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Chair

The Honourable Peter Kent

Standing Committee on National Defence

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● (0850)

[*English*]

The Chair (Hon. Peter Kent (Thornhill, CPC)): Good morning, colleagues. We are continuing today with the standing committee's study on the care of ill and injured Canadian Armed Forces members.

We have three groups before us this morning. They are the Canadian Association for Disabled Skiing, represented by Clay Dawdy, the director of Calabogie Adaptive Snowsports, National Capital Division; and Bob Gilmour, operations director with Calabogie Adaptive Snowsports.

We have the Canadian Mental Health Association, represented by Mark Ferdinand, the national director of public policy.

The third group before us this morning is the Canadian Association of Occupational Therapists, Elizabeth Steggles, professional affairs executive, and Nicolas McCarthy, communications officer.

We will begin with 10-minute presentations from each of the groups in the order I just referenced, and then we'll go around the table with our questions for the witnesses.

Mr. Dawdy, you have 10 minutes.

Mr. Clay Dawdy (Director, Calabogie Adaptive Snowsports, National Capital Division, Canadian Association for Disabled Skiing): Thank you very much.

Everybody should have a copy of our presentation in front of them, hopefully, and bear with me, because it's 15 pages. We'll skim through some of it and we'll concentrate on the important areas.

If you take a look at the Canadian Association for Disabled Skiing, you'll see that we put on winter sports clinics for injured soldiers and veterans, including their spouses. I'd like to talk about the background. We'll talk about who we are nationally and locally, how we got involved, what we are doing, the issues, and our recommendations.

If you go to the third slide, which talks to the background, we have approximately 3,000 members across Canada. We were established in 1976. We are a volunteer and charitable organization. We have snowboard and ski programs in all provinces, excluding Prince Edward Island. Locally, we have five programs, starting at Edelweiss. We have a visually impaired program at Camp Fortune, and about 10 years ago we migrated from the Gatineaus over to Ontario and started programs in Pakenham and Calabogie.

Our mission is to enrich the lives of persons living with disability through adaptive skiing and snowboarding. Notice we didn't say teach them how to ski. In other words, we're looking to enrich their lives, and I think it's important for this committee to understand that.

How did we get involved? It's on the next page. A number of our instructors have been going down to the U.S.A. Disabled Veterans Winter Sports Clinic in Colorado. They're in their 28th year. My friend Mr. Gilmour has been going down for 24 years. Unfortunately, I've only gone down for three or four years.

A number of instructors from Canada took a look at that, a model that was going on down there, putting 400 injured soldiers and veterans through such things as skiing, snowboarding, biathlon, cross-country skiing, scuba diving, wall climbing, and self-defence clinics, and learning what they can do with their new bodies and developing peer and mentor relationships. We said, “Let's see if we can migrate this program to Canada for our boys and women.” And we've done it. It's the sixth year for the program in Mount Washington, in British Columbia; for Calabogie Peaks it's our fourth year, and then there are a couple of others as well.

The next page shows a picture of 2012, with Walter Natynczyk, the Chief of the Defence Staff.

If you go to the next page, we'll get to the winter sports clinic overview. We've worked with 125 Canadian Forces members over the past years as a Canadian association. I think it's important to note that learning to ski and snowboard is not our main objective; it's rather that clinics have a physical and mental therapeutic value, allowing our injured soldiers and veterans to learn what they can do with their new bodies, resulting in higher self-esteem and developing peer and mentor relationships. That's really what we're trying to do here.

We also allow for the individual sharing of personal and family impacts related to trauma injuries. Last year this became very apparent, with one of the soldiers describing the impacts on his personal life. It's very personal, and yet I think we all agree that it becomes part of the healing process when you can verbalize those emotions and the things that happened to you.

I'd like to talk about what we do at Calabogie, and this is the same with all of our winter sports clinics right across the board. Our priorities are safety, fun, and learning how to ski. Safety is first, and if you ain't having fun, you ain't going to learn, okay? It's as simple as that.

We want to ensure success, so we take baby steps, if you will. We don't take people to the top of the mountain and say, “Here you go”, as many of us might have learned how to ski way back when, when our friends abandoned us at the top of the mountain. We'll start at the bottom of the mountain, on the learning slopes, ensuring success all the way. We don't want to have failure and then go back. It's very important and critical in this process.

We do more than just skiing. We have the participants doing social events. We introduced sledge hockey, adaptive swimming, and other events, just to keep the cycle going, and we had a lot of fun doing it. I'll tell you that sledge hockey, with the national development coaches for Canada's sledge hockey team, was a huge success last year, and this year we're introducing biathlon.

Several spouses accompany the soldiers, and we may want to talk to how they can become part of the therapeutic process as well.

The next page takes a look at a number of our injured skiers. You'll see three-track skiers and, although it might not be readily noticeable, below-knee amputees, above-knee amputees.

I would like to note that the picture on the bottom left is a fellow in a sit ski. It's an amazing story, because when he first came to us he was about four months post injury; he lost both legs above the knee, and quite honestly, he was very depressed. He thought his world as he knew it had ended. We put him in a sit ski, and we had a pretty rough year with him the first year. He had a lot of falls, but he mastered it somewhat. He left that year and we wondered if he would be back. Son of a gun, he came back, and the next year we developed the skill sets and really worked with him and balanced his equipment and so forth, and he became very good that year. The following year, last year, we put him in a custom sit ski, and this guy is now just ripping down the hill and ripping down all the hills across Canada. He's has a new raison d'être in his life.

That's what we're trying to do here. That's just one story of many.

We're getting positive feedback from all attendees, including their spouses.

We've introduced a new prosthesis in Canada called the Bartlett tendon universal knee, which allows above-the-knee or single-leg amputees to ski with two skis, instead of three-tracking down a hill. Amazing. Not only can they ski with two skis, but they can use the same prosthesis on bicycles and for doing scuba diving and so forth. Amazing things happen when you can migrate some of the technologies from the United States, and that's what Bob brings back quite a bit.

Some accomplishments listed are an improved outlook on life, especially for soldiers with OSI, and there are lot of soldiers there. There's the personal sharing of stress and issues. Finally, there are proven fundraising capabilities by our volunteers. This year we are on target to raise over $75,000 just for our winter sports clinic at Calabogie.

Here's a participant letter of appreciation. I think in this letter the only thing I wanted to note was a line where Jim Hapgood, a retired warrant officer in Newfoundland with OSI, says, “Living, as I do, in a small military community it is easy to feel alone at times in what I'm going through. This week has shown me that I'm never alone.”

Those are the peer and mentor relationships we're talking about.

Finally, we get to the important part, and that's the issues as we see them. First is planning. We need promotion and support from the military to canvass for participants. Our ratio of attendees to potential participants is extremely low. We've been told in this catchment area there should be 450 soldiers with OSI or disability injuries.

Timing, funding.... Volunteers and instructors, of course, we can get here. We've got a fairly good bunch in that regard.

Finally, it's a great opportunity for positive media relations. We think Calabogie is an ideal location—and we're going to blow our horn here a little bit—because it's got lodging, indoor pools, exercise rooms, and everything is located at the base of the hill. Your soldiers aren't travelling for an hour to get to their location. It's all right there for them, including all the social activities and the biathlon activities.

We recommend that we continue to hold an annual winter sports clinic in the east and in the west. We recommend maximizing military participation. I'd like to talk about that. We'd like to address potential roadblocks preventing access to potential participants. In other words, how do we get at the participants? And WSC, our winter sports clinic, should become a DND-approved event so that soldiers can attend while on duty. I think that's important, versus taking holidays.

Finally, in addressing planning issues, I think reviewing spousal support is a big one. The other one is that it seems we abandon our veterans after they're discharged from the service.

● (0855)

We think maybe there's a better model here, one where we can start serving our veterans as well.

All that being equal, that is the vision and growth: to continue to expand—the fourth year at Calabogie, the sixth year at Mount Washington—and to continue to grow this program.

The Chair: Mr. Dawdy, thank you very much for your presentation.

We'll move now to the Canadian Mental Health Association.

Mark Ferdinand, you have the floor.

Mr. Mark Ferdinand (National Director, Public Policy, Canadian Mental Health Association): Good morning, Mr. Chair.

[*Translation*]

Good morning, everyone.

On behalf of our Chief Executive Officer, Peter Coleridge, it is my great pleasure to be here today representing the Canadian Mental Health Association.

[*English*]

The CMHA was founded in 1918. We were then known as the Canadian National Committee for Mental Hygiene. Our main goal at the time was to provide care and treatment for people suffering from mental disorders across Canada.

For the purposes of your study, I think it's important to note that one of the first relationships CMHA had in Canada was with the Department of Soldiers' Civil Re-establishment. Our goal was to help the department—the predecessor to Veterans Affairs Canada—help Canadian soldiers returning from the First World War, who suffered from a range of different neuropsychiatric disorders, including post-traumatic stress disorder, or, as it was called then, shell shock.

Today we're proud to continue this collaboration, notably with Veterans Affairs Canada. Last year we signed a memorandum of understanding with Veterans Affairs Canada to do a number of things that we hope will help provide better supports and services for veterans in the communities we operate in.

The Canadian Mental Health Association is a community-based organization. We're located in 120 offices across Canada. We serve thousands of communities. We see roughly half a million people every single year.

We accomplish much of what we do through volunteers. We have about 10,000 volunteers and employees across the country. We provide what I would call community-based supports, services, and programs, which run the gamut from prevention programs to mental health promotion programs, interventions, and a number of other services and programs. I'd be happy to talk to you about them during the question and answer period.

