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Chair

Mr. David Christopherson

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● (1540)

[*English*]

The Chair (Mr. David Christopherson (Hamilton Centre, NDP)): I now declare this 48th meeting of the Standing Committee on Public Accounts in order.

Colleagues, before we move to the orders of the day, perhaps I could ask your indulgence for approval for a short business meeting afterwards. We have some scheduling that I need to run by you for approval. So, with your agreement, at the conclusion of our questions I'd like to move into a business meeting. It shouldn't take too long. I guess we're in agreement. I don't see anybody violently opposed so I assume we're good on that.

Therefore, we'll now turn our attention to the matter at hand. Welcome to all of our guests. We're here to study chapter 3, “Mental Health Services for Veterans”, of the fall 2014 report of the Auditor General of Canada. The Auditor General couldn't be here but his capable and renowned assistant auditor general, Mr. Berthelette, is here.

Sir, we will begin with your opening remarks. You now have the floor.

Mr. Jerome Berthelette (Assistant Auditor General, Office of the Auditor General of Canada): Thank you, Mr. Chair, for this opportunity to discuss chapter 3, “Mental Health Services for Veterans”. Joining me at the table is Dawn Campbell, the director who is responsible for the audit.

As of March 31, 2014, about 15,000 veterans were eligible to receive mental health support from Veterans Affairs Canada through the disability benefits program. An additional 1,000 veterans in the department's rehabilitation program self-identified as having a mental health condition. The proportion of the department's disability benefits clients with mental health conditions has increased from less than 2% in 2002 to almost 12% in 2014.

[*Translation*]

Our objective was to determine whether Veterans Affairs Canada had facilitated timely access to services and benefits for veterans with mental illness. We focused on the timeliness of eligibility decisions made by Veterans Affairs Canada. We did not assess the appropriateness of the decisions made or the quality of care received.

For eligible veterans, the department pays for various mental health services not covered by provincial health plans. These services can include specialized psychological care, residential treatment, and some prescribed medications.

[*English*]

We found that Veterans Affairs Canada has put in place important mental health supports. These included operational stress injury clinics, a 24-7 telephone service, and the operational stress injury social support program. However, in many cases the department was not doing enough to facilitate veterans' timely access to mental health services and benefits.

The rehabilitation program provides access to mental health care support for those veterans who are having difficulty transitioning to civilian life. Eligibility requirements are less stringent than those for the disability benefits program, but treatment and benefits end once a veteran completes the program. We found that Veterans Affairs Canada was meeting its service standards for providing timely access to mental health services through the rehabilitation program.

The disability benefits program provides lifelong access to benefits and requires that veterans provide evidence that they have a permanent mental health condition that was caused or aggravated by military service. We found that from the veterans' perspective about 20% had to wait more than eight months from the first point of contact for the department to confirm their eligibility to access the specialized mental health services paid for by the department.

[*Translation*]

Veterans Affairs Canada needs to do more to overcome the barriers that slow down the decision as to whether veterans are eligible for support provided through the Disability Benefits Program. These barriers are a complex application process, delays in obtaining medical and service records from National Defence and the Canadian Armed Forces, and long wait times for getting access to mental health care professionals in government-funded operational stress injury clinics.

● (1545)

[*English*]

We noted that 65% of veterans—843 of 1,297—who challenged denial of eligibility decisions for disability benefits were successful. While the department knows that most successful challenges rely on new information or testimony, it has not analyzed how the process could be improved to obtain this information prior to rendering decisions upon first application.

[*Translation*]

In this audit, we also looked at what Veterans Affairs Canada is doing to increase awareness among various stakeholder groups of the supports it makes available to veterans. We found that the department delivered a variety of outreach activities that target its existing clients and soldiers being released from military service.

However, it could have done more to reach other groups who can encourage veterans to seek help, in particular family doctors and families of veterans.

Veterans Affairs Canada agreed with our recommendations. An action plan was posted on the department's website. Its implementation deadlines range from December 2014 to March 2016.

[*English*]

Mr. Chair, this concludes my opening remarks. We would be pleased to answer any questions the committee may have.

Thank you.

The Chair: Very good. Thank you.

l would ask our guests, if you have colleagues with you, would you be kind enough to introduce them as you make your opening comments?

We'll move to Monsieur Michel Doiron from the Department of Veterans Affairs. You have the floor, sir.

[*Translation*]

Mr. Michel D. Doiron (Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs): Thank you, Mr. Chair.

Good afternoon. I am Michel Doiron, Assistant Deputy Minister of Service Delivery for Veterans Affairs Canada. I have been in this position for just over a year, and this is my first appearance before this committee. Thank you.

[*English*]

Joining me today is our director general of health services, Dr. Cyd Courchesne. Dr. Courchesne leads, nationally and virtually overseas, a VAC team of health professionals at Veterans Affairs Canada. She and her team provide expert advice, guidance, and direction to me and to VAC senior management. She is also responsible for a national operational stress injury network within VAC.

Mr. Chair, as you are aware, mental illness indirectly affects all Canadians, sometimes through a family member, friend, or colleague. The Canadian Mental Health Association says that 20% of Canadians will personally experience a mental health illness in their lifetime. Mental illness affects people of all ages, education, income levels, and cultures. Our veterans, as well as our men and women in uniform, are not immune to mental illness.

[*Translation*]

In the fall report, the Auditor General looked at how Veterans Affairs was managing access to mental health services for veterans. The audit aIso examined: joint initiatives, the transfer of military records by National Defence and the Canadian Armed Forces, and information on reviews and appeals by the Veterans Review and Appeal Board.

The audit focused on three lines of enquiry: facilitating access to mental health services, providing mental health outreach, and managing the Mental Health Strategy.

[*English*]

The Auditor General raised key points, and we are thankful for his valuable insight and important observations. Having that independent assessment is absolutely essential in helping the department move in the right direction to improve our delivery model and place support where our veterans, men and women in uniform, and their families need it most. To that effect, my department has put into place the mental health services for veterans action plan, and I believe you have been given a copy of that action plan.

The action plan focuses on five priority activity areas: providing timely access to psychological and psychiatric assessment and treatment; reducing barriers to timely access to disability benefits; identifying trends to overturn decisions; ensuring that outreach activities are comprehensive; and measuring the effectiveness of the mental health strategy.

The plan identifies commitment under each of these five areas, and numerous advances and improvements have already been made. To name a few, the number of psychological counselling sessions that veterans, their families, and caregivers are allowed access to has increased up to 20 sessions per issue from eight sessions, and that was effective December 1.

Along with the Mental Health Commission of Canada, a mental health first aid program has been established for veterans and their families, providing them with the tools needed to be better equipped to recognize and deal with mental health issues.

In terms of investment to our operational stress injury clinic network, OSI clinics in satellite locations provide critical assessments, diagnostics, and treatment services to those dealing with operational stress injuries such as post-traumatic stress disorder. This investment will help us accelerate access to mental health services for our veterans and will include a new clinic in Halifax in 2015.

● (1550)

[*Translation*]

We already streamlined our disability benefit application package last October, but we are also streamlining the process. This includes the adjudication of benefits for post-traumatic stress disorder using a new evidence-informed decision model, which results in faster decisions.

[*English*]

Close work with our colleagues from the Canadian Armed Forces to improve timeliness of access to disability benefits and reduce the seam and transition support between serving and civilian life.... This is managed through our Veterans Affairs Canada-CAF steering committee, and through our approximately 100 VAC employees co-located with the CAF at integrated personnel support centres on or near bases or wings across Canada.

We will communicate with the Veterans Review and Appeal Board to better understand why disability benefit claims are overturned by identifying trends. This information will be used to improve policies in the decision-making process.

A pilot four-year military family resource centre will allow medically releasing veterans and their families access to support and services at seven military family resource centre sites across Canada. This will help us identify future needs and the best approach in the future.

Lastly, our operational stress injury social support program will be strengthened with 15 more peer-support coordinators—and there will be more—focused on direct outreach to veterans.

Those are the highlights of our mental health action plan. I assure you that we are fully committed to further improving the system so that veterans and their families receive the care and support they need now and in the future.

Thank you again for the opportunity, Mr. Chair. Dr. Courchesne and I look forward to questions.

The Chair: Very good. Thank you so much.

We will move along now to the surgeon general of the Canadian Forces health services, Brigadier-General Bernier.

You now have the floor.

[*Translation*]

BGen Jean-Robert Bernier (Surgeon General, Commander Canadian Forces Health Services Group, Department of National Defence): Mr. Chairman and members of the committee, as Surgeon General, I thank you for the opportunity to speak to you about the measures being taken by the Canadian Armed Forces to address the two recommendations made by the Auditor General in chapter 3 of his 2014 report, entitled *Mental Health Services to Veterans*.

These recommendations relate to timely access to psychiatry and psychology assessments at specialized Operational Trauma and Stress Support Centres, or OTSSCs, and the accelerated transfer of medical records to Veterans Affairs Canada.

[*English*]

Also with me today is the Canadian Forces director of mental health, Colonel Andrew Downes, MD.

Access to mental health care is impacted by the demand for care, available clinician resources, and the efficiency of practices. We don't want to limit or control the demand for care but on the contrary do everything we can to encourage those who need care to come forward. We must therefore focus on maximizing clinician resources and the efficiency of our practices in striving to minimize wait times. In doing so we must be careful to avoid compromising other aspects of care such as its quality, basis of evidence, and collaborative approach.

