HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 038 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Tuesday, June 5, 2012

Chair

Mr. Greg Kerr

Standing Committee on Veterans Affairs

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● (1605)

[*English*]

The Chair (Mr. Greg Kerr (West Nova, CPC)): We're back in business. I appreciate your patience. We had some committee business we had to deal with.

As you know, we're continuing the study of transformation initiatives at Veterans Affairs Canada.

Today, we have Veterans Affairs and National Defence representatives. I want to say welcome and thank you very much, the four of you, for coming in. I think you know how this works: ten minutes to each pair and then we go to questions from committee members.

Ms. Pellerin, are you starting today? Carry on.

Ms. Anne-Marie Pellerin (Director, Case Management, Rehabilitation and Mental Health, Department of Veterans Affairs): Thank you, Mr. Chair.

Good afternoon, and thank you for the opportunity to participate in this session.

My name is Anne-Marie Pellerin, and I'm the director of case management, rehabilitation and mental health services. I'm joined by my colleague, Lina Carrese, who is the scientific director of the National Centre for Operational Stress Injuries. We also have with us today Raymond Lalonde, who is the director general of the operational stress injury national network, and Nathalie Pham, who is a client service team manager in our Montreal office.

We're happy to be here to support the committee's study on transformation at Veterans Affairs. We realize the time is tight and we have a lot to cover, so I'll get started.

[*Translation*]

Recently, Veterans Affairs Canada found itself facing an unprecedented shift in veteran demographics. Traditional veterans are, sadly, passing away in great numbers while the modern-day veteran population is on the rise.

We have also noticed that many modern-day veterans are being released from service with more complex health and re-establishment needs.

[*English*]

These factors have forced us to re-examine what we do and how we deliver service as a department in order to meet these changing needs and expectations. The results of this examination have led us into this process of transformation designed to improve the quality, timeliness, and efficiency of services, and to ensure that we are fully responsive to the diverse and changing needs of those we serve.

VAC case management services enable veterans and their families to establish and achieve mutually agreed upon goals through a collaborative, organized, and dynamic process. This interactive, problem-solving process is coordinated by the VAC case manager and includes six core functions: engagement and relationship-building, a process of building and establishing trust; comprehensive assessment, which is the gathering of information and identifying the needs of the individual; analysis, which is synthesizing information gathered from multiple sources; case planning and consultation, which is to establish mutually agreed upon goals with the veteran and family in consultation with health professionals and other experts; monitoring and evaluation, to identify whether the plan is working and to make adjustments as required; and finally, disengagement, which is ending the current case management relationship when goals are achieved. It is important to note that re-engagement in case management services is possible should the veteran's circumstances change at a future point.

The VAC case management model focuses on a holistic needs-based approach that is based upon the determinants of health as established by the World Health Organization. The model is dependent upon interdisciplinary consultation to support effective case management.

Over the past two years, we've made significant progress with our transformation initiatives and this is having a positive impact on our case management services.

For example, we've improved the timeliness of our decisions through a reduction in the turnaround time for rehabilitation program eligibility decisions. As a result, program participants are able to access needed benefits more quickly.

We have developed and implemented workload intensity tools that measure risk, need, and complexity of case-managed clients. These tools help to evaluate caseloads, based not only on the number of active cases but also on the level of complexity and intensity associated with each case.

We have developed a national case management learning strategy that focuses on development of skills and knowledge.

We have established national guidelines and protocols that support national consistency in case management practice.

The implementation of these tools and supports is enhancing the effectiveness of case management services, reinforcing standards and best practices, and assisting with the identification of training needs and resource allocation.

We have learned a great deal from academic institutions and other organizations with expertise in the field of case management.

● (1610)

Specifically, we've partnered with McMaster University and the Canadian Centre on Substance Abuse on the development of the competency profile for our case managers. This partnership has allowed us to draw upon the expertise, tools, and best practices that these organizations have developed.

We are also affiliated with the National Case Management Network, which allows us to share knowledge, expertise, and best practices with organizations across the country. Last year, Veterans Affairs Canada was invited to provide a key note presentation at the network's national conference on the topic of our core competency profile.

As of March 31, 2012, there were approximately 250 VAC case managers across the country. Our national standard is to ensure that the case manager to veteran ratio is approximately 40 to 1. Today, we are well within that target.

[*Translation*]

Our case managers come with a diversity of educational backgrounds. Our qualifications require that they have a degree from a recognized university, with specialization in social work, nursing, psychology, gerontology, sociology or some other specialty relevant to the position.

Almost two-thirds of VAC case managers have five years or more of case management experience. These factors indicate a varied and experienced workforce, something of which the department is very proud.

[*English*]

Before turning things over to my colleague, I would like to briefly highlight some of VAC's rehabilitation initiatives, an important stage for veterans and case managers, as more than 70% of our case-managed clients utilize our rehabilitation services and vocational assistance program.

The purpose of this program is to ensure that ill, injured, or disabled veterans and their families have access to professional rehabilitation services designed to facilitate the transition back into their homes, communities, and civilian workplaces. Funding is available for services that are not otherwise available through other health care systems.

Examples of services provided to address physical and mental health rehabilitation needs include: psychiatric and psychological treatment and counselling services, physiotherapy, occupational therapy, interdisciplinary pain management, and addictions counselling.

In closing, we see the transformation process that I've just described as an investment in case management, an investment that is already paying dividends. We are now more capable of identifying risks within our clients and much more able to shift the appropriate resources to quickly mitigate those risks. We have strengthened, and will continue to strengthen, case management services and will ultimately improve the outcomes for those we serve.

Thank you, Mr. Chair.

[*Translation*]

Ms. Lina Carrese (Scientific Director, Department of Veterans Affairs): Thank you, Ms. Pellerin.

Thank you, Mr. Chair.

The mental health and well-being of veterans and their families is indeed a priority for our department. We recognize the serious impact that operational stress injuries can have on Canadian Forces personnel, veterans and their families. That is why we work diligently to ensure that evidence-based services are in place to support veterans with mental health conditions, and their families, in their journey to recovery, and to help ensure their successful re-establishment in civilian life.

These initiatives are built around the Veterans Affairs Canada Mental Health Strategy that focuses on ensuring a continuum of programs and services based on the key determinants of health, such as economic, social and physical environments, personal health practices, coping skills etc., to help meet the holistic needs of veterans and their families.

The mental health strategy also aims to enhance awareness of the needs of veterans and their families in their communities, and build sufficient capacity among Veterans Affairs programs, provincial and community organizations, and providers to effectively treat veterans and their families, and ensure that there are no gaps.

● (1615)

[*English*]

Over the years, Veterans Affairs Canada has greatly expanded its mental health services. In 2006, the new Veterans Charter introduced a full package of transition programs and services that has significantly enhanced the department's capacity to support veterans and their families living with mental health conditions.