We believe that any service that's provided, whether to Canadians or to certainly military personnel in the Canadian Armed Forces, must be proactive. It must be relative to the unique needs that exist within the community at the time. It must also be integrated as best as possible with health and social services. We believe that doing this will help us achieve the outcomes we're all looking for—for Canadians and for our armed forces.

In this regard, the CMHA is very encouraged by what we have seen in the Surgeon General's mental health strategy. We feel that not only does it offer supports and services for soldiers and their families—I'll talk a bit about support for families a little later—but they've also organized the services in a very deliberate and programmatic way. I think that is extremely important for this committee to know.

We believe, in fact, that many features that exist within the Surgeon General's mental health strategy can serve as a model for what ultimately we would like to see across Canada, which is a comprehensive, universally accessible mental health program for all of Canadian society.

I don't have to tell this committee about the human costs related to combat. It's very clear. I'm sure you equally are aware of the burden associated with neuropsychiatric disorders and mental illness. I won't go into any detail on that.

What we've recognized, in the work the Canadian Forces has done for soldiers over the last two decades, is that we've seen and participated in, in different ways, the co-development and the co-design of really what is a very comprehensive program for soldiers. In this regard, we remain very buoyed by what we see in the strategy.

Now, we don't have any special knowledge with regard to how the Surgeon General's mental health strategy is being implemented on the front line. However, what we do see, based on the strategies and the priorities that have been established, is an evidence-based approach to addressing a person as a whole person. We see an approach that is multi-disciplinary, an approach that is fairly comprehensive, and we see a service that is focused not only on interventions but also on health promotion, prevention, and a number of different supports.

As well, and it's important to underline this, we see research and evaluation. We remain impressed by the way in which the strategy has been developed, because it does provide for ongoing research as well as evaluation.

● (0900)

From our perspective, in Canada we are facing a chronic underfunding of community mental health services. This has existed not only in Canada but across the world. However, we do see rays of light and hope as they relate to the role the federal government has been playing in not only bringing attention to mental health issues but also to conducting research that we know is going to make a difference in people's lives.

For example, about five years ago, one of our former CEOs, Taylor Alexander, served with DND and the Veterans Affairs mental health advisory committee. We understand that the RCMP was also involved in that work. Ultimately, we believe that this type of highly collaborative approach to supporting the design, the development, the validation, and the implementation of the mental health strategy is crucial in order to ensure that we are serving our armed forces in the most appropriate way. We strongly recommend to this committee that this type of collaboration between different parts of the community, including the medical community, continue.

In recent years, we've also seen the federal government invest around $11 million to hire mental health personnel within the Canadian Forces. We also recognize that this is the right thing to do in Canada. We have, unfortunately, chronic underfunding and non-availability of human resource planning and mental health human resources, or people who have the appropriate training in order to provide the type of safe care or trauma-informed care that is needed to intervene appropriately with people who may be suffering from a serious mental illness or a serious mental health problem. In that regard, we think that investing in both human resources as well as training is extremely important to ensure that people receive the type of appropriate care they need to prevent the onset of more serious complications associated with their mental illness or disorder, as well as to intervene in an appropriate way at the earliest time.

We would encourage the federal government to continue playing a leadership role in providing adequate training and resources to all providers.

We believe that, similar to services under medicare for physical health, Canadians and those under the jurisdiction of the federal government should have a guaranteed right to mental health services that are universal, comprehensive, accessible, affordable, and publicly administered.

We believe that particular populations' direct health care is the responsibility of public agencies, such as the armed forces, veterans and justice services, and should be guaranteed in the same way as services that we all now enjoy and receive under medicare. Services should be proactive and relative to the unique needs of a population.

We believe this is extremely well-reflected in the Surgeon General's mental health strategy, and we still remain impressed today, after years of consultation and review, that the level of integration and interdisciplinary approach to mental health problems and the mainstreaming of mental health promotion across all levels of the Canadian Forces is being accomplished. This includes, of course, surveys, research, development and publication of operational guidance for commanding officers, periodic studies, as well as comparative research with the United States and the general population. All of these facets that we see within that strategy are what we would call a true program of care that is focused on reaching better health outcomes.

As you consider your work in your study, we would ask you to make sure that you adopt or at least consider a “no wrong door” approach to receiving care. In looking through the mental health strategy that the Surgeon General published, we note there may be a tendency to look at the medical community and primary care exclusively. We would think that there's a role, certainly, for community mental health services to support the work the Canadian Forces is doing very well. There are a number of family supports that are provided within the community, and, quite frankly, we think there is something lacking in terms of community mental health within the strategy at this point.

● (0905)

[*Translation*]

After the next presentation, I will be pleased to answer your questions. Thank you.

The Chair: Thank you, Mr. Ferdinand.

[*English*]

Now we'll hear from the Canadian Association of Occupational Therapists. Ms. Steggles, you have the floor.

Mrs. Elizabeth Steggles (Professional Affairs Executive, Canadian Association of Occupational Therapists): Thank you.

Good morning, members of the standing committee. It's my pleasure to represent the Canadian Association of Occupational Therapists, along with my colleague Nick McCarthy. Thank you for the invitation to share information about the role of occupational therapy in supporting transitions of Canadian Armed Forces and veterans personnel.

I have to thank Mr. Dawdy for a perfect example of engagement in occupation. Engagement in meaningful occupation is a determinant of health.

Occupational therapists, or OTs, as we're often called, believe that occupation not only refers to paid employment, which of course is an important component, but also encompasses everything that we need, want, or are expected to do in life. Occupation encompasses meaningful everyday activities, including simple things such as walking the dog, gardening, preparing a meal, doing the laundry, and playing games. Occupations are part of life. They describe who we are and how we feel about ourselves. Occupations bring meaning to life.

To give you a little history about occupational therapy, it came into being in 1915 in order to assist soldiers who were returning from World War I in their transition to civilian life. OTs have worked with military personnel and veterans for almost a century. It was recognized that injured soldiers benefited from engagement in meaningful occupation. Ward occupation aides, as OTs were then called, worked with injured soldiers therapeutically to restore function and assist their transition to civilian life.

Today, OTs work with military personnel and veterans who have been impacted by physical and mental health issues, which may be aggravated by exposure to chemicals, diseases, and extraordinary environments. Increasingly, injuries are adversely affected by a rising tide of chronic conditions such as obesity, diabetes, and substance abuse.

OTs are highly trained, regulated professionals who work with individuals and organizations to determine and address goals that lead to productive and satisfying lives with minimal dependence on family and society at large. Dependence may be physical, emotional, or financial.

I’d like to give you an example of occupational therapy intervention. I was talking recently to an OT who was working with an Afghanistan veteran and his family. This man had always been the go-to guy, the guy that everyone relied on. As a result of PTSD, he became reclusive, unable to leave his bedroom, and detached from his wife and children.

Having discussed the issues independently with husband and wife, the OT encouraged the man and wife to explain their fears and frustrations to each other. The wife explained that she felt overwhelmed by the burden of caring for the whole family. The man explained that he was fearful of situations that would cause flashbacks and intrusive thoughts, that staying in bed was safe, but that he felt guilt and fear of failure.

The couple agreed that the husband would try to get up, washed, and dressed each day. It was a start. Today, the couple, with assistance from the OT, are setting new practical goals each day. There are relapses, but the husband has now taken on most of the household chores and has started to drive his children to sports activities. The wife is working. Life isn’t perfect, but it improves every day. This is just one example.

It's known that periods of transition may be stressful for military personnel and may affect both mental and physical health status. In fact I heard a statistic just last night that 90% of people who have mental health issues also have physical issues, so we're not talking about one or the other.

Transitions occur before and after missions, with changing rank and jobs, as well as during each posting. Anyone who is deployed on a combat, peacekeeping, or humanitarian assistance mission faces a life-changing event, and the transition home may be difficult for some.

At the end of a career in the Canadian Armed Forces, there is also the transition from military to civilian life. This period can be more difficult for those who are released from the armed forces because of a physical or mental health injury or illness.

● (0910)

OTs work with clients, which includes the families, to identify personal goals, conduct capacity assessments, and develop targeted and measurable outcomes that take into account the whole environment—physical, social, and institutional.

In other words, the OT does not just focus on one aspect of the person without considering the whole context. A physician may prescribe a medication or a physiotherapist may fix a muscle; OTs work with individual clients, taking the whole package into account.

This is why OTs are often the catalyst that pulls together the parts. They see a person’s real life in the home setting and not in the office. To go back to my example, the OT told me that she was the only professional who saw this man in his home. She saw him unshaven and unwashed. He said, “I'm sorry, I don’t really look too good”, and she said: “No, you don’t. Let’s talk about it.”

I have deliberately focused on providing you with an example of a veteran with a mental health issue, because the public is not generally aware of this area of OT practice. But I would like to provide another example from my own clinical experience.

I worked with a young man who had sustained a spinal cord injury that had left him paralyzed from the neck down. He is not a member of the Canadian Forces, but he could well have been. My OT colleagues provided him with a motorized wheelchair that enabled independent mobility, and they worked with architects and contractors to design and build an accessible home that met his individual needs. I worked with the rehabilitation technologist to provide him with voice-activated electronic equipment so that he could independently operate a computer and all that this implies—it's a powerful tool—or control his TV and other audiovisual technology, use the telephone, answer the door, and change his position in bed. The last time I heard from him, he said, “The doctors and nurses saved my life, but you gave me a life worth living.”