To measure access to mental health care the Canadian Forces health services group applies the widely accepted metric of the third next available appointment. This is considered a more sensitive reflection of true appointment availability than the first or the second next available appointments because those metrics are more affected and skewed by cancellations and other unexpected events. The third available appointment, however, does not necessarily reflect the patient's actual experience. It can often overestimate true wait times since referrals scheduled for the first and second available appointments are seen sooner, particularly when there are cancellations.

[*Translation*]

The third next available appointment metric also only applies to routine referrals. Cases that are clinically deemed to be urgent are seen much sooner, and virtually all patients awaiting OTSSC assessment are under the mental health care of a primary care physician, and in some cases, a psychologist or psychiatrist from a clinic's General Mental Health Section.

OTSSCs provide monthly reports on the average wait time between receipt of a routine referral and the third next available appointment for an initial diagnostic psychiatry or psychology assessment. Our benchmark target is no more than 28 calendar days. Although few civilian health facilities achieve this target, we pursue it in accordance with the recommendations of the Canadian Psychiatric Association and the national Wait Times Alliance.

● (1555)

[*English*]

In 2014, four of the seven OTSSCs provided an annual average third next available appointment within that benchmark. The other three experienced longer wait times, averaging 49 days among them, primarily due to staff absences for such things as extended sick leave and parental leave.

By January 2015—this year—only one centre exceeded the benchmark and then by only two days.

In 2014 the Canadian Armed Forces was authorized to hire an additional 54 mental health staff. Of these, 21 were for clinics with operational and trauma stress support centres. As of mid-January 2015, 94% of our 455 authorized mental health positions were filled and efforts continue to fill the remaining vacancies. This is a dynamic challenge affected by normal staff turnover, heavy competition with the civilian sector for mental health professionals, and difficulty recruiting personnel to certain non-urban locations.

We're in the process of installing high definition secure video teleconferencing systems in our mental health clinics to help balance short-term increased demands for care in one location, with staff capacity available in other locations. This will also reduce travel requirements for our patients in outlying locations and improve their continuity of care when they're posted to a new location.

[*Translation*]

To improve efficiency and quality of care, we have hired a mental health quality and patient safety officer to review business practices in the clinics and help establish additional performance measurement metrics.

We will also soon implement the electronic mental health record and a digital outcome measurement system called CROMIS. This system, which is also used by mental health clinicians contracted by Veterans Affairs Canada, will allow for early identification of people not responding well to treatment, thereby prompting the clinician to adjust the treatment.

[*English*]

With respect to the transfer of medical records to Veterans Affairs Canada, Canadian Forces health services group has been working jointly with VAC for a year on a project to accelerate the file transfer process. In particular, VAC and DND have created a 14-person records disclosure team with the sole focus of expediting files between the two departments, and they have established a full-time VAC adviser within that records disclosure team to provide timely and expert advice on VAC requirements.

A second team has been established to address the backlog of outstanding files due for transfer to VAC. Through their joint efforts, the backlog has been reduced by almost 50% and the overall process has become increasingly effective and efficient. We monitor the process daily and are constantly striving to pursue innovative business practices to provide the best possible service to both our serving and retired personnel.

Thank you for your attention, and I'll be happy to answer any questions you may have.

The Chair: Very good. Thank you.

That concludes opening remarks, and colleagues, unless someone has a good reason why we shouldn't, we'll now begin with the regular rotation process, beginning with Mr. Hayes.

You, sir, now have the floor.

Mr. Bryan Hayes (Sault Ste. Marie, CPC): Thank you, Mr. Chair.

My questions will be directed to the Auditor General's department, and I'll specifically focus on sections 3.25 to 3.29 in the report, about eligibility decisions under the disability benefits program not being timely. I really want to dig into that a little bit and make sure I understand the numbers.

It's my understanding that there are basically two streams, in terms of these. There's the veteran's perspective, so there's a process leading up to the application; and then there's the perspective of the department, which is once the application is received, then that's a stream as well.

I want to focus on the application being received. There's a standard that says the target rate is 80%. In your opinion, is that a reasonable target rate, to process 80% of the applications within a 16-week time period?

● (1600)

Ms. Dawn Campbell (Director, Office of the Auditor General of Canada): We did take a look at what standards were in place in other jurisdictions and we couldn't find anything that was comparable, and into that come different complexities in terms of the application process, etc. So for that reason, we essentially evaluated against the standard that the department had set.

Mr. Bryan Hayes: Within the rehabilitation program, that standard was also 80% being achieved, so 80% seems to be a reasonable target.

That being said, during that timeframe the department achieved 75% of that 80% target, which I think is pretty significant. You further state that it means that, of the 2,893 applicants in 2013-14, 733 veterans did not receive a decision within the 16-week standard. When you really extrapolate that, 733 weren't really expected to. If the standard was 80%, 600 were therefore not expected to receive treatment within that 16-week period. So there were really approximately 133 people who fell outside of the 80% standard.

Would that be a reasonable assumption?

Ms. Dawn Campbell: Yes. I think the other thing that has to be considered as well is that the measurement is taken at the point in time at which the application is deemed complete.

Mr. Bryan Hayes: Absolutely, and I'll get to the other stream later on.

Within those 733 people, or really the 144 who fell outside of the standard, if we were to go to section 3.29 of the report, some analysis was done and it basically said that you tracked 47 veterans who were on the waiting list, per se, and that:

> We found evidence that 17 of these veterans received mental health care while waiting for an eligibility decision.

We can sort of extrapolate from that and there is knowledge that there are another 19 veterans who you really didn't know whether they were receiving mental health treatment within DND.

Even in the worst-case scenario, 36% of those people waiting for treatment were actually receiving some form of mental health care along the way. I just want to clear this perception. Be it 733 who were waiting, or be it 1,000 who were waiting, at least 37% of those, according to your statement in section 3.29, were receiving some form of mental health treatment while they were waiting to determine their eligibility.

Mr. Jerome Berthelette: Perhaps I could make two points in response to that observation.

I think the first point is that for approximately 60% of the veterans implicated in this statistic, Veterans Affairs didn't know if they were or were not receiving services.

The other point is that getting services to individuals who have acknowledged that they need mental health services is and should be a priority of the department. As I said, when we look at whether it's the standard of 16 weeks or if we look at the number who have actually received a decision within 16 weeks, the point we should not forget is that veterans are looking for the service and Veterans Affairs needs to set up a process that allows veterans to access the services as quickly as possible.

In our view, and from what we have seen, that wasn't the case because, as we note in exhibit 3.5, to get to the 80% mark—and that is at page 10—it took 32 weeks from the perspective of the veteran who is looking for services.

Mr. Bryan Hayes: Can you give me a sense of the 16 weeks? The department can answer that.

I'm really trying to understand the benchmark from the department's perspective and from your perspective. There is no province that I'm aware of that even reports wait times for mental health services. To me, that 16 weeks or 32 weeks might be very reasonable with respect to the private sector. I did as much research as I could to actually find wait times and that is an issue with mental health across Canada, the reporting of wait times. There doesn't seem to be a benchmark.

● (1605)

Mr. Jerome Berthelette: I think it's true. I think there have been issues reported about wait times in the provincial health care system.

But in this case what we're talking about is not the provincial health care system but Veterans Affairs Canada, which has set a standard of 16 weeks from the time the file was complete. That's what we assessed Veterans Affairs Canada against. When veterans make application for mental health services that's what they expect in terms of a return in terms of the decision to get access to services.

Still, that being said, from the perspective of a veteran, for the reasons we've identified in this audit, it takes a lot longer than 16 weeks.

The Chair: Thank you. Time has expired.

Moving now over to Mr. Allen, you now have the floor, sir.

Mr. Malcolm Allen (Welland, NDP): Thank you very much, Mr. Chair.

I appreciate the comments. Thank you all for coming, by the way.

To my friend across the way whose comments were about provincial wait times, it seems to me that the dilemma in the provincial health care system is that one might go to a GP for mental health care, not necessarily to a psychologist or a psychiatrist, so no one knows how long you really wait to see a psychiatrist if your GP treats you, because quite often that's what happens.

For minor mental health awareness you go to somewhere like the Canadian Mental Health Association, around which I have a lot of personal knowledge because my wife worked for them for 25 years. Quite often there are different agencies in different places so you're not actually waiting, you're actually just going....

Mr. Berthelette, in questioning you were trying to talk about the wait times and the standards. If I understood you correctly, it's really the department that set a standard of 80%, which is really what they believe is fair or is a reasonable standard to try to maintain. Is that what you're telling us?

Mr. Jerome Berthelette: Yes, that's what I was trying to say.

Mr. Malcolm Allen: If I thought 90% was a better standard, that would be my opinion about what I think is the better standard. I'm not suggesting the department doesn't want to do 100%, Mr. Doiron, that's not what I'm suggesting at all. I understand you have to pick a number, you have to benchmark somewhere. My preference would be that you benchmark a little bit higher.

But I think Mr. Berthelette, in this particular chapter, you pointed out that although the department has said that 80% in the 16 weeks is their benchmark, for the actual client—and I will say patient in this particular case—who happens to be a veteran or a serving member, they don't see 16 weeks as being the outcome. Is that what you're telling me in page 9, at exhibit 3.4?