Since then, we have also doubled the number of operational stress injury clinics and successfully integrated telemental health services in all of our clinics. This ensures that all veterans in need, including those located in remote areas or who cannot otherwise easily access an OSI clinic in person, can nonetheless receive timely services. Today, between Veterans Affairs Canada and the Department of National Defence, there are 17 specialized clinics across the country that provide assessment and treatment services to Canadian Forces members and veterans with operational stress injuries.

In addition, there are approximately 4,000 registered mental health professionals across the country, 200 of whom are clinical care managers who can provide intensive day-to-day support to veterans who have particularly complex mental health needs. For veterans struggling with substance abuse problems and operational stress injuries, there are several in-patient programs available throughout Canada that specialize in the treatment of post-traumatic stress disorder, for instance, complicated by addictions.

Veterans Affairs Canada and the Canadian Forces have also developed what is now an internationally recognized peer support program, which includes specially trained peers, but also family peer support coordinators who have firsthand experience with operational stress. They provide the most vital support to fellow CF members, veterans, and their families. The department also provides, through the VAC assistance line, 24 hours a day, 7 days a week, access to counselling and referral services for mental health concerns. Also, pastoral outreach services, made up of a network of 200 chaplains, are made available by Veterans Affairs Canada. These chaplains provide spiritual guidance and support for veterans and their families in need.

Our approach is veteran and family centred. It is based on the latest scientific evidence and on the social determinants of health, and it is partnership-based. We work in strong collaboration with partners, both in the community and in government, including the Department of National Defence, and in this instance to also promote successful transition to civilian life for releasing Canadian Forces members and to stay abreast of trends in the domain of military and veteran mental health.

In short, veterans with mental health needs have access to specialized mental health care services across the country, for assessment, for early intervention, treatment, rehabilitation, and ongoing care via Veterans Affairs Canada, community service providers, and the VAC-DND network of operational stress injury clinics.

[*Translation*]

We believe that our approach is working. Today, Veterans Affairs Canada is assisting more than 15,300 veterans and their families with mental health conditions. As the needs of veterans and their families evolve, our mental health strategy is being revised to keep pace, so that we can continue to assist with the recovery process based on the key determinants of health.

The strategy will continue to support successful transition into civilian life, enhance awareness of the needs of veterans and their families in the communities where they live, further facilitate the veterans' rehabilitation as needed, contribute to the improvement of personal and family well-being, and build strong partnerships with provincial and community organizations and providers to ensure that there are no gaps in the support for our deserving veterans and their families.

Thank you for your time today, Mr. Chair. I would be happy to answer any questions you might have.

● (1620)

[*English*]

The Chair: Thank you very much, Ms. Carrese.

We'll now go to Colonel Bernier, please.

[*Translation*]

Colonel Jean-Robert Bernier (Deputy Surgeon General, Department of National Defence): Mr. Chair, ladies and gentlemen, I am Colonel Jean-Robert Bernier, Deputy Surgeon General of the Canadian Forces. I am accompanied by Colonel Gerry Blais, the director of the Joint Personnel Support Unit and of Casualty Support Management.

I am very happy to be here today and to have the opportunity to talk to you about the Canadian Forces Case Management Program.

[*English*]

The Canadian Forces health services national case management program was implemented as a result of identified gaps in the health care system, especially for transitioning CF members to civilian life. Since its inception, registered nurses have been employed as case managers to help thousands of Canadian Forces members in coordinating the myriad services they need to cope with their physical and mental health challenges.

Although many challenges influenced the program's evolution over the past decade, dedicated nurses continue to deliver professional and high-quality services to Canadian Forces members. The feedback from the case management satisfaction surveys reveals that the program is extremely valuable, both to CF personnel and to their families.

[*Translation*]

The program currently employs 57 case managers who continue to meet the many challenges arising from the medical complexity of their clients' needs. Although the work environment and the demands are in constant transformation, the program's mandate remains the same: to assist our members either in returning to duty or in making the transition to civilian life.

[*English*]

CF health services nurse case managers lead the coordination of health care and support to serving CF members in partnership with the joint personnel support unit and its integrated personnel support centres, for which Colonel Blais is responsible. As part of the CF health care team, they are responsible for developing an integrated action plan in conjunction with their patients, Canadian Forces members, integrated personnel support centre personnel, partners such as Veterans Affairs case managers, and other outside agencies.

This plan helps CF members recover by ensuring continuity in the monitoring and coordination of in-hospital and home care support. Health services case managers continue to provide support and advice even after Canadian Forces personnel return to duty. If the CF member is leaving the forces, they help with the transition to Veterans Affairs services, if required, and to civilian life. The program is focused on the client and family and applies evidence-based treatments and best practices. Because it's integral to the military health care system, it provides continuity of care and acts as a bridge between health services and other elements of the Canadian Forces and its services.

[*Translation*]

Constantly striving to improve, the case management program is currently assessing a new work tool, Intermed, which is used to determine the degree of complexity of our clients' transition process. In addition, our case managers are in constant contact with our partners at Veterans Affairs Canada, whether through bilateral groups or on a routine basis in the joint personnel support units, ensuring that we share common work tools and providing for the best possible communications between our organizations.

[*English*]

We have many collaborative initiatives with Veterans Affairs to make transition to civilian life as seamless for CF members as possible. These include referral forms, a trial assessment tool, shared electronic and computerized tools, and a new process for disclosure of health information that will involve electronic tracking and transfer to Veterans Affairs. Following a pilot project currently initiated at bases in Edmonton, Valcartier, and Trenton, this process will eventually be nationally implemented.

Other initiatives will include the sharing of program processes and structure through common staff training, joint workshops, and symposia to enhance partnership, harmonization of program and policies in order to enhance continuity of care throughout the transition, online training for case managers for common subjects, shared working groups and committees, and development of a joint quality management review process to assess the transition process and strengthen continuity of care.

To further improve our case management program, we will seek its accreditation during our next cycle of review by the national health quality assessment authority, Accreditation Canada. We will jointly also pursue opportunities with Veterans Affairs to increase our program leaders' knowledge, increase networking through common service delivery training for program managers, maintain a national-level stakeholder committee, increase outreach activities, and link with other organizations, such as provincial and international case management learning networks and organizations, such as the National Case Management Network, and seek more innovative service delivery models. We will also share our information and training on quality improvement, identify outcome measures, and review our service delivery to improve efficiency and effectiveness.

[*Translation*]

Mental health problems account for a large portion of our case managers' workload and contribute enormously to our case complexity.

● (1625)

However, the mental health team, as an integral part of our health system, has access to the case management program. This allows for rapid access and intervention, ensuring that our members are quickly taken in hand and given access to our full range of services as soon as possible.

[*English*]

As well as assisting CF personnel on a daily basis, the CF health services case management program has long been working collaboratively with the directorate of casualty support management and Veterans Affairs in striving to provide CF members with the best services and benefits to meet their needs.

Our greatest challenge in the transition of CF members to civilian life is in helping them access family physicians and mental health providers within the provincial civilian health systems. Although we continually seek and receive support in this regard from local and regional civilian health authorities, the Canadian Medical Association, the academic deans of university faculties of family medicine, the Royal College of Physicians and Surgeons, and other health authorities, this is an area over which we have little influence in the context of national scarcity and limited access to these health professionals.

