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Chair

Mr. Neil Ellis

Standing Committee on Veterans Affairs

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● (1530)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): I call the meeting to order.

Good afternoon, everybody.

Pursuant to Standing Order 108(2), a motion adopted on February 25, the committee resumes its study on service delivery to veterans.

The last part of the meeting will be on committee business.

I'd like to welcome the witnesses today.

First we have, from Maison La Vigile, Nancy Dussault, director of nursing, and Denis Simard, director general. From the Veterans Transition Network we have retired Sergeant Doug Allen, program coordinator, Atlantic, and Oliver Thorne, national operations director.

We'll follow the same order. We'll give each witness group 10 minutes and then we'll start with questions.

We'll start with La Vigile.

Thanks, and go ahead.

[*Translation*]

Mr. Jacques Denis Simard (Director General, Réseau d'accueil des agents et agentes de la paix (Maison La Vigile)): Mr. Chair, members of the committee, good afternoon.

My name is Jacques Denis Simard. I am the director general of Maison La Vigile, and I am the founding president. We obtained our letters patent in 1999.

Between 1999 to 2012, we worked with other therapy centres in the Quebec City area. Since 2012, we have had our own therapy centre with our experts and workshops for those in uniform.

During my career, for eight months, between June 1970 and February 1971, I was a member of the Royal 22nd Regiment in Quebec City.

Afterwards, I worked for the Sûreté du Québec for 33 years, from 1972 to 2005.

In 1988, I was discharged from my police duties to work as a responder for the Sûreté du Québec's peer-administered employee assistance program in Eastern Quebec. During that time, I recognized the urgency of having a therapy centre to help our men and women in uniform specifically because of the many distress calls and cases that we had to handle.

I will now give the floor to Ms. Dussault, after which I will tell you about the services provided by Maison La Vigile.

Ms. Nancy Dussault (Director, Nursing, Réseau d'accueil des agents et agentes de la paix (Maison La Vigile)): Good afternoon, Mr. Chair.

Good afternoon, everyone.

My name is Nancy Dussault and I am the director of nursing at the Maison La Vigile.

I have been a nurse for 23 years now. I have worked in various settings: hospitals, rehabilitation and geriatrics. For the past 15 years, I have been working in mental health.

From 2002 to 2014, I was the coordinator of the first responders service team for the CONSTRUIRE *en santé* program of the Commission de la Construction Du Québec. This program is available to 250,000 insured. A phone line is available 24 hours a day. It is an emergency service for people with psychological, dependency, violence and physical health problems.

I went through a career change in May 2014, and I arrived at Maison La Vigile. I am the director of nursing and my main role is to assess the clients. I supervise the alcohol withdrawal process and the physical and mental health of the people at the Maison La Vigile.

In addition to my training as a nurse, I also have training in psychodynamic psychotherapy and I am now finishing a certificate in psychology.

I also attended many crisis response training sessions for suicidal behaviours, personality disorders, post-traumatic stress disorder and depressive disorders. In a nutshell, that's my career path.

I will now give the floor to Jacques Denis Simard to tell you about our services.

Mr. Jacques Denis Simard: The Maison La Vigile has four divisions. The first is the therapy centre, which has six distinct therapeutic services. I will come back to it later. The second is PAPV, the assistance program. The third is training. And the fourth component is research and development.

The star in the logo represents those who watch over others in society. It also symbolizes the lucky star of those protecting the public. It is also La Vigile's mission to protect those who come to meet us. The heart in the logo symbolizes the humanity of those people, the staff and the clients. The double bar is a roof, symbolizing the Maison, a place of comfort for those in uniform. You will also see in the logo three unidentified individuals, suggesting that all those in uniform have access to La Vigile therapy centre.

La Vigile therapy centre is in Quebec City. We can accommodate 16 people at a time for stays ranging from one week to one month. We are a not-for-profit agency that assists past and present uniformed front-line workers. We also provide a 24-hour help line to our clients and their families.

We are well known in the entire province of Quebec. Our clients include police officers, military personnel, veterans, firefighters, peace officers, health professionals—nurses, psychologists, social workers, doctors, pharmacists, and so on—family members, spouses and children over 18 years of age, persons retired from uniformed positions, and other members of the public as needed.

