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Chair

Mr. James Bezan

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● (1535)

[*English*]

The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)): Good afternoon, everyone.

I call this meeting to order.

We're at meeting number 78, continuing with our study on the care of our ill and injured Canadian Forces members.

Joining us today for the first hour, from the Department of National Defence, we have Lieutenant-Colonel Alexandra Heber, who is the psychiatrist and manager of operational and trauma stress support centres. She is joined by Madame Huguette Gélinas, who is the Quebec coordinator of health services civilian-military cooperation, with the Canadian Forces.

I'll open it up for your comments. If you could each keep them under 10 minutes, I'd appreciate that.

Colonel, you have the floor.

Lieutenant-Colonel Alexandra Heber (Psychiatrist and Manager, Operational and Trauma Stress Support Centres, Department of National Defence): Thank you.

Thank you, ladies and gentlemen, for inviting me here today, and thank you for all the good work you're doing in studying the care of the ill and injured members of the Canadian Forces. As you may remember, I appeared before you last November with the surgeon general, and I'm delighted to be back.

To give you some of my background, I worked as a nurse in mental health for nine years before entering medical school. I worked as a civilian psychiatrist for about 10 years at Mount Sinai Hospital in Toronto before moving to Ottawa. I first took a position in the Canadian Forces health services centre mental health clinic in Ottawa in 2003 as a civilian psychiatrist. In 2006 I decided to join the CF.

Part of my motivation for joining was so that I could deploy to Afghanistan, which I did in 2009 to 2010. In many ways this deployment experience was the high point of my career, though when I think about it, the past 10 years I've spent serving our military members, both in and out of uniform, have really been the overall highlight of my psychiatric career.

Besides seeing patients, I've been the program manager of our operational trauma and stress support centre since 2003, and since joining in 2006 I've been the clinical leader for all mental health services in the Ottawa clinic, which is considered the flagship clinic in Canada. It is the largest with a staff of 35 mental health clinicians.

With my experience working in both the civilian and military health care systems, I must tell you that I'm impressed every day with the level of accessibility, quality of care, the cooperation, and facility of communication among the different parts of our health care system. For instance, in the civilian world I had never had the kind of access and close relationship with the family doctors of my patients that I now enjoy. The family docs live only one floor above us and it's not unusual for me to see one of my clinicians running upstairs to discuss a complex case that they share with one of our doctors or physician's assistants, or one of our nurse practitioners.

As well, in mental health we work on multidisciplinary teams where the care of each patient is shared by psychiatrists, psychologists, social workers, and mental health nurses, and where we have access to specialists in addictions. We have a chaplain on our team, a pharmacist, and when needed, we have case managers and peer-support workers.

I'd like to focus for a minute on the operational trauma and stress support centre, or OTSSC, in Ottawa. These centres were first stood up in 1999 as specialized clinics within mental health services to serve the needs of the members who suffered mental health problems following those difficult deployments of the early and mid-1990s to Rwanda, Somalia, and Bosnia.

The OTSSC is a multidisciplinary team of highly skilled, flexible, and creative clinicians who assess, diagnose, and treat members referred for mental health problems. But the OTSSC also responds to outreach requests from members, the chain of command, or at times, from outside agencies. For example, for two years, from 2007 to 2009, before an OTSSC was stood up in CFB Petawawa, members of my team did satellite clinics for three out of every four weeks of a month, so we could help meet the mental health needs of the people in Petawawa.

As well, for over a decade the Ottawa OTSSC has run a week-long care for the caregivers retreat for all CF chaplains who have returned from deployment in the previous year.

We've established partnerships with many organizations outside of the CF, including the Veterans Affairs OSI clinics across Canada, and most particularly with our clinic here at the Royal Ottawa Hospital, with which we have a close and collaborative working relationship. We're regularly approached by some other sister organizations, including provincial police, RCMP, and most recently, Ottawa Fire Services, to brief them on our approach to issues like critical incident stress, suicide, and managing mental health issues in the workplace.

● (1540)

I'd like to touch on another important issue as I conclude. I believe that in previous testimony you have asked the question, who helps the helpers? Well, that's a pretty important question and hopefully we'll have a chance to discuss that in the next hour. What I have learned from my 10 years with the CF is that one of the most important ingredients to preventing burnout in clinicians is to work in a team environment with the support of colleagues, a common focus, and an idealistic purpose.

In our clinic, I'm happy to report we have these ingredients in spades.

Thank you.

The Chair: Thank you, Colonel.

Madame Gélinas.

[*Translation*]

Ms. Huguette Gélinas (Quebec Coordinator, Health Services Civilian-Military Cooperation, Canadian Forces, Department of National Defence): Mr. Chair, members of the committee, I would like to thank you for giving me the opportunity to speak to you about the alliances and the partnerships that the Health Services have established with the civilian community in the field of health.

First, the Canadian Forces Health Services Group is legally responsible for delivering care to Canada's military personnel at home and abroad. However, the closure of military hospitals in Canada has resulted in the Canadian Forces becoming increasingly reliant on a wide variety of civilian health care agencies to fulfil its mission in providing this health care. In fact, the group lacks a number of components, which makes it reliant on the civilian health care network, with which it must establish partnerships with regard to these components. Accordingly, partnerships and alliances with civilian organizations are core to the Canadian Forces Health Services Group's strategy, as it is often the only way to access some of the required resources and health-related services delivered in civilian settings.

In 2003, the Canadian Forces Health Services Group implemented the national Health Services Civilian-Military Cooperation, or the HS CIMIC: a unique capacity-providing expertise with no equivalent in the civilian sector. This section comprises one national manager — a position I have held for the past four years — who operates out of the Canadian Forces Health Services Group Headquarters in Ottawa, and regional coordinators operating in various regions of the country, each with an assigned geographic area of responsibility.

From 2004 to 2008, I worked as the HS CIMIC cooperation coordinator for the Quebec region, returning to this role three weeks ago. From 2008 until this past April, I was, as I mentioned earlier, the national manager for the team. Over these past several years I have gained solid experience in the development and maintenance of strong and efficient civilian-military alliance networks and at securing access to high quality care for ill or injured military personnel.

HS CIMIC ensures and facilitates access to care in the civilian sector either as a complement to day-to-day in-garrison care or urgent care in relation to operations or exercises. In 2006, as a complement to Canadian Forces Health Services Group's support to Operation Athena, HS CIMIC was formally mandated to develop and implement the strategy for securing the care of ill or wounded soldiers in Canadian health care environments, for example, acute or trauma care in Canadian civilian hospitals, rehabilitation services, mental health services and other specialized services such as home care. Particular efforts have been oriented to mental health related initiatives for ill or injured military personnel and their families.

HS CIMIC is also responsible for securing education and training opportunities in civilian francophone and anglophone settings for Canadian Forces Health Services Group personnel. As of today, 154 memorandums of understanding were negotiated and formalized in relation to a mandatory program held in hospitals or ambulance services. The objective of this program is to maintain clinical skills of Canadian Forces health care providers so that all can provide care to ill and injured CF members, at home or abroad.

● (1545)

The Department of National Defence and the Chief of the Defence Staff both consider care offered to injured or ill members of the Canadian Forces to be a priority. Furthermore, the Canadian Forces Health Services Group has a firm resolve to provide the highest quality health care services available to military personnel. In this respect, the continuous and fruitful relationships established with civilian health services in Canada, as well as with other departments with a health mandate at the federal and provincial levels through the section that I led, play a key role in following up on this priority.

Thank you.

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

[*English*]

I think we'll stick with five-minute rounds, since we only have an hour with these witnesses.

Mr. Harris, you have the floor.

Mr. Jack Harris (St. John's East, NDP): Thank you, Chair, and thank you to both of you for coming and joining us.

Lieutenant-Colonel Heber, I was very impressed by your resumé and your journey from being a nurse to being a psychiatrist to and being a lieutenant colonel in the military, and your deployments.

I liked your description of what goes on here in Ottawa. I have no doubt that, with the 35 staff and the flagship operation, you can do very good work. One of the worries I have though is that if you have a flagship, of course, everybody wants to compare it other things.

You mentioned a special program in Petawawa from 2007 to 2009. I'm sure you're aware of the report that was done by civilian clinicians in April 2012, only a year ago, which outlined what was being done in 2007 and 2009, and we assume it was top of the line. There were serious problems at this point with complaints that the OTSSC program was under-resourced; that they didn't have a medical addictions specialist, although 60% of the caseload were addictions related; that the wait times were unreasonable if you had a psychiatric diagnosis and needed somebody else; that the salaries weren't competitive with similar positions outside; and that there was no incentive for people to come live there. You're probably aware of the litany of what happened.

We've been told that improvements have been made. We don't have all the chapter and verse on that. But what I want to know is, how can this happen? If you did set this up—I'm not doubting that—and if you have a capability like we have here in Ottawa, how can that happen in Petawawa where we have so many soldiers, so many returning soldiers, and a huge complement of people? Why not have the kind of services available to this group of soldiers as are available here in Ottawa at the same standard?