[*Translation*]

In summary, despite increasing demand and the growing complexity of the cases associated with the operational commitments of the Canadian Forces, the introduction of new policies and our new partnerships, Canadian Forces health services managers, through their commitment, are continuing to meet daily challenges, helping to perpetuate the success of the case management program.

[*English*]

Thank you for your attention. I would be pleased to answer your questions.

The Chair: Thank you very much, Colonel, and all presenters.

We're now going to start the five-minute rounds. Mr. Stoffer starts off.

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

Folks, thank you very much for coming today.

Colonel Bernier, you just indicated the complexity of trying to find civilian assistance for military personnel when they leave the forces. As you know, unfortunately, 20 military personnel committed suicide last year. That doubled the rate of last year. Even with all of the great efforts that DND and DVA are making to assist these people, it still is an unfortunate tragedy that our brave men and women, unfortunately, for whatever reason, decide to take their lives.

Would it not be advisable then, sir, in the context of that, and in the context of these severe PTSD and mental health challenges they and their families are going through, that if they exit DND on a 3(b) or medical release of some kind, they be able to keep—even though they are veterans—the access to DND, to keep that link with them until a particular private or provincial service is found? Right now, what happens is they leave DND and that's it. Then they get help and try to find another doctor. Five and half million Canadians don't have one now. It's very difficult for DND personnel to find one as well. Would it not be advisable to do that in order to assist them?

My question for Anne-Marie Pellerin—you indicated that 40 to 1 is now roughly the ratio. Are you almost there yet?

Ms. Anne-Marie Pellerin: Mr. Chair, we're actually exceeding that at the present time.

Mr. Peter Stoffer: Great. That's good. So there are 215,000 veterans who are cared for under DVA right now in terms of its benefit.

In the brochure here, Ms. Carrese said there are 15,300 under mental health. I assume they are being case managed? There are 15,300 being case managed by 250. That's almost 60 per case worker. I'm just wondering if you can explain the difference, because 250 case workers with 40 is 10,000, so 15,300 means almost 60 per case worker. I'm just wondering if you could explain the difference there.

Very quickly, my last comment—and you don't have to comment on this one. I am always a bit amused when I hear officials like yourself and others say that you have discovered that the older veterans have been dying off recently. I think we have all known they have been doing that for quite some time.

I just throw that out there. Thank you.

Col Jean-Robert Bernier: Thanks for the question.

I'd first like to just address the suicide rate issue.

Every single one of the suicides is a huge tragedy for us because they're our family members in uniform. It's a very different society, very tightly integrated, so every CF member is a brother and sister. And it affects the medics as well as everybody else. So it's a very serious problem for us to address.

However, we continue despite these years of war.... We expected an increased rate. We've always expected an increased rate because of the stresses of operations. We haven't seen it happen yet. We still remain roughly 20% below the national average for the age and sex-adjusted rate.

We had 19 male suicides last year. Suicides are such a rare occurrence, happily—even though every single one is a tragedy—that statistically, epidemiologically, we need to eliminate chance as the cause of a spike in a rate. So we've been following carefully suicide rates since 1995.

We have to block them in five-year blocks to get an adequate numerator of suicides, in order to get a statistically significant outcome for a suicide rate. The 19 for last year are in the first year of the next five-year block. It is possible that it's the indication of an upward trend as a result of operations in Afghanistan. However, even if we had five years of 19 males, or a total of 20, it would still remain below the national rate.

The rate since 1995, if anything, has decreased, but it's remained the same. We've carefully analyzed, for any link to deployment, every single suicide since last year. We examine very carefully with psychiatric expertise. We essentially do a psychological audit of each individual suicide. So far, there is no specific trend; there is no link specifically to deployment. Up until last year, the majority of our suicides were people who had never deployed before.

So we're not sure, but we're cautious, because we've anticipated an increased rate. We can't yet determine that it's an increase. Statistically that would be irresponsible of us to state at this point. We could not scientifically state that there is an increase at this rate because the numbers are so low.

With respect to the transition to civilian life of soldiers who require ongoing care, last year the defence minister announced an integrated transition plan to be applied to every soldier being released for medical reasons. That provides us up to three years of transition time, not only to get their medical care in place with the provinces and with additional services provided by Veterans Affairs, but also vocational, social, and any other element that would help set them up for a successful transition to civilian life.

We'll never be perfect because there is a national shortfall in medical care, specifically in certain health professions across the country. Constitutionally, our society has decided that the armed forces are there to conduct military operations, and the other institutions—the provinces and the provincial health systems, supplemented by care from Veterans Affairs—are there to provide care to people after they've released from the armed forces.

We do continue, for example, our specialized mental health clinics, operational trauma and stress support centres, and the 10 Veterans Affairs operational stress injury clinics. We have a memorandum of understanding where we can continue caring for each other's patients even after release. So we can care for veterans, if it's convenient logistically and otherwise, and they can care for serving Canadian Forces members as well where it's convenient. We take advantage of that, but we still do have challenges that are not unique to the Canadian Forces but that affect all of the Canadian population.

● (1630)

The Chair: Thank you very much, Colonel.

I'm going to have to ask if you will respond maybe next time in the NDP slot because we are quite a bit over time.

Ms. Adams, please, for five minutes.

Ms. Eve Adams (Mississauga—Brampton South, CPC): Thank you very much for appearing before us today.

Could you perhaps identify for us the role of the case manager and the evolving role of the case manager under transformation, please?

Ms. Anne-Marie Pellerin: Yes. Within Veterans Affairs, Mr. Chair, the case manager gets engaged during the transition process at the integrated personnel support centres, the 24 IPSCs across the country, where we are co-located with National Defence staff. The case manager gets engaged with the releasing member prior to release to get a sense of what the health or re-establishment needs are prior to release. That enables the case manager, together with the releasing member and the releasing member's family, to begin building a plan, putting a plan in place, so that upon release there is as little to no interruption in service as possible.

That plan will address not only the health needs from a medical and psychological point of view, but also the re-establishment needs in terms of assistance that may be required in finding civilian employment.

It's a comprehensive approach in terms of addressing the re-establishment needs.

As I said, the engagement begins pre-release. It's an ongoing, problem-solving relationship that's established between the case manager and the releasing member or veteran upon release. As I alluded to, we do encourage the family to be involved in that process because the family unit is important, and understanding the family dynamics, in terms of that re-establishment process, is critically important.

● (1635)

Ms. Eve Adams: What types of new authorities have been granted to case managers to make decisions on behalf of veterans? What types of authorities have devolved or have been brought closer to the veteran, and how does that reduce wait times for the veteran?

Ms. Anne-Marie Pellerin: Mr. Chair, I have a couple of examples whereby we have delegated decision-making authority to what we call the front line, making sure the decisions are made as close to the veteran as possible, whereas in the past, some of those decisions had to be escalated to either regional or central office for adjudication.

In the case of the rehabilitation program, we have delegated the decision-making authority for program eligibility to the case manager. We have also delegated authority to the case manager for making decisions on benefits within the rehabilitation plan.

