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Chair

Mr. Gary Schellenberger

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● (1530)

[*English*]

The Chair (Mr. Gary Schellenberger (Perth—Wellington, CPC)): Welcome, everyone, to meeting number 28 of the Standing Committee on Veterans Affairs.

Pursuant to Standing Order 108(2), we are studying combat stress and its consequences on the mental health of veterans and their families.

Today as our witnesses we have, from the Department of Veterans Affairs, Janice Burke, director of mental health; Raymond Lalonde, director, National Centre for Operational Stress Injuries, Ste. Anne's Hospital; and Tina Pranger, national mental health officer. Welcome.

Janice, if you're going to lead the proceedings off, please go ahead.

Ms. Janice Burke (Director, Mental Health, Department of Veterans Affairs): Thank you very much, Mr. Chair and committee members.

As the chair indicated, my name is Janice Burke and I am the director of mental health for the Department of Veterans Affairs. With me to also respond to questions is Raymond Lalonde, director of the National Centre for Operational Stress Injuries, and Dr. Tina Pranger, who is our national mental health officer for the Department of Veterans Affairs.

We are very pleased to be here today to talk to you and provide you with information on what the Department of Veterans Affairs is doing in the area of mental health and how we're responding to the needs of veterans and their families who have been exposed to trauma or operational stress injuries in the military, and how we are supporting them in their re-establishment and transition to civilian life and to their communities.

The presentation deck in your package has more details, certainly, than what I will cover, but we hope it provides you with information to assist you with your study regarding combat stress and its impact and effects on the mental health of veterans and their families.

Operational stress injury, for folks who may be new to the committee and may not be aware, is a term used by National Defence, Veterans Affairs, and the RCMP. It's defined as a persistent psychological difficulty resulting from operational stress in duties performed while serving in the Canadian Forces or in the RCMP. I need to point out that it is not a medical diagnosis; it's just a term to describe a broad range of medical diagnoses such as anxiety, depression, and post-traumatic stress disorder.

Response to operational and combat stress has been described also in different diagnostic terms over the years, from the American Civil War to World War I and World War II. It's been stated as things like soldier's heart, battle fatigue, shell shock, and psycho-neurosis. So the name has evolved to being recognized, in 1980, as post-traumatic stress disorder in the diagnostic and statistical mental disorders.

The type of trauma that can result in a significant stress reaction can range from threat of death or threat of serious injury, to the viewing or handling of bodies and the witnessing of human degradation. Reactions to such stress, I must point out, are normal, and with early intervention, education, counselling, and treatment, we believe that the impact of trauma on veterans and their families can be reduced significantly.

The development of severe post-traumatic stress disorder and other mental health conditions we believe can also be prevented, or at least the symptoms reduced significantly.

An operational stress injury without proper and early intervention and treatment can lead to things like, and not in all cases, absenteeism from work, unemployment, family relationship problems, alcohol and drug use, social isolation, involvement with the criminal justice system, homelessness, and risk of suicide.

As in the case of the general Canadian population, stigma remains a major impediment to achieving early intervention and preventing mental illness or preventing the severe impacts of post-traumatic stress disorder.

I have to point out that there has been considerable work by the Department of National Defence around reducing stigma and educating about operational stress injuries through the education that's provided by their speakers bureau network and other anti-stigma campaigns they've had under way.

The establishment of the VAC/DND operational stress injury and social support program, which is also known as OSISS, and the joint network of over 15 operational stress injury clinics has allowed us to ensure early referral, diagnosis, assessment, treatment, and psycho-social education. And this has helped, we believe, to reduce stigma, achieve early intervention, and improve treatment outcomes.

Pre- and post-deployment education and screening of Canadian Forces members and appropriate timely referral to counselling and other services are also making a difference. For example, we know that approximately 53% of our VAC clients who have service in Afghanistan and who have a service-related disability are currently still serving in the military. So we have 1,504 clients with Afghanistan service who have a disability benefit relating to a psychiatric condition, and of those, 797 are still serving.

To support veterans with mental health conditions and their families in their journey to recovery and to ensure their successful transition and re-establishment to civilian life, Veterans Affairs has put in place several important measures. I'm not going to go into the details. We may cover it throughout the session, but you'll see that they're listed in your deck in slides 17 to 21. Also listed in the deck, from slides 22 to 23, are initiatives that are in process of being implemented but are not yet completed.

● (1535)

These initiatives, I have to point out, are built around the Department of Veterans Affairs mental health strategy framework. Our framework focuses on ensuring that a continuum of programs and services are in place to fully meet the needs of veterans and their families. These areas include economic, social, health, and physical environment supports. These supports can be provided either through Department of Veterans Affairs programs or through community, provincial, and non-government organizations.

Our strategy, therefore, also includes enhancing awareness of the needs of veterans and their families in the communities where they live; building sufficient capacity in our programs and in provincial and community programs to effectively treat veterans and their families; and ensuring that there are no gaps.

Partnerships in the area of mental health are therefore extremely important to veterans and their families, and to the Department of Veterans Affairs. You will see from the deck that we are putting an unprecedented focus on not only strengthening current partnerships with National Defence and veterans organizations, such as the Royal Canadian Legion, but also on nurturing new partnerships that will improve programming, services, and supports to veterans and their families in the communities where they live.

It is important to emphasize, as well, that while all of the initiatives listed in the deck contribute to improving transitioning and the re-establishment to civilian life for our veterans and their families, the implementation of the new Veterans Charter—with its focus on recovery, wellness, and independence—has been, and will continue to be, of paramount importance to the recovery of veterans with mental health conditions and their families.

The new Veterans Charter is also enabling Veterans Affairs staff to provide more holistic case management to veterans and their families who are struggling with their mental health, and to treat all barriers including medical, psycho-social, and vocational that are affecting their re-establishment. The new Veterans Charter does not limit supports to the medical treatment of a veteran's pensioned condition, as was the case prior to the implementation.

I would like to acknowledge and emphasize the importance of family in the veteran's recovery process, and highlight that military trauma has significant impact not only on the veteran but also on his or her family. In recognition of this, Veterans Affairs has improved supports to families, beginning with the implementation of the new Veterans Charter. Families are now part of the veteran's rehabilitation and case management plan, and they receive treatment, counselling, and support if needed from the operational stress injury clinics.

The clinics have recently developed, in partnership with community organizations, two unique psycho-education programs for children affected by operational stress injury. The first is a ten-week program for children ages eight to twelve who live with a parent affected by an OSI, and the second is a six-session program for youth ages twelve to sixteen.

With the new Veterans Charter, the veteran's spouse can receive vocational assistance if the veteran, because of his or her mental health condition, is not able to participate in rehabilitation or employment due to his or her disability or death. Income support for the family is also guaranteed if the disability is such that the veteran cannot be gainfully and suitably employed.

In addition, more resources have been added to our OSISS program—and that's the peer support program I mentioned earlier—to provide more peer support to families and to strengthen our volunteer network.

I'm not sure if you're aware, but we have a volunteer network of peer support people across the country who volunteer their time to provide support to families, to peers, and also to those who are in the bereavement process.

Veterans Affairs is also forging partnerships with national, provincial, community, and non-government organizations to raise the awareness of veterans with mental health conditions and their families, and to improve access, coordination, and delivery of required supports in the communities where they live.

As a final remark, I want to mention that suicide prevention is a priority for Veterans Affairs. I know your committee has a special concern in this regard. We recognize, as you do, that one of the most devastating and tragic consequences of serious mental, physical, social, and emotional problems occurs when someone takes his or her own life.

● (1540)

Although we do not know the rate of suicide in the veteran population or in our VAC client population—the rate of suicide we hope will be obtained through data, through work with Statistics Canada and National Defence, and we'll have that in early 2011—we do know that even one death by suicide is too many.

Veterans Affairs also provided training to all staff in the area of suicide prevention in 2009. That's all front-line staff. We have suicide protocols in place for use by all staff who work with veterans and their families.

In addition, in 2010 we undertook a review of our approaches to suicide prevention, and as a result we are now implementing several recommendations to strengthen suicide prevention within Veterans Affairs Canada.

We actually have Dr. Tina Pranger here with us today. She is the author, with folks from our research directorate, of those two reports and the recommendations. If there is interest, even at a later time, we would be pleased to go through that in detail with you.

This concludes my opening remarks. Thank you for the opportunity to appear before you. We look forward to responding to any questions you may have.

The Chair: Thank you.

The first question will be from Ms. Duncan. You have seven minutes.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Mr. Chair.

Thank you to the witnesses for coming.

I am going to begin by making a few comments about concerns I have.

I really think we need to focus on the epidemiology, the extent of the problem. What are the causal factors? What are the warning symptoms for families? Prevention has to be our goal.