LCol Alexandra Heber: I'm going back in my mind and trying to think of the series of events. In fact, they do have an OTSSC in Petawawa now. It was set up, in fact, in 2010 and had, as most of these kinds of specialized clinics do, some growing pains in terms of trying to, first of all, attract clinicians to the Petawawa-Pembroke area to work.

What we had done for those two years was.... At that time Petawawa fell under us in terms of operational stress injuries. We actually have a huge catchment area for our OTSSC. At that time it also included Petawawa. Now it includes all of Ontario except for Petawawa. For those two years, we decided that we needed to have at least some kind of a solution, a temporary solution, until further action could be taken in terms of things like setting up a separate OTSSC.

● (1550)

Mr. Jack Harris: But this was 2012, two years later. They're saying, for example, that they're setting up assessments—that was April 25—in July, just an assessment. That seems to be very unreasonable if you have somebody coming forward who needs an assessment and they can't get an assessment for almost three months.

LCol Alexandra Heber: Well, here's what I can tell you. You're right, we worry about a 12-week wait time. Although, in Petawawa now they do not have a 12-week wait time. They probably have a two-week wait time. Our wait time in Ottawa is about 12 weeks now. We work on that.

By comparison, my friend and colleague, Dr. Raj Bhatla, who is the head psychiatrist at the Royal Ottawa Mental Health Centre, was quoted last summer in the *Ottawa Citizen* as saying that to get an assessment in their mood disorders clinic at the Royal Ottawa, people were waiting 12 months. Not to say that makes 12 weeks an okay wait time, but I think if you look at the comparison to the civilian sector, you can see that we actually work hard and we do quite well.

The second thing—

Mr. Jack Harris: Do you think that's a valid comparison though, because we're talking about soldiers who have presumably received their stress injuries as a result of being in the forces? Why would we compare those to civilian wait times when we have a medical service designed to treat and care for our ill and injured soldiers?

People don't wait if they have physical trauma. Let's face it, that's just the nature of the beast. Why would they have to wait if it's psychological trauma?

LCol Alexandra Heber: It has to do with our resources first of all. The second thing I want to say is that we have a system of support within mental health services so that if somebody needs care immediately, they get it. It's very much like you would see in an emergency department, where physical trauma cases are staged and some people are given priority over other people in much the same way.

We also have a team where we have two clinicians dedicated to seeing people without appointment on a crisis basis. Now, that's not the full diagnostic assessment, but they are seen quickly. They can be seen the same day they come in and they are assessed. Then we look at how to prioritize people.

The Chair: Thank you very much. Mr. Harris's time has expired.

Mr. Norlock, you have the floor.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): Thank you very much, Mr. Chair, and through you to the witnesses, Doctor, why haven't you found the cure for the common cold? There are two of us here suffering, and we don't have a cure.

LCol Alexandra Heber: I'm a psychiatrist. I can empathize with you, but I cannot cure you.

Mr. Rick Norlock: You sound like my wife telling me I have to think the cold away.

But if I may, getting down to serious matters, I'm also on the public safety and national security committee. We have seen in all areas of federal government, all government services, where the government provides—to the taxpayer—services to the ill and injured. In particular in this case, it's people who suffer from mental illness or stress-caused injuries, as we see in the armed forces. We see that there is, and please do correct me if I'm wrong, a chronic shortage of psychiatrists, psychologists, and people in that field right across society, and in some cases especially in government services, because some professionals like a broad base of injury type, whereas in the prison system they're all pretty much the same thing, and with AIDS it's all pretty well the same types of illnesses or people are suffering along the same lines.

If we could use that societal comparison—and you have the experience in both fields—could you compare wait times, the availability of professionals both in the civilian field and the military field, and in particular, could you transition—if we have time—into the differences between the experiences you've seen from Bosnia and Herzegovina right down through to today from Afghanistan?

● (1555)

LCol Alexandra Heber: Thank you for the question.

There are two parts to that. First of all, the wait times, and then the difference I've seen in how people suffer from the days when I first started working in this field until now.

I gave the example from the Royal Ottawa hospital, of the difference, at times, being 12 weeks in our system to 12 months in the provincial health care system. One of the problems for a lot of the organizations that you're talking about is that they fall under medicare. They fall under the provincial health care system, and they don't have their own internal health care and mental care like we do in the military, so it becomes much more difficult.

We've instituted programs where, for example, we will see the RCMP members who have deployed with us. We will prioritize them and see them for assessment. We will then give back recommendations to their physicians so that they can start getting treatment. It's because it was taking so long for them to get services in the civilian world, and of course, they had deployed with us and had put themselves in harm's way, the same as CF members had.

In terms of the difference, that's a really good question. One of the things that I remember from when I first started working in the OTSSC, was that when members came in and I took their history, it wasn't uncommon for them to tell me that they had not slept through a single night in 10 years since returning from Rwanda or from Somalia, and that they had nightmares for almost all of those nights.

I have to tell you, as a civilian psychiatrist first starting to see people, I was taken aback. It was a bit hard for me to believe. But, of course, I had so many people who came in over and over again telling me that same story that I realized it was, in fact, true. These people had suffered in silence for years and years, had continued to work, and were stoic. I often needed to get their spouses in to get the real story of how much they were suffering because they didn't want to say very much.

Now it's much more the case that people come in six months to a year after returning from tour if they find that they are still having nightmares or still having an exaggerated startle response. I think they are much more willing to come in. There seems to be less stigma associated with this. I think part of it is that often their partners are much better educated now. They won't let them stay in the basement and drink for 10 years anymore. They say, "Hey, you're going to go and get some help."

The Chair: Thank you.

Time has expired.

Mr. McKay, go ahead.

Hon. John McKay (Scarborough—Guildwood, Lib.): Thank you, Chair.

Thank you to you both for coming.

We had Lieutenant-Colonel Grenier here a few weeks ago, and what added particular poignancy and credibility to his testimony were his own experiences with mental health issues. If this is an inappropriate question, tell me that it's an inappropriate question, and we'll move on. It's sometimes true that, looking at it from the other side of the gurney, the belief about your clinic, etc., is different, maybe not even quite as good. If appropriate, have either of you received treatment for issues relating to mental health?

An hon. member: That's inappropriate.

Hon. John McKay: I gave them the option. If in fact it's inappropriate, say so, and I'm happy to move on, but it is quite relevant, because you speak about the burnout of clinicians, and it's true.

What we've been getting in a lot of this testimony has been people who are the providers of the service, or they are responsible for the providers of the service. We haven't been hearing so much from the people who are the recipients of the service. If it's inappropriate, just tell me so, and I'll go on to another question.

● (1600)

The Chair: I'll leave it up to the discretion of the witnesses whether or not they wish to reply to that.

LCol Alexandra Heber: I have not had treatment for an operational stress injury, if that's your question.

Hon. John McKay: Okay, that's fair.

Tell me about the profile of the individual who's going into the clinic.

A 35-person staff is a fairly substantial clinic. What is the protocol and the frequency with respect to the issuance of opiate narcotic prescriptions?

LCol Alexandra Heber: First of all, those would not be given out in mental health. If somebody has chronic pain disorder, they would be seen by their family doctor, their general duty medical officer. They may be referred to a pain specialist and some of these people may be prescribed opiates for their pain. But that's not generally in our purview.

Hon. John McKay: So that doesn't happen within your clinic, then.

LCol Alexandra Heber: No. We often see people who have, for example, post-traumatic stress disorder and a chronic pain disorder. That's not unusual. Of course, in those cases the treatment becomes more complex and we usually have more people involved.

Hon. John McKay: Might you see them after they have received the prescription and are taking the medication?

LCol Alexandra Heber: We might see them then or it may be when they come in for their assessment in the OTSSC. We also do a general physical and medical history and we may find that, in fact, here's somebody who has been having chronic pain for several years. If that is in fact the case, what we do is send them back to their medical officer to have that followed up.

Hon. John McKay: What's the frequency of people you see that have drug or alcohol abuse problems?

LCol Alexandra Heber: Alcohol abuse is often seen in conjunction with post-traumatic stress disorder. Post-traumatic stress disorder, and this has been borne out in the literature, in research, is probably the most comorbid psychiatric disorder we know of, in other words, where there are other co-existing mental health conditions. One of the big ones is drug and alcohol abuse.

In my experience in the military it has been more alcohol abuse. So again what we will do in those cases is a comprehensive treatment package right at the beginning where we will also be treating them for their addiction problems.

Hon. John McKay: Can you say in terms of comorbidity the percentage of PTSD sufferers who are codependent on drug and alcohol abuse?

LCol Alexandra Heber: Again, off the top of my head from my clinic, I can't.

Hon. John McKay: It certainly would be significant.

LCol Alexandra Heber: Yes, it would certainly be.

Hon. John McKay: It would be something that you would look for.

LCol Alexandra Heber: It's something we screen for all the time. It's very typical when we see people in OTSSC for their assessment that they have a diagnosis of PTSD, alcohol abuse or dependence, and major depression. It's a pretty common triad we see.

Hon. John McKay: So that's that.

The Chair: Thank you. Time has expired.

I know it goes by quickly when you get into the meat and potatoes of an issue.