That enables the case manager to put interventions into place very quickly. It enables the veterans to receive those needed benefits much earlier than they would have otherwise if the decision-making had remained at a higher level.

Ms. Eve Adams: You've empowered the case manager. The individual who interacts with the veteran is able to see the capabilities of the veteran as opposed to having that case manager document or make notations, and so on, and have somebody who's removed, perhaps at another office, make that final decision, an individual who had never even come in contact with the veteran previously.

Is that correct?

Ms. Anne-Marie Pellerin: That's correct.

Ms. Eve Adams: Do you have some metrics on the types of reductions to wait times that veterans are seeing now because of the delegated authorities?

Ms. Anne-Marie Pellerin: Yes, I do.

Mr. Chair, in terms of the rehabilitation program eligibility decisions, prior to the—I guess it wasn't so much the delegation of authority, but recently we've reduced the service standard around those decisions from four to two weeks. That means the veterans who apply to the rehabilitation program—

Ms. Eve Adams: Pardon me, you increase the service standard by reducing wait times, correct?

Ms. Anne-Marie Pellerin: We improved the service standard—let's put it that way—by cutting down the turnaround time on those key decisions.

Again, that enables the veteran to get access to needed benefits much sooner than had been the case before.

Ms. Eve Adams: They're half of what they were previously?

Ms. Anne-Marie Pellerin: They are half of what they were before, that's correct.

Ms. Eve Adams: That's rather remarkable.

Ms. Anne-Marie Pellerin: We are achieving that standard 85% of the time.

In other words, veterans are providing the needed documentation. Once we have that needed documentation to make a decision, those decisions are made very rapidly.

Ms. Eve Adams: There's an automatic renewal there? Could you perhaps expand on that? Is it a speedier renewal?

Ms. Anne-Marie Pellerin: Automatic renewal—I believe you are referring to the treatment benefits, so the treatment benefit programs, whereas previously authorizations were required based on renewal of treatment benefits. The requirement for those renewals, pre-authorization, has been removed.

Ms. Eve Adams: Okay, thank you very much.

Have you received feedback from the veterans on these new processes?

Ms. Anne-Marie Pellerin: We have anecdotal evidence from our veterans in terms of their satisfaction with the case management process and the earlier intervention. We haven't done a study, so to speak, but certainly the anecdotal evidence would suggest that there is certainly satisfaction with that earlier intervention, earlier access to needed benefits.

Ms. Eve Adams: Thank you.

The Chair: Thank you very much, Ms. Pellerin.

Now we go to Mr. Casey for five minutes.

Mr. Sean Casey (Charlottetown, Lib.): Thank you, Mr. Chairman.

My first question is for Colonel Bernier.

I'm interested in your comment with respect to the profound difficulty you're having in the transition of CF members to civilian life and access to family physicians.

We've heard at least a couple of times in this committee—once was that fateful meeting on February 27 in Halifax with Dr. Heather MacKinnon, but we also heard from Dr. Alice Aitken. As you may know, she is the director of the Canadian Institute for Military and Veteran Health Research. She appeared before the committee on February 14. This is a quote from Dr. Aitken, someone who is an expert in the field:

> My biggest challenge was in the transition to provincial health care, where I got the same treatment as a prisoner, and I was informed of that. When my husband transitioned out later, he was medically released and had served in both Bosnia and Afghanistan. The impact on our family was mitigated by the fact that we had both been military and knew what to do.
>
> But I think his biggest struggle was in transitioning to a civilian health care system that didn't understand his needs.... Also his front-line service provided by Veterans Affairs…is sometimes a very difficult bureaucracy for the veteran to deal with.

This is from someone who is ex-military and who is now engaged full time in military and veterans health research; this is her personal experience.

I appreciate that it's difficult because of what's happening in provincial health care systems. Tell me what you think of this suggestion and whether it's workable or what we need to do to make it work. What about having a member of the forces obligating the medical caregivers looking after that person to continue his or her care until there is a successful transition or until there is a civilian doctor willing to accept that person as a patient? I realize that increases the workload on those within the employ of DND, but it seems to me that the workload is a worthwhile priority for us to invest in, even if we need to get more.

What are your thoughts?

● (1640)

Col Jean-Robert Bernier: Thank you for that question. I know Alice Aitken very well. She was a physiotherapist in the armed forces, in the medical service. She's currently an associate professor of rehabilitation at Queen's University and assists us in coordinating health research related to the military and veterans.

Things have changed a lot since she retired from the armed forces —and her husband, who I also know very well.

Obligating Canadian Forces medical staff to continue to provide health care to persons at the point of release would be ideal. It would mean, however, either a very significant increase in resources to the armed forces, if the government and society expects the armed forces to continue having its medical service fulfill the purpose for which it primarily exists, which is to serve military missions and support military operations, or, through the constitutional allocation of responsibilities, somehow enhance the capability of provincial health care for civilians and the resourcing of Veterans Affairs. There are various measures under way throughout the provinces to expand the availability of primary care through the use of alternative providers, such as physician assistants, significant expansion of medical schools, the use of nurse practitioners. There are various efforts ongoing within the provinces to fulfill their constitutional commitments and responsibilities to look after retired armed forces members.

One of the activities that I mentioned earlier, which the minister announced a while back, was the implementation of the integrated transition plan and up to three years of transition time, to permit the establishment to help find individuals.

Other things we do, as I mentioned, are through various fora such as the Canadian Medical Association, the academic deans of the faculties of medicine, to try to generate support. In some cases there have been successful pilots or successful establishment of a commitment by civilian provincial family health teams to reserve a certain number of positions in their clinics for armed forces families and retired members.

Most recently, the Chief of Defence Staff at the Canadian Conference on Medical Education in Banff met with the academic deans of the faculties of family medicine who are undertaking an initiative specifically for that purpose.

I mentioned the U.S. system, the U.S. defence department, where there's a congressional mandate for the U.S. armed forces to provide care to veterans and their families, and after release as well, before medicare takes over. Of the massive U.S. defence budget and the massive health budget, which exceeds that of all of Ontario, only the defence health budget...a few years ago, over 70% of that money went to provide non-military operational health care. So only 30% of that budget was going to actually support the purpose for which armed forces exist, fighting wars and conducting military operations. There would be a very significant bill that would come with that.

● (1645)

The Chair: Thank you very much, Colonel Bernier.

Now we go to Mr. Chisu for five minutes.

Mr. Corneliu Chisu (Pickering—Scarborough East, CPC): Thank you very much, Mr. Chair.

Thank you very much for coming to our committee.

Ms. Pellerin, you made an affirmation in your presentation, which we have also noticed, that many modern-day veterans are being released from service with more complex health and re-establishment needs. I would like it if you could elaborate on this.

That will lead to a question to Colonel Bernier related to the Canadian Forces health services, the national case management program. In your presentation you made a statement that you have 57 case managers and that the mental health program accounts for a large portion of the case management workload and contributes enormously to the case complexity.