In stating that, there is currently no mechanism in place to say how many Canadian Forces personnel or veterans have been treated for an operational stress injury, anxiety, depression, or PTSD or how many have needed in-patient care. That national database is critical for understanding the extent of the problem. It would allow us to evaluate various clinical interventions, and it could be used to target education and training initiatives.

I'm also concerned that the automated medical record-keeping system, which was to be operational in 2008, was delayed until 2011 and is now delayed until March 2012.

Another concern is the mental health survey, which won't be undertaken until 2012. Some of these recommendations go back to 2002.

I'm going to focus on treatment. There is considerable variation across the country. If we look at the five regional mental health centres, there are delays of up to four weeks for treatment. In the last week alone, I have had ten requests, from very desperate people, for psychiatrists. I was on the phone last night until midnight with two of those people. Is four weeks okay when you have people suffering from PTSD and worse?

● (1545)

Ms. Janice Burke: I can begin. Thank you for your question.

I'll try to go in order, based on what your first questions were.

You mentioned your concern about the epidemiology and the causative factors. In terms of the research we have on PTSD, at least, it has been pretty well identified in terms of the cause. I agree with you in terms of prevention or at least minimization of symptoms. It is extremely important. That's what makes PTSD so complicated.

Our Canadian Forces, by virtue of the kind of work they do and the kinds of deployments they are undertaking, are exposed to trauma. It's part of their functions and duties. That's why the work the Canadian Forces is doing in terms of pre-deployment screening and pre-deployment education and post-deployment screening when they come back post-deployment, which occurs either at the three-month period or at the six-month period to pick up on signs in terms of reducing the impact of the trauma, is so important.

Ms. Kirsty Duncan: Sorry, I'm going to interrupt. The answer I'm looking for is we're waiting.... Some of our people are waiting up to a month for treatment. Is that okay?

Ms. Janice Burke: No.

When we look at wait times for treatment.... As you know, Veterans Affairs Canada does not actually provide health care to veterans. However, we do purchase and we do have our operational stress injury clinics that can provide immediate access to veterans who are in need of that access.

Ms. Kirsty Duncan: They get immediate access.

Ms. Janice Burke: Yes.

Raymond, I think you can respond in terms of even our turnaround times for people to get into the clinics.

Mr. Raymond Lalonde (Director, National Centre for Operational Stress Injuries, Ste. Anne's Hospital, Department of Veterans Affairs): Maybe for clarification, when you were talking about five centres across the country with wait times, you're probably talking about the Canadian Forces operational trauma clinics.

At Veterans Affairs, we have nine outpatient clinics across the country. We have over 2,000 service providers. All Veterans Affairs veteran clients have access, if it is urgent, to any public service medical attention, emergency psychiatric services; they're all available to veterans. They can go in. If there is an urgent need, they can go to any hospital or resource centre in their community to get help. As far as Veterans Affairs, they can be referred to private providers. In most of the country, we have very good coverage with the 2,000 service providers.

We have to remember that we have over 13,000 clients with mental conditions. Having 2,000 service providers registered with the department to provide services is a very large number. In our OSI clinics, once we receive a referral from the district office, we can see the clients based on need. Normally, our turnaround time for the initial visit is 15 working days, but if there is an emergency, the client can go to the public services. To come to the clinic, we say 15 days, but once we have a contact, we are in charge of the clients and we assess the level of need. Depending on the situation of the client, he could be seen in a week, he could be seen in a month. It depends. He is taken in charge by the clinic.

● (1550)

Ms. Kirsty Duncan: My understanding is it's 15 days to get the appointment, and then 15 days is the hope for treatment.

As one young man said to me.... I don't even want to use his words, they're so awful. He said those wait times don't mean anything when you've got both barrels of a shotgun....

Ms. Janice Burke: Absolutely. In those situations, in our VAC office, a case manager is generally assigned to veterans, particularly veterans who have more severe PTSD and require rehabilitation. It starts with the case manager who is working with the veteran, and if it is identified, obviously, that the veteran is either suicidal or there are major issues where they require treatment—

Ms. Kirsty Duncan: As long as they know about them.

Ms. Janice Burke: Yes, that's the key. But if I could add as well, when we have people within 72 hours.... For example, because we have agreements with seven treatment centres that treat PTSD, co-morbid conditions, PTSD and substance abuse, we have been able to get people into these centres. We have seven of them across the country. As you pointed out, the importance is our awareness of the individuals and ensuring that they get the support of—

The Chair: Okay. You will have to do it in the next round.

Mr. Vincent.

[*Translation*]

Mr. Robert Vincent (Shefford, BQ): Thank you, Mr. Chairman.

Have you read the Report of the Canadian Forces Expert Panel on Suicide Prevention, which was prepared in 2007? You say you want to know the number of suicides in the armed forces. You'll find the data for the period from 1995 to 2008 on page 9.

That same report also states: "Expansion of the CF's mental health staff will shortly result in Regular Force members having approximately twice as many mental health providers per capita relative to Canadian civilians."

How many new mental health professionals have you hired since 2007?

Mr. Raymond Lalonde: Your comment concerns the Canadian Forces, not us. The distinction has to be made between the Canadian Forces and us; we are the Department of Veterans Affairs.

The Canadian Forces were normally supposed to double their strength, which they did or are about to do.

As for us, since 2007, we have doubled the number of clinics specialized in the treatment of post-traumatic stress. We now have nine out-patient clinics, in addition to a residential clinic. So we've doubled capacity. We also have 2,000 service providers. As we said earlier, we have agreements with clinics which have residential programs, private hospitalization programs, where PTSD and substance abuse problems can be treated. Our seven clinics really respond to the demand of our clientele.

Mr. Robert Vincent: How many of the individuals you have treated for post-traumatic stress problems have committed suicide? Do you have any figures to provide us?

Mr. Raymond Lalonde: As we told you earlier, there will be a study—

Mr. Robert Vincent: At your hospital, clinicians treat patients, but you don't know whether any of them have committed suicide. Is that what you're telling me?

Mr. Raymond Lalonde: It's provincial clinics that we fund.

Mr. Robert Vincent: I visited your hospital. I saw people suffering from post-traumatic stress disorder on the third floor. So there are people dealing with this problem who are recovering at your facilities with a view to returning to society. Have any people who have come to you for specific post-traumatic stress care committed suicide?

Mr. Raymond Lalonde: There are definitely some people who have been seen in our clinics at one place or another across the country who have committed suicide.

Mr. Robert Vincent: But with regard to your institution, you don't know.

Mr. Raymond Lalonde: I don't have the figure to hand.

Mr. Robert Vincent: No one at Ste. Anne Hospital has figures. You treated Private Couture. Does his name mean anything to you?

Mr. Raymond Lalonde: Not to me.

[*English*]

Dr. Tina Pranger (National Mental Health Officer, Department of Veterans Affairs): The information we have is anecdotal. We hear from the district office staff who hear from the treating clinicians that people have died from suicide, but at this point we don't have a mechanism for recording that, and this certainly is one of the recommendations we have for ongoing work.

[*Translation*]

Mr. Robert Vincent: I'm trying to understand. In that particular case, the man lost a leg after walking on a bomb. He was treated by you for a post-traumatic stress problem and committed suicide. No clinician or any other person who monitored that man told you that you had lost one of your patients, that that person had committed suicide, whereas it occurred in your hospital?

● (1555)

Mr. Raymond Lalonde: There have been no suicides in hospital.

Mr. Robert Vincent: No, he committed suicide at his home.

Mr. Raymond Lalonde: We have to get the information from the family to determine whether there has been a suicide.

Mr. Robert Vincent: The media were all over his case.

Mr. Raymond Lalonde: Some cases get media coverage, but it's still anecdotal in that the information disseminated here and there isn't systematic. If the family doesn't inform us, based on a coroner's decision, that it's a suicide case, we can't count those cases, determine their number. On the other hand, the Canadian Forces have their own health service. The doctors belong to the Canadian Forces and handle... It's not the same situation.

Mr. Robert Vincent: I agree that an individual wounded in a theatre of operations or suffering from post-traumatic stress disorder isn't a veteran, but he is nevertheless treated by you.

Mr. Raymond Lalonde: Not necessarily.

[*English*]

Ms. Janice Burke: If I could respond as well, you're absolutely right that we do know what causes suicide is multifactorial. We do know that serious physical injury like amputations, serious chronic pain, psychiatric disorders, stressful life events, even imitation.... And when people may see their colleagues or the media report suicide, that can also be a trigger. We know that access to lethal means is also another factor, also effective care and barriers to care like self-stigma.