Madam Gallant, you have the floor.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman.

Colonel Heber, first of all, I want to thank you for any role you had in ensuring that Petawawa had its own OTSSC. It has made a world of difference to the people affected there to not to have to get on the bus, spend a whole day on the bus, and have episodes on the bus, etc.

LCol Alexandra Heber: Thank you. Absolutely.

Mrs. Cheryl Gallant: So it's greatly appreciated...and making sure that we got up to speed with the required number of people to help and the full complement of all the professionals there.

It was mentioned how there is a discrepancy between provincial care and the benefits that are awarded to people in the military. Given that a soldier in many circumstances is part of a family unit, and his or her behaviour affects the entire family, are there situations where the entire family or at least the spouses are receiving common care?

LCol Alexandra Heber: Thanks for the question.

Thank you very much. I didn't have a huge part, but because our OTSSC was providing services in Petawawa we were certainly bringing the issue forward that they needed something of their own.

In terms of spouses and families, according to the National Defence Act we only cover military members in terms of health care. However, especially in the OTSSCs, in our general mental health program we are able to push the bounds a little bit as well. But in the OTSSCs what we do is we consider helping the spouse and the family if they need help as part of helping the member. So it's as long as we can define it that way. I'll give you an example. We will see spouses for support. We will see them individually for a few sessions for support, for education. We will see them as a couple. We will see them as a family. If that spouse has his or her own depression, for example, we cannot treat their depression but what we will do, then, is help them to find a resource in the community.

● (1605)

Mrs. Cheryl Gallant: Does the OTSSC see vets from Bosnia, Rwanda, Somalia, as well?

LCol Alexandra Heber: We see still-serving members.

Sorry, I'm not sure what you mean by veterans because there are still serving members from those peacekeeping missions, and we do see them.

In terms of people releasing or on their way to releasing, we now have wonderful resources set up by Veterans Affairs. The OSI clinic is a resource that we use. When somebody is in the process and they know they're going to be leaving, we'll set up contact for them with the OSI clinic. They can go over there to meet the staff and so on, even before they're released.

Mrs. Cheryl Gallant: That's good to hear because some of the people who are on their way to being medically released are terrified of being released because they're afraid they're going to lose that continuation of care and have to go through their story all over again.

Now, back in 1999-2000, OSISS was more or less the entity that interfaced with the soldiers or vets who were buried inside their basements. There seemed to be a lot of friction between the OSISS people and the professional psychiatrists. It seems that this has transitioned and evolved over time, and that all the work Colonel Grenier did—his pioneering, his bulldozing—has made some inroads.

Can you tell us what the relationship between the two entities is now?

LCol Alexandra Heber: Sure.

First of all, one of my priorities when I first started working in the Ottawa clinic and I met Colonel Grenier was to start forming a partnership with OSISS. I don't want to speak to what was going on before I got there because, really, I can't talk about that.

We did a lot of joint presentations on how peer support and clinical care in mental health can work together. I think out of that grew much more of a partnership. OSISS also became very involved in what's called the joint speakers bureau in our headquarters. They are members of OSISS who partner with mental health clinicians and do teaching to chain of command. They do pre-deployment teaching. They go to third-location decompression and teach there. There have been a lot of ways that we have partnered.

Quite frankly, sometimes one of the problems is just staffing. We really value our OSISS workers and for whatever reason when they get too busy and they're not available to us, we often feel that.

● (1610)

The Chair: Thank you. Your time has expired.

[*Translation*]

Ms. Moore, you have five minutes.

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Thank you.

First of all, Ms. Heber, you spoke of avoiding professional burnout among care providers. When one is a care provider, experiencing a patient's death by suicide is very difficult. I went through it as a nurse, and it was not easy. Do you have a framework with the caregiving team to intervene in the case of a patient's suicide?

Furthermore, Ms. Gélinas, let's take the example of a reservist sent for care in a regional long-term care centre, so that he or she may be closer to their family. Often, the reality is very different from that of the military. In long-term care centres, one is often surrounded by people whose average age is about 90 years old, and who have Alzheimer's disease or other pathologies. It is therefore not the same situation as our military colleagues go through.

How do you work, in the context of your civil cooperation arrangements, to offer these people a stay that will still be beneficial, one that will help them, despite the fact that the people they are dealing with on a daily basis are different from their military colleagues?

[*English*]

LCol Alexandra Heber: I'll try to be brief.

Thank you very much for that question. For the last three years we have been doing what are called medical professional technical suicide reviews. Every time there's been a suicide of a CF member, we send a team of a GDMO—general duty medical officer—and a uniformed psychiatrist from away, from another base, to do a review.

I did one most recently in Petawawa. We go there and interview all the parties, including all the clinicians involved with the person. We interview the police, if it was police who found the body. We interview the family. We try to get a full picture, then we do a report back to the surgeon general. I have to tell you, suicide is a terrible thing for everybody involved, a terrible, terrible thing. But I think one of the things I didn't realize until I started doing these was the impact it has on the health care team. You're absolutely right.

It's one of the things I've been talking to my team about. Fortunately, we have not had an event like that in the last couple of years, but it really is devastating for everyone. I think it's really important to put in a mechanism of some kind of psychological first aid, the same kind of thing we would do for any kind of critical incident, for the team that was looking after that person.

[*Translation*]

Ms. Huguette Gélinas: Thank you for your question.

I find it interesting to have the opportunity to speak about this. In just one situation did I take part in discussions about the fact that reservists, for example, had to go to long-term care centres and deal with a clientele that did not resemble them at all, and that was indeed in the Montérégie region. For many years, we held a great number of discussions with the recruit school, in Saint-Jean, as well as with stakeholders in the health field. These discussions were often about the fact that many anglophone soldiers or recruits, when they needed care in the area, could not receive services in English. This was especially difficult when the problems involved mental health.

Therefore, there were discussions held to implement a privileged service corridor with the Douglas Mental Health University Institute, in Montreal. We helped people from the Haut-Richelieu—Rouville Health and Social Services Centre to offer English training to their personnel. There were also discussions when we had to send, sometimes for a few days, young recruits to environments where they would be under clinical surveillance. We held these discussions mainly with the Health and Social Services Agency in Montérégie to try and find other solutions. For example, if there were several patients, we could put them together in the same section, in a residential and long-term care centre or its equivalent, or even send them to intermediate resource clinics.

And those are the experiences I had regarding the aspect that you mentioned.

● (1615)

The Chair: Thank you very much.

Ms. Moore, your time has expired.

[*English*]

Mr. Strahl, it's your turn.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you, Mr. Chair, and thank you to the witnesses for your testimony and your questions and answers so far.

Colonel Heber, am I saying that right?

LCol Alexandra Heber: Heber. Not so fancy.

Mr. Mark Strahl: Heber, that's good.

We've heard from some previous witnesses about clinicians who work in the military system, then get frustrated and move the other way. I was interested to hear in your testimony that you started in the public system and chose to move into the military system. Can you talk a bit about the professionals—I'm sure you've seen it go the other way. For yourself, how was your experience different from that which we've heard is maybe more prevalent in the clinician field when dealing with the military?

LCol Alexandra Heber: Thank you for that question.

I actually don't think it's more prevalent that people get frustrated and leave. When I think about the teams I know well across the country, Edmonton has had a very stable group of clinicians. As for my team and the team in Halifax, you can't get these people out of the clinic. They love it.

I think, though, it takes a certain kind of person who wants to have a certain kind of practice, especially if we're talking about psychologists and psychiatrists, because I think social workers and mental health nurses work in teams naturally. I was a nurse before, and maybe that's why I was attracted to that kind of work.

If you are very independent or you need to have all the control over your practice and you don't want somebody else going into your scheduler and booking in the assessments, then our mental health clinics are not for you. But I will tell you that for a while I told my psychiatrists and psychologists that as a way of learning from each other they were going to see patients together. They didn't like that, but then after a while they loved it so much I could hardly pry them apart anymore to see people separately.

Really I think the benefits for these people are that they get to work in wonderful teams. They get to really share the load of the patients. They learn from each other. It's not the same kind of piecework or fee-for-service type work. They can do other things and still get paid. A psychiatrist can be making a phone call to a patient. A psychiatrist can be seeing a family member, and they're going to get paid for whatever they do.

Mr. Mark Strahl: I appreciate that perspective. It certainly gives us a new one here.

I wanted to ask you about pre-deployment checkups and post-deployment reviews. My question is more on the pre-deployment side—an ounce of prevention is worth a pound of cure. Has the military discovered any preparation that they can give a soldier who's about to deploy that girds them against OSIs? Has that work been done? What have we found to be effective in that regard?

● (1620)

LCol Alexandra Heber: It's a really good question.

There is not a lot of really solid evidence yet. However, we do have some, and we've based our programs on them. We know that no matter how terrible the situation is going to be, it seems that the more prepared people are ahead of time, the less traumatized they are. Surprise in and of itself produces trauma. Our whole road to mental readiness program that we devised, which I think you've heard about before, really comes out of that body of research.