Mr. Jerome Berthelette: Yes, that's what I'm trying to say. We did this audit looking at the wait times from the point of view of the veteran making the application.

Mr. Malcolm Allen: To be frank, it seems to me that if I'm the person waiting for service, although a benchmark might be established internally in a department, if I wait 32 weeks, I'm 16 weeks beyond the benchmark, in my mind. Is that what this is telling me? Is that what veterans said to you when they waited 32 weeks? It doesn't say they said it exactly like that, but they said 32 weeks. They didn't seem to think they were inside the benchmark if it was double the time.

Ms. Dawn Campbell: If I can just clarify, too, the wait times we were looking at were the length of time it takes to get an eligibility decision, just so that we're not confusing that with how long a particular veteran would wait to obtain medical services.

Mr. Malcolm Allen: Yes.

Ms. Dawn Campbell: Okay, so that's just for them to get the approval—

Mr. Malcolm Allen: Eligibility.

Ms. Dawn Campbell: —so that they can then get into....

Mr. Malcolm Allen: And then they can go and get service.

Ms. Dawn Campbell: Right. So that's, I think—

Mr. Malcolm Allen: So there could be additional wait time beyond that to actually get service.

Ms. Dawn Campbell: Right. Correct.

Mr. Malcolm Allen: This just simply gets them a card, I believe, or at least a process that says they can go ahead and get service now, but then they might wait somewhere else.

Ms. Dawn Campbell: Yes.

Mr. Malcolm Allen: But we're trying not to make it look as bad as it might be. We're trying to help you.

Brigadier-General, thank you very much for your report. It was quite interesting. On page 1, down near the bottom, you have 94% of your 445 authorized mental health positions filled. I guess the question from me to you, sir, would be this. Is 445 what you need or is 445 what your budget allows?

BGen Jean-Robert Bernier: So far our assessment is that at steady state that will be what we need. That was based on a 2002 study. We're reviewing it all based on the Canadian Armed Forces mental health survey of 2013, where we're still doing lots of analyses with regard to it. But there will always be surges, ups and downs, depending on demand. So the more successful our stigma reduction measures are to bring people in for care, that's when we'll increase wait times, where we'll overwhelm elements of the system. We're working on a number of measures I've mentioned to try to deal with these surges, but we will always have a gap. We'll never achieve the full 445—

Mr. Malcolm Allen: I just need, sir, to jump in between that because the chair will cut me off at the time limit.

I want to actually be clear here. It's 445 authorized spaces based on a 2002 survey. Is that what you're telling me?

● (1610)

BGen Jean-Robert Bernier: That's right.

Mr. Malcolm Allen: You have a new one that's done, but you haven't actually decided what those authorized positions would be based on the new piece. Is that correct?

BGen Jean-Robert Bernier: Right. There have been incremental increases over time as a result of various other studies conducted during the operations in Afghanistan, and subsequent to that over the last couple of years based on tweaking the numbers that we deem required to address the demand.

Mr. Malcolm Allen: But have you ascertained the number of positions you actually need based on that new study? Has that been determined?

BGen Jean-Robert Bernier: No, the analysis is still going on. There are about 50 subanalyses going on in that study.

Mr. Malcolm Allen: Sir, I recognize this is a tough business. I mean, it is. I can sympathize with you. But clearly we're trying to figure out what the numbers are. It's not easy; you get surges.

The other piece that was interesting here around the numbers issue was that when you had long-term absences, whether that be parental, maternal, long-term sick, you didn't seem to have the buffer to cover that. Is that what you told me here?

BGen Jean-Robert Bernier: No. We have a network of anywhere from 4,000 to 6,000 external mental health providers. When a psychiatrist or a psychologist is not available, nobody is not getting mental health care. Everybody from day one, if it's an urgent requirement, sees a psychiatrist or psychologist the same day. But they are all under primary care, and up to 85% of all mental health care in Canada is provided by primary care physicians. So they're all seeing and having access to addiction counsellors, mental health nurses, primary care physicians, in addition to sometimes general mental health psychiatrists and psychologists.

So the fact that there's some delay before getting a detailed assessment by a subspecialized operational and trauma stress support centre doesn't mean that they're not getting good mental health care. In many cases, the OTSSC specialists simply confirm the treatment plan that's already been put in place by the primary care people. All of those patients are constantly being triaged and reassessed, so if at any time their condition changes and requires more urgent, subspecialized assessment, then they get it, the same day if necessary.

The other thing is that those numbers, the 445, is double what we had before. We were ready even before Afghanistan began, and we've modified those numbers over time. It's the highest per capita ratio in NATO and close to double the per capita in any jurisdiction in Canada. Just a few years ago, we were spending roughly about six times per capita more on the mental health care of our troops than any other jurisdiction.

The Chair: Thank you, time has well expired.

Over now to Mr. Woodworth, you have the floor, sir.

[*Translation*]

Mr. Stephen Woodworth (Kitchener Centre, CPC): Thank you very much, Mr. Chair.

Good afternoon. I would like to welcome our witnesses and thank them for being with us today.

[*English*]

I hope that you will be able to tell from the number of Conservative members present here today how much interest there is on our side of the House on this particular issue and how much concern for veterans.

I'll begin with the fact that I have some worry that members of the public have been left with the impression over the last number of months that a lot of veterans who apply for mental health disability benefits have to wait many months before they receive mental health support from any source. That's not really what your report said, is it, Mr. Berthelette?

Mr. Jerome Berthelette: No, sir, it isn't.

Mr. Stephen Woodworth: In fact your report, particularly at paragraph 3.19, found that veterans who apply for mental health disability benefits have access to mental health support on a timely basis from quite a few other programs. Isn't that correct?

Mr. Jerome Berthelette: Mr. Chair, as we've noted in paragraph 3.19 and to be fair to Veterans Affairs Canada, Veterans Affairs Canada has put in many supports, the ones we've noted here in particular, for veterans in need of health support. That's right.

Mr. Stephen Woodworth: Even, for example, Veterans Affairs Canada assists veterans in accessing mental health support from provincial health programs, isn't that correct?

Ms. Dawn Campbell: Sorry, can you repeat the question?

Mr. Stephen Woodworth: Veterans Affairs Canada will assist veterans in accessing mental health support through provincial health care programs, is that not correct?

Ms. Dawn Campbell: Where that's appropriate, yes....

Mr. Stephen Woodworth: Your report, your study, didn't find any issue about timeliness in that effort did it?

● (1615)

Ms. Dawn Campbell: We didn't look at the provincial side of health care.

Mr. Stephen Woodworth: I would be worried if you had found a problem, but if you didn't look at it, didn't find a problem, I'm okay with that.

Also, Mr. Berthelette, you mentioned in your opening comments the 24-hours-a-day, seven-days-a-week mental health helpline that the department operates to give immediate assistance to veterans in crisis. There are no timeliness issues about that mental health support for veterans, are there?

Mr. Jerome Berthelette: No, sir, there are none.

Mr. Stephen Woodworth: Also as I understand it, you found that veterans can access short-term mental health supports in a timely way under the veterans affairs rehabilitation program. Is that correct?

Mr. Jerome Berthelette: Mr. Chair, the rehabilitation program is a separate program and we found that the decisions related to eligibility met the standard the department had put in place.

Mr. Stephen Woodworth: Perhaps I will ask you, Mr. Doiron. The short-term mental health supports under the rehabilitation program if needed.... If somebody said to me that they won't last the eight months or more that it might take for the disability benefits eligibility decision to kick in, would that be right or wrong?

Mr. Michel D. Doiron: There would be services available to them within that eight months.

Mr. Stephen Woodworth: So rehabilitation program benefits, if needed, can last for that length of time?

Mr. Michel D. Doiron: It can and if they are in a crisis or anything we would refer them to either one of our operational stress injury clinics or to provincial mental health centres.

Mr. Stephen Woodworth: What about the services provided, Mr. Doiron, under the short-term mental health supports of the rehabilitation program? Are they capable of meeting the needs of veterans until an eligibility decision under the disability program kicks in?

Mr. Michel D. Doiron: Yes, they are.

Mr. Stephen Woodworth: All right.

Mr. Berthelette, did your study find any evidence that would contradict what Mr. Doiron has told us, that the rehabilitation mental health supports are capable of meeting the needs of veterans for that pre-eligibility period under the disability plan?

Mr. Jerome Berthelette: I think to be clear we have to make a distinction between the rehabilitation program and the disability program. The rehabilitation program is not a bridging program into the disability program. It stands on its own two feet, so to speak. It has its own eligibility requirements. It has its own objectives and they aren't shared with the disability program. A person who wants to access a disability program would not necessarily access the rehabilitation program as an interim step because they're two separate programs.

Mr. Stephen Woodworth: Not necessarily but certainly could, isn't that correct? They're not mutually exclusive.

Mr. Jerome Berthelette: Except—

Sorry, Mr. Chair.

The Chair: You many answer that but then the time has concluded.

Mr. Jerome Berthelette: Except that the goal of the rehabilitation program is not to be a bridging program, it's to assist in the transition to civilian life.

Mr. Stephen Woodworth: We'll come back to that.

The Chair: Thank you.

Moving along, Monsieur Giguère, you have the floor, sir.

[*Translation*]

Mr. Alain Giguère (Marc-Aurèle-Fortin, NDP): Thank you, Mr. Chair.