I understand the point you are trying to make, that there are causes to this. We do know that. Yes, you're right, these are causes. What we're trying to focus on within Veterans Affairs is how, to the extent possible, when we know that these risk factors exist, that someone has chronic pain, amputations, severe psychiatric conditions, they are undergoing serious life situations.... In our rehabilitation program we have a number of clients who are very complex. They have combinations of psychiatric conditions, physical conditions, physical pain, musculoskeletal, they have addictions to either prescribed medication or to—

[*Translation*]

Mr. Robert Vincent: I don't want to cut you off, but our time is limited.

Even if these are people who are treated by other clinicians, will you monitor all the cases so that you know what is going on and if there have been any suicides? Are measures already in place for this purpose or are you going to implement any to determine whether people commit suicide following a post-traumatic stress problem?

[*English*]

Dr. Tina Pranger: Absolutely, that is one of the recommendations of our suicide prevention review. We do need to follow up with the clinicians and have better communication between us and the people who are treating clients so that we communicate with each other if someone's at risk for suicide, has attempted suicide, has suicidal thoughts, or potentially has died by suicide. So there needs to be better communication.

[*Translation*]

Mr. Robert Vincent: Are you making recommendations—

[*English*]

The Chair: Mr. Vincent, your time is up for this round.

Dr. Tina Pranger: Good questions.

The Chair: Mr. Stoffer, for five minutes, please.

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

Thank you folks for coming today.

On page 25 you put as your second bullet point that the suicide rate is lower than that of the general population. I ask this in a very respectful manner: Why did you put that in there? Why did you say that?

I had a brief of this and I showed it to a family going through these problems, and they were very pissed off, to be honest with you. It almost makes it look like, “Oh, it's okay”. You said that one suicide is too many, so I highly recommend that you take that out of there; it's not fair to compare the military service with the general population.

Second, a lot of veterans I've been dealing with lately are complaining about the fact that they're not getting help regarding their teeth problems—because as you know, they're grinding their teeth—and their sleep apnea problems. Both of these concerns are very serious for people who have PTSD. They have to go back to DVA, get another assessment, and it literally takes months and months before they get adjudicated once again on these claims.

Is there is a way DVA can balance all of the concerns of post-traumatic stress disorder and the symptoms arising from it together, so that if a person has PTSD and claims they have sleep apnea, they should automatically have the programs available to help them immediately, without having to be re-assessed once again?

My last point is that I noticed that a lot of this is based on our modern-day veterans from Afghanistan and Bosnia. But I'm going to give you the case of Stanley Eisen, from Nova Scotia. He was an 86- or 87-year-old World War II veteran. He claimed he had post-traumatic stress disorder from his World War II experience, and his claim was flatly denied. He died shortly afterwards.

I know many World War II and Korean War veterans who, because of the news from our military in Afghanistan, every time we lose one of our soldiers, relive that moment. They're suffering just as much. But I don't see the department reaching out to World War II and Korean War veterans and those who served from say 1953 to 1994. A lot of those individuals are suffering as well, and I don't see a reach-out to them looking for assistance.

I just put that out as a comment to you. I do thank you for coming.

● (1600)

Ms. Janice Burke: Thank you for your remarks.

On your first point, about the suicide rate, we'll certainly remove that reference. It wasn't intended in that way. We just tried to accurately report the results, because it is a CF study and it's based on the age group that's within the Canadian Forces versus the similar age group in the Canadian population.

On your second point, about the grinding of the teeth and sleep apnea, bruxism, as we all know, is a consequence of post-traumatic stress disorder. People do grind their teeth, and their teeth can be affected as a result, and they may need crowns and those kinds of things. So we are actually looking at those cases, because you're absolutely right. What ends up happening is that the veteran has to come back through the department for a consequential disability claim for bruxism, or for the replacement of the teeth, in order to get the treatment. At the end of the day, what they really want is the treatment.

We have expanded considerably the treatment range for post-traumatic stress disorder. We are looking at that and including those other conditions. Hopefully, the next time we're before you we'll be able to say that's been fixed.

Mr. Peter Stoffer: Okay.

Ms. Janice Burke: Now, with respect to World War II and Korean War veterans, and veterans after those wars and maybe prior to the implementation of the new Veterans Charter, you're absolutely right that we need to be doing more outreach. We actually have an outreach strategy in place where we are trying to reach out more to that particular group. It is a group that's perhaps most at risk simply because they did not have the early intervention that we have been offering since the implementation of the new Veterans Charter, and since the Canadian Forces have implemented significant changes to their mental health system and deployments. We are doing so much more now in transition, with our integrated personnel support centres, than we've ever done before.

So there is a strategy where we are going to try to reach more veterans. We have our *Salute!* magazine. We try to get that out there. When I talked earlier about our partnerships with communities and really trying to do more in communities, you will see listed in the deck that we have things like community covenants mentioned, and that we are working more with the Canadian Mental Health Association, and working with communities, because veterans and their families live in communities. We have not tapped into the networks that exist to ensure that every veteran knows about our programs and our services and how they can be helped. So we are putting a major focus on that. Hopefully, the next time I'm here we can report on progress in that area.

Dr. Tina Pranger: And in all fairness, the veterans who are post-Korea are eligible for the new Veterans Charter program, so as Janice said, it's a matter of the outreach to them. But we've had a great uptake by them.

Mr. Peter Stoffer: Thank you.

The other day in the news we heard that a clinic outside of Petawawa is stopping or reducing services for approximately 400 individuals who are seeking their services. I'm wondering if you can tell us.... First of all, I'm surprised they have to go to a provincial body for assistance. So I just wonder if you could comment on what DVA is about to do for those 400 individuals.

Ms. Janice Burke: Yes, I certainly read the article, and I also read the article today that reported the story wasn't quite factual. We did talk with National Defence, because, as you know, we work very closely with National Defence to ensure that through our network of clinics across the country and our network of service providers there are no gaps in service and that people who need treatment and need to get into counselling get that required treatment.

From a VAC perspective, we have service providers in the Pembroke-Petawawa area. We have our clinic in Ottawa. We're very confident that for any veterans—and there may only have been a few—who may have received counselling from there, it's not going to create a problem. And in terms of National Defence, they did announce today that they are establishing an OTSSC, I believe, in Petawawa. So that is great news for the still-serving members and their families.

● (1605)

Mr. Peter Stoffer: Excellent. Thank you.

The Chair: Mr. Kerr, please.

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

Welcome. We're very pleased to have you here today.

You're obviously aware of the review we're trying to do in a very brief period of time and all the issues that face us. I know the importance of the study coming in next year. Can you talk about that a bit, and what you hope to gain from that? Because it focuses on some of the very things we're going to be talking about as well.

Ms. Janice Burke: I could certainly start, and Raymond could add in.

We have a number of studies that will be coming out. For example, our research folks are partnering with other organizations to do the life-after-service study. Those results, again, will be out in early 2011. And that's looking at the physical health, the mental health, the social health, and the economic health of our veteran population since they have been released from the service. That is working with Statistics Canada.

Also, they are looking at the mortality and cancer study, and that's on data that we've had since, I believe, 1972. So all released members and veterans since 1972 are in that database. That will provide us, again in early 2011, with much more data around the mortality of our veterans and also cancer data.

Those are the two main studies.

Raymond, are there others?

Mr. Raymond Lalonde: Of course in the area of research around PTSD and operational stress injuries, much research has been done across the world in this area, a lot around PTSD from rape, from accidents, and car accidents. There has been a lot of PTSD research done in the States around the U.S. veterans and military.

In Canada the research is growing, but it's starting. For example, there is research being done right now on the use of certain drugs to limit the impact of the traumatic memories around PTSD. There is research being done around the efficacy of some treatment modalities in conjunction with one another—for example, using drugs and exposure therapy, or cognitive behavioural therapy for *conjoints*.

So there is a lot of research to better understand how these treatment modalities can be effective for our population of veterans. And the culture in Canada is different, the military environment is different, and the types of operations that we have undertaken in the past are different, so we need some of our research. For example, in one of our clinics we're also doing a research study on the emotional and behavioural impact on children having a parent who has PTSD, which is going to bring us a better understanding of what the issues are so we can direct our treatment efforts in the right direction.

Ms. Janice Burke: I may not have covered the question quite the way I should have, if you are referring to the suicide prevention report or strategy that we have developed. As I said, we're not waiting to do work in that area, for Statistics Canada to give us data, because that will just give us data. What's important are the reports and review we've done to date and the recommendations we're going to be putting in place this year. If you require more information on that, Tina certainly would be able to give you a summary.

Mr. Greg Kerr: There are a dozen areas I'd like to go to. I realize that, and I think that's why this year's particularly pivotal in making the changes and adjustments. I think it's very important to get on record what you see as the timing of and the unveiling of, if you like, the start point and the measurements that go with it.

I was at the conference Raymond Lalonde was at in Montreal just a couple of weeks ago. I did want to raise a point, because it seems to come through all this. Of course, that's the International Society for Traumatic Stress Studies. For the first time Veterans Affairs Canada was a partner there.