I would like to ask you about the prevention of substance abuse in the Canadian armed forces. When I was deployed in Afghanistan, more than a hundred soldiers were found positive for substance abuse and were not deployed. That created a big problem for our forces.

Those are the two questions I would like to ask for the moment.

Ms. Anne-Marie Pellerin: Thank you, Mr. Chair.

In terms of the release of modern-day veterans, we have been finding for a number of years that the complexity of the health and re-establishment circumstances of those releasing members is different, obviously, from the traditional clients with whom Veterans Affairs had been dealing with prior to that. What we are seeing is a combination of physical and mental health conditions among those being released in our modern-day veteran population.

For instance, at the present time, in our rehabilitation program we have participants, 55% of whom have both a physical and a mental health condition. You can appreciate that this combination presents significant challenges, not only for the veteran but for the veteran's family and for the re-establishment of that individual in civilian society. That complexity of physical conditions, often accompanied by pain, mental health conditions, the increase of substance abuse and addictions, have all increased the complexity of those who need case management services through Veterans Affairs.

So the importance of that case management relationship is critical in terms of working with a veteran, facilitating access to services within the community where the veteran resides, and supporting the family to deal with those complex issues. When the veteran is at a stage of readiness from a health perspective, and if the veteran needs support in terms of vocational re-establishment, it's putting those supports in place to assist him or her to attain suitable civilian employment.

That whole process, the engagement of the case manager, can take a fairly significant period of time.

For those reasons, we talk about the differences in terms of our modern-day as opposed to our traditional veterans.

Mr. Corneliu Chisu: Is it possible for DND, before they release the member to Veterans Affairs, to take a few more steps so that when you are presenting the case it is less burdensome for you? I'm just asking whether cooperation could be a little closer with DND.

● (1650)

Ms. Anne-Marie Pellerin: Yes.

The Chair: Mr. Chisu, I was just going to say we're going to run out of time before our DND witness can actually answer.

Colonel Blais, please.

Colonel Gerry Blais (Director, Casualty Support Management, Department of National Defence): I'm happy to say that exact situation has now developed. For about six months now we have been ensuring that every person who is medically released is presented with what is called an integrated transition plan. All of the different partners sit together at the table: Veterans Affairs, the health services case manager, people who look after education needs and employment needs post-release. We sit down and include the individual in that conversation, and a transition plan is prepared for each one of them. The member signs off at the bottom of that before he's released, indicating that he understands what's in there and is happy with it.

In that plan we also have the flexibility, if there are more complex needs, for education or whatever. We can extend the service for up to three years to ensure this transition goes smoothly.

The Chair: Did you want to add to that, Ms. Pellerin? You looked like you were going to jump in.

Ms. Anne-Marie Pellerin: No.

Colonel Bernier, I don't know if you want to comment on this question.

The Chair: Just briefly, please.

Col Jean-Robert Bernier: May I comment on your question about mental health prevention efforts?

Mr. Corneliu Chisu: And substance abuse?

Col Jean-Robert Bernier: And substance abuse.

Back in the 1990s, things were not good. We've improved dramatically since then. We spend almost $40 million a year now just on mental health—$38 million and something a year—and we have spent over $100 million since 2006 in the increased health system budget.

We do a lot of screening and a lot of education and peer support. There are screenings for mental health conditions at enrollment, regular periodic health assessments pre-deployment and post-deployment, detailed assessments post-deployment at three to six months, third-location decompression, at which there are mental health professionals and education ongoing at that time as well, enhanced post-deployment screenings at the time of release, and ongoing research all the time at a global level to try to identify the problem.

For education, there are the Strengthening the Forces health promotion programs that cover all of the impacts and basically all of the issues that are symptomatic of or causative or that contribute to mental health conditions. In particular, there are programs on addiction awareness to help people identify not just the individuals themselves but supervisors and peers where people are having difficulties. We have in-patient treatment programs and we have a series of civilian programs to which we send folks.

There's a very detailed program called Road to Mental Readiness. That's an international model looked at around the world. It provides detailed education and enhances resilience as well as recognition—self-recognition and peer and supervisor recognition—of mental health issues. That begins right at the time of basic training and has components throughout all career courses now, and peri-deployment—pre-, during, and post-deployment.

Finally, we also have a very robust peer support network of people who personally have suffered mental health conditions in the past, to help individuals who may have an issue but are reluctant to present it, or who don't recognize that they have a problem, and to get them into care, which is the best thing we can do to resolve their mental health condition and prevent things like suicide.

The Chair: Thank you very much for that, Colonel.

Ms. Mathyssen, for five minutes.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you very much, Mr. Chair.

Thank you very much for your information.

I want to go back to some of the things Madam Pellerin said, just for clarification.

You indicated that there are approximately 250 VAC case managers across the country and that the goal or standard is 40 clients per case manager. Could you explain why that is important? What's the necessity of achieving that or of perhaps, as you indicated, being well within that target?

Ms. Anne-Marie Pellerin: Thank you for the question.

The case management function is a very critical and important function within Veterans Affairs, and we want to ensure that our case managers have a caseload that is reasonable within a standard of practice, so that they can dedicate the time required to individual veterans and ensure that they are able to provide the case planning, the monitoring, and the work with the family. We are endeavouring to ensure that the ratio of caseload to case manager is no more than 40 cases. In fact, at the present time we're exceeding that number. We're at an average of about 30 cases.

If I could at this juncture get back to the question Mr. Stoffer asked earlier, I'll note that we have just over 15,000 Veterans Affairs clients or veterans who are accessing benefits of the department for a mental health condition. That could be for a disability, a benefit, or accessing a rehabilitation program. But not all of those 15,000-plus veterans are being case-managed, nor do they require case management services, because the majority of those who have a mental health issue are in fact able to function well in society and in fact are doing that. So it's those who have the most complex mental health issues—and we're running at about 25% of that cohort—who are actually receiving case management services.

● (1655)

Ms. Irene Mathyssen: I understand how important it is to have that positive ratio in terms of managers to clients.

You also said that the modern-day veteran population numbers are on the rise, and that many of these modern-day veterans are being released from service with more complex health and re-establishment needs.

Last week the veterans' ombudsman was here. He gave us some statistics, and I want to run these by you.

> The department's own life-after-service studies show that two-thirds of Canadian Forces former regular force personnel released between 1998 and 2007 are not receiving benefits. However, 54% of those report at least one physical health condition; 13% report at least one mental health condition; and many report chronic health conditions [following on] three decades of high operational tempo.

So potentially a lot of people are going to need services. You've indicated that it's important to keep the ratios down and to make sure those services are truly effective.

The ombudsman worried that needs would not be met.

The Chair: Could you get to your question, please?

Ms. Irene Mathyssen: But, Mr. Chair, you have to set the scene.

The Chair: You're doing it very well.

Ms. Irene Mathyssen: Do you have those same concerns? How will you approach those unmet needs? What plans are in place? Obviously we can't allow those folks to go without the services they have earned and deserve.

Ms. Anne-Marie Pellerin: Thank you very much for the question.

