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Chair

Mr. Greg Kerr

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● (1530)

[*English*]

The Chair (Mr. Greg Kerr (West Nova, CPC)): Good afternoon, everybody.

Welcome this afternoon as we continue our study on transformation initiatives at Veterans Affairs Canada.

I want to welcome our witnesses today. The order has been changed slightly. It looks as though we may not be interrupted by votes, which would be a nice change.

Just to briefly tell anybody who is brand new, the routine is that we have the opening statements, and then we have rounds of questions by the members. We try to get everything in that we possibly can before the time wraps up.

Having said that, I will go through the names. From the University of Manitoba, we have Professor Sareen, professor of psychiatry.

From Veterans Affairs, we have David Pedlar, director, policy and research, and Carlos Lourenso, director of treatment benefits and veterans independence programs.

From the Department of National Defence, we have Colonel Gerry Blais, director of casualty support management; Colonel Bernier, deputy surgeon general; and Susan Truscott, director general, military personnel and research analysis. If there is anybody else you want to introduce as we go through, please feel free to do that.

If we are ready to go, we will start. Each one has 10 minutes for opening comments.

Professor Sareen, please go ahead.

Dr. Jitender Sareen (Professor of Psychiatry, University of Manitoba): Thank you.

I'd like to thank the committee for inviting me to speak today. I look forward to initiating a dialogue with you about the optimum methods of improving the health of our Canadian Forces and veterans.

Canada should be proud of the efforts that have been made over the last ten years in improving the mental health care system for our service members and our veterans. However, Canadian policy-makers will need to foster strong partnerships across academic and government sectors to face the challenges of providing care for veterans who have had combat experiences in Afghanistan in the context of limited resources.

During this presentation, I'll present my background and experience to help you understand the context of my comments. I'll also provide a story that highlights some of the key issues that our system needs to consider. Then I'll describe some of the important work that our group has done, and end with future directions.

I'm an adult psychiatrist working in the Veterans Affairs operational stress injury clinic in Winnipeg, Manitoba. I'm also professor of psychiatry and director of research at the University of Manitoba, and chair of the science committee at the Canadian Psychiatric Association.

My research work has been supported by the Canadian Institutes of Health Research, the Manitoba Health Research Council, and the Canadian Institute for Military and Veteran Health Research.

To illustrate the important issues we're facing, I'll describe a case. This case is a composite of several people who I've treated so as not to breach confidentiality and potentially identify any single individual.

A 25-year-old service member is referred to our OSI clinic for assessment and treatment. The member presents with nightmares, sleep problems, irritability, and thoughts about suicide. He remembers being thrown from his vehicle, during his tour in Afghanistan, because of an explosion. His fellow soldier was killed instantly during the explosion. He lost consciousness and broke his leg. He spent many weeks recovering from the physical injury.

Since returning home nine months ago, he has been avoiding activities with his wife and children due to depression. He feels enormous amounts of guilt, and wonders whether he could have done something to help save his fellow soldier.

He's been binge-drinking alcohol on weekends to numb the memories and control the physical pain he is having and to try to improve his sleep. His marriage is falling apart.

The story that you've just heard is a common one that many of us working in the operational stress injury clinics across Canada hear on a daily basis. As you can imagine, the emotional costs of deployment to Afghanistan have been substantial for Canada. Not only do problems like post-traumatic stress disorder, depression, and alcohol abuse impact on the individual and their families, these issues have a strong impact on the military, veterans, and our society.

There are some important questions raised by these stories. How many Canadian service members have developed mental health problems related to their deployment? Why does one person who faces combat develop mental health problems while another does not? Who among service members is at risk for developing mental health problems? What can be done to reduce mental illness in our service members and veterans? Most importantly, how can we prevent suicide?

Steven Fletcher, Minister of State for Transport and member of Parliament for Charleswood, visited our clinic last year and asked the following question that I didn't have the answer to: are civilians in Canada more or less likely to get appropriate treatment for depression than our veterans? It's an important question, because the military has been previously criticized for not taking care of the emotional needs of our veterans.

To date, we don't have scientific data to answer many of the questions that I've posed to you. Through important partnerships, through researchers, Canadian Forces, and veterans, we have aimed to try to address some of these important issues.

Our research group began approximately ten years ago. In 2002 Canadian Forces and Statistics Canada conducted a landmark mental health survey to understand the mental health needs of our active military. Stats Canada conducted in-person interviews with over 8,000 active military personnel and tried to understand the mental health needs. We have been supported by the CIHR, the Canadian Institutes of Health Research, over the last ten years to analyze this rich database that's unique in the world.

● (1535)

Here are three key findings from our work.

First, we were inspired by Senator Roméo Dallaire's book, *Shake Hands with the Devil*. He describes his horrifying experiences as a peacekeeper in Rwanda. He really raised important awareness of post-traumatic stress in Canada.

Second, our research findings demonstrated for the first time that Canadian military personnel acting in peacekeeping roles who experienced combat and witnessed atrocities, such as human massacres, had an increased risk of a range of mental health problems, not just PTSD. However, it's important to note that the majority of mental illness in the military was not related to combat or deployments. Less than 10% of mental illness, if there was a causal link, was related to deployment experiences.

The third main finding from our major study showed that in 2002, untreated mental illness in the military was a common problem. Approximately 50% of people with a diagnosed mental illness, such as depression and anxiety, did not receive care.

The research findings from our work have had substantial scientific and policy impacts. We've published papers from this work in international journals and have presented our findings at national and international conferences, including workshops at NATO on suicide prevention and post-traumatic stress disorder. Two years ago, I was invited to present on suicide risk at the Senate Committee on Veterans Affairs.

Over the last 10 years, the government has taken strong action to improve access and quality of care for our members. They have expanded the Veterans Affairs operational stress injury clinics across Canada. The deployment health section has developed a post-deployment mental health screening survey to provide early and timely access to care for our returning soldiers.

It's important to note that the findings of our work were based on a 2002 mental health survey, which occurred prior to the deployment of ground troops in 2004. Thus, more recent information about the needs of our service members is required, because our recent service members have faced much more combat than ever in history.

I'd like to move towards the partnerships we're working on.

At Queen's University, Dr. Alice Aiken has been leading a Canadian military and veterans health research forum. This brings together universities across Canada and key stakeholders to advance knowledge in the area of military mental health.

I attended the conference last year and have initiated two important partnerships.

First, at this conference, I became aware of the recently collected survey by Stats Canada and Veterans Affairs called “Life after Service”. Our University of Manitoba research group was invited to partner with Dr. Pedlar and his group at Veterans Affairs to address important questions related to mental health. These include household income changes and financial stress in relation to mental illness, and physical health problems and chronic pain in relation to suicidal behaviour.

Second, one of the programs I'm leading is to design a follow-up of the original 2002 Canadian service members survey. I am working on developing partnerships, through funding from Defence Research and Development Canada, the Canadian Forces, and the Mental Health Commission. The original participants will either have become veterans over the last 10 years or will have been sent over to deployment. This would be a unique study in the world. It will address very important questions about pre-deployment, deployment, and post-deployment risk and protective factors for mental illness.

During this presentation, I've tried to give an overview of the important mental health issues faced by our service members. Clearly, there are many more details on each of these issues, which I would be happy to address in the question period.

I would like to end by reminding the committee that the investment in research and other health care areas, such as cardiovascular disease, HIV, and cancer have led to a rapid advancement in knowledge and a reduction in morbidity and mortality in Canada and around the world. I strongly advocate that the need for investment in military mental health research and partnerships can lead to a rapid increase in knowledge and can actually reduce suffering and save lives.

Thank you for listening.