So we prepare people just in the same way that we prepare them to go out with their company and fight. I'm thinking about Afghanistan. We also prepare them mentally by teaching them some techniques they can use when they find themselves feeling overwhelmed or getting very anxious as well as some things that will help them to calm themselves and calm their bodies down.

The Chair: Thank you. Your time has just expired.

Monsieur Larose, vous avez la parole.

Mr. Jean-François Larose (Repentigny, NDP): *Merci beaucoup, monsieur le président.*

I have three quick questions, and then I'll bring it to a point.

Lieutenant-Colonel Heber, have there been any cuts to any of your programs since you've been there?

LCol Alexandra Heber: No, there haven't been cuts.

Mr. Jean-François Larose: Have there been any evaluations? We have a lot of statistics and data concerning the effect this is having on the military. Are there any evaluations on the performance of your centres and the performance of the programs that are offered? Is there a necessity for more data on that?

LCol Alexandra Heber: Just yesterday we had a meeting at our headquarters to look at revitalizing the treatment standardization committee—which had run for a number of years, and then I think everybody just got so busy that it fell by the wayside—and it's exactly to look at this.

Over the last several years we've done a lot to develop pre- and post-deployment screenings, and looking at that and evaluating them. Major Sedge did his piece of research in Gagetown, looking at people developing PTSD and the course of that over time. The other thing we've done is a lot of educating and training of our staff in evidence-based treatments for such things as PTSD. Now we're looking at what we need to start putting in place to evaluate.

There certainly are tools. We have a tool that we've used in Ottawa for the last two to three years. You give a kind of quick checklist to the member every time he or she comes in and you look at symptoms, at how they're doing in their interpersonal life, how they feel about themselves in their role. It's very well researched. We've been using it in Ottawa in an unofficial way, but I think this is the tool we're going to go forward with. It's a great tool, because you can then look over time at whether people are actually getting better, and at what is reducing.

Mr. Jean-François Larose: That would be my next question.

We mentioned in a conversation that, compared with the civilian life—and that was my point at the last committee meeting—the military on these issues is highly advanced.

Do you feel that everything as it is right now is adequate, or are there quite a few points that would need to be bettered?

LCol Alexandra Heber: We can always improve, and this is one example for us, to start looking at outcome measures in a much more standardized way. I think this is going to be our next step.

We know that we help people and we can see that their symptoms decrease, but to be able to capture that objectively would be very helpful.

Mr. Jean-François Larose: I wonder whether you can help me in an assessment. I'm looking at all the witnesses the committee has had so far....

I want to thank everyone from the military who has been here so far. I think your commitment and your energy are absolutely wonderful. I've never seen so many people in the clinical environment taking so much to heart their helping of our military. It's absolutely amazing.

The problem I see—and I wonder whether you see the same thing—and the feeling we get is that there will be cuts. Finally we're getting somewhere, but at this point the cuts are coming in.

Then, we're also referring a lot to civilian life. We're getting reports that there are military personnel who can't get access to these programs, that they're just not sufficient and that we need to do more. They end up having to go into civilian life, and while there is a collaboration with the civilian system, it is not up to par with the studies you're doing.

So where are we going with all of this? It's very confusing and we need to clarify this.

● (1625)

LCol Alexandra Heber: Huguette may want to add something to this.

Since the time when we closed our military hospitals, which was in the early or mid-nineties, we have been dependent upon and working with the civilian system in different ways.

For example—you're absolutely right—we assess, diagnose, and set up a treatment plan for every single member who comes with a mental health problem in our catchment area. But we cannot provide the therapy for all those people within our clinic. So we have a system, mostly of psychologists in the community in Ottawa, to whom we refer people. But every 10 sessions, that member comes back in, meets with one of my social workers, who does one of these instruments, these checklists, to see whether they are actually progressing, and talks to them about what is happening in the therapy and whether they have set goals.

The last thing we want is for that person to go out to see an external provider and see that person for years and years while we have no idea what is going on. So we don't let that happen. We meet with our providers twice a year. We have them come in.

The Chair: Thank you. That time has expired.

We have time for one more round.

Mr. Chisu.

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

Thank you very much to our witnesses for your testimony, and thank you for the work you are doing for our men and women in uniform.

I have a question for Ms. Gélinas.

I understand that the health services civilian-military cooperation program works closely with federal, provincial, and territorial health authorities and with professional licensing bodies. Can you explain exactly how you work with these different levels and types of health care providers? What do the Canadian Forces gain from the various partnerships that your program works to make?

I am looking also at the aspect of training. You mentioned in your testimony that you are in agreements to keep the Canadian Forces workers up to date at a certain level, such as that which the licensing bodies are probably requiring.

[*Translation*]

Ms. Huguette Gélinas: Thank you for your very interesting question.

Our group is responsible for a program that I mentioned earlier, the Maintenance of Clinical Readiness Program. My team works in close harmony and synergy with them. My team's role is to promote opportunities within civilian hospitals or with ambulance services, for example, so that our clinical personnel maintain their readiness and keep their skills up to date.

It takes different shapes, depending on the profession. For example, our specialists work full-time in hospitals, in highly specialized centres like McGill and Sunnybrook in Toronto. They work full-time to be at the top of their game. The only exceptions are when they need to take predeployment training or be deployed. That is how it works for our specialists.

Doctors and nursing staff are in demand. They go primarily to hospitals, where they work in various departments, generally speaking in the emergency room, to deal with trauma and anesthesiology. This program works very well. Our collaboration is excellent. It is a win-win situation. We provide assistance, and the experience our personnel receives is incomparable. It is very enriching for them to receive that. We offer our personnel these opportunities to keep their skills up.

My team has put in place memoranda of understanding. The collaboration is two-way, not just one way. We prepare the arrangements for activities like these and negotiate favourable conditions. Sometimes that means negotiating certain aspects with provincial departments of health.

● (1630)

[*English*]

Mr. Corneliu Chisu: I have another question. Do you have your 35 people licensed—psychiatrists or others? I ask because licensure is a provincial responsibility.

LCol Alexandra Heber: Yes, absolutely. We only employ registered health professionals. It's the same with the external providers I talked about using. We also only use external providers who have a college, basically, that registers them.

Mr. Corneliu Chisu: Okay.

And you, Madame Gélinas...?

[*Translation*]

Ms. Huguette Gélinas: Moreover, this skills maintenance program enable these professionals to keep their licences.

[*English*]

Mr. Corneliu Chisu: Thank you very much.

Do I have time for a very short question?

The Chair: You have less than 10 seconds, so we'll cut it off there.

Mr. Corneliu Chisu: Perfect.

The Chair: Thank you very much.

I want to thank our witnesses for appearing. I know that time goes by quickly, but we appreciate the information you were able to bring to the committee to help us with our study on the care of the brave men and women who have served us so valiantly. We know that they appreciate all the care and attention that you both have shown them.

With that we'll suspend, then we'll call our next witnesses to the end of the table.

LCol Alexandra Heber: Thank you.

● (1630)

(Pause)

● (1635)

The Chair: We'll call this meeting back to order and continue with our second hour.

Joining us now is Wounded Warriors Canada. We have Mr. Derrick Gleed, who is the board vice-chair and chief financial officer. He's joined by Padre Phil Ralph, who's a program director and regimental chaplain for the 32nd combat regiment in Toronto.

Welcome both of you to committee, and thank you for helping us out with our study.

Mr. Gleed, you have the floor.

Mr. Derrick Gleed (Board Vice-Chair and Chief Financial Officer, Wounded Warriors Canada): Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, on behalf of Wounded Warriors Canada, we are truly honoured to be invited to appear before this committee and to be part of a very important discussion on the care of ill and injured Canadian Forces members.

By way of introduction, my name is Derrick Gleed, and I am the vice-chair and CFO of our board of directors. I am joined today by Captain Phil Ralph, padre and program director.

In our capacity as board members, I am proud to say we have been able to oversee the implementation of a robust slate of programming, benefiting our ill and injured Canadian Forces members.

To briefly introduce you to our organization, Wounded Warriors Canada was founded in 2006 by Captain Wayne Johnston, a distinguished serviceman with four decades of service within the CF, and is most widely know as the repatriation officer for the fallen in Afghanistan. Through a wide range of programs and services, we help find solutions where gaps have left our CF members in need, be they full-time or reservists.

With the majority of our troops having returned from Afghanistan, our primary focus has shifted from physical injury support to mental health, and as a result to the staggering impact of PTSD, perpetrated by operational stress injuries.

Overall, however, our mandate is to help any injured veteran in need as they transition into civilian life. We are a not-for-profit corporation operating exclusively as a result of donations made by Canadians and Canadian businesses from coast to coast to coast. One of our guiding principles is to keep our annual operational expenses below 20% of our annual revenue. Further, we work diligently to ensure the hard earned funds of our donors are allocated to best make a difference to the lives of our ill and injured soldiers, and their families.

The following is but a sample of our programs this year.

We launched Ontario's first veteran transition program as part of our $100,000 contribution to British Columbia's veterans transition network. At the end of May, we will be taking a team of CF members, who are battling with mental health, on the Big Battlefield Bike Ride, cycling from Paris to London. This is but one of our mental health challenge programs and follows the overwhelming success of our ride last year.