I understand that there are some areas of growing concern for military personnel and veterans. Canadian Forces and Veterans Affairs Canada will be addressing the health needs of 30,000 Canadian Forces members and veterans who have served in the Afghanistan mission. Soldiers are getting lost in the system, finding it difficult to access services and benefits in a timely manner because of complex eligibility criteria, lack of clear program and benefits information, the amount of paperwork needed to access programs and benefits, and the length of time it takes to access programs and benefits. And we know there are discrepancies across the country.

National Defence is looking to evolve from a program-centric model to a family-centric comprehensive and holistic health and wellness model for active forces members, veterans, their families, and communities. National Defence is considering an alternative service delivery initiative to supplement the delivery of core health services.

CAOT proposes the Canadian Armed Forces and veterans wellness action plan. We propose working in collaboration with the Department of National Defence and Veterans Affairs Canada to develop a strategy that will facilitate access to timely and effective occupational therapy services in order to manage and assist the transitions within and after military life.

We also propose the development of a Canadian Forces-centric model in order to help build capacity among Canadian occupational therapists to support the understanding of and education for caring for our military forces.

The goal of CAOT is to work with the Department of National Defence and Veterans Affairs Canada to support access to meaningful and effective interventions that will successfully allow transitions within and after military life. There are many opportunities to advance this goal through cost-effective physical and mental health interventions. CAOT also believes that it is important to stress that timely action is required. The result will be improved overall health and well-being, which can be measured through increased success in transitions to active deployments and to civilian and family life, improved productivity, and labour market engagement.

Thank you.

● (0915)

The Chair: Thank you, Ms. Steggles.

We'll now begin our first round of questioning.

Ms. Gallant.

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

I have ten questions and we have seven minutes, so if we can, let us time our answers accordingly.

The first is to the Canadian adaptive skiing people.

Who pays for the cost of the room, board, equipment, and trainers, and what costs are incurred by the military?

● (0920)

Mr. Clay Dawdy: Go ahead, Bob.

Mr. Bob Gilmour (Operations Director, Calabogie Adaptive Snowsports, National Capital Division, Canadian Association for Disabled Skiing): As an organization, we do our own private fundraising, as I think Clay has indicated. We have a budget of $75,000 this year, and basically that money is used to house and feed all our volunteers, who actually donate a week of their vacation to come up and be part of this whole thing.

Also, part of all the other expenses concerned, for all the Canadian soldiers who are coming this year, and for both the soldier and the spouse...everything is covered for them too. There are no expenses for them. They just have to get there, and everything is looked after for them.

Mrs. Cheryl Gallant: What number of Canadian soldiers were in your sports clinic last year?

Mr. Bob Gilmour: We were able to find eight soldiers who could take part.

Mrs. Cheryl Gallant: How do you find the soldiers who may benefit from the activity?

Mr. Bob Gilmour: That's one of the reasons we're here, to inform you. We have everything: we have all the volunteers; it's at no cost to the Canadian government, no cost to the participants. Basically all we need to do is find a way to get to these soldiers and help them. That's where we are right now.

Mrs. Cheryl Gallant: So as of 2012 or 2013, are we at a lower participation rate than in previous years?

Mr. Bob Gilmour: Starting off, in our first year we were able to gather six participants, and it went up to 10 or 11 in the second and third year. This year, because of the fundraising that we've done through public organizations that have supported us, we're looking to get at least 20 soldiers and their families this year. I showed you the advertising in the white envelope. But it almost seems that we'll have to go to the *Ottawa Citizen* and put in an ad to say: this is available, if you're out there; whether you're a veteran or whether you're active, we are basically here to help you.

We want to build this thing slowly. I think we mentioned that in the U.S. they have 400. Well, they started with a very small number too.

Mrs. Cheryl Gallant: Do you work with the JPSU to find which soldiers may benefit from this type of activity?

Mr. Clay Dawdy: We worked with the Soldier On organization in the first two years. Last year and this year, Soldier On said they would concentrate their limited resources on sports clinics in British Columbia, including Whistler.

Mrs. Cheryl Gallant: Okay, so you're having a hard time finding the soldiers who would benefit from this. Would you compare the cooperation that you receive from the U.S. military and the Canadian military?

Mr. Bob Gilmour: Not at all.

Mrs. Cheryl Gallant: I'm asking you to compare.

Mr. Clay Dawdy: It's an interesting question.

Right now we have 15 disabled American veterans coming fully funded to our winter sports clinic as part of our international esprit de corps, including one of their national Olympic biathlon coaches. So far we have found two new injured soldiers who will be coming to our sports clinic this year, and we plan to go on a major advertising campaign within the next two to three weeks.

Mrs. Cheryl Gallant: Have there been any adaptations to the buildings at Calabogie to improve the access for the amputees?

Mr. Clay Dawdy: There have been major renovations. We now have two new wheelchair ramps to allow for access and egress, a separate meeting facility, a new equipment room. Our main facility is 1,700 square feet. We have automatic door openers, disabled access washrooms. Chris Werhane, the safety supervisor for the DAV—the U.S.A. disabled veterans association—went to 15 ski resorts last year. Out of the 15, he said that Calabogie Peaks was the best-adapted facility that he has been to.

Mrs. Cheryl Gallant: Very good.

You mentioned that soldiers must use vacation time. Now, besides the fact that some soldiers are given one day's notice prior to the commencement of their vacation, what other timing problems does this pose? You have a definitive week for your clinic.

Mr. Clay Dawdy: Go ahead, Bob.

Mr. Bob Gilmour: Cheryl, could you ask that question about getting the notice to them again, please, so that I have it clear?

Mrs. Cheryl Gallant: Some soldiers only get a day's notice before their vacation commences, though they put in the request months in advance. How does that work into their being able to participate?

● (0925)

Mr. Bob Gilmour: What happens, if you're part of Soldier On and are part of their event, is that they go to the commanding officer and are granted that whole week with pay to come to the winter sports clinic. However, if they come through us, they can go to their commanding officer, but they may not get an official leave. Then they have to take a week of their holidays to be able to participate.

Mrs. Cheryl Gallant: Is it just soldiers that your organization serves, or do you serve other amputees?

Mr. Bob Gilmour: For this event, it's soldiers and veterans.

Mrs. Cheryl Gallant: Beyond this event.

Mr. Bob Gilmour: When we have a soldier who goes off to war and he's gone for 18 months and comes back with no legs, we feel that maybe there's a bit of trauma there for the spouse and the children getting their father back.

What we have tried to do is to invite the spouse to also partake in that whole week. If the spouse is able-bodied and can learn to ski, we put her in a ski program for the week. We teach the soldier to sit in a sit ski and ski from the top. Then on the Thursday morning, they ski together down the mountain, and they smile. You see the smiles, that they can do something together again.

We feel it's extremely important. And in the United States they do exactly the same thing.

The Chair: Thank you, Mr. Gilmour.

Thank you, Ms. Gallant.

The next questioner is Mr. Harris.

Mr. Jack Harris (St. John's East, NDP): Thank you all for your most interesting presentations.

Given that there are only seven minutes, I'd like to focus a bit on the occupational therapy side of things. It's enlightening to know that your profession actually came out of war experience.

Is there a role for occupational therapists beyond the therapeutic role? I will go back to a conversation I had with one of your national presidents, I think a year or two ago. He talked about OTs as potentially involved in assessments and designing programs, or participating in a holistic assessment of what this person may need.

Are assessments a part of your role as well?

Mrs. Elizabeth Steggles: Absolutely.

We cover the gamut. We work with individuals to assess their specific needs and engage in an action plan and review how that's working. We change things along the way if we need to. But we certainly also work with organizations to shape and develop rehabilitation programs.

The other role that we fill in many areas is as case managers, to oversee the whole process with individuals.

I hope that answers your question.

Mr. Jack Harris: Yes.

Are OTs used in that role with the Canadian Armed Forces?

Mrs. Elizabeth Steggles: No, they are not.

We have one occupational therapist on staff in Valcartier and a contract occupational therapist in Edmonton.

Mr. Jack Harris: And that's it.

Mrs. Elizabeth Steggles: Yes.

Mr. Jack Harris: You have what you call a proposal. You're making a proposal, which sounds like a formal proposal.

Is this a suggestion, or is this a proposal that you put together and presented to the Canadian Armed Forces? Or are you telling us that you would like to do that?

Mrs. Elizabeth Steggles: That's something we would like to do. We are in communication with staff at the Department of National Defence. We haven't discussed this particular plan. We are meeting next week at the MVHR conference.

What we would like to do is to help capacity building with occupational therapy. As you can imagine, you don't appoint a pediatrician to do a neurologist's job. It's a very specific area of practice. When occupational therapists are working within National Defence, they need specific skills to be able to deliver that service. It's a whole different culture, if you like. Picking up an occupational therapist off the street isn't quite the same as having somebody who is experienced and knowledgeable about the needs of military personnel.

That's where we feel we have a role, to help develop that capacity.

Mr. Jack Harris: Is there something from this committee...?

If we're hearing from people like you making recommendations, at the end of the day do you feel this committee could or should make a recommendation with respect to the use of OTs?

Mrs. Elizabeth Steggles: Yes.

In 2008, it was recommended that six occupational therapists be appointed across the country. My understanding is that we have two occupational therapists. With the announcement of mental health funding, there was to be an appointment of six occupational therapists to help with mental health conditions. We would certainly like to see those positions appointed.

We know that occupational therapy is cost effective. I heard recently that the one occupational therapist at Valcartier, who was working on return to work initiatives, has a success rate of return to employment that is twice as high as other rehabilitation facilities across the country.