It goes without saying that mental health disorders are a major problem. Since 2004, 168 members of the military have committed suicide. In addition, of the 2,620 veterans who have died, 696 committed suicide. Therefore, 27% of former members of the military who died committed suicide. It would seem that mental health problems are five times more deadly than the Taliban.

We should be asking ourselves a number of questions, particularly concerning section 3.7 of the report, which states that members of the military often fear declaring an illness because it might threaten their career.

The Canadian armed forces recently adopted a series of positions that seem to harm those who make these requests, particularly veterans who fought in Afghanistan.

Is it possible to avoid penalizing people who wish to access mental health services in the Canadian armed forces, by simply letting them go, for example, a few months prior to their retirement? Do you have control over this type of situation?

● (1620)

BGen Jean-Robert Bernier: Individuals with mental health problems are kept in the Canadian armed forces for a long time. They sometimes remain there for a number of years before employment restrictions are placed on them that no longer allow them to pursue military service.

If they are kept in their position as soldiers, we may not be doing them any good. In fact, putting them in a situation where they would relive operational stress could worsen their condition. It could very well kill them.

In those cases, they need to be provided with ongoing access to the best health care offered in Canada. Authorities from mental health organizations have told the Department of National Defence and Veterans Affairs Canada that they need to be provided with Cadillac care.

Mr. Alain Giguère: I would like to ask you a question on this issue.

Do you know whether the 168 members of the military who committed suicide were receiving treatment?

BGen Jean-Robert Bernier: We are the only organization in Canada that conducts a complete analysis of each suicide, on a case-by-case basis. Our analysis shows that roughly half of the individuals who committed suicide were receiving treatment. This data is similar to data for the general public. The other half was not receiving treatment. On the one hand, treatment is insufficient and more research is needed. On the other, there is still work to be done to encourage individuals in this other half to ask for care.

That being said, only one third of the suicides that have unfortunately occurred since the beginning of operations in Afghanistan occurred in that country. This means that most of the suicides were caused by the same problems affecting the general public. Whether members of the military participated in operations or not, the suicide rate remains the same.

Mr. Alain Giguère: Thank you.

If I understand correctly, you have analyzed the situation to determine whether waiting times had an effect on morbidity, and you concluded that this was not the case.

BGen Jean-Robert Bernier: For each suicide, a psychiatrist and a general practitioner conduct an in-depth analysis. However, in no case did the timeliness of care or the waiting time have an impact on the suicide. These were either individuals who were not receiving treatment because they hadn't asked for it, or people who were receiving good care, as is often the case in the general public.

Mr. Alain Giguère: My next question is for Mr. Doiron.

In sections 3.10 and 3.2, the report deals with delays of favourable decisions with respect to applications for disability benefits. In 20% of cases, individuals must wait more than a year, which is a major delay. For the remaining 80% of cases, who receive their disability benefits within a one year time frame, there may be a wait of 11 months, which is an enormous delay.

Could this situation contribute to crime, self-harm, or spousal violence? Among the individuals who have applied for this disability benefit, how many are now homeless?

Mr. Michel D. Doiron: Our analysis does not go that far, but I agree with you that one year is too long of a wait. That's why we are trying to implement procedures that ensure that appropriate care is available much faster. These are individuals who are waiting a year before receiving psychological care. However, studies show that there could be long-term impacts. Furthermore, recovery can take longer.

With respect to your question, I don't have specific data available.

Mr. Alain Giguère: The department...

[*English*]

The Chair: Sorry monsieur, time has expired.

Moving over to Mr. Albas, you have the floor sir.

Mr. Dan Albas (Okanagan—Coquihalla, CPC): Thank you, Mr. Chair, and thank you to all of the officials here today. Certainly this is an important topic, and I do appreciate what you do for our veterans.

First of all, let me start with the Auditor General's department.

Assistant auditor general, there was a mental health action plan that was put forward by the government as a response the very day that the Auditor General tabled this report, “Mental Health Services for Veterans”.

Have you viewed the action plan? Have you made a comparison with your recommendations? Does the action plan substantially meet the vast majority of the recommendations?

● (1625)

Mr. Jerome Berthelette: We appreciate the fact that the department has put the action plan in place. However, we'll make no comment on the action plan until such time as we have conducted an audit and followed up on the action plan in that manner.

Mr. Dan Albas: Okay, but does the action plan seem to address areas of the recommendations that were raised in your report?

Mr. Jerome Berthelette: We do our work on the basis of audits.

Mr. Dan Albas: Sure. I just wanted to see if that is something... because the government, obviously, has spent a fair bit of time to make sure it's a complete list. We have a copy of it here today.

Changing gears, I'd like to talk to some of the other officials from DND, as well as from Veterans Affairs.

We recently conducted a study on transnational crime. One of the unique aspects of the report that came out of that was the impact the Privacy Act can sometimes have on process.

Sometimes, there are things within the government's ability to control. Sometimes there are limitations on government put in place by the Privacy Act for very good reasons, but which may cause, you know, unintended consequences. Mr. Hayes has raised the point that, sometimes, we could look at simplifying some of the forms that Veterans Affairs uses to get these applications done sooner.

Could you please speak to the Privacy Act, and whether or not that could sometimes provide a challenge in getting files and histories from DND, and what kinds of constraints that puts on your ability to process these files quickly?

Mr. Michel D. Doiron: Thank you for the question.

I'm not sure that I would quantify the Privacy Act as a detriment to the service. I'd be careful saying that because it's there for a reason as you've highlighted, sir. But we have seen that in the exchange of information between DND and VAC, we have to comply with the Privacy Act. When we do, it does create additional challenges to getting the information, especially when reviewing the personal file of a veteran where there's some good recent, third party information. We have to comply.

The Privacy Act says you can only share for the reason that you've taken the information. Therefore, we do need releases and we do need permission to share that information. It therefore adds, I don't want to say a delay, but it does add a step in the process where my partners at CAF have to redact a file prior to providing it to Veterans Affairs to process a disability claim, or anything else that we may do with the file.

We work with it. We comply with the Privacy Act. We feel very strongly that it's important, but it does sometimes cause us some additional steps in the process.

Mr. Dan Albas: Chair, maybe I should clarify. I don't view the Privacy Act as being detrimental, but it does have an impact, I think, on the overall process. There are certain things that we can control, and there are certain things that we can make more efficient.

I do know that the Brigadier-General had mentioned business practices, and always being open to being innovative, and making it more and more efficient. That being said, this is not just a typical business enterprise. There are limitations enshrined in law, such as the Privacy Act.

Brigadier-General, is there anything that you'd like to add or comment?

BGen Jean-Robert Bernier: Just that the protection of the confidentiality of the health information of our troops is critical, vital ground for us.

If our troops, especially those with sensitive conditions like mental health conditions have the slightest concern that we are not strictly protecting their confidentiality, and completely complying with all elements of the Privacy Act strictly, then we run the risk of those people suffering from mental health conditions, who are already vulnerable, not presenting for care and their conditions getting worse and worse until, in some cases, they'll commit suicide.

Strict compliance with the Privacy Act is absolutely critical for us. But it does pose some delay because we necessarily have to have the consent and we necessarily have to do the severances for any third party information. Often with psycho-social or mental health issues there are third parties involved in the notes, in the files, that have to be extracted before they can be legally and ethically transferred to another authority that serves a different government purpose, in the interest of the individual.

Mr. Dan Albas: Okay. Thank you very much.

The Chair: Okay. Moving over we now go to Mr. Valeriote. Welcome, you're not a regular member of the committee, but we're glad to have you here today, sir. You now have the floor.

Mr. Frank Valeriote (Guelph, Lib.): Thank you, Chair.

Thanks, everyone, for appearing before us.

Mr. Doiron, I'm going to speak directly to you.

It's nice for certain members to bring forward the successes, or partial successes or efforts on behalf of VAC, but I have to highlight the failures, sir, just so you know.

We've had $1.13 billion in cuts retracted from Veterans Affairs that must have put some pressure on Veterans Affairs Canada in providing the services it needs. We closed nine Veterans Affairs offices, and there's been a huge impact and a huge response by the Canadian public, particularly veterans. We know from the Auditor General's report that over 15,000 applied for those benefits and we know that 24% were denied, and of that about a third appealed.

I think about how difficult it is for somebody to come out from under the cloud or the shadow of mental illness and come forward and actually seek help. Of those who appealed, 65% were successful. I think about the ones who gave up, who didn't appeal. Not just as an MP but as a person, I automatically think, my God, there must be a culture of denial at the veterans appeal board, at any level there, and not a culture of “give these people the benefit of the doubt”, those who were prepared to and do put their lives on the line and who suffer the ultimate liability.

I'm concerned, Mr. Doiron, that we are not responding.

Last year we presented a report—and Mr. Hayes was on the committee—to the then Minister of Veterans Affairs who accepted everything but virtually did nothing.

My first question is this. You said 50% of the 168 who died by suicide were not self-identified. Can you tell me if any of the 50% who were not in treatment were any of the ones who were denied treatment but had applied? Before you answer you could give some thought to this, Mr. Doiron. It says the Auditor General recommended VAC “work with the Veterans Review and Appeal Board to identify whether reasons for successful reviews...indicate a need to modify the application process.”

I'd like to hear from you about that and I want to know what's happening now, not what you will do, because we've been hearing a lot of “wills” but not a “now”.

You can go first, Brigadier General.