We contributed $50,000 toward Wounded Warriors Weekend, a provincially designated event in Nipawin, Saskatchewan, that brings together more than 130 Canadian, American, British, and Australian wounded soldiers for a weekend of camaraderie and mental healing. We've entered into partnership with a pioneering PTSD elite service dog program, which operates out of Manitoba. This year we will provide close to $100,000 in funding, targeted to assist this program for its national expansion.

We have partnered with an organization called Can Praxis, an innovative equine program in Calgary that uses horses and the staff's extensive experience in communication to promote personal renewal and improved quality of life for veterans coping with PTSD. We just recently launched a national awareness partnership with the Royal Canadian Legion, highlighting the support services available at all 1,450 Royal Canadian Legion branches in Canada.

On May 15, we will be launching a 10-year, $400,000 Wounded Warriors Canada doctoral scholarship in veterans mental health. This is in partnership with Queen's University and the Canadian Institute for Military and Veteran Health Research. Just this week, we provided $15,000 in support funding to Fay Maddison's Natasha's Wood Foundation, aimed at assisting the children of service members affected by PTSD and related issues.

Much of our work, as our diverse slate of programs and initiatives highlights, is targeted toward ensuring our returning veterans, suffering from a range of personal, health, and financial issues, are supported as they transition to civilian life. Given the fact that we are not clinicians, psychologists, therapists, or even financial advisers, we put our money in the hands of the best people to deliver programs and ultimately the best results for those who need our support.

As you're all aware, the unique circumstances of military service, coupled with personal and environmental factors, affect and shape members of our Canadian Forces. It is understood that everyone is affected by the world they interact with. When CF members return home, they have been changed by their service. For some, these changes are as obvious as the physical scars they bear. Some have learned to appreciate life all the more. For others, their scars are invisible. In some ways, it is as if they left a part of themselves over there.

● (1640)

Friends and loved ones of those members affected by operational stress injuries often remark to us that the person who returned is not the same person who deployed. Having listened to the stories shared by our soldiers, their families, and their friends, that is the reason we've built into our mandate a simple yet powerful guiding ethos: honour the fallen, help the living. We seek to uphold this by doing our very best to empower members suffering from operational stress injuries and related conditions to return home in a holistic manner, psychologically, physically, financially, and spiritually.

Of course, developing partnerships is most critical when dealing with issues of this scope and scale. We not only partner with independent groups, we also work in conjunction with those who provide care to Canadian Forces members from VAC, including CF health services, OSISS, unit chaplains, and DCSM. In all, we seek to encourage members to avail themselves of the programs and services that are in place while providing a healthy environment to assist in their recovery.

Of particular importance related to partnerships, I am proud to state today, and as you will hear publicly in the coming days, that Senator Roméo Dallaire has accepted the position of national patron for Wounded Warriors Canada, an extreme honour for our organization, as you can well imagine.

It is also important to note that since our founding, we have paid particular attention to the well-being of our primary reserves. Anyone affected by an OSI faces a number of obstacles and challenges on their road to recovery and transition to civilian life. However, within the Canadian Forces community, these challenges are particularly daunting for members of the primary reserve. The often unspoken reality is that members of the primary reserve, whom Canadian Forces leadership have spoken of as being essential to their ability to accomplish the most recent mission, return home with little requisite support to manage the transition to civilian life.

Those who have provided 30% of the effective deployed forces return to a civilian society ill-equipped to appreciate, recognize, or deal with their needs. Further, should they seek to access the programs that are in place, they often feel abandoned due to the realities of time and space, coupled with the pressures of trying to provide for themselves and their families. In addition, members of the primary reserves face the real risk of losing their civilian job due to injuries resulting from their service. This is particularly true with respect to mental health injuries. Finally, they face real challenge getting on reserve-force compensation, commonly referred to as “dis comp”, when a mental health issue manifests itself after their final 30 days of class C service.

In summary, we consider ourselves to be a grassroots charity, interacting, listening, and responding as best we can to the needs of the men and women who so bravely serve our country. From our day-to-day interactions with our veterans and their families, we would be remiss if we did not offer some practical suggestions as to where the CF can work more effectively to address the needs that exist, for example, elimination of the long administrative delays for receipt of awards and compensation.

SISIP needs to be broader in their coverage definitions, particularly in the area of education, both in terms of programs offered and durations covered. CF should also improve retraining in education by providing the tools, such as laptops and related tools of their chosen trade, to enable them to complete their education and compete in the real world. Finally, the shift from the pension system to the lump sum payment as part of the new Veterans Charter is commonly brought to our attention as something requiring review.

In closing, we thank the committee for the invitation, and we wish you every success as you work on behalf of our veterans. We remain at your disposal should the committee have further questions now or at any time in the future.

Thank you.

● (1645)

The Chair: Thank you.

Padre Ralph, did you have anything you wanted to add to that?

Mr. Phil Ralph (Padre and Program Director, Regimental Chaplain, 32 Combat Regiment, Toronto, Wounded Warriors Canada): Nope.

The Chair: With that, we'll stick again with five minutes.

Mr. Harris.

Mr. Jack Harris: Thank you very much for that presentation.

You've identified a few issues that probably need further exploration. First, let me ask, are you focusing now on the mental health aspects? We have Wounded Warriors. We have Soldier On. We have the Military Families Fund. We have the Maple Leaf fund, and we have other things out there.

Are we at a point at which there needs to be some specialization, or are there gaps that remain? We have the Canadian Legion doing work. We have, as you mentioned, the B.C. organization that's active. There are other advocacy groups out there as well.

Why is that?

Mr. Derrick Gleed: Why is that?

Mr. Jack Harris: Yes, do you have a problem? Are you not getting enough from the government?

Mr. Derrick Gleed: I don't think there's—

Mr. Jack Harris: Are we not looking after our soldiers well enough that we have to have various charities out there doing the job?

Mr. Derrick Gleed: Sir, with all due respect, the one thing about Canada is that we are a great country and great people. As the treasurer and CFO of this charity, and in my ongoing activities with various charities, I've never seen anything like this in my life where Canadians from all walks of life are donating to support—

Mr. Jack Harris: They want to help—

Mr. Derrick Gleed: They want to help.

Mr. Jack Harris: Yes.

Mr. Derrick Gleed: In terms of Wounded Warriors, I can't speak for other charities and their mandates, but our mandate is focused primarily on the mental health issues that exist. That's mainly because.... In fairness, the CF have done a very good job with the physically injured. One thing about mental health issues is that unfortunately they have a much longer life cycle in terms of the needs and can manifest themselves in a number of different ways and over a longer period of time. That's where our focus is.

Mr. Jack Harris: So you are focusing on that aspect?

Mr. Derrick Gleed: That's correct.

Mr. Jack Harris: Good. I'm glad to hear it.

Can you elaborate a little more on one of your last remarks about the concerns of class C reservists, the 30 days, and getting considered for compensation? We do know that with mental health and the progress of that disease, particularly PTSD, it emerges sometimes well after the incident took place.

What is wrong with that and what recommendations should we be making to try to fix it? We're talking about the care and treatment of injured soldiers. They're still injured soldiers when they've left the reserves, even though they may qualify as a veteran or whatever. The care for that person who was injured as a soldier is important.

Mr. Derrick Gleed: I will defer that question to our program director and padre for more specifics.

Mr. Phil Ralph: In a nutshell, when somebody has augmented from the reserve force and has deployed with the regular force, when they return to Canada they get a brief post-deployment screening, and then they have to take their leave. They have a couple of days at the reserve unit, where they parade half-time and have to be seen, and then they have to use up their leave. There's their 30 days.

They're asked questions right off the bat about having any symptoms. They go through the screening tools, but as we know—it's pretty common knowledge—mental health issues, as you said, sometimes take months and sometimes years to manifest themselves.

Once you've finished your 30 days and the class C contract ends, you're back, ostensibly, to civilian life. You might go back to being a class A soldier where you're parading at the regiment once a week and training on a monthly basis, but for the rest of your life you're out there in the workforce trying to make a living and provide for your family, for yourself, etc. If the mental health issues begin to surface as a result of your service, it's really difficult, especially for reservists.

There are two issues: time and space. If you're from Flin Flon, Manitoba, all these wonderful centres we hear about are kind of far away, so getting access from there is one issue. Secondly, because you are now a class A soldier, you come in and you sign into the regiment and you work with them on your Friday night or your Thursday night, whatever your parade night is, and that's your military service. However, your problem now is that you're having mental health issues, you need to get treatment, and you need to get issues looked at, but you're still trying to provide for your family, hold down your civilian job, and do all the things that everybody else has to do, and yet you have this additional problem.

You're right. My parents taught me when I was a kid that if I broke something, I had to fix it. I think that as the Canadian Forces it's incumbent upon us, if we break something in this context, we need to address it. I've seen soldiers, especially those with physical health issues, and they get addressed within that 30-day period. Great, you have an injury, we're going to treat it, extend your contract, give you a place to hang your hat, and make sure you're still getting paid. We're going to treat you and get you all the way through to recovery. That works really well in that model.