● (1540)

The Chair: Thank you very much, Professor Sareen.

I'm sure there will be lots of questions when we get around to it.

Now I believe David Pedlar is going to take the next round, for 10 minutes.

Dr. David Pedlar (Director, Policy and Research, Department of Veterans Affairs): Thank you very much.

It's a pleasure to be back before committee, this time to talk to you about how research work at Veterans Affairs is primarily conducted in partnership with various departments and organizations to strengthen our collective understanding of the health and well-being of veterans.

I would like to acknowledge my research colleagues who represent some of our partners, who are here with us today to join in this discussion.

I lead the VAC research section. Our work is applied, meaning that it directly supports and advances Veterans Affairs Canada's priorities. Although our capacity is modest in size, we have a strong track record of conducting and analyzing military and veteran health research and have produced many studies, reviews, and publications. We also provide technical and administrative support to the Veterans Affairs Canada Scientific Advisory Committee on Veterans' Health.

Our research team includes a gerontologist, an epidemiologist, a health economist, a medical adviser, and statistical experts. Our work supports the advancement of effective policies, programs, and services that respond to the needs of veterans and their families. It also helps play an important role in clarifying and understanding emerging mental and physical health issues that can impact veterans across the life course.

The work we do has two key functions. We produce new knowledge through research studies linked to our priorities. In recent years, a key research priority has been understanding transition from military service to civilian life. For example, the “Life after Service” studies that I spoke to you about in February helped address this priority. This work is essential to understand the health, well-being, and disability of a new generation of today's veterans so we can move forward on a foundation of solid evidence.

We also synthesize existing knowledge, meaning that we interpret and monitor military and veteran scientific evidence and expert opinion. This work informs best practices in disability compensation and care of veterans and their families.

Let me underline that this is a specialized area. Many health problems encountered by military personnel, veterans, and their families are common to civilians, but there are differences owing to the unique aspects or context of military service. For example, the military nature of service-related physical and psychological trauma is rarely encountered by civilians. Consider the extreme mental stress of combat or consider a blast injury. These are relatively rare in a civilian context but are more common in battlefield or military operations. The transition from military service to civilian life is also unique.

Partnerships are absolutely essential, so we can conduct this work more effectively, much more so than doing it alone. Through partnerships, we coordinate our research priorities so that we're working toward complementary goals and avoiding duplication. They also bring some of Canada's best minds to the table to help us work on these problems, minds like Dr. Sareen's. Working as a team also allows us to learn together, leverage resources, and maximize efficiency and outcomes. Some of our research partners are the Department of National Defence, the Canadian Forces, and the Canadian Institutes of Health Research. Other key partners are Statistics Canada and the Canadian Institute for Military and Veteran Health Research.

We have a very close working relationship with the Department of National Defence and the Canadian Forces in the area of research. This connection is natural because a veteran's health today is determined by their experiences earlier in life, and of course these experiences include service. Consequently, our research is integrated into a close working relationship on a wide range of issues. Over the past several years a key area of mutual interest and collaboration has been on understanding transition from military service to civilian life, and generally how well released personnel do in life after military service.

Working closely with Susan Truscott's group and Statistics Canada, we completed two studies to inform VAC's work in support of military to civilian transition. One was on income and one was on health and well-being. These studies looked at all former regular force full-time personnel who released over a recent 10-year period.

We also collaborated with the Canadian Forces Health Services Group, Colonel Bernier's group, on a third study, the Canadian Forces cancer and mortality study, for which they are the lead. The mortality study, which compared rates of death in serving and released personnel to the general Canadian population, was released in 2011, and the cancer study is under way. A wide range of analyses are under way from this information that we've collected on topics like mental health, income, suicide, and whether VAC programs are reaching the people they were intended to reach.

Statistics Canada is also a big player. They bring technical expertise and hold secure national registries of information on things like cancer, causes of death, and income. They're essential to do this work.

Regarding the Canadian Institutes of Health Research, VAC researchers have a track record of involvement in a number of projects, including one we led on the challenges of workplace reintegration of veterans with mental health conditions.

● (1545)

Last October, Veterans Affairs, the Canadian Forces, DND, and the Canadian Institute for Military and Veteran Health Research met with the president of the CIHR and their scientific council to explore opportunities to strengthen collaboration through CIHR research programs. Since that time, VAC researchers have participated in an invitational workshop on traumatic brain injury that will lead to a national network on traumatic brain injury, which we'll be part of. We're also in discussions about participation in a number of other opportunities, including one that can lead to best practices in mental health.

This work is international in scope. A great deal of veteran health research is conducted by our allies in other countries, especially the United States, but also Australia and the U.K. Therefore, we're actively involved in research information exchange. For example, I chair an international research subcommittee of a group called the Senior International Forum. This forum involves senior officials from the United States, the United Kingdom, Australia, New Zealand, and Canada. We meet annually to discuss issues and initiatives, and in fact research was the theme of the 2011 forum that was hosted in Ottawa. The discussions at the forum and the preceding ministerial summit focused on this question of transition from military service to civilian life.

As I move towards closing, another key partnership is with the Canadian Institute for Military and Veteran Health Research. This organization represents a network of about 21 universities across Canada, and it is successfully increasing the engagement of Canada's university community in the area of veteran health and veteran health research. We're very active, providing in-kind support to this organization and participating in its governance structure, on its advisory council, on its scientific direction committee, as well as on other committees. We also contribute heavily and we're very involved in the annual forum that Dr. Sareen talked to you about, through planning, sponsorship, and participation. In fact, our minister, the Honourable Steven Blaney, gave the opening remarks at the forum last year.

We have worked extensively with university-based researchers across the country for many years, but recently the Canadian Institute for Military and Veteran Health Research has helped us facilitate these relationships even more. As Dr. Sareen mentioned, we are working with his group on three studies, including one on suicide ideation and another on the impact of income on mental health. This work will further inform our work in a number of areas, including suicide prevention.

We're also working with Queen's University on two studies related to chronic pain and well-being, because chronic pain is another problem that's common among veterans.

We're also working with the Université de Sherbrooke on a tool to help in assessment of barriers to workplace reintegration for veterans in our rehabilitation program.

The energy and interest generated among Canadian research continues to strengthen. We look forward to the third Military and Veteran Health Research Forum hosted by the institute this fall. The forum showcases the increasing scope of current Canadian research, which is supporting the needs of veterans and their families.

In closing, despite or perhaps because of the modest size of our research section, VAC has leveraged partnerships to be a national leader in veteran health research, and we're proud to have played a role in the growth of key research partnerships in this area over the past decade. The collaboration in this research area ensures strong evidence to inform VAC programs, policies, and services, with the goal of benefiting Canada's veterans.

Thank you.

● (1550)

The Chair: Thank you very much, Mr. Pedlar.

Now we move to our last 10 minutes.

Ms. Truscott is going first? Okay. Thank you very much.

Ms. Susan Truscott (Director General, Military Personnel and Research Analysis, Department of National Defence): Good afternoon, Mr. Chair and members of the Standing Committee on Veterans Affairs. Thank you for the opportunity to speak to you today about the research we do and our partnership with Veterans Affairs.

My name is Susan Truscott. I am the director general of military personnel research and analysis. I am a defence scientist with 30 years of experience conducting and managing research related to military personnel in the Department of National Defence and the Canadian Forces. With me today are Colonel Jean-Robert Bernier, Deputy Surgeon General, and Colonel Gerry Blais, director of casualty support management.

I'd like to tell you a little bit about my organization, the type of research we do, why we do it, and why our collaboration with Veterans Affairs Canada is beneficial both to the Department of National Defence and to Veterans Affairs, and, importantly, to service members, veterans, and their families.

