very different. So if you look at the single dimension of money, of course we'd all be happy with more money, but it doesn't necessarily mean better outcomes.

Certainly as a district director in Ottawa, the problem we often encounter is people who had lower percentages of chronic back pain, 10%, 15%, 20%, who couldn't work, and it was all about money. They needed more money. It wasn't intended to be a program to replace income. They didn't have enough money, but there were no other tools we could use to assist them and help deal with that pain and earnings loss. We would see it time and time again. So they would become focused on the pension system and other conditions they had and how they could get more money, as opposed to getting better and reintegrating and re-establishing in civilian life.

The Chair: Mr. Tweed.

Mr. Merv Tweed (Brandon—Souris, CPC): Thank you very much.

I represent Brandon, which has Shilo in my community. I want to start by thanking you. We get great service out of the office there and the people we deal with.

I want to comment on the form. I'm not being critical of Mr. Stoffer's position, because I think we want to make it as easy and as accessible as possible. I believe the scrutiny you provide is to make sure you are providing services in an orderly fashion to the people who have most need.

One of the challenges I hear is with regard to family counselling. I have veterans and soldiers who have returned from service saying they don't have access, there's not enough of them, there's some hesitancy to deal with them in certain situations in public facilities. In small communities a lot of people know what other people's business is.

Is there a process to provide more of those family counsellors? I've had representations made to me from family counsellors who tell me they've been asked but can't provide the services because they can't get paid for them, and the veterans have to go through a process that directs them to the counsellor who is providing the service. Could you address that?

Ms. Janice Burke: I could start. Certainly there's a recognition that this is very important to the veterans and the family to have access to the counselling. We have a vast provider network, certainly for mental health supports: social workers, psychologists, and that kind of counselling. We have over 2,000, and it's even greater than that when you look at all providers.

Marriage and family therapists—I had met with that group as well, and they offer a tremendous service. We are probably the first department to do this, but we have added them to our provider registry in Quebec, where they are regulated now. And I think they're moving into Ontario, and there's movement across the country to get registered in their province, because that is the key challenge for that particular group. Fantastic services, and they really offer a lot to families that are struggling.

Ms. Brenda MacCormack: The other resource that's readily available to families for counselling is the VAC assistance line that provides 24-hour service, where they can be set up with a counsellor, and then, depending on the circumstances, transition to community resources. If they are within the VAC treatment program and if they're a veteran, there are certainly lots of opportunities for us to provide and pay for that direct care, provided the resource is available. As Janice pointed out, that's a challenge across the country, and we're looking at various means.

● (1240)

Ms. Jane Hicks: Certainly the registered providers we have can bill us directly. Often we have clients who are going to providers who are not registered; then we have to reimburse the clients. So we encourage clients to go to registered providers. It makes it a lot easier.

The Chair: Thank you very much.

[*Translation*]

Mr. André, you have five minutes.

Mr. Guy André: I want to share my time with Mr. Vincent.

My question is quite simple: do you speak French? Whenever I ask you a question, you answer in English. I will take my question a step further, because there are veterans who complain that they do not have access to adequate services in French.

Today, I asked you some questions, and each time, you answered in English. I would like you to answer my question. First off, why do you answer in English? And are services available to veterans in French? I am asking because I have gotten a number of complaints about that.

Ms. Jane Hicks: Absolutely. Services are available to veterans in both official languages across Canada, especially when it comes to the calling network, which is available in both official languages; we have an English line and a French line. Even the district offices have francophone and anglophone counsellors, especially in Ottawa, Quebec and New Brunswick. Services are available in both languages throughout Canada. Occasionally, there are problems with service providers, but, generally speaking, it works.

Ms. Brenda MacCormack: The reason we chose not to speak in French, even though we can, is that—

[*English*]

The Chair: Excuse me, Madam MacCormack.

Go ahead, Mr. Tilson.

Mr. David Tilson (Dufferin—Caledon, CPC): I think it's fair to question the process, but I think it's most inappropriate for Monsieur André to question witnesses as to which language they're going to speak. They can speak English or they can speak French, just as you or I can if we wish.

[*Translation*]

Mr. Guy André: Can I respond, Mr. Chair?

[*English*]

The Chair: On the same point, Mr. André.