One of the things that was said there, in the brief time I was there, and it seems to be an extremely important thing for us to consider, was about the stigma and the public education or understanding. You hear it over and over again that if only the public—the public being all of us—would treat this as easily as it treats physical injuries, we'd be making a lot of progress in terms of moving forward.

I guess the stigma question is what I wanted to raise specifically in light of that conference. Do you see progress being made such that people, particularly these veterans who are in this circumstance, are more prepared to come forward because the public is more accepting?

● (1610)

Ms. Janice Burke: I could certainly start, and Raymond and Tina can respond.

The post-deployment study, for an example, that the Canadian Forces did to identify any physical and mental health problems following deployments indicated that 13% of the 8,000-and-some they had surveyed indicated they had problems in five or six mental health areas. Because of that, they are being referred and they are being put in counselling.

Anecdotally, what I'm hearing within National Defence is that there are a lot more younger veterans coming forward to the mental health clinics on the bases and to the OTSSC centres, and they are talking more. They are talking about what their issues are. So they're seeing progress in that area.

Even when you look at it from a Canadian perspective, stigma is still a major issue. The Mental Health Commission of Canada, as you know, is embarking on a nine-year or ten-year anti-stigma campaign. We are working closely with the Mental Health Commission on some of these areas to ensure that veterans and their families are considered in all of the work they're doing, including the anti-stigma campaign.

Mr. Greg Kerr: Okay, thank you.

The Chair: Five minutes, Ms. Sgro, please.

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

Mr. Lalonde, it's nice to see you again.

I look at the deck—beautifully done. It's full of information that's valuable and all of that, and the health and wellness framework.... If you listen to the folks I have heard for the last two or three years coming before our committee and when we visit, everything should be just fine, because there's so much work being done, so much outreach being done. Clinics are set up here, there, and everywhere.

We shouldn't have all these other issues that we're hearing so much about in these last six or eight months if we were to believe everything that's in here and everything that we've seen and heard. The best intentions in the world, I have no doubt about that...but there are lots of issues out there that none of this is covering.

The fact is we have veterans who are having to go to food banks in western Canada, who are in a homeless shelter in downtown Toronto. There are all these other issues where people are coming forward and saying they couldn't get heard, they couldn't get help, whatever the case may be.

In spite of all of this, there are some serious issues out there. We're missing the boat somewhere.

Ms. Janice Burke: Yes.

I'll respond, and then certainly you can add to it.

When you look at the system that we have today between Veterans Affairs and National Defence, and what has been built over the years, I feel it's a pretty good system in terms of our having all of the major areas covered.

Are we satisfied? No, we're never satisfied with the status quo. We need to continue to work on it.

What I am seeing over the years is that we're talking about veterans who had been released following the Gulf War, for an example, and their involvement in Croatia. They had been released without the benefit of this early intervention and without the benefit of some of the programs that exist today, without the benefit of the transitioning programs that exist. I feel that because of that lost opportunity, really, it is very challenging for some veterans. They may not even be aware of our programs. That, again, is—

● (1615)

Hon. Judy Sgro: Why are we not able to track them? They all get disability pensions of some sort. Where we send the cheque is where we should send the letter saying "By the way, we're doing all these wonderful services for you. If you need them or you need help, you don't have to go to an emergency ward at the Ottawa hospital where everybody else goes."

We keep putting in place all kinds of things that are there to help the people we care about. All of us as Canadians want to see that veterans have a special place in society. They don't have to go to the emergency ward where I have to go. They can go where they will get that special care. What is wrong with them is probably a result of what they went through in whatever war or whatever period of time.

Why can't we communicate more directly with them so they know that Veterans Affairs Canada cares and is there?

Ms. Janice Burke: That is certainly the role of our district offices. If they are clients, they are in contact with them. We have a proactive screening unit that does proactive kinds of contacts.

I'm not sure whether the group you may be referring to is in our program itself. But there's also a group out there that may not even be aware of our programs. We recognize that we need to do more outreach and get more knowledge and information to these veterans and their families. If they are clients of the department and in these situations, they should be case-managed.

Hon. Judy Sgro: If they are getting a pension cheque from Veterans Affairs Canada, does that automatically make them a client, or is it only when they reach out for a particular service?

Ms. Janice Burke: If they are in receipt of any benefits from Veterans Affairs they are considered a VAC client, and they therefore would be entitled to case management, rehabilitation—

Hon. Judy Sgro: So why don't they know that? Why do they seem to be unable to access this bureaucratic system that we have out there? They're turned off from accessing it, and would rather live in a shelter with next to nothing than go to VAC and have you help them. They think it's a big, crazy, bureaucratic nightmare of a place, and they don't want to be bothered, I guess. I don't know.

Ms. Janice Burke: Are you referring to our veterans who are in homeless situations?

Hon. Judy Sgro: Yes. I'm referring to veterans not going to you and saying "This is my situation. I don't have a place to live."

The Chair: We have come to the end of the five minutes. Can you respond, please?

Ms. Janice Burke: You're referring to veterans in homeless situations. When you look at how they got there, had there been early intervention programs they wouldn't be there. Now that they are there, quite a bit of work is happening through the department in Vancouver, Montreal, and Toronto. We're also working with the Mental Health Commission. There are five or six pilot sites across the country where there are veteran identifiers, and they're being referred to our district office.

We are helping those veterans, but as you indicated, some veterans are saying they would prefer not to get support. We are getting the majority of them into our programs and it is making a difference. Continuing with the outreach and working with the veterans will take time. When a veteran reaches the point where they are either homeless or have a severe mental health condition, it takes time to establish a relationship and trust in the system.

Hon. Judy Sgro: Thank you.

The Chair: Mr. McColeman is next, and then Mr. André.

Mr. Phil McColeman (Brant, CPC): Thank you, Mr. Chair.

Thank you for being here to delve into this study we're embarking on.

Can you discuss the treatments for us? What things would a veteran experience if they walked into one of the OSI clinics? Can you walk us through that?

Mr. Raymond Lalonde: As I said earlier, most of the clinics are provincial ones that Veterans Affairs funds. We have established protocols with the clinics to ensure that the types of services across the country are similar, even though they're delivered by different health authorities.

On the initial contact, the clinic receives a referral from the district office with details on the veteran's needs. The first thing the clinic does is contact the client to set up an appointment. Initial screening is done over the phone to see if there is any urgency or if any issues should be addressed right away. Once the clinic takes responsibility, they ensure that those who are in danger are referred or taken care of immediately.

So the initial activity in the clinic is the screening interview. It's normally done by a nurse, who gathers all the information she needs to present to the clinical team, because all the clinics we have are specialized clinics. They work in an interdisciplinary team of psychologists, psychiatrists, social workers, and nurses. They work together and say, "We have a new client who needs to be assessed. We don't know what the diagnosis is, so we need to do it."

Depending on the initial interview, it may involve the psychiatrist and the psychologist. We invite the family members as part of the assessment plan, because we know that the impact of PTSD is not only on a veteran or the member, it's on the family. So we invite the spouse to accompany the veteran to the assessment so we have a global understanding of the family situation, not only the patient situation.

A standardized test is run. It's the PTSD anxiety scale. Different scales are used to try to understand the condition. A diagnosis is made by the interdisciplinary team—let's say it's PTSD. Then the treatment can start.

For treatment, there are different modalities depending on the condition. We use prolonged exposure therapy, for example. It's a type of treatment where the therapist ensures that the patient relives the trauma. It makes them speak about the trauma and write about it so it comes back. After that session the therapist is able to put things in perspective to make the difference between the situation then and the situation today. Over time, with exposure therapy, the feelings associated with their trauma will diminish.

There are different modalities of treatment that can be used. We use Telehealth as part of our treatment modalities. After an initial assessment at the clinic, treatment can be provided in the home community through Telehealth services. It's a new type of treatment modality we've started using. More than 85 of our clients have already received treatment through Telehealth facilities in their own communities.

They go to the local hospital or any centre that has Telehealth equipment. They might receive therapy from a psychiatrist. The psychiatrist will renew the medication or see how the medication is going. There is group therapy. There is couples therapy and group therapy, like anger management. At the conference two weeks ago we shared with the participants a new anger management protocol for group therapy that was shared with all the participants of the international traumatic stress society conference.

● (1620)

So there's either one-to-one, couples, or group therapy. In some cases we involve the children in group activities. And there's Telehealth. We use drugs and therapy. Those are the basic things you can expect from the clinic.

The Chair: Thank you.

Mr. André.

[*Translation*]

Mr. Guy André (Berthier—Maskinongé, BQ): Good afternoon. I'll quickly ask two questions. I wondered about the death of Private Couture, who took part in your therapy. I saw the film at the time, and it somewhat surprised me to learn that the mother was not aware of what had happened on the battlefield. I understand that a confidentiality rule was observed by the armed forces professional.