● (0930)

Mr. Jack Harris: We've all heard stories of the soldier who doesn't come out of his basement or his bedroom. I've met spouses of people like that, and I'm sure others have as well. It's rewarding to hear that your profession is able to give hope to people in that situation, so thank you for bringing this to our attention.

It's interesting to know that your contribution as a group started as being the ones who helped soldiers to get back to normal after the kinds of deployments they've had. I just want to thank you for your presentation and for opening at least my eyes to some of the things you can offer to soldiers who are injured mentally and physically. Thank you very much for your presentation.

The Chair: Thank you, Mr. Harris.

Mr. Norlock.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): Thank you, Mr. Chair, and through you to the witnesses, thank you for appearing today.

I think I'll start with Mr. Ferdinand and the Canadian Mental Health Association. You did mention, of course, things that weren't necessarily related to the military, especially surrounding mental health services and the finding of individuals who are qualified to assist, in that area, the men and women in uniform. I have sat on another committee where the government does provide mental health workers, in particular, in our prisons. One of the things we find, and you can verify this or not, is that there is a lack of professionals in that area who wish to work in a field where it's basically the same work every day. Not every mental health worker wants to work in a prison facility or perhaps any other. As a society, we have a shortage of people who are qualified to do those things.

Would I be correct there?

Mr. Mark Ferdinand: I think I could extend your statement to apply to more than just people who may not work within prisons, for example. I think the challenge is not just about the numbers or the interest; it's also with regard to curriculum, for example, in different types of schools.

I think nurses and doctors have come a long way over the last several decades, just as an example. There is a good example of a group of professions that have integrated into their curriculum at the university level collaborative and shared care with regard to mental health issues, co-occurring disorders, physical ailments as well as mental health issues, and when to treat the person's mental health issue versus the physical health issues.

There are now guidelines, so we have great examples of certain professions that have done great jobs. Occupational therapists have been doing it for 100 years, we heard today. So I think we have really great examples, such as social workers, psychologists, psychiatrists, where that integration is happening. The challenge is that when people structure programs in our health and social systems today, we tend to focus on acute or serious issues more so than prevention or health promotion. That is really the area, I think, the Canadian Mental Health Association is working in, how you help someone cope and develop strategies to get on a path to recovery.

Mr. Rick Norlock: Having only seven minutes to ask questions, I'll ask you to, as best you can, be succinct in responses.

Do you believe that in most cases crime prevention and health prevention are usually the cheapest route? How do you prepare a soldier for a situation where they probably will be exposed to things that most people aren't? I'm referring specifically to PTSD, which is probably one of the most difficult, I understand, to treat because of the different forms. Is there a way we can better prepare our Canadian Armed Forces personnel for exposures to those types of situations so that we don't have the numbers of people suffering that we do?

● (0935)

Mr. Mark Ferdinand: I might refer the committee to some good work that has been published by an organization called Klinic, in Manitoba, with regard to trauma-informed care. One of the features of trauma is that it's unexpected. So when you ask the question about whether or not we can prepare people to deal with certain types of trauma, we have to recognize that it's not always possible. In other words, when people experience trauma, just under 10% of people will have a very serious impact on their lives to the point where they can't cope with daily living. Then there are others who will have other types of reactions.

I think the bottom line is that in any of these situations we need to deal with the person as a whole person when they present to anyone —a health professional, a chaplin, etc.—and talk to them in a way that's trauma-informed.

That is a very challenging question you asked.

Mr. Rick Norlock: I asked it on purpose because I know it is difficult. Some people think that you can do psychological hiring and hire people who are better able to cope. But as you said, it's difficult to assess trauma because you can't know how you're going to handle it until you do.

If I could turn to our occupational health therapist, one of the things that we see in our whole health care system is a great number of people who can do many good things, and they all overlap. When you overlap, there's waste. Would you see an increased reliance on or increased activity with occupational health therapists as a way to ensure that each individual receives individual care to make sure there isn't that kind of overlap? Would you see your occupation as one that could best analyze, from a personal perspective, each individual patient or client so that there isn't that overlap, there isn't that waste, there isn't that time out?

One of the things we've seen here is it takes too long sometimes for someone to be assessed, and to know who the right person to go to is, and sometimes the right persons. Do you see yourself as facilitating a more efficient and effective delivery of health care services to ill and injured soldiers?

Mrs. Elizabeth Steggles: Certainly we do. I think there are two answers to that question.

As I mentioned before, there is a well-proven role for occupational therapists as case managers because we have that overview of the whole person. The other area that I think occupational therapists excel at is as interprofessional practitioners. We are all trained now at the Master's level and we receive training in interprofessional practice. It's a phrase that's thrown around a lot, but what it actually means is that everybody within the team is working, including the client, toward a common goal. I think if there's a common goal, the OT can certainly help facilitate reaching that common goal, which I think addresses the issue you're raising here. If one person is working on one goal and one person is working on another, what we need to do is determine with the individual what their specific goal is, so we can then all work together toward that common goal.

The Chair: Thank you, Ms. Steggles.

Thank you, Mr. Norlock.

Ms. Murray, please.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you.

And thank you for the information you've provided to our committee.

I have a quick question for Mr. Dawdy.

In Whistler, do you work with the Whistler adaptive sports program?

Mr. Clay Dawdy: No, but I have met the folks who do.

Ms. Joyce Murray: Yes, it's very embedded in the community, and growing. If you're looking for more connections to expand the winter sports clinic that you can offer, that's an excellent partnership potential.

Mr. Bob Gilmour: I'll interject here. It's Soldier On that decides. This year they decided on one clinic in Canada, and they're running it at Mount Washington, but they're doing an international event at Whistler. But they decide where they're going to have the venue, so that's basically really still controlled by Soldier On. They simply show up at Whistler and Whistler accommodates them at their adaptive ski school.

● (0940)

Ms. Joyce Murray: Thank you.

Really, I want to focus my questions on reservists, having had a meeting with one of the Legion command executives, who noted that their experience is that reservists who are injured are more likely to fall between the cracks than full-time personnel, partly because the process of tracking them after they come back from a mission doesn't really exist in a coordinated way, especially related to operational stress injury or mental injury. If they don't show up for a parade with their unit, it's not clear if there is a tracking system.

Mr. Ferdinand, you were saying there's a gap in connecting the injured with community mental health services. Have you experienced the difference between the permanent armed forces members and reservists in terms of connecting the injured with community health services, or is that something that's not really been distinguished in the analysis your organization has done?

Mr. Mark Ferdinand: I'd say the only thing we've recognized when speaking with Veterans Affairs Canada over time, as well as with members of the armed forces, is that we don't have data. I think that's the biggest challenge. We don't measure very well who's coming in through the door. We know what types of disorders people may have, what types of mental health issues or problems they might have, but we couldn't say that in any venue outside of the acute care health system in this country that we can actually systematically measure if the person is a reservist or a member of the armed forces. To my knowledge, that doesn't happen. And it's a gap.

Ms. Joyce Murray: So there are no specific recommendations that you might have that would address that difference between people who are full-time armed forces members who come back and have their base, their job within the National Defence family, versus those who come back and may go back into the private sector and are not as connected with the armed forces. Do you have any thoughts? Do you see any need to address the reservists with some specific processes, or just armed forces personnel as a group?

Mr. Mark Ferdinand: When I think about people who are working day to day in Canada or elsewhere versus people who may be deployed internationally, there may be differences, and I think the armed forces would probably be best to talk a little bit about those differences that are experienced by the different members.

We've had preliminary discussions with Veterans Affairs Canada on how we might do that at the community level—track different people—because their experiences might be different, and therefore the trauma they might experience might be different, or the types of problems they have might be different. So we've had preliminary discussions, but we still need to determine how we actually go about setting up a tracking system.

Ms. Joyce Murray: Thank you.

I didn't mean so much that their experience or their injuries are different; it's more that because they are not part of the regular forces, they might fall between the cracks, and nobody knows the mental injury until it's much more serious.

I'd like to ask Ms. Steggles a similar question.

You were saying that there are 30,000 post-Afghanistan personnel, and soldiers are getting lost in the system. That's what I've heard specifically about reservists, in a different way from the comments you made. I've heard that it's the length of time to access their benefits, the complexities of the different programs, and the paperwork, especially if someone is injured, perhaps with a mental injury, and is having difficulty functioning in a normal way. Have you observed that it is different between reservists and regular armed forces members because of their different lives when they come back to Canada, as I've just explained?

Mrs. Elizabeth Steggles: I'm not sure I can answer your specific question about reservists because I haven't particularly heard that, but since you raise it, I can quite see there might well be a difference. We certainly know there is a difference between veterans and military personnel. But I think because we have occupational therapists working in the civilian community, the reservists might head in that direction and be picked up that way by occupational therapists. And occupational therapists typically do look into all the resources that are available to a specific individual. If, for example, they would be eligible for benefits from Veterans Affairs, we would help facilitate that process.

● (0945)

Ms. Joyce Murray: Have you experienced that there is a benefit to early intervention or a difference in the difficulties that are being experienced if someone has been living for a number of years with the effects of operational stress injury or PTSD versus an early intervention or early reaching out for help?

Mrs. Elizabeth Steggles: There are certainly numerous statistics that support the fact that early intervention is beneficial—return to work, for example. If somebody has been out of work for six months, then we know the chances of getting back to work after six months get pretty slim. So in that sense, yes, getting onto things as soon as possible is critical.

The Chair: Thank you, Ms. Murray.