[*Translation*]

Mr. Guy André: Quite simply, I think it is an important issue, because there are a number of veterans complaining that they do not have access to services in French. I simply asked the witnesses, who are employees of the Department of Veterans Affairs, if they could speak French. I think it is very relevant in terms of implementing the charter and providing services to French-speaking veterans.

I do not see why Mr. Tilson has a problem.

[*English*]

The Chair: You can return to your questioning.

I think the point Mr. Tilson is making, if somebody has a language preference and can articulate their answer more effectively in one language than the other, then of course they always have the freedom here of speaking in either official language. That's why we have translation.

So certainly continue with your answer, Madam MacCormack.

[*Translation*]

Mr. Guy André: Now that I have asked my question, Mr. Vincent will take over.

Mr. Robert Vincent: You are all directors. I just wanted to know whether people in more senior positions could speak French and communicate with people in French. I was just wondering about that.

Earlier, if I am not mistaken, we talked about the 75% amount allocated to an individual who receives a disability award of 100%. That person would receive 75% of the gross amount they were making at the time of the incident. Earlier, Ms. Sgro said that the 75% plus the lump sum payment of $260,000 added up to a lot of money.

I did a few quick calculations. Over a period of 40 years—in the case of a 25-year-old receiving the pension until the age of 65—$260,000 works out to $542 a month. So that means $542 a month plus a pension. If that person was making $40,000 a year, they would receive a gross amount equivalent to 75% of that, in other words, $30,000, which is subject to source deductions, leaving the person with around $21,000. If you add $6,500 to that—I did another calculation using the monthly amount to get the total annual amount —it comes out to approximately $27,000 a year.

So the person who received a disability award of 100% gets $27,000 a year; that is all. If they have two children and a house payment, how can they live on $27,000 a year?

● (1245)

[*English*]

Ms. Brenda MacCormack: The way the earnings loss benefit is currently constructed, it's 75% of the salary they were making at the time of release, and the minimum standard is—

[*Translation*]

Mr. Robert Vincent: That is gross.

[*English*]

Ms. Brenda MacCormack: —the senior private, which is $46,000, so they would be receiving $36,000 a year. The $21,000 in terms of the annual amount that one would be receiving would not be realistic in terms of how it's—

[*Translation*]

Mr. Robert Vincent: Very well. If I understand correctly, an entry-level private in the Canadian Forces makes $46,000 a year. He enlists and makes $46,000 a year. I was sure they earned $40,000 a year, but if you say it is $46,000, I will take your word for it. My calculations were based on a salary of $40,000; 75% of $40,000 is $30,000, and that is gross, not net. So it should actually be 75% of $46,000, which is $36,000, less source deductions.

Regardless, I am not sure that that is enough for someone to support their family on, when they themselves need special care on a daily basis because they are quadriplegic and have a 100% disability. How can they survive on that?

[*English*]

Ms. Brenda MacCormack: That's a very important question in terms of the level that is enough to enable somebody to participate in rehabilitation if that's the goal, or live their life with dignity over the longer term if they're unable to work. Those kinds of observations certainly have been made by many of the groups that have looked at the new Veterans Charter, and the sufficiency of the income stream in certain cases has been identified as a gap. It's one of the areas that's currently being looked at by the department in terms of what is enough.

There's a lot of geography across this country, but I think the challenge is to sort out a reasonable monthly income stream in the variety of different circumstances we have. They may well be entitled to other streams of—

Mr. Robert Vincent: [*Inaudible—Editor*].

The Chair: Mr. Vincent, we're way over the time limit now. I'm trying to be fair to everybody, and I have ten minutes left.

Mr. Kerr and then over to Mr. Oliphant and Madam Sgro.

Mr. Greg Kerr: Thank you, Mr. Chair.

We've heard quite a bit about the difficulties for the new vets, and Afghanistan is mainly mentioned. How do you see your programs adjusting and changing as their needs and demands come into focus? What kind of pressure is that going to have on the charter itself?

Ms. Brenda MacCormack: The programs as they're currently structured certainly go a long way to meeting those needs in terms of the focus on rehabilitation: giving people opportunities to live independently; the capacity we have to look at the person, their situation, their family situation, their community situation; and trying to respond in a more holistic way to achieve the best outcome possible.