The reason for my question is that, in everyday life, in our usual social systems, in our CLSCs, in our suicide intervention structures, when a professional, psychologist or psychiatrist believes that the life of one of his patients is in danger, that that person is mentally unbalanced or wants to commit suicide, he may circumvent the confidentiality rule, professional-patient privilege, and decide to confine or hospitalize that person. That's an intervention process that can be carried out.

I had a question about that situation. I don't know whether you are aware of this type of case. What is the battlefield protocol in the case of a suicidal individual who wants to take action?

The soldier wanted to commit suicide on the battlefield; he had lost a leg. He was subsequently found hospitalized in one of your institutions. Are you aware of that? Are you able to answer that question? Is there a protocol?

● (1625)

Mr. Raymond Lalonde: The first thing I must say is that I can't talk about the case of the client in question, and I am not aware of the details of that case, as the—

Mr. Guy André: I'm talking about a response protocol.

Mr. Raymond Lalonde: All right. With regard to what happens on battlefields, you should ask the Canadian Forces officials when they appear before this committee what the protocols are because we don't know that.

Now I would like to clarify a second point in connection with the question Mr. Vincent asked earlier. The care given to Canadian Forces members wounded in Afghanistan is the responsibility of the Canadian Forces. Those people are not necessarily seen at our clinics. Our clinics are mainly for veterans. In places where the forces have no clinics, we will offer Canadian Forces members access to certain clinics, such as in Winnipeg, where we have a number of Canadian Forces members. However, care is normally provided at National Defence clinics.

Mr. Guy André: What surprises me as well, in the wake of Mr. Vincent's questions, is that you're saying you don't have any statistics on clients who are hospitalized or treated at your post-traumatic care clinics. Those clinics—we visited them—are excellent, and I was amazed and interested. However, there's no follow-up.

So I'm also wondering about that point because there doesn't seem to be any follow-up. We don't know the suicide rate among individuals dealing with post-traumatic stress disorder who are hospitalized at your facilities. They are hospitalized, but one would say no one knows what happens to them after that.

And yet, it seems to me that the entire question of subsequent support for families is very important. Someone who suffers post-traumatic stress changes character, behaviour, and there is a whole adjustment that has to be made with the family. After that person has been treated at your facilities, I suppose there must be psychosocial follow-up, follow-up with the family, to promote that individual's return to society.

How long does that follow-up last? Why is there not more follow-up? I don't understand. You can't tell us that. In fact, it's not you I'm speaking to. It's our system which is unable to tell us how many people have committed suicide. Follow-up has been done with the families. I don't understand. I'm trying to follow, but I don't understand.

[*English*]

Ms. Janice Burke: I can respond perhaps to one part of your question, certainly not to the clinic protocols.

Just so that you're aware, when a veteran comes into our programs there is a full assessment that's completed on the veteran. There's also the screening for suicide as well that occurs. To the extent possible, we encourage the participation of family in the case planning, because they are absolutely key to supporting the veteran in their recovery, no question.

So we do work with the veteran. We work with their families. We work with their providers in the community—their psychologists—to the extent that we have permission from the veteran in terms of discussing and sharing that information. And if there are indicators and if the risk factors exist—and I went through what those risk factors were earlier—those are exactly the signs that our staff, working with the veteran and their family, need to be aware of and need to ensure that the veteran's primary physician is aware of as well.

So we do have protocols in our department in terms of how to deal with clients who could potentially die by suicide, and also for clients who call into our national call centre. Because that occurs as well, when a client will call in crisis, indicating that they wish to take their lives. So we have protocols there. We've given the training. That then works with the case manager in the district office.

Tina, you could perhaps expand upon the protocols.

● (1630)

Dr. Tina Pranger: I also understood you to say, around support for the families, you were interested in that?

[*Translation*]

Mr. Guy André: I'm interested in the statistics on follow-up, the number of suicides, the number of homeless individuals, the number of individuals who are separated—

[*English*]

The Chair: We have to wrap this up.

Dr. Tina Pranger: Yes, we do take into consideration the impact that someone who has suicidal ideas.... They probably have a whole lot of issues going on, and the case managers do ensure that the family of someone who is thinking of suicide is getting support. The case manager helps look after the needs of the family of someone who has died by suicide. So we very much take into consideration the need to support the families in all this as well.

The Chair: Thank you.

We did go quite a bit overboard on that one.

Mr. Lobb.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you, Mr. Chair.

My first question is very specific. It's to do with therapy once somebody's within the system.

I'm wondering, has there been any work or any research done on equine-assisted therapy? What work has Veterans—

Mr. Raymond Lalonde: What work?

Mr. Ben Lobb: Equine-assisted, horse-assisted therapy.

Ms. Janice Burke: Certainly we are looking at that body of research that exists around animal-assisted therapy.

The research to date—and Raymond could certainly speak to it more than I—the body of research just doesn't exist to necessarily definitively support it as improving treatment outcomes clinically for somebody with post-traumatic stress disorder. However, we're continuing to look at that body of research, even if it's not in the context of assisting the veteran in their psycho-social rehabilitation and their integration into communities and things like that. So we're continuing to look at that.

Mr. Ben Lobb: Great. Specifically with that body of research, is that body of research in the research conducted by Veterans Affairs in Canada?

Ms. Janice Burke: No, it's literature research.

Mr. Ben Lobb: Is this research that's been done across the globe? Because it's used extensively in the United States, for sure. They do have quite a few results that are out there in the public domain. So you could maybe just tell the committee a bit more about that then.

Mr. Raymond Lalonde: Well, the research on equine therapy, using horses, has not been done by Veterans Affairs Canada. It has not been done in Canada for the ones we've looked at. It's the same thing with PTSD dogs. It's the same thing.

There has been some research done, but the number of cases used are very few, and also the conclusion is not sufficient to support. It's not evidence-supported to be effective.

So prior to adopting some of these therapies, Veterans Affairs has to ensure that it is effective. Even though there are some, it's not scientifically evidence-supported.

Mr. Ben Lobb: Just so I'm clear, this is the work, you're saying, in Canada.

Ms. Janice Burke: This is the literature research that was done. I think you looked at the Americans.

Mr. Raymond Lalonde: Oh, yes, we looked at what existed across the world.

Mr. Ben Lobb: You're claiming that's insufficient?

Mr. Raymond Lalonde: At this time there's not enough of a body of evidence to support that it is effective.

Ms. Janice Burke: I would emphasize as well that most people would conclude that working with animals has certainly worked in other organizations—I don't know if they've had it in Correctional Services—where there's been supervision and a different type of program. We're certainly looking at it, not necessarily from a clinical perspective but maybe to assist veterans to better reintegrate into their communities and to provide better support. So we are looking at that component of it.

● (1635)

Mr. Ben Lobb: Certainly in the research I've looked at, they pretty well go right down the checklist of issues you mentioned: anxiety, depression, anger, and so on.

So the last question I'll ask, whether we're talking about equine-assisted therapy or therapy using other animals, such as dogs, is what your timeline is. Are we talking about a year, five years, ten years? If the research is heading in the right direction—and it looks as though it is—are you looking at pilot projects?

Ms. Janice Burke: We're actually considering looking at a number of things, up to and including pilot projects. Because our programs have to be evidence-based in terms of what we provide to our veterans, we need to establish that there are going to be benefits. So we're continuing to look at that. We did the research on it from a clinical perspective. That was completed by the National Centre for Operational Stress Injuries. Now we're looking at it from a different perspective, more from the perspective of integration into community life.

Mr. Ben Lobb: Okay.

I'll finish off with a quick question.

I've spoken with a few area councillors, and I think they really try hard to do the best job they can. If there is an issue, from their perspective, what abilities do they have to communicate that issue with the bureaucracy within Veterans Affairs to get the issue dealt with?

Ms. Janice Burke: Well, certainly if there are client issues.... Are you referring to process issues or policy issues?

Mr. Ben Lobb: It would be to do with the inability to deliver the services they feel were necessary for the veteran. What abilities do they have to reach above and say, “Hey, this person has an issue. We aren't delivering the services to them. We have to intervene and help this person”? What's out there?

Ms. Janice Burke: We have very good networks, on the service delivery side, for staff to provide their feedback on things that aren't working. This year we're actually embarking upon considerably reducing complexity around our policies and our processes, because of what veterans have said but also because of what staff have been telling us. Hopefully, you'll start to see some improvements there, for example, even in the disability process, in which we aim to reduce turnaround times by 30% by April.

We're also looking at all of our policies that may have added complexity, for which we may have asked for more information than was even required to make a decision. We're delegating more decision-making down to front-line staff. So I think from that perspective, work is under way. We've certainly heard loud and clear what veterans want, and certainly, from a front-line perspective, we have received feedback regarding what processes and policies could be improved.