We'll now begin our second round of questioning, with five minutes per questioner.

Go ahead, Mr. Opitz.

Mr. Ted Opitz (Etobicoke Centre, CPC): Thank you, Mr. Chair.

I'm just going to pick up on a line of questioning that Ms. Murray had, because I am a former long-term reservist. When I was commanding officer, I would instruct my returning troops, and we would monitor them very closely, as best we could, for signs and symptoms of mental trauma. Now, when they're on tour and away with the regular force—and some of these deployments are up to two years, as a soldier could go between his pre-deployment training, his deployment, and then his post-deployment—you're under close supervision with your battalion in the regular force.

The issue is when they come back. The system does work. We do try to stay on top of the soldiers; we do try to watch them. I've had many soldiers self-identify. That's part of the problem: soldiers don't want to self-identify, especially if they're combat arms. They don't want to admit any form of weakness. They don't want to admit that something is wrong with them. Getting them out or starting to address or notice symptoms—and that's where, if you're in a regular force battalion, your buddies see you all the time and they'll see if you're not the same, if you're doing something different, if all of a sudden there are signs and symptoms of trauma manifesting itself.

As you know, for some people it manifests immediately, and for some people it may take years to manifest. We're seeing that in the United States with the long deployments in Iraq and Afghanistan, and here as well now. I know we're collaborating very closely with what the U.S. does, as do our defence scientists at DRDC, who are working on this problem.

Have you worked with DRDC at all, Mr. Ferdinand?

Mr. Mark Ferdinand: No.

Mr. Ted Opitz: So you haven't worked with our defence scientists? They have some programs and treatments that they're working on to address pre, during, and post mental stress. I think we'll be hearing from them down the road.

The issue with reservists, sometimes, is when they're finished their post-deployment leave and training and they're back with their home battalion, it's sometimes hard to track them. If they don't want to self-identify—no matter how many times I've asked them as a CO and how much the sergeant and the warrant officers in their chain of command monitor them, sometimes they try to conceal those symptoms. It's very hard, when you're a reservist and you also have a civilian component to your life, to be able to get them to do that.

Now, many of them may address and have addressed these issues on their own through the provincial and civilian systems. They try to keep it out of the military because they don't want their chain of command to understand that they've come back with an issue. That happens. People hide this sort of thing, and that's just a human dimension to a soldier.

Ms. Murray's point is well made. But through my experience, this is generally what happens with reservists when you're not able to monitor and supervise them 24 hours a day, as you can in a regular force battalion. Those are some of the differences.

Mr. Ferdinand, it sounds like you have a pretty decent relationship with Veterans Affairs. On a collaborative level, you have a lot of conversations and you're working very closely in being able to find solutions for our soldiers. Would that be a fair statement?

● (0950)

Mr. Mark Ferdinand: Yes.

Mr. Ted Opitz: That's great.

Ms. Steggles, I think you said you have about 15,000 occupational therapists. You're not aware, by the way, if any of your therapists are seeing reservists at this time, or you wouldn't know if they're reservists, necessarily?

Mrs. Elizabeth Steggles: Yes, I can't specifically answer that question.

Mr. Ted Opitz: But you're saying that there are fewer occupational therapists on bases than you would like to see?

Mrs. Elizabeth Steggles: Yes.

Mr. Ted Opitz: What would your recommendation be to develop this role?

Mrs. Elizabeth Steggles: What I would ideally like to see is that we have one occupational therapist representing physical health and one in mental health to teach at the rehabilitation facilities across the country.

Mr. Ted Opitz: I don't mean to cut you off, but I think I'm down to 45 seconds here.

You guys are talking my language when you're talking about skiing. I wish I could spend half the year doing it, if I could, but that's clearly not going to be possible.

What you're doing for the soldiers—I'm just going to comment—is excellent. It's great physical therapy. I like what you had to say about the couples skiing together because it is a very family, collaborative sort of thing, where the entire family can go to Calabogie, where you have your pool and gym and everything else. A soldier wants to stay fit, and it takes more than skiing to develop the muscles to be able to do that. The program that you have going right now is a very good one and something that's very productive and showing positive results.

Thank you.

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

[*Translation*]

And now, Ms. Michaud.

Ms. Michaud, the floor is yours.

Ms. Élaine Michaud (Portneuf—Jacques-Cartier, NDP): Thank you all for your presentations. They were really enlightening.

My first question is for Ms. Steggles.

I represent the constituency of Portneuf—Jacques-Cartier, in which the Valcartier military base is located. Could you tell me a little more about the role of the occupational therapist at Valcartier, what she does and how she works with soldiers and veterans?

[*English*]

Mrs. Elizabeth Steggles: Yes, certainly. I've only met her briefly, but I know she started off working with people with mental health issues and then was actually transferred to working with people with physical conditions, which is quite a shift and I think highlights the need for expertise in both areas, and thankfully we are trained in both areas. My understanding is that the majority of her work now is on return to work, driver rehabilitation, vehicle modifications, and home modifications.

[*Translation*]

Ms. Élaine Michaud: When you say return to work, do you mean moving to life as a civilian or returning to work in the Canadian Forces?

[*English*]

Mrs. Elizabeth Steggles: Both. It depends on what's most applicable. If possible, it's to return people to their former employment or former role, and if that's not possible, then perhaps an adapted role that's still within the military. If that's not possible, then it would be for a return to employment within civilian life. It's a process that looks at individual skills and abilities and what's going to be the most appropriate and what can be accommodated if necessary.

[*Translation*]

Ms. Élaine Michaud: Thank you.

Could you briefly comment on your organization's position on the new policy in the Department of National Defence and the Canadian Forces, whereby military personnel who are ill or injured are retained in the forces for a maximum of three years following an injury?

[*English*]

Mrs. Elizabeth Steggles: We don't have a specific position, but off the top of my head, I would say that if we had occupational therapists working closely with those people, it would be much more likely that they would be able to meet that qualification and stay in the role for a period of three years.

[*Translation*]

Ms. Élaine Michaud: Thank you very much.

My next question goes to Mr. Ferdinand.

What are the main challenges you face when you have to deal with ill or injured soldiers?

Mr. Mark Ferdinand: We have no statistics for soldiers, but I can say that they are able to access our services in the community. When people identify themselves as soldiers, reservists or veterans, we can help them find the appropriate social or mental health services. We have no statistics on that per se. So I cannot answer your question about particular challenges.

● (0955)

Ms. Élaine Michaud: In previous meetings of this committee, witnesses have told us about cases where military members with mental health issues have been improperly diagnosed by Canadian Forces health care providers. Can you talk to us a little about the difficulties in diagnosing mental illness, particularly with respect to post-traumatic stress disorder?

Mr. Mark Ferdinand: First of all, I must tell you that I am not a health care professional. My association is not aware of problems with diagnosis, and neither am I. That said, diagnosing some mental illnesses is still not an exact science. My suggestion to you is to put that question to psychiatrists, social workers, psychologists and doctors in order to get a specific answer.

Ms. Élaine Michaud: Thank you very much.

Do I have any time left, Mr. Chair?

The Chair: You have 30 seconds.

Ms. Élaine Michaud: Mr. Dawdy, do you receive support from health care professionals such as psychologists and psychiatrists when soldiers who come to your clinics share their experiences on the stress they are going through or their injuries?

[*English*]

Mr. Clay Dawdy: We have included therapists upon occasion at our winter sports clinics, but we do not have a fixed defined role at this time. It's kind of on an ad hoc basis.

The Chair: Thank you, Mr. Dawdy

Merci, Madame Michaud.

Mr. Allen, please.

Mr. Mike Allen (Tobique—Mactaquac, CPC): Thank you very much, Mr. Chair, and through you to the witnesses, I appreciate the testimony you've given here today.

As a new member to the committee, it brings a couple things to my mind. Number one is the multidimensional challenge of providing the support to our veterans and injured soldiers when they come back, but also the challenge of making sure we have minimal overlap and at the same time we don't have any gaps in the services. That's the thing I see as a challenge.

Ms. Steggles, I'd like to start with you. You talked a little bit in your answers to Mr. Harris about Valcartier, and you pointed to a situation where she was able to achieve a double return-to-work rate. What specifically was that attributed to?

I ask that question because when you look at our joint personnel support units and those types of things, the idea is to bring together all the people, the social workers, the occupational therapists, and the whole thing.

What can you attribute that return-to-work rate to specifically? And how does that differ and vary from other locations? I assume in each case these people have case managers. Is that processed differently?

Mrs. Elizabeth Steggles: I think the difference between Valcartier and other areas is that there's an occupational therapist doing return to work and there isn't at any of the other facilities.

In answer to your question about what the occupational therapist would do that is different from anybody else, we look at what people actually need to do for their job. We don't only look at a specific symptom or a specific life circumstance; we look at the individual's abilities around a particular job, or any job. We look at those skills and abilities, we look at the environment in which they work, and, if necessary, we can modify the environment to make it fit better with the person. So we're really focusing in on the activity.

I guess the best way is to suggest thinking about your own specific job and then something else gets in the way. It's no good to say to you that now you have a mental health illness it's going to be tricky. Rather, it's what are the specifics of the mental health illness that would make it difficult for you to perform the duties that you need to do every day. We would then identify how we can work on those specific skills, or if we know that those skills are not available to that person anymore, then how we can adapt the job itself.

It's a very much more focused, practical approach to what an individual needs to do.

Mr. Mike Allen: I'll ask the next question to both you and Mr. Ferdinand.