I think we certainly have that properly constructed, and that will continue to evolve. We have built into the legislation the capacity to continue to evolve the rehabilitation program to be in line with best practice as we go forward. So as new evidence comes forward about the most appropriate kinds of interventions that achieve the best outcomes, then we're well positioned to respond to that.

In terms of the other complementary benefits—and we've had lots of discussion here today about the financial benefits and whether they are adequate—those issues are currently being looked at. Not only have we had multiple reports from committees, but we also are undertaking an internal evaluation of the new Veterans Charter, which is looking at how it's working and if it's going to be prepared to respond in the future.

So it's all those pieces, not just the new Veterans Charter, but the complementary pieces that need to go along with that, like enhancing case management so we have staff prepared to deal with these clients, making sure we have the appropriate mental health supports in place across the country.

We're on the bases. We're building relationships with the Canadian Forces at the local level, and that's where we're going to see lots of solutions for these clients, because our people are involved from the get-go. From the time they're injured, there's an opportunity to build the trust, do the transition planning, and carry on.

● (1250)

Ms. Janice Burke: When you compare our population of clients who have been to Afghanistan in multiple deployments and are suffering from mental health issues, 56% of them are under the age of 39; in our general population of veterans who have mental health conditions, 14% of them are under the age of 39. The number of our veterans under 30 is growing.

If we didn't have this kind of programming in place, the only thing we could offer them would be a disability pension; and again, it would be the focus on illness and promoting that way forward, as opposed to, if they're transitioning, we can work with them in terms of getting them to better integrate into the communities, better support their families, help them with the job and their economic benefits. It's really helping us meet the determinants of health. We haven't been able to do that before.

Mr. Greg Kerr: Thank you.

The Chair: Thank you, Mr. Kerr and Madam Burke.

Now to Mr. Oliphant, then Madam Sgro, for five minutes.

[*Translation*]

Mr. Robert Oliphant: I want to begin by thanking our interpreters. Thanks to them, we are able to speak to our witnesses in either French or English. That is one advantage of a bilingual institution. Thank you for your professionalism and hard work.

I have two questions.

[*English*]

First, I'm wondering if you can quantify—and you may not be able to do it today, you may need to do it in a written submission—the training or expertise exchange that is going on between the centre and research capacity and ability on mental health issues particularly, and the caregivers who are the service deliverers. How much money is spent on that? How many trips are there? How many conferences are there? What kind of a learning exchange goes on? I've heard there is one, but I am doubtful it's big enough.

Ms. Janice Burke: I can't speak to how much it's costing to do that, but I can certainly emphasize—and this is another tremendous capacity that we have with our operational stress injury clinics, the ten clinics we have across the country—that they are involved not only in outreach to the community and to the physicians in the community and the providers, in terms of educating, best practices around how you treat people, but they're also involved in research. They're also affiliated with the universities, or defence, or the Canadian Institute for Health Research—they're affiliated with that as well—so they're looking into some very interesting kinds of research, things like resilience and risk factors for post-deployment, for injured, such as why it is that some people go through traumatic events but come out the other end fine, while other people do not. I mean, they're looking into a lot of different research, and the clinics are a prime area for that in terms of data and that kind of thing. So there's some really interesting research.

We're also looking at integration of our veterans into the workplace. That research is happening. We have, for example—

Mr. Robert Oliphant: If I could, then, get a little bit of quantitative detail on that, in terms of hours or numbers or dollars, it will be helpful. I suspect I'm going to be advocating for more, no matter what it is, because it's my job. And I think it will help you, if I have the numbers, to demand that your minister goes to Treasury Board to get more money to do the kind of work I think is necessary.

I'll also be advocating for two centres of excellence, and I have already made this public. We need Canadian-born research because I think the cultural context of soldiers returning to Canada is different from the cultural context in the United States. There's a different sociological reception. So I'm pushing hard on a Quebec centre and an Alberta centre,

● (1255)

[*Translation*]

two centres of excellence in post-traumatic stress research and the research of other mental health conditions.