DGMPRA is both a division of the Military Personnel Command under the Chief of Military Personnel and a research centre within Defence Research and Development Canada, DRDC, under the assistant deputy minister, science and technology. It is comprised of both civilian and military researchers who hold PhDs or master's degrees in a variety of disciplines but predominantly in the social sciences.

Our mission is to inform personnel policy and decision-making in the Canadian Forces and the Department of National Defence by conducting relevant and responsive strategic and operational personnel research and analysis; by developing and employing innovative methodologies and measures such as selection tests, survey instruments, and workforce models; by exploiting cutting-edge technologies to enhance research effectiveness; by providing expert, objective, evidence-based advice to leadership; by prioritizing and coordinating research to achieve the Canadian Forces mission; and by engaging academic, industrial, government, and allied partners in the development and application of personnel research and analysis.

The Canadian Forces military personnel management system is a complex system of interrelated and interdependent subsystems that require constant monitoring, prioritization, and transformation. Because of these interdependencies, policy decisions made in one area need to be taken with the full knowledge of the impacts, both short and long term, that may occur in a number of other areas across the system.

As a consequence, personnel research is a core military personnel management capability and is essential to the development of informed, evidence-based policy and strategic planning in support of personnel management. This is the function that DGMPRA fulfills for the Chief of Military Personnel in his role as the Canadian Forces functional authority for military personnel policy.

We conduct much of this research with our own in-house resources, but, where possible and appropriate, we employ contracts and collaborate with other organizations within and external to government in order to maximize our research capability. One of those organizations we collaborate with is Veterans Affairs. This makes perfect sense, not just in the area of research related to the transition from Canadian Forces to civilian life, but also from the perspective of the life course of veterans.

As you are already aware, DGMPRA and Veterans Affairs have collaborated on the “Life after Service” studies, which produced three reports discussing the methodology, the results of the income study, and the results of the survey on transition to civilian life. In addition, the medical researchers in Colonel Bernier's organization, the director general of health services, led the Canadian Forces cancer and mortality study in collaboration with Veterans Affairs.

DND has also conducted its own research on transition. A recent literature review on transition to civilian life focused on mental health and career challenges of individuals who have transitioned out of the military. As a result of this research, a number of important areas for further collaborative research with Veterans Affairs have been identified, and initial work involving secondary analysis of the data collected in the “Life after Service” studies has already been initiated.

The Department of National Defence is also involved in projects led by university researchers that are exploring the “Life after Service” data, examining the relationship between chronic pain and reduced well-being, and the effect of all co-existing physical and mental health conditions on individual veterans.

● (1555)

Finally, planning is under way to conduct a study of reservists, which will employ the same methodology as the survey on transition to civilian life of former regular force members. As was the case in the former survey, our department is participating in discussions related to research methodology, providing administrative data, and providing guidance on policies related to reservists, and we will participate in the writing and the review of the reports. It is anticipated there will be issues unique to reservists, and conducting the study separately has the benefit of enabling us to identify these issues and focus on them in the survey and analysis.

I fully expect the research collaboration between the Department of National Defence and Veterans Affairs Canada will continue and we will derive benefits from this collaboration in terms of a coordinated approach to evidence-based policies and programs for Canadian Forces members, veterans, and their families across the life course.

Thank you, Mr. Chair.

The Chair: Thank you, Ms. Truscott.

Colonel.

[*Translation*]

Colonel Jean-Robert Bernier (Deputy Surgeon General, Department of National Defence): Mr. Chair, committee members, thank you for this opportunity to speak about Canadian Forces health research partnerships.

[*English*]

As the senior defence department advisor on all matters related to health and the provider of health services to the Canadian Forces, the Surgeon General requires a robust health surveillance, analysis, and research capability to identify concerns and improve related policies, programs, and clinical capabilities. Because of the unique nature of military service and its operational, occupational, and environmental hazards, specialized applied research is necessary that's very often not, or cannot be, adequately addressed by civilian research.

The Surgeon General's health research strategy and its program, therefore, focus on military needs and pursue maximum efficiency and productivity through collaboration with other organizations.

We have significant internal research capacity through our clinician-scientists in Canadian Forces clinics and university medical centres and through scientific staff at our national headquarters and at the Canadian Forces Environmental Medicine Establishment. They annually publish dozens of peer-reviewed studies, academic theses, and technical reports, and they have a worldwide reputation as leaders in key areas of military health research, such as trauma management, critical care, and mental health.

[*Translation*]

Defence Research and Development Canada is one of our most important partners and we currently have over 40 joint projects together. It provides some nationally-unique and critical research capabilities in such areas as medical defence against chemical-biological agents, blast injury, elements of mental health, and other militarily-significant areas. We also collaborate with other DND elements, several other government departments and agencies, industry and academia.

[*English*]

Collaboration with academia in particular is increasing since the Canadian Institute for Military and Veteran Health Research was established in response to a proposal by the Surgeon General. This network of 22 universities aims to supplement our research through coordination of relevant academic work, and it has already organized two research forums to maximize the transfer of relevant findings nationally.

We also collaborate bilaterally and multilaterally with allied military health research authorities, including several NATO health research organizations. By pooling resources to research common interests, we often achieve results at relatively little cost or with a disproportionately high return on investment.

By increasing research efficiency and collaboration with our partners, we strive to continue maximizing health research output that makes a difference in protecting the lives and the health of Canadian Forces members.

[*Translation*]

Thank you for your attention.

[*English*]

The Chair: Thank you very much, Colonel.

Ms. Truscott, I want to ask you this just before we do the tour—you would probably be asked anyway. You're going to collaborate on the study for reservists. Is that something that will be undertaken fairly soon, do you know?

Ms. Susan Truscott: It's already under way to some degree.

The Chair: Thank you.

As I say, I don't want to take questions away, but that's been a question that has come up quite often, so thank you.

We'll go to Ms. Mathyssen, for five minutes, please.

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

And thank you to all of you for being here and providing us with this other aspect of the research we would like to do in connection with transformation.

I have a couple of questions. Anyone can answer, but I thought I'd start with Dr. Sareen.

You talked about the research and the concerns in regard to veterans adjusting. One of the things I've been particularly concerned about is homelessness among veterans. Those men and women have served in peacekeeping missions and have done remarkable service for their country, yet we're hearing tragic stories of these folks ending up in the most desperate of circumstances.

You talked about mental health and the research you've done around that. Have you connected or thought or done work in terms of homelessness and mental health and how those two things seem to go together?

● (1600)

Dr. Jitender Sareen: That's an excellent question. I'm one of the co-leaders of the Winnipeg site for the Mental Health Commission's homelessness project. As you're aware, the Housing First initiative of the Mental Health Commission of Canada has five cities, and part of that is a small but significant proportion who are veterans.

I do think that mental illness can impact on personal income and household income and lead to what's been called “social drift”. Also, if you have financial strain and you're in the United States, you have financial strain all the time right now. There have been household income and financial stressors around the world. We've done studies on this showing it has an independent risk for mental health problems, as well as suicide.

As you're saying, there's a strong link between homelessness and financial stress and mental health, and it's a bi-directional relationship. If you're depressed and you can't work, then you're on disability, which can then lead to financial problems. On the other side as well, if you had financial changes or a job loss, whether you're in the military or moving from the military into life after service, it's a very important issue.

I don't want to get into the homelessness study, but I think one of the key questions the homelessness study is trying to address is the idea of housing first. Rather than treating the mental illness and then the person gets into housing, it's trying to go after it from a housing first approach. I think that is the right way.

We were invited from Winnipeg because of our work in aboriginal and mental health. I think you'll hear positive stories from that study.