Certainly our outreach strategy, in terms of Veterans Affairs, is very much in response to the studies that have been done that would indicate a veteran population not currently accessing services of the department.

Through that outreach strategy, the department is endeavouring to educate people, to encourage people to approach the department if they have a need they think may be related to service, and then in that way to determine eligibility, and if that eligibility is established, to provide the services.

We're continually pursuing that outreach, and so far that has meant a slight increase in terms of people approaching the department for service.

The other avenue we're monitoring very carefully with our colleagues at National Defence is the potential releases. Colonel Blais mentioned there is a period of up to two or three years during which members are retained in the military before release. That period enables the Department of Veterans Affairs to plan and be proactive in getting ready to serve that population that is going to be releasing from the military.

We feel that we're relatively well positioned to be able to absorb more cases, based on our exceeding the standard at the moment, and to put services in place through our existing case manager complement and through our health professionals and contracted services as well.

The Chair: Thank you very much, Ms. Pellerin.

Now we go to Mr. Storseth for five minutes, please.

Mr. Brian Storseth (Westlock—St. Paul, CPC): Thank you very much, Mr. Chairman.

Thank you very much to the witnesses for coming today.

Colonel Bernier and Colonel Blais, it's good to see you again.

I have a couple of questions. I'd like to dive right into them.

If there are Canadian Forces members looking to medically retire, then I assume, from the conversation we just had and your presentation, that an integrated transition plan would have been done for every one of them in the last six months.

● (1700)

Col Gerry Blais: Yes, it would have been done in the last six months. Especially as we begin the process, we are focusing on those who have complex needs. The plan is that by the end of the year everybody releasing for medical reasons will have an integrated transition plan.

Mr. Brian Storseth: Who would be included in who they would be sitting down with?

Col Gerry Blais: I'm sorry?

Mr. Brian Storseth: Who would they be sitting down with, then, to create the plan?

Col Gerry Blais: At the table there is the Veterans Affairs representative who works in the integrated personnel support centre. There is the case manager from health services. There are the services staff from the integrated personnel support centres who ensure either return-to-work programs, employment programs, or education programs. There are people from SISIP financial services and insurance. There is the individual himself or herself and a family member, if he or she so chooses, and basically anybody else who can assist in making sure that transition goes smoothly.

Mr. Brian Storseth: How many meetings would they traditionally have on this before they created the plan?

Col Gerry Blais: It's an ongoing process, because as a person is advised that they're going to be medically released, they've basically known in advance for some time, and the process has already begun —we have looked at education programs, we have begun to access employment services, etc.

There are as many meetings as are required. By the time we get to the transition plan meeting, in most of the cases one meeting does the trick.

Mr. Brian Storseth: You talked a little bit about flexibility. Explain to me the flexibility within this system.

Col Gerry Blais: As Colonel Bernier mentioned, there is a tool that analyzes the complexity of an individual's needs. If a person is considered a complex transition, be it because there are modifications required to the home for the long term—for health care or for potential employment—or perhaps there's a mental health condition that would preclude employment for a couple of years, then from the medical side of the house they recommend a period of retention, which can go from six months up to three years. We work within those parameters to ensure that the person is given every chance to succeed on the way out.

Mr. Brian Storseth: What do you mean by "retention"?

Col Gerry Blais: That means they remain in uniform; they are not released from the armed forces.

Mr. Brian Storseth: If I were a member who was, say, just a few months short of my 10-year mark to qualify for my pension or some pension benefits, would this flexibility, nine times out of ten, be invoked so that it could carry me over that point?

Col Gerry Blais: That's not considered an aspect of complexity; however, we want to set people up for success, so any benefit of the doubt.... If a person is within a couple of months of the ten-year point, unless there are really odd circumstances, we will get them there.

Mr. Brian Storseth: Thank you very much. It sounds like a good system.

We've had OSI clinics on some of the bases I represent, and I know they have gone over tremendously well, especially for their ability to give current serving members access from remote rural locations. And some of these more remote locations are getting clinics. That has been a big step for some of our guys.

You talked about Edmonton as one of the pilot projects. Could you give some details on that and say whether you see it as a success story, Colonel Bernier?

Col Jean-Robert Bernier: That pilot project is only just starting, and it's only to track, digitize, and electronically transfer to Veterans Affairs all the medical records of people undergoing medical release in order to accelerate the process for them to adjudicate the benefit or whatever is required. That pilot project is just starting now. We hope to have it finished by September of this year and then to have it fully implemented across the armed forces clinics two years later, by September 2014.

Mr. Brian Storseth: I see this as being a big step forward for our men and women who are moving from active duty to becoming veterans. Often one of the logjams in the system, as you say, is accessing medical records and having to swap them back and forth. This is something that's very important.

How much time do I have left, Mr. Chairman?

The Chair: We're actually over, but I'm waiting for your question.

Voices: Oh, oh!

● (1705)

Mr. Brian Storseth: Thank you very much. I appreciate the chairman's leniency with me.

The Chair: Do you have a final question?

Mr. Brian Storseth: No, that's fine.

The Chair: That makes you the shortest of the lot so far today, Mr. Storseth. I'm most impressed.

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

Mr. Ben Lobb (Huron—Bruce, CPC): I just want to make sure I am clear here, Ms. Pellerin. Other people have talked about case managers. The first point you made, on page 3, was that you had "improved the timeliness of our decisions through a reduction in the turnaround time for Rehabilitation Program eligibility", etc. Is this what you are crediting the streamlining of the case managers to, their being empowered to make decisions? Am I clear on that?

Ms. Anne-Marie Pellerin: That is one of the elements of streamlining decision-making and improving the timeliness of decisions. The other is the authority the case managers have been given, as of about a year ago, to actually make decisions on specific benefits and services that veterans need to support their rehabilitation plan.

Mr. Ben Lobb: Those, then, are the two improvements that came through the transformation initiative on that point?

Ms. Anne-Marie Pellerin: That's correct.

Mr. Ben Lobb: Another question I have is for the colonels. On pages 1 and 2, near the bottom, the Intermed is mentioned, the new work tool for case managers. Is Veterans Affairs using this same software program? Is it the same program, or do you use two different software systems?

Col Jean-Robert Bernier: That program is to help us in their medical care and assessment. While they're still in the armed forces, we want to retain them. As Colonel Blais was mentioning, by the time we come up with a need to meet for an integrated transition plan, in some cases the medical system may have hung on to someone for up to three years to provide them with every bit of rehabilitation that we possibly can. It's only at the point that we see that there's no possibility of retaining that individual in uniform to continue serving in the armed forces that we then have to throw in the towel and embark on the integrated transition process to transition them to civilian life.

The Intermed, at that point, allows us medically to assess the degree of biological requirements for medical care, but it also includes parameters that permit an assessment of the social, vocational, occupational, and other similar kinds of factors. It's used within the armed forces to guide the integrated transition plan for transition to civilian life and to determine the amount of time and the various efforts that would be required to give the person the best possible transition before being released from the armed forces.

Mr. Ben Lobb: Okay.