[*English*]

I was going to ask about dental care and teeth grinding, frankly, with respect to post-traumatic stress disorder, and the difficulty some veterans are having in the bureaucratic maze they're going through. They are grinding their teeth because of PTSD, it's been acknowledged, but they can't get crowns replaced because of the rules. Can't we get more flexible on this?

Ms. Janice Burke: I could perhaps answer that, only because of my previous life in the disability pension program. Bruxism, or people who have had problems with that.... Certainly it's acknowledged that it's consequential to PTSD, and we've done that. So if there's a disconnect between the award that's provided and then the treatment.... Again, it's all in their benefits grids, and things are mapped. It's definitely something we should look into. But it's certainly recognized, and it's an unfortunate consequence, again, of PTSD.

[*Translation*]

Mr. Robert Oliphant: I had no idea what bruxism meant.

[*English*]

Ms. Janice Burke: I'm surprised I remembered it too.

The Chair: Thank you very much.

I want to ask, Madam Burke.... We have four minutes, and I'll give you a brief moment to summarize, if you wish. Did you say there are 500 CF members right now who have post-traumatic stress disorder and are still in the service?

Ms. Janice Burke: Yes. Well, actually, 50% of the clients who have Afghanistan service are still in. But in terms of the overall population of our clients who have a psychiatric condition, because it's more than only clients who have had deployment to Afghanistan, it's 12%. So 12% of our clients who have psychiatric conditions are still serving.

The Chair: Am I wrong in saying that this in and of itself is a large paradigm shift? Ten years ago, if you were diagnosed with PTSD, you would be discharged. Is that correct?

Ms. Janice Burke: Yes, absolutely. I think that's a really positive story as well, because it shows they're getting early treatment, early intervention. Things are happening in terms of reducing stigma in the military. That has the effect, then, of keeping people employed in the military, which is where they want to be. So it is a good outcome.

The Chair: Well, Mr. Stoffer's the only one who was.... This committee's only been around since the 39th Parliament. At the beginning of the 39th Parliament we were hearing there's still a large stigma. To hear now, already, that there are that many who are still enlisted is something that's very heartwarming, actually.

Ms. Janice Burke: It's starting, yes.

The Chair: Do you have any closing remarks, Madam MacCormack?

Ms. Brenda MacCormack: Yes, I'd like to thank you for giving us the opportunity to speak to you today to explain more about the new Veterans Charter. I hope we've been able to convey some messaging about what's different with the new Veterans Charter in a positive way. As we move forward, I think it's important for us to maintain the foundation we've built but to take a serious look at where there are fundamental gaps in terms of meeting the needs of individuals into the future. We're absolutely committed to doing that, so thank you.

Some hon. members: Hear, hear.

The Chair: Thank you very much. Thank you for your good answers and your service to veterans.

I want to advise my colleagues, because we're going to constituency week now, you have a new calendar that the clerk has provided based on all the agreements we made in the last business session. Our witnesses will be Francine Matteau and Harold Leduc when we return.

Yes, Mr. Vincent.

[*Translation*]

Mr. Robert Vincent: It has to do with the new calendar. I noticed some changes. The old calendar we had in March included a study on suicide, and it is no longer there. But I think we agreed in March that one of our next studies would focus on suicide.

On Tuesday, I found out that we would be studying veteran homelessness later. But I did not understand that discussing it in the steering committee automatically meant that we would study it. In March, I thought that the calendar had been determined and that we would be studying the issue of veteran suicide before the end of June.

I understand that Bill C-473 takes precedence, because it is a bill. We did not object to that, because that is how things work. But when I looked at the new schedule, I was very surprised to see that the study on suicide had completely disappeared and was no longer on the calendar for the months leading up to June.

● (1300)

[*English*]

The Chair: The suicide topic is still on the list, Monsieur Vincent. However, because of the time constraints and the other parties we had, that's what the committee agreed upon until the rising in June. When we get back in September, we'll have a business meeting right up front and then we'll see what's left on the party list. The committee will decide as a whole what will be the first priority.

[*Translation*]

Mr. Robert Vincent: But if we do not have enough time to study it before the end of June, it will take priority when we reconvene in September, correct?

[*English*]

The Chair: That would be the determination of the committee, not my determination, Monsieur Vincent.

I really need to adjourn the meeting; we have other members who have committee obligations.

The meeting is adjourned.

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