With mental health issues, they may come up six or eight months later. Try to get them back onto a contract and have the system take care of them; it's near impossible. I know. I've tried.

● (1650)

Mr. Jack Harris: But they're not really veterans. They're still in the forces—

The Chair: Your time has expired, Mr. Harris.

Mr. Jack Harris: At that point, they're still in the forces.

Mr. Phil Ralph: They're still in the forces, yes.

Mr. Jack Harris: Thank you.

The Chair: Mr. Opitz, you have the floor.

Mr. Ted Opitz (Etobicoke Centre, CPC): Thank you, Mr. Chair, and through you to our witnesses, thank you both for appearing today.

Padre, congratulations on your imminent promotion to brigade padre. That will be good to see.

This began in 2006, essentially, and started off fairly modestly, really. It started by getting TVs and some of the niceties into the hospital rooms for the troops, because it was fairly basic accommodation at the time when they were being treated. You grew from there, so can you describe what that growth curve has been since 2006, and how you've migrated to all these other programs?

Mr. Derrick Gleed: As you indicated, Landstuhl, Germany, was the start, with a single soldier being severely injured. Padre Ralph and Captain Johnston went to visit, and over an evening came up with the idea of the Wounded Warriors fund.

We have evolved. Our rapid expansion has happened probably in the last year or year and a half, where we've seen a ramp-up of third-party fundraising events, a very large number of them producing substantial dollar amounts. In turn, we've seen the requests for support growing. One thing about growing in size is that you get noticed. When you get noticed, there are more requests. We manage those requests mostly on a volunteer basis, with the clinical help and support from clinicians.

We have taken on the thought pattern that our role in this will be to be front and centre. We want to get the brand out in front of the public—public awareness is a big factor in mental health—and raise as much money as we can. We will then use that money with various programs, to help out.

I can tell you that our financial growth has been substantial in the last two years. We're not the biggest charity in Canada—certainly not. We don't have the same type of corporate funding that some charities have. We are truly a grassroots organization, but it is growing dramatically.

● (1655)

Mr. Ted Opitz: Well, sure, but you did a great job.

Go ahead.

Mr. Phil Ralph: From a personal point of view, as a padre in the reserves, I've been called on a number of times to do notifications overseas, because I'm the guy who's long in the tooth and who's been around the longest. They look to me when such things have to be done.

In the last few years, I've done a couple of notifications of soldiers who have returned home but had some issues they needed to deal with. I had to go to families and knock on those doors. I would much rather do this and have programs in place and see people get better than visit families, knock on their doors, and tell them that their son or daughter is not coming home. That's why we do this.

Mr. Ted Opitz: There are those other programs. Do you share clientele? Do they go between the various groups? How does that work out? You have, probably, more expertise with reservists than most groups do.

Mr. Derrick Gleed: That's a fair question. It's not really a competitive space. We are, I guess, in a sense competing with other charities, whether they be charities related to this issue or even the Cancer Society. The Canadian public has only so many dollars to spend on charitable endeavours.

In a sense, our charity is closer to the soldier. We deal directly with soldiers. I could speak personally. I spent Saturday morning with our Hand Up program, helping two young soldiers who were both PTSD. Through the help of a television personality, they learned a trade, and they are now starting their own company. They came to us for some assistance to start that company. Those are fun things to do.

These are good people. We like to get right down in the weeds, if you will, and help them out. I think that's what makes us a little bit different from some others, perhaps.

Mr. Ted Opitz: I'm going to shift to your work with animals—dogs and horses. We've had groups come in here, and they've talked about the effectiveness of that. I'm sure the equine program has similar benefits.

Could you tell us whether you believe the CF and National Defence should be taking on those programs officially? What would your recommendations be? How effective are you finding them right now?

Mr. Derrick Gleed: The dog program in particular has been an interesting one. We've been working with it perhaps a little bit longer than the horse program. The feedback has overall been very positive. Dogs are amazing animals and they provide confidence to an individual, along with their treatment. One thing I want to point out about these programs is that they are not a replacement for any treatment the soldier is receiving. That's an absolute necessity for us to point out. We never get involved in a program that's going to replace the good clinical programs they're receiving.

The comments have been quite favourable, though. Perhaps Padre Phil might be able to add a couple of comments to that.

Mr. Phil Ralph: I know, in particular, in talking to Colonel Jetly, who is head of mental health in the CF, we've talked about animal programs and how they feel about them. From a clinical point of view it's hard to get all the clinical data. It's a lot of testimonial and personal stories, and those kinds of things.

One thing we know is that it doesn't hurt and it may help. For some people it gets them out of the house and gives them some confidence. The equine program is a really interesting one. We just started working with Can Praxis. I know that Veterans Affairs Canada is very much looking to work with Can Praxis and to do a study on its effectiveness. I know that's really close to coming to fruition. We've been really happy. We basically got their first two pilot projects off the ground so that they could see how it ran and have a look at it.

The great thing about the Can Praxis program is that it involves the family. It's not just the injured soldier. It's his partner and his children, and they come to the program together. It's great.

The Chair: The time has expired.

Mr. McKay, you have the floor.

Hon. John McKay: Thank you, Mr. Chair.

I want to thank you both for the work that you do. Certainly, Wounded Warriors is a very impressive organization. In some respects you are an organization that goes where the government can't go and leads into fields of therapy that the government can't go into because there is no statistical or evidence-based proof that some of this stuff works.

On Mr. Opitz's reference to the dog and horse program, when you start to fund something like that do you have any intention in the back of your mind of developing, if you will, evidence that this kind of program actually does work, that you can move beyond the anecdotal to the evidence so that the government can actually see its way clear to moving into the program, and if you will, taking over from you?

I think you are leading-edge. Do you do it on an intentional basis?

● (1700)

Mr. Derrick Gleed: Thank you for that, and thank you for your comment.

One of the reasons we involve clinicians is to assess the program at the front end and also at the back end. In particular, Dr. Alice Aiken, at Queen's University, and her clinical support team are taking a more active role in looking at some of these programs to make sure that, first, we're in good standing to be offering funds to support them—to be very candid with you, it's a bit of a protection for us—but also to look at the results and the evidence so that we can go beyond the anecdotal evidence.

It's fair to say that animals such as horses and dogs have a great history in helping and supporting humans for many situations. I think we're on fairly good ground to say that animals of that sort would be helpful, but still it is good to do that.

Hon. John McKay: I like the way the transition occurred out in B.C. Some doctor, I've forgotten his name...on to the government. You were one of the first in the door.

Do you have any programs with respect to soldiers in conflict with the law?

Mr. Derrick Gleed: I'm sorry, the question was whether we have any programs assisting soldiers with legal issues. We can't speak to it yet, but we've been contacted by an organization, by a firm that wishes to engage us to assist in the creation of a fund that might be able to support soldiers in that regard.

It's not our mandate to get into the defence mechanisms of soldiers in legal issues.

Hon. John McKay: I was watching "60 Minutes" and it was about American soldiers. In Texas they actually set up a special court. I don't know that we actually have as significant a problem here.

My third question has to do with the Veterans Charter. You referenced it in the last part of your comments. What are your observations with respect to the Veterans Charter?

Mr. Phil Ralph: The main thing is that we have feedback on that. It will be no secret to the members of the committee that there is a lot of discussion and some angst. I think there are a lot of very good things in the charter. For instance, there is the definition of a "veteran", and bringing that up to date was the most basic thing. That was a very good thing.

There's a lot of angst around a lump sum versus a pension. Basically, the issue is you give a 22-year-old—

Hon. John McKay: —$250,000.

Mr. Phil Ralph: One-third of $1 million sounds like a lot of a money, but if he has all these ongoing medical or mental issues, what does he do in three years? How does this go, and is it really a healthy way of dealing with it?

I know that's an issue the government and the opposition is going to discuss, but it's an issue we thought we'd bring forward as one that we hear often. It's not the essential part of our mandate, our mandate is to help soldiers, but this is something that we find is brought up to us on occasion.

Mr. Derrick Gleed: As a point to add to that, in the case I spoke of earlier with regard to the two soldiers on the weekend, we always ask the question: where are your other financial resources, and what have you done with them?

It was interesting to get the response from this one particular individual. He simply said, when I got it, it was too soon.

● (1705)

Hon. John McKay: Really.

Mr. Derrick Gleed: In other words, he was not treated. He was in the middle of treatment, received funding, and did as most, or as a lot of young 25-year-old people do. We won't discuss the specifics but I think you can figure that out.

The Chair: Thank you.

Time has expired.

Mr. Alexander.

Mr. Chris Alexander (Ajax—Pickering, CPC): Thanks, Chair.

Thanks to you both for your testimony and for the work of the organization.

I think it's a particularly powerful example of the response of Canadian society because of your beginnings in 2006 when we were, for the first time in decades, in serious, large-scale combat in Kandahar. We were doing that on behalf of Canadians but in the context of a NATO mission where the NATO forces had never been in combat as NATO forces, and we needed a response from Canadian society above and beyond the response from the government.