Dr. Tina Pranger: And on an individual basis, an area councillor —they're now called case managers—can talk to their managers, to their client service team managers. And if something can't be resolved, then they will bring it to their district directors. And if it can't be resolved there, then it goes to the regional office. So there is a chain of command, so to speak, along which they can take their concerns and have them addressed.

Mr. Raymond Lalonde: I would also add that the minister and the deputy minister have invited the staff to write them directly. Also, on the Internet there's a place for staff to share directly with senior management any initiatives they think we should put in place.

The Chair: Okay, thank you.

Mr. Mayes.

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

I think there are a lot of positive things the department is doing, and obviously you have some positive outcomes.

One of the things I was wondering about is the timeline for rehabilitation. From the time a client comes in, do you have an average timeline? And what percentage of your clients do you feel are actually successful in being rehabilitated and in regaining that mental wellness?

● (1640)

Ms. Janice Burke: While I'm obviously not the expert in the rehabilitation program, I certainly have a tremendous interest in it. Over 50% of the veterans in that program have a service-related disability for a psychiatric condition. Also, I believe it's up to over 70% of the veterans in the rehabilitation program who have mental health needs.

As I said earlier, the veterans who are in the program today have very complex needs. Over one-third, and it may in fact be more than that, were released from service more than five years ago. I think the statistic in one of the samples is that one-third were basically within one year of release and the other one-third were within five years.

We're finding that the people coming into the program with one need—there's a barrier to their vocational needs or obtaining employment—can go through the program much quicker than the people who are coming in with very complex physical and mental needs. As you know, we have to focus on stabilizing, getting their medical and psycho-social needs met, before we can even begin to look at employment possibilities. We are finding that the people who have come into the program more than five years from release are taking longer to go through the program—in fact, more than 24 months.

I think the last statistic—and if it's not correct, I'll certainly ensure that you have the right number—is around 690 who have completed the program since it started. As you can see, looking at a program of close to 4,000, we have a number of people who are benefiting. But they are very complex cases because of the mental health, the chronic pain, and the addictions we're seeing.

We're there for the veterans for as long as needed. If they are successful, they can move into employment. If they can't, we have a safety net for them in terms of ensuring their income. If they do in fact get employment....The process is not linear for people who have mental health conditions. There are often setbacks.

The real benefit of the new Veterans Charter programs is they can come back into the programs any time that's required. That is happening, as well. We have some people who have been out of the program and they are coming back in. It's a safety net. It will be there for every veteran when it's needed and for as long as it's needed.

Mr. Colin Mayes: You've stated that the earlier they enter the program the quicker the rehabilitation and identifying of some of the issues. Is there anyone in the department, or is there any assistance, to make sure veterans who need that help are encouraged to seek it as quickly as possible so you can get started on the rehabilitation?

Ms. Janice Burke: We've been very fortunate since we started these transition interviews that with the new Veterans Charter we can now move them into these kinds of programs.

As you indicated, there is this group previous to the new Veterans Charter who have not had the benefit of the programs. We are focusing on doing more outreach, working with communities—I talked about that earlier—with the Canadian Mental Health Association and with the Royal Canadian Legion's network to get more information on the ground, at the grassroots level, for the veterans we know are there and their families, so they can get this support as soon as possible.

Mr. Colin Mayes: The new Veterans Charter is not perfect, but it has improved everything in the last four years, since its existence. Would you say that is a good observation?

Ms. Janice Burke: Yes, absolutely.

Mr. Colin Mayes: Okay.

The Chair: Thank you.

Ms. Zarac, please.

[*Translation*]

Mrs. Lise Zarac (LaSalle—Émard, Lib.): Thank you, Mr. Chairman.

Good afternoon. Thank you for being here today and for giving us so much information. You are our first witnesses, and we are looking for information.

Wanting to be better informed, I went on the Internet this week and, Mr. Lalonde, I saw that you had attended a symposium on psychological trauma among veterans in 2007. That wasn't so long ago. Unfortunately, there wasn't a detailed report, just press releases. I was wondering whether recommendations were presented at the symposium. Were any recommendations made following the symposium?

● (1645)

Mr. Raymond Lalonde: In fact I only attended it. The symposium was organized by my team, but the purpose of the meeting was not to make recommendations. The symposium was somewhat like the one that was held in November, which we organized in partnership with the International Society for Traumatic Stress Studies. That is a symposium attended by scientists, researchers and clinicians in the field. They present their research, their approaches, and so on.

Mrs. Lise Zarac: These are presentations; there were no conclusions.

Mr. Raymond Lalonde: These are presentations. There were no conclusions or recommendations as such.

Mrs. Lise Zarac: If I'm looking for recommendations, I won't find any in your report.

Mr. Raymond Lalonde: You won't find any.

Mrs. Lise Zarac: I'm always looking for information; I was looking for—

Mr. Raymond Lalonde: If you want information on the kind of research that's being done in the world, in the trauma field, the ISTSS.org website has all the information on the symposium—

Mrs. Lise Zarac: I could find information on the symposium there.

Mr. Raymond Lalonde: —and hundreds of topics were presented —several hundreds of pages of topics. It can also be helpful in understanding the state of research, the questions that are being raised in the field.

Mrs. Lise Zarac: Perfect. We'll go and visit that site. Thank you for the information.

The press releases I found on the subject concern the clinics you referred to, among other things, and I'm pleased to learn that five more of those clinics have been opened. That's good news.

Do they have the necessary resources, qualified staff? We see—and you said it clearly—that 10 clinics have been established. However, I wonder what can be funded with $9 million. You're also telling me that this is a provincial jurisdiction.

So, first, I would like to know whether we indeed have the qualified staff to meet needs.

Mr. Raymond Lalonde: These are provincial clinics, which are funded by Veterans Affairs Canada to serve the clientele of veterans, military members, RCMP members and their families. These are specialized clinics for our clientele. We fund the premises and so on.

Mrs. Lise Zarac: Is funding adequate for the clinics to be open from 9:00 a.m. until 5:00 p.m. every day of the week?

Mr. Raymond Lalonde: Yes, nine of these are out-patient clinics. Every regional health board, every hospital has managed to find staff, and nearly all the clinics have enough staff. Obviously, there is always turnover, but the clinics have normally been able to find the staff they need. That's harder in certain professions, such as psychiatry, but they're managing.

Mrs. Lise Zarac: That's why I was asking the question. A psychiatrist I know did interviews for a year and a half before being hired to do the work. That's where my question comes from. Do you have qualified staff? If it takes a year and a half to hire a psychiatrist... Do you have all the necessary psychiatrists to meet the needs?

Mr. Raymond Lalonde: Yes, all the clinics have almost all the resources they need. It's always hard to replace mental health staff because there's a shortage in Canada. However, we've managed to fill the positions in the clinics. Currently, I can tell you that we have more than 1,500 clients at our clinics. That's a 30% increase since the start of 2010. So the clientele is increasing and the—

Mrs. Lise Zarac: How may psychiatrists are there?

Mr. Raymond Lalonde: I don't have the exact figure for the entire network. There are approximately one and a half psychiatry positions per clinic. Some have two.

[*English*]

Mrs. Lise Zarac: Do I still have time?

The Chair: The last time we had short questions it took a long answer, so we'll move now to Mr. Lobb.

Mr. Ben Lobb: I know you can't give any specific examples, but I think for the purposes of this committee we want to get right to the root of the issues and make sure we feel satisfied that the Department of Veterans Affairs is reacting where it needs to react.

I want to go back to the case manager or area counsellor issue again. I know you can't give specific examples, but I would be interested if you could provide us with general examples of where a case manager has come across an issue that was of concern to him or her and responded and the chain of command has worked. I think we've all had jobs before and we've all worked in management and we know in theory it all sounds good, but in practice does it actually work? If you had some examples you could provide to the committee for our report, it would be helpful in satisfying us that the chain of command actually does work.

● (1650)

Ms. Janice Burke: Obviously I can't pinpoint any case manager or any particular staff. We look for this kind of feedback from all our front-line staff, whether they work in our contact centres or they're actually case managers on the ground working with the veterans. In some of the areas we're looking at in terms of reducing complexity in policies, they have no doubt arisen from ideas from staff.

I'll throw out some that are in the disability process. We know, for example, that the quality of life form that we ask veterans to complete as part of their disability application was intended for veterans who had indicated that they wanted the impact of their disabilities on their everyday life to be considered, as opposed to the medical piece. However, we've found out since, through feedback from staff, that they find some of these forms very daunting to complete. It's not clear to them why it's required. In fact, some of these forms are not mandatory for the veteran to complete either. So we're really looking at the different forms that are used in the pension process, the medical information that we collect, the forms we give to the veterans to take to their doctors—too long, too complicated. We're reducing that as part of the disability process.