I know you can give a comment about how closely the occupational therapists work with the other specialists. Quite frankly, do you see a conflict situation between the providers as to who should take the lead on these files? That's the thing that strikes me as a potential issue here.

● (1000)

Mrs. Elizabeth Steggles: We'll fight it out, right?

Voices: Oh, oh!

Mr. Mike Allen: I was hoping you would, but I didn't mean it on purpose.

Mrs. Elizabeth Steggles: I actually don't see a conflict.

I mean, everybody has their own specific skill and ability. Ours happens to focus on occupation. Practitioners have their own individual skills and abilities, too.

If we take the example I used in my introduction around a physiotherapist versus an occupational therapist...if we have the same patient with, say, an upper limb injury, the physiotherapist will work on the upper limb. That's important. We need to get the muscles working in a range of motion. But what the occupational therapist will do is work with the physiotherapist to say the reason we need to get that arm working again is because this person needs to do X, Y,and Z. So the occupational therapist will gear things toward the actual activity or occupation.

That's an example of how we all need to work together with our different skills, but again, toward a common goal.

Mr. Mike Allen: Mr. Ferdinand, do you see that fitting well?

Mr. Mark Ferdinand: Very briefly, yes.

We have psychiatrists who work with us, and psychologists and social workers who work in CMHA's.... The goal is not to think about it from a provider perspective; the idea is to think about it from a person-centred perspective.

Mr. Mike Allen: Okay, I appreciate your saying that, because I think that is exactly where we need to be.

Thank you.

The Chair: Thank you.

Go ahead, Monsieur Larose.

Mr. Jean-François Larose (Repentigny, NDP): Thank you, Mr. Chair.

Thank you to the witnesses for being here today.

[*Translation*]

Mr. Ferdinand, in your presentation, you mentioned the problem of underfunding. Could you give us some more details of the impact of the inadequate funding? If funding was not inadequate, which priorities would need to be addressed?

Mr. Mark Ferdinand: That is a very good question.

Our health system is definitely organized around urgent care. A good report published by Health Canada 40 years ago now said that we have to make a greater investment into prevention and health promotion. Some provinces have done that. At times, the federal government has done it as well. The Mental Health Strategy that the Canadian Forces have just published is a timely step in that direction.

In terms of family support, other witnesses have said that families help veterans to get back on their feet, but they do not have the same access to services as a soldier or a veteran. So we must make sure that families and close friends have access to some services. I do not have statistics on the way programs and services can be organized so that soldiers or veterans can get back on their feet with the help of their close friends and family. At the moment, this is a shortcoming that your study might identify. I could quantify it in due course, but, at the moment, we do not have the necessary statistics.

Mr. Jean-François Larose: You may not have statistics on the impact of the lack of family support, but is it something you have heard?

Mr. Mark Ferdinand: In mental health, unfortunately, economic analysis arrived on the scene very late. In the last three decades, there has been some economic analysis in other areas of health, but our area is lagging behind, both in Canada and around the world. At the start of this year, the Mental Health Commission of Canada published a report on the effect greater investment might have in some areas of promotion, but that focuses on the workplace. The committee might find it interesting to look at that report from the commission.

As for soldiers and veterans, I do not know whether there are any studies that provide figures on the economic aspect and the personal impact.

● (1005)

Mr. Jean-François Larose: As I understand it, the Canadian Forces strategy mentions family support, but there is no associated funding. Is that correct?

Mr. Mark Ferdinand: I do not know whether there is funding or not. I just know that the strategy talks about family support and the importance of family in a soldier's rehabilitation. It also says that appropriate services for family members have to be found in the community. That is all. At that point, the strategy should be identifying the encouraging relationships to promote and the lines of communication that need to be established between the Canadian Forces and the community. That is in the knowledge that community resources will not be able to support the families in the hoped-for way. At the moment, the words sound good, but we have to continue our work together so that we can find out if we can achieve our goals in this phase that, at the moment, unfortunately ends with nothing more than a fond hope.

The Chair: Thank you, Mr. Larose.

[*English*]

Mr. Williamson, go ahead, please.

Mr. John Williamson (New Brunswick Southwest, CPC): Thank you, Chair.

Thank you to all the witnesses for being here today.

I'm going to begin with Ms. Steggles. Could you perhaps elaborate? You were kind of cut off, because of the time, on a question that Mr. Ted Opitz asked you with respect to your recommendation. It was regarding the number of officials you would have at each of the facilities across the country, if you want to follow up.

I'm a new member of the committee. Have you talked about how many facilities there are across the country in that recommendation, and what would it mean, please?

Mrs. Elizabeth Steggles: Yes, certainly.

As I am quite sure you know, there are rehabilitation facilities within National Defence across the country. We would like to see, ideally, two occupational therapists at each, so that we have physical and mental health expertise. It's not that they would do all the work. It's that they recognize the issues and can direct the occupational therapy treatment for those individuals. What they would also do is recognize if other occupational therapy services are needed, and some of those are currently contracted by civilian occupational therapists.

One of the things we would like to recommend, as I mentioned earlier, is that we realize that civilian occupational therapists don't necessarily recognize the culture of the needs of people who are in the military, so as an association we would like to help build capacity for those individuals. We already provide a number of educational resources on a number of topics. To give you an example, I've been in communication recently with the Canadian Pain Coalition. And we have a networking group of occupational therapists. Some of them work already with people who are in the military, although the OTs are not employed by the military.

What we would like to do is provide some webinar services, lunch and learn services, which we already do, that help focus more on the specific needs of people within the military. As I said, that's the kind of service we supply already, but we would like to focus in on the needs of people who are in the military who need our services, so that the occupational therapists are better able to provide those services.

Mr. John Williamson: Would you envision these occupational therapists working directly with—if that's the right term—or interacting directly with soldiers who have been injured, hurt or—

● (1010)

Mrs. Elizabeth Steggles: Absolutely.

Mr. John Williamson: I wasn't sure if it was coordination or.... Okay, good.

I'm sorry, how many facilities are there across the country?

Mrs. Elizabeth Steggles: It's six or eight. I'm sorry, I've forgotten.

Mr. John Williamson: That's fine. Thank you very much.

My next question is for the Canadian Association for Disabled Skiing. I thought your presentation was interesting, and again Mr. Opitz talked about the importance and the uniqueness of the program, but I got the sense you're a bit at your wits' end or frustrated by the inability to kind of punch through and have your program perhaps a little better known by soldiers themselves.

What could be done to improve that, versus your advertising in a newspaper to get to soldiers to offer them your program?

Mr. Clay Dawdy: In dealing with the Soldier On organization for the first two years, what happened is they just indicated to us that they had a human resource problem in handling everything they do. Consequently, we were kind of left on our own out here.

First of all, we need somehow to take a look at that organization within the military and see how it can disseminate our information packages. For example, at the army run this year we thought it would be an excellent opportunity to advertise for new applications for soldiers and veterans. We weren't able to secure a display space after about three or four months. That could be due to our own incompetence, but I would think that at the same time it is due in part to the bureaucracy that we were trying to get through there to get a display space at that run.

Consequently, it would be of great assistance to somehow allow us to have the Soldier On organization distribute that information for us, with the applications coming directly to us.

The other key here was the ability for the military to recognize our winter sports clinics as an approved event. That enables the soldiers to get leave to attend our event and get paid, to be considered on duty.

[*Translation*]

The Chair: Mr. Brahmi, the floor is yours.

Mr. Tarik Brahmi (Saint-Jean, NDP): Thank you, Mr. Chair.

My question goes to the Canadian Association of Occupational Therapists.

You said that, in Canada at the moment, only two occupational therapists are working directly with the Canadian Forces and that, of those two, only one, the one in Valcartier, is a permanent employee. At least, that is what I understood.

Do you have an idea of the number of soldiers or veterans who might benefit from occupational therapy services?

[*English*]

Mrs. Elizabeth Steggles: No, I'm sorry; I don't have that statistic at hand.

[*Translation*]

Mr. Tarik Brahmi: You recommended that it would be a good idea for the Canadian Forces to have six permanent, full-time occupational therapists across the country.

Could you give me an idea of the number of people that might cover? Would it be hundreds or thousands? Do you know the figure?

[*English*]

Mrs. Elizabeth Steggles: I'd like to clarify. We would like six to look at mental health and six for physical health.

[*Translation*]

Mr. Tarik Brahmi: So we are talking about 12 occupational therapists for the Canadian Forces as a whole.

[*English*]

Mrs. Elizabeth Steggles: Yes.

[*Translation*]

Mr. Tarik Brahmi: Is that what you are recommending?

[*English*]

Mrs. Elizabeth Steggles: Yes.

I'm sorry; I really can't give you the numbers, except to say that the scope of practice of occupational therapy looks at anybody who has a physical or mental health condition, so it would be those numbers. It may be a very limited contact with those people or it may be something that goes on for several years.

I'm sorry that I really can't answer your specific question, but I can find out and get back to you with that.

[*Translation*]

Mr. Tarik Brahmi: Okay, thank you.

Mr. Ferdinand, you mentioned a number of times in your testimony that you do not have information and that prevents you from determining the real needs. I am sure you are aware that Statistics Canada conducts a survey called the Canadian Community Health Survey. It is modular in form, meaning that, for a certain period, every department can add a module about the particular aspect of health they deal with.

Could the Department of National Defence explore that possibility? It could add a module every six months, every year or every two years that would deal specifically with the mental health of military personnel. You would then also have access to more information, which would allow you to make better decisions and come up with better recommendations. What do you think about that?