Dr. David Pedlar: If I could address that as well, I want to build on Dr. Sareen's remarks. He mentioned the Chez Soi project. It's a large-scale demonstration pilot around an intervention for homelessness at four or five sites across the country. We've been engaged in that since the very beginning.

It's a demonstration project, but it's also a research project, to find out what works and what doesn't work and more about that population. During the beginnings of that project we worked with a scientific team to ensure veteran identifier questions were part of the protocol for every participant in that program across the country, which could be as many as 2,200. We will be in a position to work with the Mental Health Commission to look at the veteran dimension of that moving forward.

Ms. Irene Mathyssen: Thank you.

The Chair: A very brief question.

Ms. Irene Mathyssen: Okay.

Dr. Sareen, you were also involved in work with regard to suicide and the impact of low income on mental health. You've perhaps answered that to a degree. In terms of your preliminary findings, is the impact of low income different for veterans than the general population?

Dr. Jitender Sareen: There is no study that's been done. We have a doctoral student who's doing a PhD on this issue because we couldn't find any literature. There's a lot of literature on two issues. There's literature on whether money buys happiness: if you win the lottery, does it buy happiness in the general population, and does it buy happiness if you have mental illness and poverty?

There's very little to no information in military samples. As you're aware, disability and benefits and those kinds of issues have a big impact.

● (1605)

Ms. Irene Mathyssen: Thank you very much.

The Chair: Thank you very much, Professor.

Now we go to Ms. Adams, for five minutes, please.

Ms. Eve Adams (Mississauga—Brampton South, CPC): Thank you all very much for coming today.

Dr. Sareen, we heard earlier that Veterans Affairs conducts research focusing on two key functions. The first is synthesizing existing knowledge, interpreting and monitoring military and veteran scientific evidence and existing expert opinion. The second is undertaking primary research, which produces new knowledge through studies such as the one that was discussed, the “Life after Service” studies.

Could you give me a high-level overview of the study's findings and whether or not that study is completed at this point?

Dr. Jitender Sareen: On the “Life after Service” study, it's probably better if Dr. Pedlar addresses that specific question. We're addressing specific issues around that, but I think it might be better....

Dr. David Pedlar: Is it okay if I take this?

Ms. Eve Adams: Of course.

Dr. David Pedlar: The study was undertaken to get an understanding of the transition experience from military service to civilian life, as well as to understand the health and well-being of veterans after they're released from service. One of the limitations of work we've done in the past is that we've only looked at our clients, who tend to be about 10% or 15% of this broader veteran population. One of the strengths of this study is that we were able to look at the entire 37,000 full-time force—not reserves—that released over a 10-year period, from 1997 to 2007. It was our first broad look at this new population.

There were a number of important findings. This population is very heterogeneous. In other words, one can follow a lot of different trajectories in the process of transition, and many of them are positive trajectories. Most veterans said they did well in transition and that their transition was relatively easy. However, an important minority, around 25%, found transition to be difficult or very difficult. So it allowed us to identify a subpopulation who experienced more problems.

Ms. Eve Adams: What was the methodology? Was this a paper-based questionnaire to the entire cohort or...?

Dr. David Pedlar: There were two main pieces. It was a linkage study where we were able to identify with a list of all the released members, which was provided by the Department of National Defence/Canadian Forces. One study that focused on income over a 10-year period was linked by Statistics Canada to a Revenue Canada file, so we were able to look at 10 years of income experience, starting before transition to after transition.

We also used that list as a frame for Statistics Canada to do interviews with over 3,000 veterans who transitioned. That was a national survey. That was the basic methodology for the two primary studies.

Ms. Eve Adams: I interrupted you as you were about to share the high-level findings of the study.

Dr. David Pedlar: Yes. The high-level findings were that there was a lot of variation in transition experience, but some people did have a difficult transition. With respect to income, veterans were less likely to experience low income than the Canadian population. They're about half as likely to fall under what is called the low-income measure, which is a StatsCan measure for low income.

Ms. Eve Adams: And that makes sense intuitively. These are folks who are used to showing up to work and doing a good job and serving their country. I would imagine they would be incredible employees to have.

Dr. David Pedlar: Right. There was a relatively low rate of those who were using provincial social assistance programs. I think it was rarely more than 1% or 2% in any given year.

However, some veterans experienced challenges. Some of them had changes in income upon release. Those who experienced the largest changes in income after release were the medically released, women, and those who served from 10 to 20 years, so they were in mid-career. They were more likely to experience an impact on their career trajectory by leaving in mid-career.

In the area of health, there were a number of findings. One was that there were areas where veterans experienced a higher burden of health issues than other Canadians. One of those was the area of musculoskeletal conditions, such as arthritis. It was about double the rate. Back problems were about double the rate as well. Generally, they had higher levels of problems with disability—that's functioning in the community. However, a lot of this was concentrated in about 16% of that broader population. They didn't have just one condition; they tended to have multiple conditions. So it drew our attention to a population that could have high needs in terms of how they are approached through case management and other services we offer.

A final area we looked at was program reach. We learned that we do very well with some of our populations, especially those who are medically released. That's a population we've targeted since the beginning of the work on the new Veterans Charter. We have a high level of contact with that population, but there are some groups we haven't been reaching, for example, groups that have shorter periods of service, groups that had certain kinds of releases—they may have been released voluntarily—younger veterans who stayed for a shorter period of time, and other categories that concern us in terms of reach and other questions.

That's a short high-level overview.

● (1610)

The Chair: Thank you very much, Mr. Pedlar.

Mr. Casey, for five minutes.

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

I was interested that three of the four opening presentations referenced the Canadian Institute for Military and Veteran Health Research. I'm quite happy to have all of the five minutes allocated to the Liberal Party spent discussing how the Government of Canada can do more with respect to the sustainability and the success of that body.

The Deputy Surgeon General states in here:

> Because of the unique nature of military service and its operational, occupational, and environmental hazards, specialized applied research is necessary that very often is not, or cannot be, adequately addressed by civilian research.

I absolutely accept that and thereby the rationale for better support of the CIMVHR.

Mr. Pedlar, you very carefully chose your words—and I can understand why—when you said that VAC is engaged in providing "in-kind" support to the CIMVHR. You stated also that you "contribute heavily" to the annual Military and Veteran Health Research Forum. We see that kind of language coming from VAC in an awful lot of things where they partner with somebody else without putting in real dollars. Helmets to Hardhats comes to mind.

And Dr. Sareen, you indicated that CIMVHR aids your work.

Now, I'm sorry for the long introduction, but I invite comments from anyone on the panel as to....

I have one more thing before I hand it over to you. I know, and several of you know, that representatives from CIMVHR made a very compelling case to the finance committee of the House of Commons in the pre-budget submissions looking for funding—real, meaningful funding—for them to do their work. They didn't get it.

I'd like to hear from each of you on what the Government of Canada could and should be doing, and on what results we could achieve if they were to do what they should do with respect to CIMVHR.

Thank you.

Dr. David Pedlar: I'll start.

We've been engaged with the institute from the very beginning. We've supported it in the ways that I've mentioned.

In addition to the ways that I've mentioned, we also work with them on research applications to group organizations such as the Canadian Institutes of Health Research. We have one application that's under review right now. If that application is successful, they would administrate that research grant. There would be administrative moneys available through granting opportunities as we move forward. We're collaborating very closely with them in those granting opportunities.

So that could provide additional moneys directly to the institute.

● (1615)

Mr. Sean Casey: Thank you.

Col Jean-Robert Bernier: I'll talk about the origins. For many years, we had academic researchers or co-investigators from the armed forces who were quite interested in obtaining data to assist in their own or their faculties' interest in doing research on military populations or areas relevant to military health. The Canadian Forces, Defence Research and Development Canada, and I think perhaps Veterans Affairs as well, would independently fund individual academic researchers or faculties to address very specific questions.