● (1630)

BGen Jean-Robert Bernier: While still serving in uniform, the short answer is no. We drag people in and we do everything we can. We have multiple mechanisms across the armed forces to bring people into care—

Mr. Frank Valeriote: Sorry to interrupt.

I understand but I'm talking about the veterans who had taken their own lives.

BGen Jean-Robert Bernier: We don't treat veterans.

Mr. Frank Valeriote: Mr. Doiron, can you give me that answer, then?

Of those who died, of the 168, how many had sought benefits and were denied? You don't know. Do you keep track?

Mr. Michel D. Doiron: No, they were Canadian Armed Forces; they were not veterans.

Dr. Cyd Courchesne (Director General of Health Professionals and National Medical Officer, Department of Veterans Affairs): Those were military members.

Mr. Frank Valeriote: So there's no.... I'm talking about the veterans who died by suicide.

Dr. Cyd Courchesne: But the number you're quoting is not the veterans. It's the serving military members.

Mr. Frank Valeriote: Can you tell me of any of the veterans who died by suicide, had they applied for and were denied? You don't keep track. Okay.

Then can you answer my second question?

Mr. Michel D. Doiron: Absolutely, sir.

We have taken a lot of steps to improve, following and at the same as the Auditor General was in with us reviewing it.

As an example, we have simplified the application process for mental health but also for all our application processes for disability. We went from an 18-page form—and I know 18 pages is incredible. I've only been here a year and I'm reviewing all forms, and our forms are complex. We're down to 11, and you say that's not much better but the form itself is four pages and it includes a quality of life. The other part of the package is information. That was implemented in October. It has been done. We're now doing a secondary review to see if we can simplify that even further.

On mental health, we've implemented an accelerated, evidence-based process for PTSD or for mental health. Now, when we speak of mental health, 72% of our cases are PTSD. But it's not only PTSD. We have various cases.

We've had about 250-odd applications to date under this new model. It is done at a lower level closer to the veteran. It is much quicker. It is an accelerated process so we get that answer quicker to the veterans so we can get them into care much faster.

Mr. Frank Valeriote: Can I ask you another quick question?

We lost the equivalent of 949 front-line workers. We know that the caseload is about 40:1 for the case workers. That's increasing in certain areas where back offices have been closed. For instance, in Sydney, they now have to go to Halifax.

You talk in your report here about a number of people who will be hired. Can you tell me specifically what financial resources you've been given to hire more people, the exact number you are hiring, and where they're each going to be deployed?

● (1635)

Mr. Michel D. Doiron: I cannot give you that number.

We have hired five to date, five additional case managers. The additional are not all in the areas where the offices were closed. We have to be very careful. Ottawa is a high-volume area for obvious reasons. There are a lot of military in the greater Ottawa area.

We are adding resources. I've been instructed by my minister and by my deputy minister to go ahead and risk-manage those resources and add the resources I think we need in the areas where we need them. We are doing that presently. There was a public selection process about a month ago. We have 600 applications for case managers and 600 applications for client service agents. We are now going through the phase of evaluating them.

I want to be clear. When you said 40:1, you are correct. In some areas it is higher than that. You are totally correct.

Mr. Frank Valeriote: The average is 40:1.

Mr. Michel D. Doiron: That is average. The actual average in the country is about 34:1. Our target is 40:1. Our office is very much on the average.

It fluctuates. As the Brigadier-General also mentioned, our volume will fluctuate from month to month or from year to year. Unfortunately, we have case managers who are carrying more than 40:1. That is a fact, and we are tracking that closely.

The Chair: Thank you.

Moving along, we'll go to Vice-Chair Carmichael. You have the floor, sir.

Mr. John Carmichael (Don Valley West, CPC): Thank you, Mr. Chair.

Welcome to our witnesses today. Thank you for joining us.

I'd like to shift the focus a little bit to information flow and talk about some of the causes of the delays that are inherent in the process. I'll start with Mr. Berthelette, and then, Mr. Doiron, perhaps you could offer a few thoughts of your own.

Mr. Berthelette, you identified in the audit report delays in the disability program. I wonder if you would be able to confirm whether the primary cause of that delay is the transfer of records from National Defence and CAF to Archives Canada and Veterans Affairs. It is my understanding that this process could take up to nine weeks. I understand privacy and the Privacy Act, etc., but I wonder if you could talk about some of those delays and how they impact the process.

Mr. Jerome Berthelette: I would make reference to paragraph 3.35 of the audit, in particular the last sentence. It says, “Officials advised us that the time frame for transferring records has improved from 18 months to approximately 16 weeks.” The transfer of records can add up to 16 weeks, approximately, to the time it takes for a file to be complete.

Mr. John Carmichael: Mr. Doiron, if....

Mr. Michel D. Doiron: The transfer of the records was at around nine weeks for us to get them from the Canadian Armed Forces. It's not all because of privacy. I want to be clear. They do have to cull the information. They do have to make sure that there is no third party information and that we comply with the Privacy Act. That's very important to all of us.

Some of the files, and the Brigadier can explain that much better than I can, are held on bases across Canada, and the veterans will have both an electronic file and a paper file, depending on how long they've served and where they've been. Those files have to be taken from the bases, sent to our central area in Ottawa, where we work together—we have people from both departments working in that area—and then transferred to the disability area.

It was taking about nine weeks. They've added resources and that has come down. I don't have the latest number.

BGen Jean-Robert Bernier: The news today is five weeks.

Mr. Michel D. Doiron: I knew it had come down.

Mr. John Carmichael: That's certainly an improvement and shows good signs of meeting the objective of process improvement.

Mr. Berthelette, in paragraphs 3.65 and 3.66 of the audit, you talk about the client-reported outcome monitoring information system, CROMIS, and its development. I wonder if you could speak about what we are going to see in terms of improvement and treatment of our veterans by the application of this particular system.

● (1640)

Ms. Dawn Campbell: Thank you. I think I'll ask Michel to follow up on my response because I think he has more of the details.

CROMIS is being piloted and it's going to be rolled out to a broader audience. It was our perspective that this was a good initiative and it holds promise.

Mr. Michel D. Doiron: I'll start and I will pass it over to my doctor expert beside me.

CROMIS is an outcome-based system that tracks not the name of the individual but what type of care we're giving them and what the outcomes are. CROMIS is recognized internationally and the doctor who works for us, who works for Dr. Courchesne is speaking about it internationally because not many other organizations are doing what we're doing with CROMIS and saying, “Did this treatment work for this area?”

We are expanding it to all our clinics. We did have a bit of a push-back initially in the Quebec region from some psychiatrists who weren't very comfortable. We're okay now. That's okay; it's done. Our colleagues at CAF are now implementing or have implemented the same tools.

Doctor, do you want to add something to that?

Dr. Cyd Courchesne: CROMIS has been implemented and rolled out in all of our OSI clinics right now. We're expecting first reporting results in the first quarter of the next fiscal year.

What CROMIS does, if I can simplify it, is a little bit like monitoring your blood sugar. It's monitoring the vital signs of mental health. With this system we can demonstrate that there are improved cure rates, less time in the system, and fewer people who relapse.

We're very excited about the rollout of the system, what we'll be able to learn from that to be able to improve our treatment programs, and sharing that information with our colleagues at the Canadian Armed Forces because we'll be using similar systems to compare.

The Chair: Very good. Thank you. Time has expired.

Back over to Mr. Allen. You have the floor again, sir.

Mr. Malcolm Allen: Thank you, Chair.

Mr. Berthelette, in looking through your chapter that the Auditor General's responsible for, I found the conclusion. This clearly wasn't a snapshot of 10 years ago. This is more recent in a sense. It took a period of time, for sure. You looked at a large period of time but it also includes very recent data.

One of the recommendations is what has given us CROMIS, quite frankly. Prior to that, according to the Auditor General's report, you had a mechanism for looking at things but not measuring them. So you didn't actually measure outcomes, you just had outcomes. We now see...which is a good thing. It will now measure outcomes.

We're now going to see them next year, I believe, Dr. Courchesne. Is that what we're looking at, the first quarter of next year when we actually get those metrics of that kind of measurement?

Dr. Cyd Courchesne: By July 2015.

Mr. Malcolm Allen: Okay.

In 3.68, Mr. Berthelette, your conclusion—let me just read it—says:

> We concluded that Veterans Affairs Canada is facilitating timely access for veterans to the Rehabilitation Program.

Kudos, Mr. Doiron. We should point that out.

But unfortunately that's the smallest component of your overall program. It runs to about a total of 18%. Therefore, 82% is in the other part of that statement, which says:

> Access to the Disability Benefits Program, through which the majority of veterans receive long-term mental health support, is not timely.

That's a bit of a failing grade, unfortunately

But I want to turn specifically, Mr. Berthelette, to the issue of folks who actually went into the appeal process. My colleague has already pointed out the fact that a number of folks decided not to, for whatever reason. Either they were fed up with the system or they just felt, “Well, perhaps I don't need the services so I'm not going to bother.” We don't know. I don't think the department knows. I don't think you probably track those. I see Mr. Doiron saying no. I'm not asking you to track them, by the way. If folks don't do things, they don't do things.

What's interesting in this is the length of time that a denied veteran ended up having to wait to get service unless, of course, they went and got private service. Now, they may have done that. I'm not suggesting that may not have happened. In some cases they may have gone into the public system and said, “I need some help,” or they went and paid for it, or did whatever. They may have done that.