● (1015)

Mr. Mark Ferdinand: Yes and no. The department already works with people from Statistics Canada. They take part in program evaluation and they conduct one-off projects for the department. So, as I understand it, there is already a relationship between the department and Statistics Canada.

That said—and the answer to this part of your question is yes—those surveys are not regular. Since they are not really regular, we cannot really determine trends over time. The surveys could take place every two or three years. It would depend a lot on the department's or the Canadian Forces' strategy.

If I were to make one recommendation, it would be to standardize the kind of survey a little. That would help us to determine the needs of the soldiers and their families. It would let us tie the forces in with community services more fully. It is difficult to plan without that data.

Mr. Tarik Brahmi: Thank you, Mr. Ferdinand.

Mr. Dawdy, you mentioned a clinic approach whereby people go to participate in winter sports for a week.

Could the approach work all winter at military bases located near ski resorts? Have you thought of that?

[*English*]

Mr. Clay Dawdy: As we mentioned, we certainly think that CFB Valcartier is close to Mont Sainte-Anne, which is excellent. I'm not fully aware what the facilities are for adaptive skiing at Mont Sainte-Anne. I know that we have a program there.

There is certainly a possibility for more regionalization right across the country. What we really would like to do is introduce a host of adaptive sports that we could demonstrate to the newly injured soldiers and veterans to show that these are possibilities they can succeed at.

The Chair: Thank you very much.

Mr. Bezan, please.

Mr. James Bezan (Selkirk—Interlake, CPC): Thank you, Mr. Chair.

I want to thank our witnesses for appearing today and for the great work you're doing with our military members as well as veterans, and indeed all Canadians, in providing the services you provide.

My first question is to Ms. Steggles.

You're talking about occupational therapy, and I think this is a critical profession. I witnessed it first-hand with my mother after she had a stroke and saw how important it was. Her recovery was really dependent upon the occupational therapy she received to be able to go back home and live independently and do the things she loves to do. I totally appreciate your profession and the services you provide.

Were you aware that the Canadian Forces Health Services Group has a physical rehabilitation program, with seven centres of excellence across the country that include at least one physical therapist and one occupational therapist?

Mrs. Elizabeth Steggles: I know of those facilities across the country, but they do not each have an occupational therapist.

Mr. James Bezan: They don't, so far?

But they're also instructed to work with civilian providers as much as possible. So your membership is working with those centres, I would hope.

Mrs. Elizabeth Steggles: Yes.

Mr. James Bezan: If they don't hire locally, then it is important that—

Mrs. Elizabeth Steggles: Yes, but it goes back to the issue of their not necessarily understanding the specific needs of military personnel.

Mr. James Bezan: In the wellness action plan that you're recommending, you want to have more integration, with their either being directly hired within the health services directorate of the Canadian Forces or having more cross-training so that they can better serve the members at that level of health.

● (1020)

Mrs. Elizabeth Steggles: Both, I would say, would fit in with the current model.

Mr. James Bezan: Okay.

My next question is for Mr. Ferdinand.

We have all been hearing a lot about mental health issues—PTSD, operational stress injuries—and we as a government have increased dollars to mental health by more than $50 million a year now. We have hired currently 378 mental health professionals within mental health services, and we're trying to hire more.

Is that enough? We always hear that we have a higher ratio than our allies of mental health workers to soldiers. Do you think we've gone far enough, or do we need to go farther?

Mr. Mark Ferdinand: Any good health program based on guidelines published by the World Health Organization would suggest that you need to start a population need first and then determine what types of resources you need in order to meet that population need.

I don't know immediately; I can't say whether these are enough. When you look at the general context, you have to take into consideration what types of operations are ending, who will be coming back to Canada, and what percentage we could predict, among those who are coming back to Canada, will possibly experience a mental health issue for which we'll need very specific types of services.

Good planning is based on an appreciation of all of those different variables, so it's difficult to say whether this is enough. We heard earlier that there are a number of soldiers returning from tours internationally. The Surgeon General's mental health strategy notes that there are people here in Canada already serving in different roles.

Is it enough? It's all based on population need. We don't have special knowledge as to what the forces are doing with regard to the implementation of their strategy, so it is difficult to say whether it is enough. What we can say is that we are pleased to see that there was that hiring, because we know there was a lack of mental health professionals to begin with several years ago when we collaborated on some of this work with Veterans Affairs, DND, and the RCMP.

Mr. James Bezan: Would you have any comparison, taking the Canadian Forces population and that of the provinces or of Canada in general? Do we have a higher ratio of mental health workers at the Canadian Armed Forces level than the civilian population has?

Mr. Mark Ferdinand: This may be simply my own personal conversations with Statistics Canada or someone else, but the reality is—and the mental health strategy actually points this out—there are wait times associated with mental health services for all of Canadians, and we know that from surveys that have been done by Ipsos-Reid with the Canadian Medical Association. We know what the wait times are.

Apparently, wait times and affordability are not issues the Canadian Forces necessarily deal with. But there are still some challenges with regard to the supports they may not be receiving in a timely manner because of geography.

I think we heard of some of those challenges. When you look at the number of centres that exist across this country for forces, they are not as numerous as one would like. There are great geographic distances for some people to travel in order to get the care they need.

The Chair: Mr. Harris.

Mr. Jack Harris: Thank you, Chair.

Mr. Ferdinand, your original comments suggested that your organization was supportive of and generally pleased with the Surgeon General's mental health strategy. But did I get it right when you said you really had no knowledge of how good the implementation was, or how successful the implementation was? Did I get that right?

Mr. Mark Ferdinand: That's correct. We just have not read the evaluation reports that we know are planned for and that have been done, but we know they have been planned for and have been done. So I can only assume they're telling the forces something with regard to the types of services they need to have in place. But we just don't have special knowledge with regard to how these services are evaluated.

Mr. Jack Harris: But you like the theory.

Mr. Mark Ferdinand: Well, the theory, as well as what we saw maybe 10 or so years ago when we were first involved and what we're seeing now.... There's a world of difference in terms of things being structured in a way that's more person-centred.

Mr. Jack Harris: Mr. Gilmour or Mr. Dawdy, I'm interested in your program, but I'm also curious that there doesn't seem to be much pick-up or take-up.

What should we recommend? Should this be on the menu of resources available to soldiers who are ill or injured and could benefit from this? Should that be part of what the CF offers to soldiers? Is that where it's lacking?

● (1025)

Mr. Clay Dawdy: Exactly.

Mr. Bob Gilmour: Can I just interject—

Mr. Jack Harris: It seems to me to be odd that you only have 10 or 12 people, and you offer something that Mr. Opitz says certainly appeals to him, and I'm sure it would appeal to a lot of soldiers who are physically fit and active individuals who might benefit.

Mr. Clay Dawdy: We've been told that the local catchment area is 450 potential participants, and yet based on our statistics, we have to fight hard to get 8, 10, 12 people out. So where are the rest of them?

Bob, did you want to add to that?

Mr. Bob Gilmour: I just wanted to add that when we first started this, when I came back from Colorado a number of years ago and I wanted to start this whole program, we talked about a national event, like we do in Snowmass, Colorado every year. We've done it for the last 28 years. We were told that Canada is too big; we would have to run regional programs. So we ran them in the east, we ran them in Quebec, we ran them in Ontario, and we ran them out west. And this year, Soldier On has decided that because of resources and money, they can only run one in western Canada, on Vancouver Island.

So we're looking at it and saying, okay, they're trying to put together 40 people for Vancouver Island, and we're saying, well, we're in the east. The ones we're missing...that's where we run our program. We try to catch up to them.

Mr. Jack Harris: Okay, thank you.

Ms. Steggles, I have one further question in regard to case management. I'm assuming the case manager of OT would probably think this is not a bad idea for disabled skiing, potentially.

But on the case management system, do you know if the Canadian Armed Forces use that as part of their rehabilitation? I know they do in workers' compensation. For example, you would have a case manager who would coordinate health professionals of various sorts and the needs of a client.

Do the Canadian Forces do that with someone who is a returning soldier—appoint a case manager? Or is it done through the chain of command and sent off to a psychiatrist one day, or whatever the individual soldier seeks out? Is that case management system in use, to your knowledge? And would occupational therapists be able to play that role?

Mrs. Elizabeth Steggles: It's a very good question and I can't give you an answer. I'm sorry, I don't know whether that role is in place in the military, but there certainly is precedent for occupational therapists being case managers. Here in Ontario, for example, the community care access centres use occupational therapists frequently as case managers to coordinate which services an individual might need.

Mr. Jack Harris: Thank you. That's all I have.

The Chair: Ms. Gallant.

Mrs. Cheryl Gallant: Thank you, Mr. Chairman.

When you're trying to make contact with soldiers who would benefit from this, in the past have you gone through the JPSU, and did they send out a blast email? How has it been done successfully in the past?

Mr. Bob Gilmour: It's basically just by word of mouth. I'm trying to even find the right people in JPSU to be able to put it forward. We do have a number of names this year from JPSU, and we're certainly going to give them the information that's available. It's just more of the knowledge getting out there to the people to let them know that this is available, and it just seems to stop at the front door.

Mrs. Cheryl Gallant: So in addition to helping soldiers and veterans who are amputees, do you help any other members of society?

Mr. Bob Gilmour: We have run an adaptive ski school in Calabogie for the past 10 years. We have 40 participants. We have 80 volunteers who basically work with.... It's an eight-week program, and we bring children from age 3, 4, 5, whatever, to teach them the same thing. What we're teaching here is not the skiing; it's the self-esteem we're teaching. It doesn't matter whether it's a 10-year-old or a 40-year-old soldier, if you can build that self-esteem and make them feel good about themselves, and if they can do this, what else can they do in life? They feel good about themselves. That's what we do there.