There's a whole bureaucratic process to contracting and having bids and all that kind of thing.

The Surgeon General had the idea a few years ago of having a central clearinghouse, a central point of access, to establish a collaborative process for all of these universities. They would have one-stop shopping to find out what was relevant and of interest in addressing military and veterans' health problems.

CIMVHR does not itself have an in-house research capability. It's an administrative vehicle or institute that enhances and administers the collaborative efforts of the various elements of academia that are interested in assisting. Any moneys that would flow to them from the defence department or from Veterans Affairs would be administered by CIMVHR, which would determine the collaborative mechanism or the group of academic researchers. In most cases, our research requirements are so broad that there's no one university in Canada that can handle them all.

Often, to address these research requirements, collaborative efforts by a number of individual researchers in the same university or in multiple universities are needed. In such cases, we will often assign a military co-investigator, or a Defence Research and Development or a Veterans Affairs co-investigator, to inject the reality and the context that's so critical for making civilian health research done by civilian academic faculties specifically applicable to the armed forces.

There is some money from the defence department and Veterans Affairs, currently. We have specific research questions we want to address and have asked CIMVHR to solicit interest from the universities. We're also working on a large standing offer for research to avoid the need for a very prolonged and painstaking bureaucratic process to solicit bids for research. We hope to have a standing offer with CIMVHR that will serve as the vehicle for establishing that collaborative effort among all the best researchers across academia who have the academic and research competencies and interests.

I'll just highlight that the Australians have a military and veterans' health institute as well, but it took them 15 years to get it going. CIMVHR has only been around for two years, and we already have the first award for military health research. That has never occurred before. The Surgeon General established it with the aid of a private sponsor. Professor Sareen was the first winner for the high quality of the research he presented at the second annual Military and Veteran Health Research Forum.

Things are progressing. There is a progressively improving committee structure. It will allow us to be more efficient and to establish a fair process by which all of the research interests and competencies and capabilities of all the universities can be represented. There will be a single point of contact established for adjudication on the distribution of that money from the federal government.

It will take a while to get this fully up and running, but there has been significant progress. In the end, this will mobilize, at very little expense to the Canadian taxpayer, a much more efficient and effective and productive system for addressing military and veteran health research questions.

The Chair: Thank you very much, Colonel Bernier.

We'll now go to Mr. Chisu, for five minutes, please.

Mr. Corneliu Chisu (Pickering—Scarborough East, CPC): Thank you very much, Mr. Chair. Thank you very much to the witnesses for coming to our committee.

As you know, military service is both physically and mentally demanding. Yet we often hear that there is little information available about ongoing health effects after release from the military.

Professor Sareen, in your presentation, you mentioned *Shake Hands with the Devil*, which was written by General Dallaire, now Senator Dallaire.

Have you ever spoken with anyone from the Medak Pocket? It was the first engagement the Canadian Forces had in Bosnia, and it was in a fighting capacity.

● (1620)

Dr. Jitender Sareen: Yes.

Mr. Corneliu Chisu: That was in 1995. That is very interesting because it set the stage for Afghanistan. Now these people are veterans. Did you ever contact anybody who participated in this conflagration, or do you have any data about it? I think this was the first time that Canadian soldiers shot at, and eventually killed, somebody.

Dr. Jitender Sareen: Yes.

Mr. Corneliu Chisu: That was the first military engagement that was completely different from the peacekeeping operations. That sets the stage, again, for the involvement in Afghanistan between 2006 and 2011.

Another issue that I would like to draw to your attention is the so-called “holding platoons”. Probably the colonel will know about that. What does it mean, “holding platoons”? It's about somebody who is joining the military, but for various reasons is not loaded in the courses, is releasing, and it is taking a long time to release from the military.

When I was a construction engineer officer in Meaford in 2006, we had a couple of accidents; one was a suicide. So I think it is worth it to be seen. I don't know if your “Life after Service” study is touching on this important element in military life.

Dr. Jitender Sareen: Thank you for the question.

I am treating some veterans currently who have served in the Bosnia experience. I think the previous survey that was done in 1995 looked at that issue. I agree with you that before Afghanistan and before Rwanda and before Bosnia, with most of the peacekeeping experiences, the biggest stress at times was boredom.

Mr. Corneliu Chisu: I'll just take a moment to say that there was a book written about the Medak Pocket. Have you had an opportunity to see that?

Dr. Jitender Sareen: I have not, no.

Mr. Corneliu Chisu: I really recommend that you see it, sir.

Dr. Jitender Sareen: On one other point, just like for who is going to develop cardiovascular disease, there's a huge range of things that happen—and we're just trying to understand even cardiovascular disease or cancer. These are complex illnesses that have genetic, environmental, family.... Thirty years ago, most of us would have been smoking cigarettes in this place, but over time, knowledge has shown that smoking is a key risk factor.

I think mental illness is like other complex illnesses, where we don't have a good understanding of why one particular person.... This is one of the important things, to go back to the forum idea, that it's a special population. If we can bring the great minds together.... I think money is important, but it's really....

We had students who I brought to the conference and they were excited to see Roméo Dallaire and listen to his speech. It's trying to get the next generation of scholars who are going to actually make the discoveries.

Col Jean-Robert Bernier: Specifically related to the Medak Pocket, that was the 2nd Battalion, Princess Patricia's Canadian Light Infantry battle group, and the senior medical officer for that battle group was my deputy base surgeon in Calgary. He and I established, after that operation, the first critical incident stress debriefing program for the armed forces for the western area of Canada, where the troops had come from. He had been there throughout the whole mission, including the Medak Pocket battle, and saw the development of the mental health problems that occurred, as well as the follow-on.

We had a fairly robust mental health program, or mental health clinical capability, in the armed forces at the time, but you'll recall that was right after the end of the Cold War, when we were expecting mass casualties in western Europe. We had not focused, to the extent that we have since in the last few decades, on mental health. There was the stigma that existed at the time and society declining to celebrate that particular operation. The attention and the resources available, the efforts to decrease stigma for the presentation of care, and the attitudes that existed even within the armed forces were nothing like they are today. We've gone light years beyond that now. I wouldn't say it was deplorable, but they did not have the mental health resources and the setting, ambience, and atmosphere that would have been best for the veterans of that particular battle. So some of them suffered quite intensely for a long time before getting adequate care.

Today, as I described in previous testimony, with the standard of care of screening and stigma reduction in the armed forces, and the programs that are available, even though they're not perfect, and even though occasionally there are still individuals who don't show up, or don't get the care they need.... In most cases, it's a result of self-stigma, where they simply decline to present for care.

We've come light years in the clinical mental health care, the non-clinical supports, and the atmosphere of almost the elimination of stigma. It's a countercultural change in the way mental health issues are perceived, partly because of General Dallaire's example, but also because of many other efforts to achieve where we are today.

● (1625)

The Chair: Thank you very much, Colonel Bernier. We're quite a bit over time.

Ms. Papillon, I would like to say welcome back. You have five minutes, please.

Ms. Annick Papillon (Québec, NDP): Thank you very much, Mr. Chairman.

[*Translation*]

I would like to thank all our witnesses very much for being here today.

I spoke to a number of veterans over several months when I was the deputy critic for Veterans Affairs Canada, and they told me about the importance of front-line services. When we spoke about their needs, it was the importance of talking to people that came up the most. I have to say a few words about all the staff cuts, particularly in Quebec City, where I am the MP. Eleven public service positions have been eliminated in Quebec, including three in Quebec City. These are people whose main responsibility is to help veterans dealing with operational stress trauma. Of the four positions in Quebec City, only one remains. Ultimately, 75 client services positions will be eliminated. That will certainly prevent the department from responding directly to the needs of veterans. I would like to hear what you have to say about that.