Mr. Ben Lobb: We're running short of time, so I want to ask another question.

If a person is stressed out and obviously under some strain from post-traumatic stress and all the other things that go on with even regular life, if that person is in the queue within Veterans Affairs and they are under the earnings loss benefits program and they want to get some training, whether it's in school or whatever vocational training they may pick, I understand there is a bit of a lag between the time they get into the queue before they're actually able to get into the training. I understand the reason is because they have to meet certain criteria for either mental or physical health. Is that accurate?

Dr. Tina Pranger: No, that's not accurate. This is part of the rehabilitation program, and there is medical rehabilitation, psycho-social, and vocational. When someone is referred and it's deemed that a person is ready for vocational rehabilitation, we have external providers, vocational—

Mr. Ben Lobb: Okay, if I can go on that point, you said when "it's deemed". What does that mean?

Dr. Tina Pranger: That is a discussion between the client and the case manager and often the interdisciplinary team.

Mr. Ben Lobb: Okay, that is the point where I understand the frustration comes from, the length of time it takes to be deemed ready. I understand it can be a long time. They're very anxious to get into this training, but the length of time it takes to be deemed ready for it is what frustrates—

Dr. Tina Pranger: But they are part of that discussion. They are clients. They work with the case managers. They are part of that discussion. They have input into it.

Perhaps sometimes the case manager and the interdisciplinary team and all the treatment providers have information about the client that the client may not be aware of themselves. They may not be aware of what some of their limitations are. They might not have the insight into it.

Mr. Ben Lobb: How long would it take until you're deemed ready?

Dr. Tina Pranger: But it—

Ms. Janice Burke: I think the point you're getting at, though, is that there is a delay in needed access for a veteran to get the support. The other program we are looking at within the department in terms of reducing some of that red tape and the delay is the rehabilitation program and looking at the front-end piece, because staff have given a lot of feedback. For example, some of the things we've started doing is putting the decision-making down closer to the case manager, who knows the client and can actually make those decisions without having to involve a whole team of people, or without having to elevate that to head office, which was the case. So in the rehab program—exactly what you're talking about—they are looking at that front-end piece. They recognize there could be a delay in terms of getting the veteran into the program.

Mr. Ben Lobb: Simply to close here, I hope that as the study goes along you provide us with some examples, because I know that's what this committee is interested in. We want to be reassured that these bureaucratic levels are not causing some of the issues that we're studying.

● (1655)

The Chair: Thank you. We have to move on.

We have three more questions, but then we are going to terminate this part of the meeting at quarter after. I have a little bit of committee business that we have to do, so I ask that we try to stay within the five minutes.

We move now to Mr. Stoffer, for five minutes, please.

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

I notice on page 19 that there are no clinics shown on your map in Saskatchewan, Newfoundland and Labrador, and northern Ontario. The territories are understandable, I guess. I was wondering why that would be.

Also, you talk about Brad here, which is not his real name. On the back it says that "VAC will be there to provide support, when needed, for as long as it is needed."

I have a gentleman who had to leave Halifax because he couldn't afford to live in his home any more. He was seeking psychiatric assistance through DVA. Because he now lives in Truro—he doesn't drive a car, because he can't—DVA won't assist him in getting to his psychiatrist in Halifax. They say that he has to pay for that himself. I'm just wondering whether you are aware of this. What can I do to pursue that? I've spoken to the regional director, and they've said no, it's for that area. They don't supply transportation from an area like Truro into Halifax, which is about 50 miles, which is not much.

I just bring that up as a case.

Also, Mr. Lobb talked about and you talked about those forms. Can you send us a copy of all the forms they have to fill out so that we can have a look at them? I know that some of them are quite cumbersome.

One thing that is very therapeutic for veterans is massage therapy. In Halifax, some therapists charge $70 to $75 per session, but DVA's limit is only $58. I've seen the forms these massage therapists have to fill out. It takes a long time to fill out that form to get the $58, even though they charge $70 or $75. They were told that they cannot claim the additional difference. If their rate is $70 an hour, and DVA only pays $58, they cannot get the extra $12 from the client. They're told that. I'm just wondering if that is indeed correct.

Second, if they're not downtown but they're in an outside area and their rates are a little higher, why wouldn't DVA meet the rate of what a massage therapist charges, if that's the going rate in that particular area? Is it just a blanket rate they receive?

Ms. Janice Burke: I could start on some of the questions, and certainly you can respond, Raymond.

The Chair: Again, you have about two and a half minutes to finish.

Ms. Janice Burke: I'm not an expert in health-related travel, but I do know that the policy exists and the benefit exists for veterans if they have a disability benefit relating to service and they have a requirement to travel for their medical appointment or treatment. So we'll certainly look into that.

I obviously can't speak to specific cases.

Dr. Tina Pranger: They pay, and then they're reimbursed.

Mr. Raymond Lalonde: Maybe I could clarify. It's the closest available suitable therapist. If he can get the service in his area, we will not pay for him to travel to another city.

Mr. Peter Stoffer: This is just it. His psychiatrist has been working with him for a while. For him to go to a new psychiatrist would set him right off-kilter again. The psychiatrist and the patient develop a relationship of trust. To ask him to go see another one because he lives next door to one puts a burden on that individual, don't you think?

Ms. Janice Burke: It's certainly something we can look into. Continuity of care and support for veterans is very important. We'll certainly look into the issue you've raised around health-related travel and will also get the copies of the forms you would like to see.

In terms of the rates for massage therapy, again, that falls under the treatment program. I don't have expertise in that, but I do know that they follow the general kinds of basic rates one would have in provinces and what the reasonable rate would be in that geographic area. We can certainly look into that and get back to you on that particular benefit.

You can speak to the clinic piece, Raymond.

Mr. Raymond Lalonde: Why there are no clinics in Saskatchewan and Newfoundland is a matter of the number of clients. To sustain a clinic, you need a minimum number of clients. If it's too small, you cannot justify having a psychiatrist or a psychologist.

As I explained, using Telehealth, the client may come to Calgary and then go back to Regina and get treatment, either by Telehealth or from a local psychologist. That can be supported by the clinic. It's the same thing in Newfoundland, where we're starting to have a number of clients from Newfoundland being treated by the clinic in Fredericton.

● (1700)

The Chair: Thank you.

Mr. Vincent.

[*Translation*]

Mr. Robert Vincent: Thank you, Mr. Chairman.

I would like to raise a completely different problem. What is the procedure for handling the request of a veteran who comes to you seeking care? I know you have to complete a lot of documents. We also know that these people have to appear at a review hearing before the tribunal to have their post-traumatic stress recognized.

How many post-traumatic stress-related applications have to be submitted to the review board? In addition, what is the delay between the moment when the application is submitted and when care is provided?

[*English*]

Ms. Janice Burke: I can respond to your question from a departmental perspective.

For an example, just in this last year, for all of the claims and applications we received for disability benefit relating to PTSD, the favourable rate has been over 80%. The favourable rate is quite high in comparison to all of the general conditions, which is around 70%.

In terms of the processes that we have put in place, when you look in your deck at the increase in claims, the favourable rate, and the number of clients since 2001—we put those protocols in place in 2001 to simplify the application and to reduce the burden around evidence that someone would have to provide to demonstrate trauma—I think you'll see that the trend has changed considerably.

What we don't know is in fact what the rate is in terms of any of the 20% that didn't get approved at the departmental level, what percentage of that went to VRAB, the Veterans Review and Appeal Board, because not all of the cases go, and then what percentage of that would have been favourable. But we can certainly try to obtain that statistic for you.

[*Translation*]

Mr. Robert Vincent: The waiting time between—

Mr. Raymond Lalonde: It's currently 24 weeks, but it will be reduced to 16 weeks. However, that doesn't mean the person can't receive service in the meantime.

Mr. Robert Vincent: All right.

Mr. Raymond Lalonde: We receive these people at our clinics, conduct an assessment, reach a diagnosis and send it to the district office. We continue treatment pending the outcome of the decision process.

Mr. Robert Vincent: But when a person's case is accepted, some compensation is attached to that.

Mr. Raymond Lalonde: In a disability case, yes.

Mr. Robert Vincent: There's a risk that a person suffering from post-traumatic stress disorder will be suicidal. The fact that that person has no income increases the likelihood of suicide.

Do you have any statistics on suicide among individuals whose cases have been dismissed? We're talking about 20% of cases here.