Ms. Pellerin, I have another question for you about the second of your bulleted points on page 3. You "developed and implemented Workload Intensity Tools" that the case managers can use. When you did this, where did you get the idea from? Is this something that other countries are doing, which you picked up? Where did it come from?

Ms. Anne-Marie Pellerin: We've introduced one tool that allows us to measure risk of veterans who are being case-managed, and in fact those who are not being case-managed. It allows us to assess the risks to see whether they may in fact be in need of case management services.

The risk tool is one that we modified. It was developed out of Regina by one of the Regina health authorities. They allowed Veterans Affairs to modify a tool they had developed. We have modified it not only for our traditional veterans but also for our younger population, for the needs they have around re-establishment.

It's a tool that has been tested and validated through the work of the Qu'Appelle Health Region in Regina. As I said, they've allowed Veterans Affairs to modify that tool for our use.

The other tool is based on need and complexity. It is one we've developed in-house, within Veterans Affairs, with the support of our departmental research directorate. It's a tested tool and has been implemented nationally. It's showing very good results in terms of uptake by our case managers and of allowing them to understand their caseload and dedicate their time and energies toward those veterans who are most in need of case management services.

● (1710)

Mr. Ben Lobb: You've likely talked to peers from other developed countries that have developed militaries and subsequently have developed veterans affairs departments to one level or another. As the director, where do you feel Veterans Affairs Canada sits with respect to case managers and mental health?

And as part of the transformation initiative, where else do you see your goal heading in the next, say, three to five years?

Ms. Anne-Marie Pellerin: In terms of Veterans Affairs' position and research around the services we provide and the programs we offer to veterans, the research and the collaboration we have with our international partners has been well established. We've looked at the work ongoing in the U.S., Britain, and Australia and we have presented at what's called a seniors international forum at our ministerial and deputy levels. Veterans Affairs Canada was cited a couple of years ago by those international partners as leading-edge in our rehabilitation and Veterans Charter programming and the case management services associated with the delivery of those programs.

We don't, of course, rest on our laurels. We're continuing through transformation to continuously improve, to look at the ongoing development of standards and best practices in the field of case management. This is why, through our transformation agenda, we are investing in tools that help us assess our workload and manage our cases well to ensure that our veterans are receiving the best services we can possibly provide.

The Chair: Thank you very much, Ms. Pellerin.

That will end round one.

Round two is a four-minute round. We'll start with Monsieur Chicoine, please.

[*Translation*]

Mr. Sylvain Chicoine (Châteauguay—Saint-Constant, NDP): Thank you, Mr. Chair.

My thanks to our witnesses for their presentations and for making themselves available to answer our questions.

My first question goes to Ms. Pellerin. In the engagement section of your presentation, you mentioned the possibility of ending the case management relationship when the goals are achieved, and of re-engaging the veteran in the case management process.

Who decides when the case management relationship should end?

Ms. Anne-Marie Pellerin: Thank you for the question.

[*English*]

Case management services are available to veterans whenever they need them and for as long as they need them.

As I described in my opening remarks, the relationship between the case manager and the veteran is about establishing goals, realistic goals, in terms of what the veteran is likely to achieve from a health, a social, and an employment perspective. Once the veteran has achieved those goals, the likelihood is that the intervention of the case manager is no longer required. The goals have been achieved, and the veteran can reintegrate successfully into civilian life.

If at some future point something happens to the veteran or there is a change in the veteran's situation, either from a health perspective or from an employment perspective, there is an opportunity for the veteran to reconnect with Veterans Affairs. If at that point there is a need for case management intervention and re-engagement with that case management process, that opportunity is provided.

The veteran is disengaged, which is the term we use, when he or she has achieved the goals and is ready to be fully independent in society. But as I said, the opportunity to return to the department at some future point, based on a change in circumstance, is there. It's encouraged. We certainly inform our veterans and our veterans' families of that opportunity.

[*Translation*]

Mr. Sylvain Chicoine: As I understand it, a veteran has access to a case manager for as long as he has not achieved the goals. The case manager does not decide whether the veteran has achieved the goals and that the relationship is over. It is done by common consent.

● (1715)

[*English*]

Ms. Anne-Marie Pellerin: The goals are established mutually between the veteran and the case manager. It's not the case manager dictating the goals. It's working with the veteran to establish realistic goals, given the veteran's health situation and given the skills the person has attained through the military and the likelihood of transferring those skills to a civilian employment situation. Providing retraining may be necessary. The goals are mutually established, and when they have been achieved, it's obviously a mutual agreement on that goal attainment.

[*Translation*]

Mr. Sylvain Chicoine: Thank you.

[*English*]

The Chair: Be very brief.

Mr. Sylvain Chicoine: It will not be very brief. It will be too long for Monsieur Bernier to have time to answer. It's okay.

The Chair: What you could do is put your question and get the answer back in writing.

[*Translation*]

Mr. Sylvain Chicoine: Mr. Bernier, I have read in some reports that there is a significant lack of clinical psychologists in the Canadian Forces. Is there a plan to hire more, so that we can reduce the psychological distress that veterans are suffering, especially those coming back from Afghanistan, for whom that distress is catastrophic?

[*English*]

The Chair: Colonel Bernier, what we're going to do is send you the question as asked by Mr. Chicoine and ask for the answer back in writing.

Sorry, but we are being squeezed for time.

We'll go to Mr. Harris, for four minutes. Thank you.

Mr. Richard Harris (Cariboo—Prince George, CPC): Thank you, Mr. Chair.

Thank you all for coming today.

Colonel Bernier, in your text you talk about seeking accreditation for your case management program. Could you maybe expand on that a little bit? I imagine that the value of the accreditation is to measure the success of the program. Maybe you could talk a little bit about that.

Col Jean-Robert Bernier: Accreditation Canada is the national quality assurance body for health systems and health facilities, primarily hospitals, but various other types of health facilities as well. They're completely independent. They have independent peer assessors from across the country who are experts in assessing the quality of health care provided by various systems. They do that not only within Canada but various other countries in the world ask them to accredit theirs as well, because their reputation is so good.

They have accredited our entire Canadian Forces health system and determined very favourably that it ranks among the best. What we didn't do is have a precise, more detailed specific accreditation of the case management system within the armed forces specifically. Independent assessors who are experts in case management will be coming in to assess the quality and report back to us where improvements might be made that we may not have identified on our own.

Mr. Richard Harris: Would you use that input as a measure of the success of the program so far, but also to provide a road map for where you want to go to make any improvements that might be needed?

Col Jean-Robert Bernier: That's correct. When they do assessments of hospitals or health systems, even ours, even though they tell us verbally that it's one of the best they've ever seen anywhere in the world, their duty is to find things that can be improved. There's no health system anywhere that has a perfect record, although we scored pretty high. Our whole health system, as it stands now, has been improved significantly over the years, because there have been problems in the past, but it will give us a road map for things to improve to make it progressively better.

Mr. Richard Harris: Thank you.

Ms. Carrese, thank you for the size of the font in your presentation. It's sure easy to read.