But the dilemma here is that the Auditor General's report talked about the fact that the wait times exceeded your benchmark, and for those who were successful, the length of time it took at the outside was up to seven years. That appeal was successful. That is a catastrophic amount of time to wait to be told, “You're successful.” How does that happen, Mr. Doiron? How does it happen that we end up with a system that takes seven years potentially for a veteran to actually get through the appeals process to get what turns out to be a “yes”?

● (1645)

Mr. Michel D. Doiron: I don't want to talk about the case in particular because—

Mr. Malcolm Allen: No, of course not. I would never ask you to do that, sir.

Mr. Michel D. Doiron: Veterans Affairs offers multiple levels of appeal rights to an individual. You can appeal at the first level. At the second appeal, you go to the veterans review board. You can actually go to the Federal Court. In all my 25 years in the public service, I don't think I've seen any other organization that not only offers so many levels of appeals, but where we actually pay the lawyer to represent the individual—

Mr. Malcolm Allen: Sir, listen, I don't get very much time. I appreciate multiple levels of appeal. Whoever this particular case was, it was ultimately a yes, that you should provide the service. What I'm saying to you, sir, is that even though there are multiple levels of appeal, and you pay for this and you pay for that and it's all wonderful, the bottom line is that whoever that serving member was didn't get service. Basically, if they had gotten the benchmark of your 16 weeks, which really is 32...but it was seven years. Let's do the math: seven times 52. It's a lot of weeks. It's way past your benchmark.

How is it that a system that eventually says “yes” would have taken seven years to get to a yes? What was systematically missing in your system? Because ultimately, it's about medical information. That's what we're looking at, mental conditions and a mental health issue that is actually and literally an illness.

We're looking at how you prove you have an illness and how you prove that you actually got it when you were serving, right? There are two components. I used to do WSIB cases. There are two components in all of this. First, did you get hurt at work? That's where you are serving. That's your workplace. Second, do you actually have that particular illness? That's what you have to prove to get service.

It took seven years, sir, for this serving member who's a veteran in this country to get a yes. How did the system fail—in my view—that veteran? Have we seen the weaknesses in it to make sure that it doesn't happen again?

Mr. Michel D. Doiron: In this case, we have reviewed to make sure that type of weakness does not occur, but you are right, sir, there are two areas. Usually it's not the illness. The doctors tell us what the illness is. That's pretty clear. The big challenge we have is service relationship. We have to remember in Veterans Affairs legislation, to open that door, it has to be linked to your service. There are exceptions, but typically it is that service.

Often, for a veteran to prove this, especially in an area where files were not really completed, or people did not report injuries.... We know that our older veterans did not necessarily report that they injured a knee or whatever it may be. The files are incomplete. We have to follow legislation that stipulates, as you know. If there was no documentation and the individual cannot provide documentation at one of the levels of appeal, then you go into a long period of time.

At some point, documentation was provided, but seven years...I agree, it's a long time.

The Chair: Thank you. Your time has expired.

Mr. Aspin, you have the floor, sir.

Mr. Jay Aspin (Nipissing—Timiskaming, CPC): Thanks, Chair.

I welcome our guests for this important testimony.

I think it's important that the public is aware of this, so my first question is to you, Mr. Berthelette. Just to confirm, sir, if a veteran is in need right now, right now at this instant, is there help available to them? Could you also confirm what your audit team found for emergency or critical cases? I think it's important that veterans and their families who are listening know this.

● (1650)

Mr. Jerome Berthelette: Mr. Chair, I think the answer to that question is a little difficult, because we didn't audit as widely. As the question implies, the answer would be that an individual who is having a mental health crisis does have access through the provincial system to some crisis care. It is available in the provincial system. That doesn't necessarily mean they know where it is or how to access it.

When we talk about the two programs we looked at, there is an application process that the serving members or the veterans must go through in order to be eligible to access mental health services. Are they able to access services right away? In some cases, I think it's fair to say not directly through the program—I'll ask Mr. Doiron to respond specifically to that—but there are other programs we have mentioned here, like the 24-7 program, for instance, which provides support that is available right away.

So there are supports out there that are available right away. That's true.

Mr. Jay Aspin: So can you confirm that? Because there is a perception out in the public that some of these veterans.... In fact, my good friend Mr. Valeriote mentioned that there are a lot of “wills” and not a lot of “nows”. Can you confirm that there are nows and that these people are taken care of?

Mr. Jerome Berthelette: I think I confirmed that there are some nows available for mental health services to veterans, but I can't say that they are in fact taking care of it. I don't think.... I can't speak for Veterans Affairs, but from what we saw, I don't think Veterans Affairs can state that they are actually receiving services.

Mr. Jay Aspin: You can't confirm that they're taken care of right now.

Mr. Jerome Berthelette: Right now.

Mr. Jay Aspin: In your estimation, there's a lot of people being cast off?

Mr. Jerome Berthelette: I think that in this area, as we say, there are people who may not understand where services are available to them, what services are available to them, and how to access some emergency services. I can say that.

Mr. Jay Aspin: I'd like to pose that very question to Mr. Doiron.

Mr. Michel D. Doiron: I'm going to be a little bit more categoric. I think the services are there.

We link disability benefits to mental health services, and I think we have to be very careful when we do that. The disability benefit—the 16 weeks, the 32 weeks—for sure, it opens the doors to many services for a veteran.

That said, there is a lot of other support available to a veteran. We have the crisis line, which will give them 20 sessions with a psychologist. You can call 24-7. You will get to meet a psychologist. There are peer networks, such as OSISS, where a veteran can talk to a fellow veteran who has been where this individual man or woman has been. The services are there.

First and foremost, we can't forget that we have national health care in Canada. Any one of these...and actually, we're not a 24-7 operation at Veterans Affairs, so when we have a crisis at two in the morning, my counsellors—I do have people on phones—call 911. Any veteran that is in a crisis, the national safety net is there to take care of them.

Now, if you talk purely about Veterans Affairs programming, the one about the 20 sessions is with us. OSISS is with us. We use the services of our colleagues in the CAF for veterans. They are available to help veterans also. They have full-time psychologists, psychiatrists, and things like that.

The review looked at the disability process. It is 16 weeks, and 32 weeks from the view of veteran. We agreed with the OAG on that. I think we have to be careful, because there are services—not that everybody would take those services, as there's still the stigma. I'm not going to...but the reality is that there are services available to a veteran.

The Chair: Sorry, Mr. Aspin. Your time has expired, sir.

We're moving back over to Mr. Valeriote.

You have the floor, sir.

Mr. Frank Valeriote: I'd just like to know.... We got two contradictory answers to Mr. Aspin's question. Mr. Berthelette said there are services that aren't there, and Mr. Doiron says there are services that are there, but I'm not going to pursue that line of questioning.

You'll recall the earlier question I asked about the faults with the Veterans Review and Appeal Board and how long it takes, etc. I would have thought that you would have, in addition, sought the opinion of veterans themselves. I know you're waiting for this question, Mr. Doiron, because you know there was a survey done in 2010, and we had a drop in satisfaction from 80% to 68% for those who served in Afghanistan.

Now we're not even seeking the opinions of veterans. In fact, not only are we not seeking them, but there are a lot of stakeholder veterans who want to express their opinion and are no longer considered stakeholders by this minister, because, in my opinion, respectfully, sir, he doesn't want to hear from everybody. He typically prefers to hear from people who—

● (1655)

Mr. Dan Albas: On a point of order—

The Chair: Sorry, Mr. Valeriote, hang on. We have a point of order. Let me deal with it.

Stop the clock.

Mr. Albas.

Mr. Dan Albas: I don't like doing this to any guest, but really, Mr. Chair, the point of order I'm raising is on relevancy. We have the Auditor General's staff here today to speak specifically to the content of this report and officials who are here today to speak specifically to the content of this report. While I know that Mr. Valeriote has many opinions on veterans, we are studying this report, and hopefully he would be so good as to come back to the actual issue, not personalities. This is about veterans. This is about their concerns specific to this report.

Mr. Frank Valeriote: With respect, Chair—

The Chair: Yes, go ahead.

Mr. Frank Valeriote: —I think it's quite relevant as to what appears to be a prevalent attitude of the government in not really wishing to consider the opinions of the veterans themselves. I get veterans who come to me. I can't tell you how many. I know that Mr. Stoffer typically gets veterans coming to him by the hundreds complaining that they're not being heard, that their concerns are not being heard.

Having said that, I'm happy to withdraw that particular comment, continue on, and return to what you might consider relevant, Mr. Albas.

The Chair: There we go. I love it when problems solve themselves, which this one just did.

Please continue.

Mr. Frank Valeriote: What I do consider relevant is that the survey would be an appropriate tool with which to obtain opinions from veterans. I'm wondering when and if that survey will be introduced, and if not, why not?

Mr. Michel D. Doiron: There are no plans that I am aware of at the moment to reintroduce the survey, so I can't answer for the future. It's something we'll have to discuss.

However, we are using a different tool to assess our services. It's the Life After Service Survey, which is more scientific and more evidence-based. It's public. It's on the website. It does identify and has identified some of the issues. We now know who is struggling more with transition: the combat arms, and junior NCOs, and things like that. We can start with this evidence and improve our programs.

I talk to stakeholders on a regular basis, sir. Today I talked to one group. But when it comes to that actual survey, there are no plans that I'm aware of.