Everyone has been changed by this experience—I totally agree with that assessment—and in some respects for the better. Experience is always a great school. But clearly with the clients you're dealing with, who are close to our hearts for the purposes of this report, they have been changed in ways that have generated suffering and need, to which you have responded.

Thank you for describing the evolution.

Give us a sense of what your vision is for Wounded Warriors in the next four or five years.

Also, to what extent do you formally or informally try to ensure that roles and responsibilities with regard to those in need across Canada are more and more coherently shared among the many organizations that are out there, some of them very small scale, and some of them very local, and some of them absolutely national? Do you have a formal process of consultation?

I know that we all see each other—True Patriot Love, Soldier On, yourselves, and many other organizations—but how comfortable are you that a serious discussion about roles and priorities is taking place within that community?

Mr. Derrick Gleed: Thank you for that.

Four to five years out is a long time, but the flippant answer would be that I hope we're out of business. The reality is that we won't be.

In terms of interacting with other charities, with other organizations, there is some of that already taking place. When there is a large-scale project that needs to be done, there is only so much that any one particular charity can do. If we all have a similar mandate then there is the opportunity to work together. With respect to the question earlier about the competitive aspect of it, I'd like to think that we're not competitive. If there is a need, we will answer the need. If the need is such that it's beyond our scope and scale, then by all means we will engage other charities to work together with.

In terms of our longer-term objective, certainly the example of the $400,000 commitment is a 10-year commitment to the scholarship program. That's a $40,000 per year commitment for students to study PTSD in their post-grad. One of the big reasons we did that was the harsh reality that as a nation, going as far back as the Boer War, we have never entered into a conflict with full, complete preparation. It's not to suggest that we never will, but we need to take steps as a nation so that we enter conflicts, which will happen in the future, having as much knowledge and ability in all aspects as we can.

Mr. Chris Alexander: Certainly some of us around this table think healthy competition is a good thing in areas like this. Probably the word that is even more appropriate is “redundancy”. If one case gets missed here, if there are several organizations who feel responsible then it may be picked up there.

Tell us, with a bit more specificity, about your programs for the homeless. Do you have a sense of numbers, either in the urban areas, I presume, where you're most concentrated, the GTA, elsewhere, and/or nationally?

Secondly, on stigma, we've heard good things from many witnesses about Canada's efforts to reduce the obstacle that stigma represents to treatment of mental health. Do reservists face an additional obstacle there? Is it harder? Do we need to do more to make sure that stigma isn't holding back the care they need when they move outside the military family?

● (1710)

Mr. Derrick Gleed: I can speak to the stigma part.

My background is that I'm a volunteer in this organization. My business is in the financial services sector. Employers in Canada are very cognizant of mental health issues, far more than some people may realize.

It is safe to say that a reservist who comes forward in any organization, as any employee would be, is nervous about their future. I think that's a general comment about a societal issue. We may accept the problem of the individual, but as far as the individual's ability to perform in advance within an organization, it is naturally put into question. I think that's a rather anecdotal response, but a fair response.

As far as the homeless funding, we funded, British Columbia funded homelessness this past winter. I'll let Phil speak a bit further with regard to that, but we have done that on numerous occasions.

The Chair: I will ask the padre if he could be very brief because we have—

Mr. Phil Ralph: We don't have a homeless program ourselves, but we have funded them.

We've helped to keep the veterans homeless shelter in Vancouver that was in danger of closing. We had a presentation with Veterans Affairs on that. We've done one or two others. We have a van that we donated to Montreal to do street outreach, and that was also in cooperation with Veterans Affairs Canada. There's the cooperation, as you said.

We will cooperate to get the job done. It's not about us. It's about the soldiers.

The Chair: Thank you.

Monsieur Larose.

[*Translation*]

Mr. Jean-François Larose: Thank you, Mr. Chairman.

I thank our witnesses for being here today.

First of all, how much is the organization's annual budget?

[*English*]

Mr. Derrick Gleed: Our annual budget?

This year our expectation of revenue is in the $750,000 range.

[*Translation*]

Mr. Jean-François Larose: Where do the funds come from?

[*English*]

Mr. Derrick Gleed: The composition of the funding?

Mr. Jean-François Larose: Yes.

Mr. Derrick Gleed: It comes from a $25 cheque from the grandmother in Kelowna, B.C., all the way through to an organization called Tough Mudder, if you're familiar with that, where we have raised over $100,000 in the past two years.

We've had a number of corporate sponsors, as well, that have provided substantial donations.

Mr. Jean-François Larose: Is there any governmental funding?

Mr. Derrick Gleed: No, sir.

Mr. Jean-François Larose: None whatsoever? Wow.

Mr. Derrick Gleed: No.

Mr. Jean-François Larose: You're one of the few organizations that's actually doing it on your own.

Mr. Derrick Gleed: No. We don't—

Mr. Phil Ralph: We are proudly independent.

[*Translation*]

Mr. Jean-François Larose: Excellent.

Among other things, you look to see if there are any gaps affecting soldiers. Can you tell us what some of the situations are and indicate if any of them are currently getting worse?

[*English*]

Mr. Phil Ralph: If you look at our mandate as described—you can look it up on our website—60% of our program and funding is targeted toward mental health issues. That is going to be the greatest need going forward. Obviously once you know the scope of the physical wounds, there are the things that take place there. They are pretty well...you can categorize them and you can look at them. But obviously all the issues falling out from any mental health issues....

We are proud that we are the one organization in Canada that has a particular focus on primary reserves. That shouldn't surprise you, since I am one. I know the very real challenges of the soldiers who come in my door, even just getting to a clinic.

My regiment is in Toronto, so there is a clinic there. But guess what? It's open from eight o'clock to three o'clock. The regular force guys come in and out, and the class B guys come in and out. The guy who's on the job, oh boy, he's having a hard time. Never mind if you're in Flin Flon, Manitoba or you're with the Regina Rifles or whatever unit, or you're up in Thunder Bay—it's getting to the service.

● (1715)

Mr. Jean-François Larose: We can assume there's hype going on. There's more and more demand for it.

Mr. Phil Ralph: Yes. I would guess that there will be a significant spike in mental health issues in the next five years.

Mr. Derrick Gleed: I'd also like to add to that. We've been in consultation at work with British and American charities of similar scope. Their concerns are parallel. They're lockstep in terms of the percentages. Obviously the numbers are larger, but the percentages are the same.

Mr. Jean-François Larose: I appreciate your comment that you're hoping in five years you're not going to be in business. I think we all join yourselves in the sense that—

Mr. Derrick Gleed: I'm kidding.

Mr. Jean-François Larose: I know. You're doing a wonderful job, by the way, and we really appreciate what you're doing.

Mr. Derrick Gleed: Thank you.

Mr. Jean-François Larose: I've had instructors who were affected, but that was in 1994-95, and to see this entire evolution.... That being said, the worry that we have is this.

[*Translation*]

Is the government's lack of accountability acceptable?

[*English*]

Sorry. That you have the attitude of saying that you hope you're not going to be there anymore is an excellent one. Right now there's an urgency. You need to be there, absolutely, but we're hoping that it's within the intent that the government's going to take up its responsibilities. I don't think it's normal that we send military overseas, then they come back, and then we realize with all these studies that there are about a million problems, but nothing's there. We're hoping that we're not going to discharge it on you and not do it ourselves.

Mr. Derrick Gleed: I realize and respect the role that you folks play. Our role is not to be in the political business. As I mentioned, the problem of PTSD was shell shock in previous conflicts. It was cowardice in others. It has been there for a long time, long before Canada became a nation. Our role is pretty straightforward, and we try to accomplish that.

Mr. Jean-François Larose: That's why I'm absolutely congratulating you on that.

Mr. Derrick Gleed: Thank you.

Mr. Jean-François Larose: The fact that so many civilians, so many ex-military and military are stepping up and saying that there's a problem and we have to fix it is great. What we're hoping is that it will be fixed. That's the whole issue.

Mr. Derrick Gleed: We all do.

Mr. Jean-François Larose: Thank you.

The Chair: Thank you. Your time has expired.

Mr. Chisu, you have the floor.

Mr. Corneliu Chisu: Thank you, Mr. Chair.

Thank you very much to all witnesses for appearing and for your testimony. Thank you for your service, for the soldiers, the men and women in uniform, and especially for the reservists.

We have heard from past witnesses that often there are families of the veterans, soldiers or reservists, who see the first signs of PTSD. They are often left to deal with the effects that this illness has on the family alone. Mostly I'm speaking in the context of reservists, as 25% of our reservists have seen combat in Afghanistan. I'm especially looking at the years 2006 to 2011.

Do you work with the families? I think that the families are an important aspect.

Mr. Phil Ralph: It's important to know we are not direct service providers, other than our Hand Up! program, which is a very specific "I need these tools to get on the job" kind of thing. That's a pretty straightforward one. We look for programs, experts, and people who are in communities and doing jobs. We get applications from them. We vet it through the people at Queen's University. We get some feedback. I look at it again as program director to see if this is something that we want to go ahead with. We send it to the board. We have an obligation on behalf of that organization to report back to us, to tell us where the money has gone, what they're doing with it. Accountability is important with us.