You talked about collaboration with partners in the community, the government, etc. Specifically in the community, maybe you could just review again some of the partners you would get involved with.

Ms. Lina Carrese: We spoke earlier about the big challenge, for example, with accessing medical professionals in the community. We are actively trying to do more outreach and network with the medical professions. We did have a collaboration with the Canadian Psychiatric Association and the Canadian Institute for Military and Veteran Health Research to have, in the five major cities across Canada, at the annual CPA conference, modules specifically on post-traumatic stress disorder and treatment for it, specifically in the context of veterans, which we know can be different.

It's really important that the medical professionals know that we are here to help. With our 200 clinical care managers across the country, if these very busy medical professionals in their private offices know there is support and that Veterans Affairs Canada has a lot to offer...we're hoping we can help with this very difficult situation in the medical system. That is an example.

We are working with the Canadian Mental Health Association. They have lots of programs. We can't reinvent the wheel. We always have to do our part in terms of making what they have available specific to the needs of our veteran population, because we know it is different. There's a lot of expertise out there, and we think we can be more effective and efficient by partnering with all the different associations, such as the Mood Disorders Society of Canada, the Canadian Mental Health Association, etc. That really allows us to do better.

It goes internationally as well. We have had symposia in the past with the International Society for Traumatic Stress Studies, where we were able to bring in all the prominent experts in the field of operational stress injuries, and lots from the different VAs across the country, so that we could learn from each other and become better in the services we offer.

● (1720)

The Chair: Thank you very much, Ms. Carrese.

Ms. Perreault, for four minutes.

[*Translation*]

Ms. Manon Perreault (Montcalm, NDP): Good afternoon, thank you for being here. Thank you very much for taking care of our wounded and disabled soldiers.

In his presentation, Colonel Bernier mentioned suicide. I would like to link that to your presentation, Ms. Carrese, where you specifically mentioned telephone assistance.

Ms. Lina Carrese: Yes.

Ms. Manon Perreault: Has the telephone assistance line been in place for a number of years?

Ms. Lina Carrese: It is more about the services, but I think that it goes back to 2002, as Mr. Lalonde is telling me. So it is quite a while.

Ms. Manon Perreault: Have you noticed a decrease in the number of suicides since the line has been in operation? Do you have any data on that?

Ms. Lina Carrese: Veterans Affairs Canada is not like National Defence. It is very difficult for us to get information or statistics on the number of veterans who commit suicide or who die as the result of a suicide, because, unfortunately, it depends whether it really is a suicide. It depends on the family. Will they choose to tell us? There are confidentiality concerns. So we do not have that kind of information about suicides among veterans. But we are actively researching it. We have some data.

Ms. Manon Perreault: Last May, a lady lodged a complaint. She said that it took a lot of time before she got an answer. She wanted to know whether her long-time spouse had taken his own life or had died of natural causes. Is that the same phone assistance line or are they two completely different things?

Ms. Lina Carrese: I am sorry, but unfortunately, I cannot answer that. I have no specific information on that case.

Ms. Manon Perreault: Do family members who call, but who are not veterans or soldiers, have a specific line that they can call, as opposed to the veterans who have a line where they can be provided with assistance and be given the support they need?

● (1725)

[*English*]

Ms. Anne-Marie Pellerin: I can perhaps shed some light on that, Mr. Chair.

The VAC assistance service is a 24-hour, 7-day-a-week, 1-800 number that is available to veterans and family members. Family members are free to access that service. It provides short-term counselling for situations that may be of an urgent nature, and also referral to community-based services. Again, depending on the urgency of the situation, the referral could be to a hospital emergency room or to other types of services. Bottom line, the service is available to both veterans and family members.

[*Translation*]

Ms. Manon Perreault: Very quickly, can you tell me one thing? Is this linked to the 200 chaplains you mentioned in your presentation? Are those two completely different things?

Ms. Lina Carrese: Those are two different things; two different services.

Ms. Manon Perreault: Thank you.

[*English*]

The Chair: Thank you very much.

Mr. Lizon, for four minutes, please.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much, Mr. Chair. Thank you to all the witnesses for coming. I thank you for your great work.

I will ask my questions first, because normally I am told that I am out of time. Whether we have enough time to answer them or not, maybe we will go the same route and I will get the answers in writing.

The first question I have is for Madam Pellerin and the second question is to Colonel Bernier.

Madam Pellerin, in the beginning of your presentation you talked about the case management services process and you named six important tasks. I would like to focus on two: engagement and relationship-building, building trust, and monitoring and evaluation.

With regard to the first one, in our travels with the committee we did hear from some people that in some cases there was a problem establishing trust, and sometimes people didn't want to talk to anybody else except the person in uniform or the person who had served. How would you deal with this under the transformation initiative, and how is this different under transformation from the process that was in place before?

Colonel Bernier, in your presentation last week you mentioned, among other things, the pilot project of electronic tracking and transfer to VAC. My question is—if I understand you correctly—would this be tracking all the people you release from service, and would this be done in collaboration with Veterans Affairs so that this monitoring or tracking would continue to keep in touch with veterans?

The Chair: If I cut you off at 5:30, which will automatically happen, I'll have to get the rest in writing.

Ms. Pellerin, please go ahead.

Ms. Anne-Marie Pellerin: The case management functions and the engagement and relationship-building that are established at the outset and throughout the case management process are not new. This is a practice within case management that has existed for a long time, and certainly one that we've had in place within Veterans Affairs since we've been engaged in the business of case management. That relationship is critically important.

What is maybe a little bit different in terms of our more recent practice and our work with our colleagues at National Defence is our integration with them at the integrated personnel support unit and getting engaged with releasing members prior to the release. We establish that relationship with the CF case manager, the VAC case manager, and the client family all together, so that once the member is released, that relationship can carry on. It's an ongoing relationship. It's one that needs to be cultivated throughout the whole case management process.

Col Jean-Robert Bernier: The pilot study is simply for tracking the medical records that are required for those individuals who require ongoing Veterans Affairs support. It's only the tracking digitization and electronic transfer of medical records. It's not an ongoing...we have an electronic health record for all armed forces members, so that we can track their health throughout the country and anywhere in the world where they are. But that is not part of this pilot project.

We do some studies. For example, last year we did the Canadian Forces cancer and mortality study, where we followed Canadian Forces members who had served from 1972 to 2006, and followed their causes of death. Now we'll be following up on their causes of cancer down the road to assess those kinds of things. It found, for example—from one question earlier—that there was a 1.5% higher rate of suicide among a certain cadre of released veterans.

So collaboratively we do all kinds of research to try to identify where the issues are. But this particular medical records tracking project is purely for the tracking, digitization, and electronic transfer of medical information for individuals who are being released from the armed forces and who need help from Veterans Affairs after release.

● (1730)

The Chair: Thank you very much.

I don't dare let him back in. I want to appreciate the fact that we are pretty close on time.

I do want to thank the witnesses very much. We've received a lot of great information today. Thank you again for coming.

That's it for the meeting today. Thank you very much.

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