We also do a community living program. We used to shut in all the people in the 1950s who were different—Down's syndrome, cerebral palsy, muscular dystrophy, whatever it was. What did we do? We put them in an institution and closed the door.

For the last nine years now, in Renfrew and Arnprior, we have brought about 30 of these people out for a special day the first Monday of every February. We bring them out and basically show them a good day. They ski, they get assist ski and do that, and we have a banquet for them at lunchtime. We make them feel good, because when they all leave there, they are all smiling.

The Soldier On program is one, the community living is one, and then the regular program we run is one.

● (1030)

Mrs. Cheryl Gallant: Has this made a difference in school activity participation? Sometimes a gym class will go to the ski hill to learn a new skill.

Mr. Bob Gilmour: I just did a presentation to all of the eastern Ontario schools for special ed, and basically it's exactly what you say. But we encourage all the schools to do it, because we have the facility. We just finished building—thank you to the federal government for the accessibility grant—a $350,000 facility to assist.

When the schools come now, they bring all the children, they're in wheelchairs or whatever, and they all partake together. For the other kids, it actually helps them all fit in, because they think it's just wonderful that these kids can come up and take part and they can ski. For a lot of them who walk through the schools with their passes on, with crutches or if they have cerebral palsy, other kids will ask them how they can ski when they can't even walk. And they say, “Come on, I'll show you.” That's the kind of self-esteem that we want to have.

The offset in peer groups at schools, and in any relationship, is once you bring that self-esteem up, that person becomes that much more productive in society. If we can get them at a young age and help their self-esteem as they grow, it's even better.

Mrs. Cheryl Gallant: Now back to soldiers and veterans: in the adaptive ski program, can you give us any examples of how having these individuals in the program really made a difference in their lives?

Mr. Bob Gilmour: I have one, and I think you guys will probably all remember it.

Two years ago we had our winter sports clinic here, and we had one fellow who was extremely struck with PTSD. The whole family was falling apart. I remember his wife came to us and said, “You know, this is the first week I've seen my husband smile since he's come home.” They just sort of bonded together because they were able to have that whole week to just talk and feel, and also to talk with other PTSD victims too. It just made a world of difference to them. Unfortunately, that gentleman was hit by a bus outside of Petawawa—and he was making it; he was really getting it. But all of a sudden he has an accident and that's what happened.

Mrs. Cheryl Gallant: How does your program help toward the overall recovery?

Mr. Bob Gilmour: In the United States we call it “miracles on a mountainside”, and we can call it that here in Canada, too, because we have good mountains. It's just the chemistry that works. They're concentrating so much on trying to learn a new skill, and basically a lot of the stuff that's on the outside, even for the PTSD guys.... We're not experts on PTSD, but when we had these guys here, it was a matter of just working with them and helping them.

At one point I said, “Okay, we have the skis, we have this, and now we're going to go down and get our helmets.” And this one fellow said to me, “Um, I don't wear helmets, because a helmet—boom—I'm back there again.” So hey, we're going to wear a toque and have fun.

The Chair: Thank you, Mr. Gilmour.

Ms. Murray.

Ms. Joyce Murray: Thank you, Mr. Chair.

Mr. Ferdinand, you talked about

[*Translation*]

shortcomings in the support provided to the families of armed forces members facing mental health difficulties.

● (1035)

[*English*]

The ombudsman also talked about military families and the stresses of their own they undergo, especially in a changing social environment, where it's no longer standard for a partner to stay at home with the children. It's standard to have two working parents creating careers. There are stresses in terms of the absences of one partner and single parenting, frequent relocations the family may have no choice in, and the elevated risk of the serving partner. Those stresses can create problems for the non-serving partner. Those stresses can break up marriages or can cause the serving member to leave specifically for that reason, which then costs the armed forces, of course, as they are trained personnel.

Do you see a level of support that is adequate for that component of stress and really a need for mental support?

[*Translation*]

Is that a shortcoming you have noticed too?

[*English*]

Mr. Mark Ferdinand: I think we can do better. The Surgeon General recognizes that there are mental health, physical health, and psycho-social dimensions to the mental health problems or illnesses that members of the forces face as well as their families. I think the strategy also recognizes very clearly that.... The report actually says very bluntly that they support the establishment of community mental health services, and then there's a caveat: within constitutional or jurisdictional limitations. There's that little piece that's added to the end of it.

The reason why I mentioned that it was sort of a wish when I read it is because, on the one hand, it's nice to say, okay, here are the needs and we understand the needs—and I think you've just articulated very well what those needs are around the family. We know what role family members play in the recovery of individuals. The question is, to what extent are those conversations happening, the collaboration that is needed? Is it between the federal government and the civilian services or health professionals? What is going on there that would make the strategy sing in terms of reaching people who might be, quite frankly, falling between the cracks?

Ms. Joyce Murray: Do you see this being a reformulation of resources that are already out there, or do you think there actually needs to be more money put into the mental health support for the injured and their families?

Mr. Mark Ferdinand: The discussion has to take place. I think at a very minimum the discussion needs to take place so that we can understand, again, whether or not population need is being met with the resources we have or we might learn we don't have. I'm simply unaware of whether or not that type of discussion is taking place. I think it's a very good suggestion to at least start that discussion, because we might learn that the resources exist in Toronto but they don't exist in Podunk.

Ms. Joyce Murray: Four years ago I was on the health committee doing a health human resource study, and one of the things we learned was that there was not a single clinical psychologist or psychiatrist in the employ of the armed forces at that time. That's only four years ago. Shifts can happen. Potentially community health service that is more proactive for family members as well as injured spouses could be something that is a part of the strategy, but—

Mr. Mark Ferdinand: It needs to be detailed.

Ms. Joyce Murray: What's the next step? What's one single, focused next step?

Mr. Mark Ferdinand: It's to take those words that say family supports are important, recovery to the individual who we're concerned about is important, and actually articulate more formally. I saw that part of the next steps this strategy articulates is to formalize, for example, a suicide prevention strategy. Right. To formalize a strategy focused on providing family support would be wonderful to see, because right now...I didn't even see that at the end of the document as something that needs to formalized in some way. Who's involved is an open question, but the discussion needs to take place across a number of different partners, quite frankly, at the community level in order for this to really hit home and to make a difference in terms of the health outcomes we're striving for.

The Chair: Thank you, Mr. Ferdinand and Ms. Murray.

Before I give the floor to Mr. Bezan for the last five minutes, I have questions for Mr. Dawdy and Mr. Gilmour on the point that you have had trouble connecting with approximately 400 individuals in this, as you said, catchment area, who might avail themselves of your program.

I see among your many sponsors that there is the Legion, and I'm wondering what the relationship is. Might the Legion be a connector with regard to reaching out?

Mr. Clay Dawdy: We work quite extensively with the legions. They are really behind us 100%, as well as other organizations that are associated with the military, such as the CAV, Canadian Army Veterans. There is also the other organization, True Patriot Love, which has really stepped on board this year. Wounded Warriors is another organization that we have contacts with. We are working with the legions to further those inroads.

By the way, they seem to be having a problem with their membership as well, with getting the young veterans to come into the legions.

Do you have anything else to add, Bob?

● (1040)

Mr. Bob Gilmour: I think one of the challenges the legions have nationally is that they have this great poppy fund that they do, but the mandate within their poppy fund says it doesn't fit their criteria to help injured soldiers or veterans. I mean, it's a perfect fit, and I think it's something they are looking at.

Regardless, that organization has donated funding to help us supply the services.

The Chair: Thank you.

Mr. Bezan.

Mr. James Bezan: I have one final question, and it plays on what Ms. Murray was asking about: what type of support we're providing to military families. We do have military family resource centres across this country, and I'm thinking from the standpoint of reaching out, as Mr. Gilmour talked about, and having spouses skiing down the hill with their loved ones who are survivors of traumatic injury in the armed forces.

To Mr. Ferdinand and Ms. Steggles, what about your organizations working with the military family resource centres that are set up right across this country to help the spouses and children deal with their loved ones who have returned home and are dealing with all sorts of injuries, both visible and invisible illnesses that they have encountered while in service?

Mr. Mark Ferdinand: I think right now what happens is there are agreements that exist between different organizations within the community. There are warm hand-offs, as they are called. If someone walks through a single door, they are treated as though they are not walking through the wrong door, and a referral takes place.

That relationship exists already across the country between CMHAs in certain communities and family resource centres and other similar organizations.

Mr. James Bezan: Ms. Steggles.

Mrs. Elizabeth Steggles: As occupational therapists, we will always, if possible, include the family in whatever we do, because it's integral to who we are. We relate to our families. We relate to our employers, our environment, so we see that we have to work together with families.

In terms of an organization, the Canadian Association of Occupational Therapists works with organizations a great deal. We have representatives within organizations. We can certainly arrange to do that. We're member-dependent for our income, but we do have a lot of volunteers who will work with different organizations and represent occupational therapy with those organizations.

I would say that's probably the way to go, and we would certainly facilitate doing something like that.

Mr. Clay Dawdy: From a recreational perspective, we certainly promote that type of activity. The reality is that there are always funding issues.

We've been able to raise the funds this year. We're on target to support the spouses and the family members as required, but that's an ongoing issue.

Mr. James Bezan: Thank you.

The Chair: Thank you all.

It's been a very informative and a very valuable meeting this morning.

Thank you very much.

The meeting is adjourned.

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