You'll see the last one there is Natasha's Wood Foundation. Fay Maddison, who is the wife of the commander of the Navy, has a foundation that is putting out educational materials to deal with post-traumatic stress, specifically aimed at children in families that have a service member suffering from post-traumatic stress. We are looking at programs that deal with families.

The equine program in Calgary with Can Praxis, they bring the entire family. We are looking at families and family issues. It doesn't just affect the soldier. It affects their spouses. It affects their children. It affects everybody around them.

● (1720)

Mr. Derrick Gleed: Just to add to that, General Dallaire has a real passion for being involved with families, and we've made a commitment that this will be a strong aspect of our program, going forward.

Mr. Corneliu Chisu: Thank you.

Can you elaborate a little bit more on this "Hand Up" program?

Mr. Derrick Gleed: Sure.

Mr. Corneliu Chisu: I think it's a new program that you have. Can you tell us a little bit more about it?

Mr. Derrick Gleed: Actually, Hand Up is not so much a new program. it's just not one we publicize a lot. It's dealing with an individual one on one.

We get a mountain of requests from people. These requests range from books to assist them with their education through to clothing to assist them in their jobs, home improvements, or whatever it might be. We vet those requests, and we vet them with the assistance of others as well. We will fund them, where possible, if it's an assistance where the individual is going to be getting a hand up rather than a handout.

We do believe very strongly in that. It would be very easy for us to hand out an awful lot of money to an awful lot of people, but we feel that our donors want to in effect receive a return on their donation, if you will, by the measurement of the individual's improvement in their well-being.

Mr. Corneliu Chisu: Do you offer any scholarship—for example, a scholarship for the wounded?

Mr. Derrick Gleed: A scholarship? No, not for the wounded. But of course our scholarship program is there, being announced next week, through the Queen's University initiative.

Mr. Phil Ralph: That's aimed at doctoral students in their third and fourth year who already have demonstrated interest and demonstrated expertise.

Mr. Corneliu Chisu: I'm sorry, I'm looking more at Wounded Warriors in terms of increasing the education—for example, a scholarship for somebody who would like to pursue university or trade courses. That's how I'm looking at it: education.

Mr. Derrick Gleed: We don't have any formal program with regard to that, but I would suggest to you that we look at a number of requests. If, from a non-formal basis, it has merit, and there's an end result that's going to be a positive result for the individual, we will look at it.

Mr. Corneliu Chisu: Okay.

The Chair: Thank you. Your time has expired.

The last question goes to Madame Moore.

[*Translation*]

Ms. Christine Moore: Thank you, Mr. Chair.

The first question I would like to ask you—

[*English*]

Mr. Derrick Gleed: The translation device is not working here, and I'm afraid I'm....

I'm very embarrassed to say that I'm unilingual; I'm sorry.

[*Translation*]

Ms. Christine Moore: Mr. Bezan will start the clock over to be fair. I know that he is a good chair.

Can you hear me now? Can you hear the interpretation?

[*English*]

Mr. Derrick Gleed: My 17-year-old daughter would be shaking her head at me right now.

Voices: Oh, oh!

The Chair: Okay. We have it now.

Mr. Derrick Gleed: I apologize.

The Chair: Go ahead, Madame Moore.

[*Translation*]

Ms. Christine Moore: Coincidentally, one of my questions deals with translation.

In the case of many organizations helping injured soldiers, the people involved are anglophone, like the majority of the organization.

You have quite a limited administrative budget. How do you familiarize francophone CF members with your programs? Translating a website and programs is costly, administratively speaking. Few organizations appear to have bilingual administrative capabilities. How do you reach out to francophone service members?

Finally, do you have some general or specific recommendations to make for our report in order to improve care for injured soldiers?

[*English*]

Mr. Derrick Gleed: I could comment with regard to the web issue.

We actually are bilingual on our website. We weren't previously; we are now. Going forward, that will be improved dramatically.

With regard to the other question....

● (1725)

Mr. Phil Ralph: By the way, our website I think went live this week in French.

Yes, it was a long process to translate all the documents and to get everything, but we think it's an important thing. When we had discussions with Senator Dallaire on becoming our national patron, it was one of the absolute things he insisted on, which was a good thing.

We are also moving forward structure-wise, because Canada is such a large country. Obviously we're a very small board. We can't get to the whole country all the time, especially those of us who have other employment. That's difficult. But what we're doing now is we're installing provincial representation. Our representative in Quebec is bilingual.

Mr. Derrick Gleed: General Dallaire's assistant is initially our support in Quebec, but we are very rudimentary at this point. We have a lot of growth to do.

Mr. Phil Ralph: But we have earmarked that as a growth area for us.

Mr. Derrick Gleed: I would like to add to that. One of our corporate sponsors, Tough Mudder is having their first event in Montreal with thousands of people participating, all of whom have the opportunity to donate to Wounded Warriors Canada.

So it's very much on our radar.

The Chair: Okay. Do you have any supplementary questions?

[*Translation*]

Ms. Christine Moore: Well, I had also asked the witnesses if they had recommendations, but none of them answered. I just wanted to give them some time to make recommendations for the report.

[*English*]

Mr. Phil Ralph: Obviously we're a volunteer board so if somebody out there is fluently bilingual and wants to help us, we welcome help from right across the country. If people want to work with us and think what we're doing is wonderful, they can look on our website and see what we do.

Mr. Derrick Gleed: If you have someone in your riding who is interested in this subject matter, by all means, we are more than open to their help. We are already supporting programs. We obviously funded the homeless program through Montreal, and we've done other work as well.

Again, our growth in Quebec needs to be bigger than it is, and if you'd like to assist us with some recommendations, please, by all means.

The Chair: Okay. Thank you.

I want to thank both our witnesses, Mr. Gleed and Padre Ralph, for speaking with us today.

I'm going to excuse you from the table. We have one order of business here to deal with. All of you received a notice of motion from Mr. Harris. He's asking if we can debate that now. To do so requires unanimous consent, so I can waive the normal routine motion, which is 48 hours' notice. Do I have unanimous consent to deal with it?

Some hon. members: Agreed.

Mr. Harris, please read your motion into the record.

Mr. Jack Harris: Thank you, Chair, and thank you, colleagues, for unanimous consent. It's a very short notice of motion and I read it as follows:

> That the Committee invite the Auditor General of Canada to appear before the committee to discuss his report on Search and Rescue Activities found in Chapter 7 of the Spring 2013 Report of the Auditor General of Canada.

I think is pretty self-explanatory. The report was fairly comprehensive. It is an issue and we would have an interest in many aspects of it. We're not doing a study on search and rescue as such, we would have other studies available, but I think we've always wanted to be able to deal with things as they come forward. This is clearly in the public eye.

The Auditor General has brought it to the attention of Parliament and said it's one of the three most important issues of the 11 chapters in his book. I would urge us to ask the Auditor General to come for one meeting and that we have a two-hour meeting with the Auditor General as soon as that can be fitted into the schedule. I'm not suggesting a date at this point.

The Chair: Okay, the motion's been moved by Mr. Harris.

Other comments? Mr. McKay.

Hon. John McKay: I think the Auditor General did us all a great service yesterday with his observations with respect to the personnel and the deterioration of the equipment and particularly his concerns about the comments about the system failure. I'm given to understand, essentially the system can only track 25 incidents at a time, and I'm picking a number out of the air here. Frequently there are more than that. I think it's a very good motion, and I'll support it.

● (1730)

The Chair: Are there other comments?

Mr. Alexander.

[*Translation*]

Mr. Chris Alexander: We acknowledge the reasons mentioned by my colleague to justify this motion, but we will not support it, because the Auditor General is already appearing tomorrow, if I am not mistaken, before the Standing Committee on Public Accounts. In our view, that is the usual way of proceeding when considering the Auditor General's reports. We will encourage our colleagues to give the NDP and the Liberal Party an opportunity to ask questions of the Auditor General on the chapters they are interested in. That is our tradition.

[*English*]

The Chair: Mr. Harris.

Mr. Jack Harris: The public accounts committee, of course, deals with accounts and money generally, and will do so. They will be dealing with all 11 chapters of the Auditor General's report in a single meeting. Given the importance and the comprehensive nature of the report with respect to search and rescue....

If you're calling it a tradition, I don't think it's a tradition. If you're saying it is one and that's exclusive, I don't think it is exclusive.

Secondly, the fact that he's written a whole chapter on this one important issue and given it as one of his top three priorities.... It's one of these value-for-money audits. It's a management audit. There's a lot of information that is basically not accounts-related. It's related to the life and safety of people who require the service. As he said yesterday to the CBC, there are matters of life and death involved.

This committee, with its knowledge of Canadian Forces and operations, is ideally suited to deal with that.

The Chair: The bells are ringing. Can we dispose of this motion, or vote on it?

All in favour?

Mr. Jean-François Larose: Could we have a recorded vote, please?

The Chair: We will have a recorded vote.

(Motion negatived: nays 6; yeas 5)

The Chair: With that, can I get a motion to adjourn?

This meeting is adjourned.