Mr. Frank Valeriote: Mr. Berthelette, I'm wondering, as you are from the Auditor General's office, whether you would think that this kind of survey of which I speak, which used to be sought by Veterans Affairs but has not been recently sought, would assist Veterans Affairs in better addressing the culture or the difficulties they're having in processing applications, particularly the difficulties that the veterans themselves are having in processing them.

Mr. Jerome Berthelette: Surveys are a valid tool that can be used by departments to measure effectiveness and to gather other forms of information.

Mr. Frank Valeriote: You might recall Jenny Migneault, who attempted to get the attention of our former Veterans Affairs minister, Julian Fantino. I spoke to Jenny. Her effort really was to try to allow the engagement of spouses in the treatment of a veteran, because they are often affected as well. I'm asking again, Mr. Doiron, can you tell us of any programs that are available in which the spouse, or the children, or the parent, are actually involved in the treatment of a veteran suffering from PTSD?

As well, given our request last year in our report from the committee that those services be available to more than the veteran, that they be available to the spouse, common-law or otherwise, to the child, or to the parent, can you tell us how much has been done since then in order to address those issues and the specific request of Jenny Migneault?

● (1700)

Mr. Michel D. Doiron: I will not talk about the request from Madam Migneault because these are private files, and I will not discuss any of our veterans' files. I apologize, but....

The Chair: You don't have to apologize.

Mr. Michel D. Doiron: Thank you, sir.

Mr. Frank Valeriote: Can you speak about requests like that generally for spouses to be involved?

Mr. Michel D. Doiron: Absolutely, that part I can. We have added families, because it's a scientifically proven fact with mental health issues that having the family involved—the spouse, the children, the caregivers—often helps in the treatment of the individual.

Our 20 sessions that I talked about are open to family members, not just the veteran. They don't even have to be diagnosed. They can call and get the services just like any veteran. That is effective today. Our OSI clinics encourage families to come, if it's comfortable. It's a family decision. It's not the psychologist or psychiatrist. It's a family decision, right?

Mr. Frank Valeriote: What if it's not the veteran—

The Chair: Mr. Valeriote, I'm sorry. Your time has expired.

Mr. Woodworth, you now have the floor, sir.

Mr. Stephen Woodworth: Thank you very much, Mr. Chair.

Mr. Doiron, I want to reassure you again, as the chair has said, that you need not apologize for refusing to answer an inappropriate question requiring you to divulge information about a constituent. In fact, the member who asked that question should be apologizing to you.

I also want to address what I believe is a mischaracterization by Mr. Valeriote when he says that there have been two contradictory views offered to us about services: one saying that there are services there, and another saying that there are services that are not there.

Mr. Berthelette, I don't believe you have said that there are services that are not there. In fact, I believe that your report, particularly in paragraph 3.19, says exactly the opposite and reviews the mental health services that are available for veterans. Am I correct in that?

Mr. Jerome Berthelette: Just so I can be absolutely clear, there are services available to veterans outside of the two programs. Some of these services are emergency-type services. We didn't audit those services, so I'm unable to tell the committee whether people are utilizing those services or whether they know those services are available.

Mr. Stephen Woodworth: That's perfectly fine and accurate. I'm certain that if Mr. Valeriote thinks about it for a few minutes he'll see fit to retract his mischaracterization.

I'd like to go back to where Mr. Giguère left off with Mr. Doiron some time ago, and that's the point that in fact veterans shouldn't have to wait a year to receive mental health supports. I just want to be clear, because as I understand it, we have operational stress injury clinics, we have case management services, we have the 24-7 line, we have the operational stress injury social support program, we have the rehabilitation program, we have in fact mental health supports provided by the service income support insurance plan.

With all of those opportunities out there, Mr. Doiron, is there any reason why a veteran would have to wait a year if he or she asked for mental health supports?

Mr. Michel D. Doiron: No, sir.

Mr. Stephen Woodworth: That's what I thought. Thank you.

To go back to where you and I left off when I ran out of time, Mr. Doiron, I think I heard you tell me that the rehabilitation program is capable, if needed, of providing necessary mental health supports for veterans through a wait period that might be as long as eight months or a year. Then Mr. Berthelette said, well, the purpose of the rehabilitation program is to reintegrate people into the workforce.

I want to ask you this directly, based on what Mr. Berthelette said. Does the fact that the purpose of the rehabilitation program is to reintegrate veterans into the workforce mean that somehow the mental health supports that the rehabilitation program provides are substandard or will not be adequate to meet the needs of veterans if they happen to be waiting for a disability eligibility decision?

Mr. Michel D. Doiron: No, sir. When they go into the rehab program, if they are not mentally fit, they will get the mental health services they require prior to their getting into the program of their choice. There are services available there. It's detached from the disability benefit process.

● (1705)

Mr. Stephen Woodworth: Thank you.

Mr. Berthelette, as I understand it, of the 15,000 veterans who are in fact eligible for the disability program mental health supports, about 3,600 of them are also accessing support from the rehabilitation program. Is that correct?

Mr. Jerome Berthelette: Yes, that's correct.

Mr. Stephen Woodworth: Is there anything that you can show me, any paragraph in your report, that would contradict what Mr. Doiron has just told me in saying that the mental health supports of the rehabilitation program, which we know are delivered in a timely fashion, are adequate to meet the needs of veterans who access them? Is there any paragraph you can show me where you found evidence to the contrary?

Mr. Jerome Berthelette: I would just go back to the point I raised earlier, that the rehabilitation program is a separate program from the disability program, with its own requirements. It's to help transition from military to civilian life. It's not a bridge program to provide mental health services to individuals who are having to wait for a decision from the disability program.

Mr. Stephen Woodworth: Understood, but I don't hear you telling me that the mental health supports offered under the rehabilitation program, if they are accessed at that point in time, would be inadequate for the veterans if they haven't yet been able to access the disability program supports.

Mr. Jerome Berthelette: Well, we didn't look at the actual programs being delivered, but they can access mental health programs through the rehabilitation program.

Mr. Stephen Woodworth: And I—

The Chair: No, sorry, time has expired.

Mr. Stephen Woodworth: Thank you very much.

The Chair: Moving over to the official opposition, I understand, Mr. Allen, that you and Mr. Giguère will be splitting the time.

With that, you may kick off.

Mr. Malcolm Allen: I have a really quick question, Mr. Doiron.

In your action plan, page 6, where you're digitizing more records, are we talking about that sense of your being able to have the records, so that they've actually moved from DND to you? Is that what that digitization means?

Thank you. I thought so.

The second part of that would be, it says “Q4 2015-2016”. It's an ongoing process. Is that an end date?

Mr. Michel D. Doiron: No, it's an ongoing process.

Mr. Malcolm Allen: It's just an ongoing process, so the next plan may be more quarters of 2016-17, 2017-18, whatever. Do you have an end date in mind, in any sense, at this point?

I recognize it's a dual program. You're both kind of working on this.

BGen Jean-Robert Bernier: We'll always have paper records for people who've served before 2011.

Mr. Malcolm Allen: I have to share my time.

It's an ongoing process, fair enough. I just wanted to make sure that I was looking at it correctly.

My last comment, Mr. Chair, is to the Brigadier-General.

I reread your opening statement, and we had this conversation—I don't have time to go through it again—about the numbers. According to what you told us today, 94% of 455 authorized mental health positions are filled as of mid-January. Last year you had a problem because some folks went on parental leave and some folks were on long-term sick leave, but by January you were okay because they'd probably finished their parental and they'd probably come back to work. The fact is that you're short 6%, about 27 full-time spots, give our take.

I hate doing half a person because I'm not sure what that looks like. I know we do FTEs but I always have a problem with what looks like half a person. I know human resource folks do them differently. But if we have some more folks going on parental leave, we may be back to a place where it says that the OTSSCs experienced longer wait times, in fact up to 49 days, based on the fact that they didn't have enough folks.

So, this is what you've told us, in the sense that these are your numbers. If we can't find the full complement, and some folks go off on parental leave—and heaven knows, we certainly want families to have children—it seems to me, we're back where we were last year. It seems unfortunate.

Mr. Giguère.

[*Translation*]

Mr. Alain Giguère: As we all know, among veterans, 696 men and 29 women committed suicide

Can you tell me how many of these individuals were waiting for care? If these numbers are compared to those of the Canadian Mental Health Association, your failure represents 400%. Indeed, the suicide rate among veterans is 400% higher than among civilians.

Can you provide an explanation for these numbers?

● (1710)

Dr. Cyd Courchesne: In my opinion, the numbers that you are citing...

Mr. Alain Giguère: They're your numbers.

Dr. Cyd Courchesne: No, I believe that they are from the *Canadian Forces Cancer and Mortality Study: Causes of Death*.

Mr. Alain Giguère: Exactly.

Dr. Cyd Courchesne: Those numbers covered the period from 1972 to 2006.

Mr. Alain Giguère: It was from 2006 to 2011. I have the document here with me.

Dr. Cyd Courchesne: You said that from 2006 to 2011? In that case, I am not certain of the numbers. I won't be able to confirm them.

Mr. Alain Giguère: How many of the veterans that you treat are homeless? How many families of veterans are dealing with cases of spousal violence or self-harm? Can you provide us with this information?

You gave us data on the accessibility of care, but we would like to know more about the quality of service delivery.