[*English*]

Ms. Janice Burke: To address the very issue that you said, in terms of delays in the pension process for people who really need it and need the treatment, because of the new Veterans Charter, we don't have to put people through the disability process in order to get them into treatment. We can get them into treatment immediately, into our rehabilitation programs, into the clinics. So we don't have to wait for a disability award decision. And that's what changed with the new Veterans Charter. You don't have to have a service-related disability. You're medically released or—

[*Translation*]

Mr. Robert Vincent: To a certain degree, I understand, but as Mr. Stoffer said, treatment can be provided 50 km or 75 km from the home of the person who is suffering and that person may not have a cent. If that person has to travel for treatment which is not yet recognized by the board and, in addition, has no money to pay for that travel, what do you do in that case?

[*English*]

Ms. Janice Burke: Maybe I didn't quite phrase it properly, but that particular veteran doesn't have to wait to get their treatment and to get their treatment paid for while they're waiting for a disability pension or a disability award.

Dr. Tina Pranger: Or their travel....

Ms. Janice Burke: Their travel will be funded by the department when they're in the rehabilitation program. That has been a major improvement to our system since the new Veterans Charter, because prior to that people had to wait until they got a disability pension decision in order for us to get them into treatment. So we can get them into treatment immediately, without waiting for it.

[*Translation*]

Mr. Raymond Lalonde: The decision is made by the case manager at the district office level. Economic support may be offered to replace income. That represents 75% of income. The person does not have to go through the disability process, wait a number of weeks and file an appeal, and so on. Services can be provided in the context of the rehabilitation program.

● (1705)

Mr. Robert Vincent: Yes, but that person's case has to be accepted. If it isn't, does that amount—

[*English*]

The Chair: We have to wrap it up, Mr. Vincent.

The final question, Ms. Duncan, and then I have a couple of things to say.

Ms. Kirsty Duncan: Thank you.

Again, I'm going to come back to prevention. I really believe prevention starts as soon as someone enters the forces, with the education awareness and what the symptoms are.

If I look at the data for the number of clinicians—psychiatrists, clinical psychologists, etc.,—to forces members, we're looking at 32 psychiatrists, for a ratio of about 0.0049. They're saying 350 clinicians for 65,000, which comes out to about 1 to 186. The psychiatrists matter. You have provided information for VAC: 2,000 clinicians registered. I would ask that you table with this committee the number of psychiatrists, clinical psychologists, mental health nurses, social workers, health service chaplains, addiction counsellors, and what the ratio is to VAC clients.

I'm going to finish by saying that I was going across the country last week and we met a veteran who asked for a private meeting. He explained that there are a lot of suffering veterans out there who VAC knows about, and even more out there who no one knows about. They're not followed. He told us of three young veterans who died alone, suffering with PTSD. They had lost their spouses. I'm wondering if there's something we can do.

They come home. They become a veteran. Are they assigned a case manager? Can a case manager have 30 or 40 people they can check on? They've got to be tracked.

Ms. Janice Burke: To go in order of your questions, the reference to the 65,000, I'm not sure if that was the Canadian Forces.

Ms. Kirsty Duncan: Yes.

Ms. Janice Burke: Okay. I can't confirm that number, obviously —

Ms. Kirsty Duncan: I can.

Ms. Janice Burke: —but on the second, we actually have our providers registered in a database. Of the 2,000, we can provide you with what proportion of them are mental health nurses, psychologists, psychiatrists, occupational therapists, social workers.

Ms. Kirsty Duncan: Could that be tabled?

Ms. Janice Burke: Yes.

On the third point you made, certainly it is not acceptable that any veteran is alone and not getting the kinds of services they need. That's certainly an area of concern to Veterans Affairs, if that is happening.

Again, one of the things we're trying to do for the people who are being released is the transition interview, to flag people, and then for case managers to follow them. That's the way the process is supposed to work. We do know, as I said before, that there are a number of veterans who were released after the Korean War, up to 2006, who didn't have the benefit of that process.

We are looking at ways we can do better outreach. Again, it's making people aware, and communities as well. I mentioned the Canadian Mental Health Association. We're doing work with different community organizations who provide social support, and we're working with homeless shelters to try to identify these veterans and get them into treatment.

Ms. Kirsty Duncan: Could they be tracked the way Ms. Sgro has suggested? If they have a pension, are we checking in with them every three months? Are we checking in with them more often?

Ms. Janice Burke: Yes. We actually have statistics on all of our veterans who are in receipt of a disability pension for a psychiatric condition. We know exactly where they're located. We know how many there are. We know their age.

We have done a lot of work in terms of trying to really understand the profile. That information is provided on an ongoing basis to the district offices as well. I mean, they obviously have their own inventory; they do know who their clients are.

Again, this requires more work to ensure that not one veteran doesn't have the support they require. It's really important.

The Chair: Okay, thank you.

Mr. Vincent, I know you had another question and I cut you off. So out of the kindness of my heart, please give us that final question.

● (1710)

[*Translation*]

Mr. Robert Vincent: As the researcher told me earlier, when you're released from the Canadian Forces as a result of a post-traumatic stress problem, you receive an amount equal to 75% of your salary. I understand that. You told me that earlier. The question I want to raise is that, four years later—and the statistics show this—many of those people leave the armed forces on their own. They hang up their uniforms and it's all over.

I would like to know what happens if, seven, eight, 10 months or one year later, individuals believe they need care for a problem that arose when they were military members but that they didn't talk about when they were in service. Those people come to you and tell you they're really suffering from a major problem.

You told me those people had a salary. Is that the salary they're paid when they're released? Or how can they receive compensation when they're still employed, before being released? How long does it take for them to get a consultation if they file an application?

Mr. Raymond Lalonde: If a veteran comes to see us five, 10 or 15 years later because he is having service-related problems returning to civilian life, because he has mental health problems that he was not aware of earlier, the new charter gives us the opportunity to consider a rehabilitation plan.

In the context of a rehabilitation plan, we put services in place to solve medical, psychosocial and professional problems. During that time, even 10 years later, individuals can receive 75% of their salary to support them during their rehabilitation. That amount is indexed on the basis of the number of years that have elapsed since they left the Canadian Forces.

Mr. Robert Vincent: What's the waiting time? Is it the 24 weeks you referred to earlier?

Mr. Raymond Lalonde: No. The 24 weeks is for disability pension applications. It's much quicker for rehabilitation program applications, 95% of which are accepted. Those applications are processed by the case manager at the district office. The case manager responds to them very quickly. I don't know the exact time frame.

Mr. Robert Vincent: I have one final question.

Mr. Guy André: How much time does it take to be called back? Is there a policy on calls made at the Department of Veterans Affairs? Do you have to call back within 48 hours, 72 hours?

Mr. Raymond Lalonde: There is a policy, but I couldn't give you any details about it.

Mr. Robert Vincent: Again on the subject of suicide prevention that we're studying, do you share with the Canadian Forces the data or impressions you gather when you provide clinical treatment to people suffering from post-traumatic stress disorder?

[*English*]

The Chair: Mr. Vincent, it's time to stop. We've gone on. I have allowed you an extra question.

[*Translation*]

Mr. Robert Vincent: I was trying to make it to 5:15 p.m., as you told me. You had to stop me at 5:15. I was trying to get there.

[*English*]

The Chair: Okay. I appreciate the questions and answers. I do have just a couple of things for our witnesses today.

First, you've mentioned various studies that have been done. Some of those that were mentioned today, both from Veterans Affairs and DND, I don't know if there's a way you could get some of them to our clerk and then we'd pass them on to people. That's just in case we can use them.

Again, a veteran is a veteran, but all veterans don't receive pensions. Some veterans have been in the Canadian Forces for four or five years and have decided to go into another field, whether it be police work or maybe work in a member of Parliament's office doing case work, or have gone back to university and those types of things. In order to keep track of those people once they leave, unless they've come to Veterans Affairs with a problem you wouldn't have any know-how of where those people necessarily are. A person doesn't have to be a veteran, doesn't have to have served in Afghanistan or Croatia, and doesn't have to have served outside the country. They can be in the Canadian Forces for that time. They're still a veteran, correct? So every person who comes out of the military does not have a pension.

I know that because my father was a veteran and he now gets VIP. That's something we should all remember, that people are classified as veterans—and I would hope that no one would ever have to go to a food bank. But some of those people have come out of the service and maybe at an earlier time have made the decision that they wanted to be civilians again. Am I correct when I think that way?

● (1715)

Ms. Janice Burke: Yes, absolutely.

When you look at the veteran population—and that's through a Statistics Canada study that was done, I think it was back in 2002—749,000 is the estimated veteran population, and our client population is 218. So we're very fortunate in terms of the number of people who are leaving the military and that they are leaving in good health. They often have no need or requirement for our programs, but there are veterans who do. As I said before, we need to be doing better outreach to ensure that all veterans are aware of our programs in case there is need.

The Chair: Great. Thank you very much.

I appreciate your answers today here for everyone.

I ask that we take a little recess here. We have to do a little bit of business. It will only take a minute or two, but we have to do it in camera.

Thank you again.

[*Proceedings continue in camera*]

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