This is of enormous concern to us. If we continue in this direction, there will be serious problems within five years, given our presence in Afghanistan and the fact that we will have more and more veterans. In addition, the effects of missions in Bosnia, Rwanda and Somalia are still being felt. What will the situation be in the coming years? I would like to hear what the Veterans Affairs Canada representatives have to say about that. We can talk about statistics and reports and making investments, but what about direct services for veterans and their families?

[*English*]

Dr. David Pedlar: Carlos, do you want to speak to that?

Mr. Carlos Lourenso (Director, Treatment Benefits and Veterans Independence Programs, Department of Veterans Affairs): First of all, Mr. Chair, the department is continuing to ensure that its focus is on veterans being able to choose the channels of service that fit them the best. Things are changing. We know technology is changing and we know we're able to serve people in a variety of different ways. Veterans today are very different from veterans of years before. They expect to be able to be served in a variety of modalities, which means they expect to be able to go online, through the telephone, in person, and so on. Veterans Affairs is committed to ensuring we have all of those channels available to veterans.

In terms of being able to access a service face to face with the department, that service will continue in all areas where veterans need that service. In years gone by, veterans were scattered all across the country, in various points where there weren't service offices or district offices—they could have been in northern Ontario or in northern Quebec somewhere—and that would mean we would have people who would go visit them. That will still be the case in the future. We will always have points of contact where veterans can walk in and receive the services, and we will have points of contact where we will go out and we will meet with veterans, but we're making changes to ensure, as well, that we're cutting red tape, making things easier for them, and ensuring that all of those different service channels are available to them, regardless of the way they present to us.

[*Translation*]

Ms. Annick Papillon: That, of course, is the point of view of Veterans Affairs Canada. It is cutting the number of public servants and thinks that every veteran is able to transition easily into civilian life in less than six months. Unfortunately, that isn't the case. When you listen, when you ask veterans in Quebec City, in Quebec, for their opinion, that isn't what I am hearing, and I am sure that veterans in Quebec City are no different from veterans in the rest of Canada. They are not getting services. They have told me that they never complained about services; they are only asking that there be more people to respond to their needs. They have never complained about the work of public servants, and salute their work, but they think that there aren't enough of them. So, imagine how it will be with the cuts that are under way in this area. It really isn't the right direction to take.

That is the message that needs to be put across on behalf of all veterans. They want to know that this committee and the department will take their needs into account. They are asking for more direct services, to speak to a person and not stay on hold after dialing a 1-800-something-Canada number. They want to speak to people and do not want to go from one case manager to another, and tell their story again and again to each one. They want to feel that they can trust the individuals who will remain in place and who will be able to provide them with services. That is the first important thing.

I'm wondering if you have a game plan for long-term health care, which continues to be a problem. Given the closure of the Sainte-Anne hospital, this will be abandoned. Have you thought about providing veterans with long-term health care?

● (1630)

[*English*]

The Chair: Unfortunately, we're quite a bit over time. That was a very articulate presentation. I think it's on record. If any of you want to respond in writing to the questions, certainly we encourage that to take place.

Now we go to the very quiet and subtle Mr. Storseth for five minutes.

Voices: Oh, oh!

Mr. Brian Storseth (Westlock—St. Paul, CPC): Thank you, my valued Chair.

I'm going to go back to the transformation initiatives.

Colonel Bernier, you've been here before, and I always appreciate your testimony. You talked about the stigma, though, and I think this is critical. I can tell you that Mr. Chisu is right—the stigma of the men and women who served in Bosnia and other places.... Certainly I've sat with them. It has taken them years, and they've suffered for many years before coming forward. We must strive to never have that happen in our country again.

There have been some great changes in the leadership of the Canadian Forces. Generals Natynczyk and Hillier have both taken on strong roles and are making sure they try to change that stigma. I take it from your testimony you feel as though the stigma has changed as well.

Do we have any indicators or measurements that show this is working, that the stigma is actually changing?

Col Jean-Robert Bernier: Yes, sir. In addition to the general cultural mindset that's palpable in the armed forces, where it is countercultural to not be supportive as a result of all of the education that has occurred to sensitize leaders, peers, subordinates, and individual members and family members to the signs, the symptoms, and the ways to obtain care, we have about five objective measures that demonstrate....

One is a study we did just two or three years ago, in which we found that only about 7% of Canadian Forces respondents would think less of another individual soldier who had a mental health problem or who presented with a mental health problem. That's quite significant, even compared to the civilian population.

The Royal Society of Medicine in the United Kingdom published a study comparing the stigma levels in five Anglo-Saxon and Canadian major allies—New Zealand, Australia, Canada, the U.S., and the United Kingdom—and found that the Canadian Forces had the lowest level of stigma among its service members.

The enhanced post-deployment screen that we apply to everyone is a very detailed and thorough evaluation for mental health and physical health problems. It's applied three to six months after deployments of about two months' duration. Formerly, at the time of the Canadian Forces supplement to the Canadian community health survey in 2002, we were finding that it took an average of 5.5 years before people would present for mental health care.

Only a couple of years ago, by the time of that enhanced post-deployment screening, three to six months after return from deployment we found that over half were already in care.

Finally, a U.S. researcher who is very well known and very credible compared U.S. data on stigma to Canadian data and found that levels of stigma in the Canadian Forces were about one-third of those in the U.S. military population.

● (1635)

Mr. Brian Storseth: Excellent. Thank you very much.

I have one quick supplemental question to that. Do we expect any ongoing studies? You may not know the answer to this, but is there an expectation that every five years, three years, or ten years there will be follow-up studies on that?

Col Jean-Robert Bernier: We have a long list of ongoing studies and planned studies, and it would probably take up more than your time to go over all of them. Some of them are quite significant, including a repeat of the Canadian Forces supplement to the Canadian community health survey, which will be next year. There is another health and lifestyle information survey. There are a wide variety of studies that will help us characterize the impact of the mental health programs that have occurred over the past decade, as well as to see where the current problems and the current needs are today.

Mr. Brian Storseth: I'm sorry. Go ahead.

Ms. Susan Truscott: I would just add that we also do surveys. One is called Your-Say. We do that every six months with military personnel. We also do ongoing surveys with spouses. We ask the member questions about things such as their level of confidence that the Canadian Forces will look after them or their family if they're injured.

It's another mechanism in support of those that Colonel Bernier mentioned, to have ongoing evidence about the confidence of personnel that the system will look after them.

Mr. Brian Storseth: Thank you.

You read my mind. My next question was going to be about family and spouses as well. That's excellent.

Lastly, Colonel Bernier, do we have anything to indicate that the remaining stigma is present more in any one aspect of the forces than in others—in the air force or the army versus the navy—or is it pretty much across the board at those levels?

Col Jean-Robert Bernier: The indications we have were that in the lower ranks there were higher levels of stigma, and, as it is in many of these kinds of things in the general population, levels of education are sometimes correlated. But we don't have extensive objective data on that.

Mr. Brian Storseth: I'd like—

The Chair: Thank you very much for that, Mr. Bernier.

Mr. Brian Storseth: I just asked because I have both an air force and the PPCLI in my riding.

The Chair: Now we go to Mr. Lobb for five minutes, please.

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

Ms. Truscott, Mr. Storseth mentioned that you read his mind. Would you care to enlighten the committee as to what else you saw when you read his mind?

Voices: Oh, oh!

Mr. Ben Lobb: Maybe that's an "after 5:30" answer.