Do you have statistics or information proving that you are helping to improve services?

Mr. Michel D. Doiron: We have some numbers, but I don't know whether they include what you are asking for specifically. Even if I don't have this information with me, we know how many of these people are homeless. I will send you this information. However, these numbers should be taken with a grain of salt because they are not absolute numbers. Approximately 700,000 veterans and families are registered in the system. We have 200,000 clients, and our case managers handle 7,200. Honestly, I will say that of the 500,000 individuals, some may well be living on the street. We don't always know. We have data on homelessness and drug addiction, I believe, but I don't have that data with me.

Mr. Alain Giguère: In that case, let's talk about the conclusion of the report. In section 3.64, it says that your department is more interested in the quantity of services and the speed with which they are provided than by their quality and the impacts on the lives of veterans. The report even states that it cannot be determined whether your strategy has borne fruit or whether the mental health needs of veterans are being met.

This problem was already raised in the 2012 report on the transition from military to civilian life. At that time, you said that you would accept all recommendations. However, despite this, three years later, nothing has changed. The same problems that existed in 2012 are reappearing in 2015. They are exactly the same. The only thing that you have done is to decide to calculate the 16 weeks from the moment the file is considered complete rather than the moment the application is submitted.

You have played with the numbers. In fact, you had promised that it would be 16 weeks from the moment when the file was submitted. You promised that in 2012. In 2015, the delay is now 32 weeks and you are giving yourselves six weeks to send a response.

There is a problem in your department. Are you able to correct this problem by yourselves? Do you need the Treasury Board or the Privy Council to give you the resources to correct your problems?

Mr. Michel D. Doiron: We can correct some of the problems ourselves. I have been in this position for a short time. We have been working on this for the last year.

Don't forget that the waiting period was 24 months just a few years ago. I'm not saying that things are good right now, but they were much worse before. Now, the waiting time is 16 weeks from the moment when we receive the documents. The Auditor General mentioned 32 weeks, and we accepted his assessment. We have had a lot of discussions on this issue because there are a lot of factors at play. But if, at the end of the day, someone calls me and tells me that it's 32 weeks, I accept that.

How should we address this situation? The forms need to be simplified. We have done so, and we will continue to do so because the forms are still too complex. We are working on it, and we have initiatives to achieve our goal.

Mr. Alain Giguère: Don't get me wrong...

[*English*]

The Chair: No, I'm sorry, you may not.

You may conclude.

[*Translation*]

Mr. Michel D. Doiron: To answer Mr. Giguère's question, we are working to reduce the processing time to 16 weeks.

The Chair: Thank you.

[*English*]

Moving along to our last spot, you have the floor, Mr. Hayes.

Mr. Bryan Hayes: Thank you, Mr. Chair.

First I'd like to go on record as respectfully disagreeing with Mr. Valeriote's position in terms of our unanimous report "The New Veterans Charter: Moving Forward" and his opinion that the government has done virtually nothing. I will go on record as disagreeing with that completely.

Second, I'd again go back to Mr. Valeriote's comments with respect to the Veterans Review and Appeal Board and the appeal process. I just want him to know that prior to his being part of the Standing Committee on Veterans Affairs, we actually undertook a very comprehensive study on the Veterans Review and Appeal Board. Veterans Affairs witnesses were there, and we indeed sought the opinions of several veterans.

I do encourage you to read that report, and I will go on record as maybe forewarning you that we may be having a look at where you are with respect to the recommendations from that report of our Standing Committee on Veterans Affairs.

That said, I want to step back to Mr. Berthelette for one second.

From the veterans' perspective, you mentioned in your chart 3.4 that there's an up to 16-week period. Within that, you've also stated that there are certain factors that Veterans Affairs can control and there are factors that are outside of their control within that 16-week period. I would like to have an understanding of that. Which is most responsible for that 16-week period—factors within the control of Veterans Affairs or factors outside the control of Veterans Affairs?

● (1715)

Mr. Jerome Berthelette: Mr. Chair, we don't know the answer to that question.

Mr. Bryan Hayes: You made the statement that there were factors outside of the control. Can you identify what factors would be outside of the control of Veterans Affairs that would contribute to that delay?

Mr. Jerome Berthelette: Some of the factors may be that some of the veterans may not have access to a family physician. It may take time to get the information together that is required to support the physician's analysis or assessment. I don't know; it may take a few sessions to meet with the veteran to determine his or her mental health and to put together an assessment and send it in to Veterans Affairs.

Those are a couple of examples. I'm sure there are other reasons why it may take longer.

Mr. Bryan Hayes: I'll put the same question to you, Mr. Dorion, in terms of what you think might contribute that's outside of your control. Also—because you'll have the floor and I probably won't get another spot here—I think what is within your control has been identified by the Auditor General in that chart. The application is complex, and it takes time to gather all the required information. That is certainly within your control, so I'd like you to speak to what you've done to rectify that situation. It also says, "Veterans Affairs Canada may advise veteran that the application is incomplete and must be resubmitted", so it seems to me that would be something within your control as well in terms of ensuring a complete application.

I'd like you to speak to the those, please. Thank you.

Mr. Michel D. Doiron: The OAG is correct. There are a multitude of reasons—and I wouldn't want to speculate on all of them—but the points that were raised were correct. Sometimes it's just a matter of organizing themselves. There's a multitude of things. Why would it take so long to send it to us? Our responsibility, once we get it, is to get it out as fast as we can. I don't want to speculate on all the reasons.

But you're correct. We are modifying our forms. The forms are very complex. Our programs are complex. When I arrived at Veterans Affairs, I was very surprised at the complexity of the programs and eligibility for the programs. If I, after 25 years in the public service, have a hard time sometimes figuring out the eligibility, then some of our veterans...so we have to simplify that.

Our deputy minister and our new minister have been very clear that they want us to be more veteran-centric. We're working very hard on that to show that care, that compassion, and that respect for the veteran not only in our forms but also in the services we are offering. So we are looking at the forms.

We are also doing some things that may resolve some of the issues with the appeals process. We're actually calling the veteran now with regard to disability. Before saying "no", we tell the veteran that, based on what we have in front of us, the answer is going to be "no", and we ask them if they can provide us with anything that may bring us to a "yes", to allow us to give the benefit of the doubt to the veteran within the confines of the act .

We've seen an increase in our approval rates since we started doing that. Around the time the OAG was coming in, probably in July, I implemented that. Since then, our first-level approval rate went from 71% to 79%. We touched 80% in one month, but I'll say 79%. So we're taking steps to be more client- or veteran-centric in the way we are doing our business. It's not an easy business. There are a lot of avenues for the veterans and navigating this is difficult. That's why we want to reinstall or reimplement—I hate saying the personal touch because then people expect that every veteran will have somebody, but at least help for individuals to complete a form and help for individuals to get the services.

At the end of the day, employees at Veterans Affairs care a lot for the veterans. They are totally committed. They have hard jobs. I know some of you have been to our offices. Our offices deal with veterans on a day in, day out basis, as do our mental health clinics, and that's not an easy job. They care for the veterans. We want to move that care to make sure it shows up in the forms, in the calls, and in other places, and that's what we're really working on.

● (1720)

Mr. Bryan Hayes: Very good. Thank you, Mr. Chair.

The Chair: You're welcome. Thank you.

That draws to a conclusion this public hearing.

Mr. Giguère.

Mr. Alain Giguère: On a point of order....

[*Translation*]

Mr. Woodworth said that I had mentioned over 2,000 people waiting longer than one year. He questioned my statement. However, I would invite him to read section 3.10...

[*English*]

The Chair: Sorry, that's a point of debate, not a point of order.

Mr. Alain Giguère: But—

The Chair: But what? This better be good.

[*Translation*]

Mr. Alain Giguère: Mr. Doiron indicated that he was open to sending us two responses, given that he did not have the data with him. I would like the clerk to note down the two questions to which he must respond in writing.

The first question deals with the number of homeless people and with problems involving family violence and self-harm. The second question concerns the support that the department must receive from Treasury Board and the Privy Council to overcome its operating problems.

[*English*]

The Chair: Very good.

The first one I remember clearly. I don't remember the second one as clearly, but I'll ask our witness.

Mr. Michel D. Doiron: I thought it was on homelessness and on addiction. I didn't say anything about Treasury Board. I apologize.

The Chair: I have to say I didn't hear it that way, but you did say that you had that information but it just wasn't with you. Are you comfortable providing that on a request basis?

Mr. Michel D. Doiron: The homelessness and the addiction problems, yes, absolutely....

The Chair: Thank you so much. Anything else, monsieur?

Very good. Thank you.

Therefore, colleagues, on your behalf I will thank our guests, our witnesses today. Answers were very fulsome and much appreciated.

Mr. Doiron, I hope you enjoyed your first visit to public accounts, but not too much, because it means we weren't doing our job properly if it was a walk in the park for you.

Mr. Michel D. Doiron: It was not a walk in the park.

The Chair: But I hope that it wasn't too bad.

Mr. Michel D. Doiron: Thank you.

The Chair: We look forward to seeing you again.

Again, thank you all very much for being here today. We appreciate it.

Colleagues, this part of the meeting is going to be suspended for a moment while we clear the room, do a little bit of a tech change, and go into a business meeting. So with that, I will adjourn the public part of the meeting, suspend, and we'll reconvene in camera to do business.

Thank you all.

[*Proceedings continue in camera*]