One thing I wanted to ask was this. Mr. Bernier, you mentioned that the Canadian Forces had one-third the stigma level towards mental health that the U.S. forces had. I just wondered what the U.S. is not doing that Canada has done well. Help us to understand that, because it's important. It's because we're doing something well, but what are they missing out on?

Col Jean-Robert Bernier: I can't speculate, but there are significant differences in the way they have historically viewed and treated mental health conditions. Also, there are significant differences in the support provided to their troops and in the duration of their deployments, for example, and the frequency of their duration. There are just too many variables for us to pin it down to particular things.

But there are many differences in the way the U.S. runs its armed forces, and in particular how it deals with suicide or mental health or stigma, that make it unfair to try to make direct comparisons.

Mr. Ben Lobb: Okay.

To any of our guests here today, with the transformation agenda, obviously, there are pillars involved with it, and the final outcome of the transformation is a better outcome for our veterans. One of those in this area, specifically, that we're dealing with today is research. In Mr. Bernier's paper he mentioned working with other NATO countries and—I'll paraphrase—kind of cherry-picking their best practices.

How does that process work? It must be an ongoing process, but just explain to the committee how that process takes place and is actually implemented or at least screened for potential implementation either through VAC or DND.

● (1640)

Col Jean-Robert Bernier: Ms. Truscott can answer some of these questions as well, because of her involvement in the technical cooperation program between Australia, Canada, the United Kingdom, the U.S., and New Zealand.

I'm the chairman of the NATO medical and health research committee. We have multiple research task groups. The way it works there is that enough nations have to have a common interest, an aligned interest, and all agree on the specific activity that's to be researched, the specific research question that's suitable and addresses a problem that exists in their own countries. Then each will provide what resources it can to collaboratively address the research question, primarily through literature reviews but sometimes through original research as well, but typically applied to military populations.

One example of a research task group is one on military suicides, specifically, that one of our researchers is chairing. That involves about 15 other countries.

Then the results of those are published, so the best practices, the evidence-based results, are published. Then each individual nation applies it individually, based on the specific parameters and social factors and organizational factors relevant to its armed forces.

There's common funding. There's a wide variety of multinational and also bilateral efforts—for example, primarily with the United States, where we'll sometimes put in a small amount of money and a small amount of research effort and the Americans will put in up to 50 times as much.

I'm not talking here specifically about mental health; for example, we're developing biological defence vaccines—vaccines against biological weapons and other medical counter-measures—where, for one of them, we're paying 2% of the bill and the Americans are paying almost all of the rest, with the British paying a part as well. So for a very small contribution on our part in research, sometimes funding an analytical effort, we're getting a massive return on investment in many cases.

But all of these questions are always aligned so that they're based on a common interest with the common research questions that are equally applicable to all of them, and it has to be that way, particularly with our closest allies, because when we deploy, we deploy together. We'll rarely deploy on an operation alone, so there's a whole effort in NATO to try to be interoperable and to try to standardize all our practices and programs, in medical, health, and all other elements of military operations.

The Chair: Okay. We're up to our time.

I would just point out that we let our witnesses go on at length. We like to get the answers. It's the questioners who we cut off at their time.

That's the end of round one. We'll now go to round two, which is a four-minute round.

I understand that Mr. Chicoine is going to start.

Go ahead, please.

[*Translation*]

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

I would also like to thank the witnesses for being here to share their knowledge and observations with us.

I have a question about the findings of coroner Hélène Lord, who conducted an inquest into the suicide of a soldier at the Valcartier base. She indicated that the waiting times were much too long. In fact, the wait for care at the mental health centre on the Valcartier base was 120 days.

I would like to know if any action has been taken to reduce the waiting times so that they are consistent with the 30-day standard of the Canadian Forces, instead of 120 days, as was the case at the time of the coroner's inquest.

Col Jean-Robert Bernier: I cannot talk about individual cases because privacy laws prevent me from doing so. However, I can say that this is a problem that affects the Canadian population as a whole. Last week, an Ottawa newspaper, the *Ottawa Citizen*, indicated on the front page that the Ottawa Hospital has a one-year waiting list, just for an assessment, not for treatment. These wait times are much shorter in the Canadian Forces. There are problems in certain areas, such as at Valcartier and Petawawa, but we have the government's permission and the resources required to hire twice as many mental health professionals than in the civilian sector in Canada. The current number of professionals in Canada, compared with the population, is higher than all NATO countries.

That is what we have, but we always want to improve. We would like to fill all these positions, but we are having a lot of difficulty doing that because there is a major shortage of these professionals in Canada. That's why we are establishing and strengthening our ties with professional societies. For example, a job fair was recently held in Quebec City. Our mental health employees made a number of presentations on military issues, including post-traumatic stress syndrome, and we do the same during scientific conferences attended by professional associations. As a result, 10 psychologists in Quebec did express interest following the job fair. We are increasing our capacity and our ties with these professional associations in the context of these scientific conferences to try to arouse more interest.

We also have an agreement that allows us to hire mental health professionals and pay them higher salaries than what is permitted by the public service. However, despite all of that, we have difficulty finding them, like all the other health care institutions in Canada, because of the shortage.

● (1645)

[*English*]

The Chair: Very briefly, please, Mr. Chicoine.

[*Translation*]

Mr. Sylvain Chicoine: Has any thought been given to using clinical psychologists? I don't think the Canadian Forces is using these professionals. When our troops are deployed abroad, the Canadian Forces doesn't include clinical psychologists.

What is the opinion about hiring these psychologists?

Col Jean-Robert Bernier: We are currently using clinical psychologists in all our large mental health centres. However, they are civilians and not military personnel. During deployments, we use psychiatrists, mental health nurses and social workers with special skills, as well as our general practitioners, who have some specific skills.

Given how we are currently organized, we don't need the skills of clinical psychologists during deployment operations, but we do use them, for example, for decompression in a third location, in Cyprus, after lengthy deployments. That is the case if we are able to deploy civilians, if we need them and if we determine that it would be necessary for operations.

We are constantly assessing our needs with respect to all the professions and all the skills in all areas of health care.

[*English*]

The Chair: Thank you.

Now we'll go to Mr. Harris, for four minutes, please.

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

Mr. Lourenso, I want to get back to you, as you were not able to give a response. I need you to give some words of assurance to some of the people over there who have a faulty belief that it's impossible to transform or make something better unless you simply throw more money and more people at it.

I know that's a wrong mindset, and I know that your commitment to veterans who have health issues, mental health issues and others in this case, is to give them the best possible service you can. I just need you to expand a little on that and maybe give some reassurances for the folks across the way that you are on the right track.

Mr. Carlos Lourenso: Absolutely. As you've heard from previous witnesses, the department has undertaken a variety of different measures to try to streamline and make more effective the types of services we're providing to clients. Our focus is to ensure that those who need us the most will have the people in front of them and beside them that they need to help them.

We've tried to streamline the administrative activities that exist in the department: the processes, the mailings, the forms, all the paperwork, all the various items that people do on a day-to-day basis, and automate them, rid ourselves of multiple client signatures and multiple forms for different purposes.

That enables us to take the people we have—and other resources as well, because it's not only the people we have in our offices. We have instituted Integrated Personnel Support Centres, we have OSI clinics; we have access to 200 critical case managers and to over 4,000 mental health providers across the country. So we've expanded the base of potential service points for clients well beyond the borders of our department, to ensure that veterans who are scattered across the country—not only in large urban centres and not only in centres where there is a higher percentage of CF members and so on—have a variety of different supports and different ways to interface with the department and get a much broader spectrum of services than they may have needed in the past.

We know that today's veterans, unlike the veterans of previous years, who were confined to an age cohort that was maybe four or five years apart—those who were in World War II and so on—have a very broad age range and therefore a very broad range of needs. As a department, we need to respond to that, and ensure that the types of services and the way we service veterans corresponds to that wide scope of need as well.

● (1650)

Mr. Richard Harris: I would imagine that during all these changes and the streamlining, one of the challenges you have would be to get the word out to the veterans who need help that you have a new way of doing things, so they shouldn't come to you looking for the old, slow, and even more complicated way. They should try your new streamlined service; you think they'll like it. That must be one of the challenges, and some of the vets who have problems may not have caught on to the new and efficient streamlined way you want to do things now. That's the challenge: to get those folks comfortable with it so they can be better served.

Mr. Carlos Lourenso: Absolutely. One of the greatest transformations we've had to undertake is moving away from having offices that were concentrated in certain urban centres and having a way to be able to branch out and reach out to veterans in the various environments they live in, whether it's in rural centres, near bases, or in urban centres. We've had a very active approach going out to bases, working with our colleagues in DND, establishing Integrated Personnel Support Centres, where we have VAC employees, DND employees, and members, and changing our online systems, our websites, our ability to interface with a younger cohort of veterans who demand that kind of online service. So outreach has been a key component of what we're trying to do.

The Chair: Thank you.

I know Colonel Blais was trying to get in there with a comment.

Colonel Gerry Blais (Director, Casualty Support Management, Department of National Defence): A lot of what I was going to say, Mr. Lourenso just indicated. The Integrated Personnel Support Centres have allowed a lot more of that face-to-face contact, especially with the younger veterans, because now we have Veterans Affairs on the Canadian Forces bases and we bring them into Veterans Affairs, so they do get that face-to-face contact.

Also, when we brief all the reserve units and regular force units on the care of the ill and injured and the benefits available, we bring Veterans Affairs Canada staff with us so they can get the word out as well.

Mr. Richard Harris: Excellent.

The Chair: Thank you very much.

Now to Ms. Perreault, for four minutes, please.

[*Translation*]

Ms. Manon Perreault (Montcalm, NDP): My questions are for Mr. Lourenso and have to do with the Veterans Independence Program and support at home.

I really want to understand what the program is about. I imagine that when this program was created, it met the needs of veterans who are now ageing. They may be in institutions. Have these institutions been modified to meet the needs of the new cohort of young veterans? These people have different needs, after all.

[*English*]

Mr. Carlos Lourenso: The veterans independence program has been described as probably the most generous broad-scope home care program in Canada. I would hazard to say there is no provincial program in Canada that has the scope of services the VIP program has.

The program was designed at a time when most of the veterans were not very old but were getting older. The program was initially designed in 1981. The services from that time have undergone a lot of change in the last 15 or 20 years. We now have a program that has an abundance of services, that are designed to support a very elderly client, for example, such as personal care and nursing services in the home and so on.

At the same time, if you are a younger veteran who has had a catastrophic injury, an amputee, for example, and you need assistance with your yard maintenance, housekeeping, being able to get to services and so on, the program makes all of those types of services available to a younger veteran who has different needs.

We are constantly looking at the program and designing small changes to enable it to be much more suited to a younger population.

● (1655)

[*Translation*]

Ms. Manon Perreault: Excuse me for interrupting. That means that people who benefit from this program probably undergo annual or periodic assessments, meaning that someone who uses the program may not necessarily receive those benefits for his or her entire life.

[*English*]

Mr. Carlos Lourenso: True. The program is designed in a way that it is able to help people either for a long time, in terms of chronic needs, or through a transitionary-type period. In other words, somebody comes back from service and they need certain supports at home. The program can be employed to help them in conjunction with other programs—rehabilitation programs, career transition services, and so on.

The VIP program can be instituted for a shorter period of time. A person's needs are assessed by case managers at different points in time and the program is modified accordingly.

[*Translation*]

Ms. Manon Perreault: Are there currently individuals who might need the support of the program but can't access it?

[*English*]

Mr. Carlos Lourenso: Any veteran who has a service-related injury and requires the services available under the veterans independence program, generally speaking, would be able to receive the services of that program. I think that's the easiest way to answer it.

[*Translation*]

Ms. Manon Perreault: It's a program—

[*English*]

The Chair: Thank you very much. We're at the end of our time.

It went quickly, didn't it?

[*Translation*]

Ms. Manon Perreault: My time is already up.

[*English*]

The Chair: Now to Mr. Lizon, for four minutes, please.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much, Mr. Chair.

I would like to thank the witnesses for appearing at the committee.

I would like to direct my question to Professor Sareen, and then I would like other witnesses who would like to comment to do so.

Usually our capable chairman tells me I am out of time. Therefore, if we run out of time, please do it in writing.

The Chair: You still have a minute or so left.

Voices: Oh, oh!

Mr. Wladyslaw Lizon: Professor Sareen, we've talked a lot about the treatment of mental illness. In your experience, in your studies, anything we try to treat is better if we have an ability to stop it or prevent it. Should something be added to military training? You mentioned predeployment preparation. Can something else be done to protect soldiers who engage in a military operation, not only from physical injuries, through equipment and innovations, but from emotional and psychological injuries?

I would like you to start, and if others join in, I would appreciate it.

Dr. Jitender Sareen: This is in a paper our group presented. At this time, I think there is some evidence that people who were exposed to physical and sexual abuse when they were young were at increased risk of mental health problems. Childhood abuse plus deployment and combat exposure had an additive effect. That's probably the strongest predeployment risk factor.

At this time, there's a lot of interest in psycho-educational interventions. We've got physical training. Can we do some mental health training? The forces' members can probably answer what's happening. My understanding is there isn't a lot of evidence for that, but trying to prevent illness has always been one of the core pieces.

At this time, I don't think we have a pie-in-the-sky...that this is the perfect thing to do. There's been interest in whether you had a history of a mental health problem...if we should try to minimize people being deployed. That's also been a very controversial area, because if you look at serious mental illness, like schizophrenia or a psychotic illness, it makes some sense, but distress, depression, anxiety.... If you exclude everybody, then you won't have a military either.

I don't think at this point we have evidence, but the forum and the partnerships could allow for intervention studies and those kinds of things, and our study is trying to do that as well.

● (1700)

The Chair: Sorry. We're over time. Did you want Colonel Bernier to respond?

Col Jean-Robert Bernier: Everything that is known or that may potentially assist in prevention is being done—screening, for example. Right from recruitment, we screen out anybody with a mental health condition. Throughout the course of their career, people get periodic health assessments that include mental health screening questions. Predeployment, there's psychosocial and mental health screening. Before deployment and afterwards, there's an extensive “road to mental readiness” program, to try to enhance resilience based on some evidence in sports psychology, with special operations in the U.S. and other sources of data, and then post-deployment as well.

There's also the Canadian Forces Expert Panel on Suicide Prevention, which was held a couple of years ago, which included civilian and military experts from Canada and from other allies around the world. It reviewed all the possible preventive efforts that the literature suggests might...or anything that has any evidence in favour of it. Even in the absence of evidence, those that might potentially have an effect...they have been implemented, and the suicide expert panel found that.

Separately, the Rand Corporation in the United States did a similar evaluation, and everything they found, as far as a good, solid mental health program to try to minimize mental health conditions, was already in place in the Canadian Forces.

The Chair: Thank you very much.

At this point, I want to thank our witnesses very much for their contribution. It's very much appreciated.

As our study goes on, it's obvious we're involved in a pretty major undertaking.

We have some committee business to take care of, so I'm going to suspend and ask folks to wish our witnesses well as they leave, please.

[*Proceedings continue in camera*]

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