We provide two 30-day programs, the addiction program and the depression program. All our programs entail psychoeducational workshops and a cognitive behavioural approach, the approach recommended by health professionals, particularly for past and present uniformed members.

The addiction program provides an opportunity to follow an alcohol and drug withdrawal program under medical supervision. It is available 24 hours a day. We also provide one-on-one meetings with a worker twice a week, and more than 20 group sessions and weekly workshops on various addiction-related topics.

The depression program seeks to improve self-awareness and understanding of depression and its impacts, to develop coping strategies and to improve interpersonal relationships. It also includes the teaching of calming techniques and a personal development component with eight one-on-one meetings.

The short workshop on post-traumatic stress disorder, or PTSD, is part of the psychoeducational workshops. We focus on general facts about PTSD, core beliefs, symptom management strategies, managing emotions, cognitive distortions and various calming techniques. Our goal is to help program participants understand why they have certain ailments or certain negative thoughts and reactions. According to Kessler, 80% of people with PTSD also have another psychological condition.

Anxiety management focuses on signs of anxiety, cognitive distortions, coping strategies, automatic thoughts, risk factors for stress, self-medication risks, control strategies and calming techniques.

We also have an eight-day anger management program. The basic principle is that anger in and of itself is fine as an emotion, but that someone who channels it in a different way may end up in a bad situation. We look at anger and how it can be productive, the consequences of poor anger management, triggers, perceptions and reality, as well as the stages of emotional management.

Respite services are available to individuals who come to us and need some downtime for various reasons.

● (1535)

The length varies. It can take from two days to four and a half months. I will not elaborate, since I want to have time to finish my presentation.

The second division is the assistance program, PAPV. We have service contracts with Sûreté du Québec, the MRC des Collines-de-l'Outaouais and the CSN Fédération de la santé et des services sociaux to serve their clients with an external assistance program. All those employees have free access to the Maison La Vigile and external consultation, with no interview limit.

Our third division is training. We are experts in training those in uniform. We provide sentinel training and training on stress-related interventions in particular.

We provide sentinel training to police officers in the City of Lévis and the people of the MRC des Collines-de-l'Outaouais. We are also preparing training for the dispatchers of the City of Montreal Police Service.

We also provided in-house training to the firefighters of Lévis, Kingsey Falls and Danville, as well as the Radio-Canada cameramen and journalists. We also provided training on stress to the members of the Quebec City Police Service.

The fourth division is research and development. We give students from Laval University and CEGEPs an opportunity to do internships with us in psychoeducation, social services, as well as delinquency and addiction intervention techniques.

La Vigile is also organizing an international conference, in partnership with the École nationale de police du Québec. The conference will take place in 2018 and focus on health and public security issues.

That is the end of my presentation. Ms. Dussault will continue.

● (1540)

Ms. Nancy Dussault: I will provide you with some figures on the admissions of clients to our programs. From 2013 to 2015, 36% of requests had to do with an addiction issue, 32%, depression, 19%, respite, 8%, PTSD, 4%, anger management, and 1%, anxiety management.

It is important to understand that someone in one program, such as the addiction program, can also have a depression and PTSD diagnosis, as well as an anger and anxiety management issue. Furthermore, 58% of residents have suicidal thoughts.

The requests of Veterans Affairs Canada clients come mainly from the department's case managers, the operational stress injury clinic, the OSISS program—for the operational stress injury social support—or directly from veterans who call us. In that last case, the veterans are redirected to Veterans Affairs Canada to talk to a case manager who will then connect them with us for their application. Generally, the confirmation of the stay at La Vigile from Veterans Affairs Canada case managers takes less than 48 hours.

The main reason for admission of military personnel and veterans is addiction, meaning the alcohol and drug withdrawal program, which requires 24-hour medical supervision and participation in psychoeducational workshops.

La Vigile is the only specialized centre for those in uniform in Quebec that provides a 24-hour medical service for alcohol withdrawal. It is important to understand that alcohol withdrawal comes with risks, especially during the first 48 hours after stopping consumption. There are risks of convulsions, delirium and even death. The presence of medical staff is a must for the first 48 hours.

The respite service is also very much in demand for managing post-traumatic stress symptoms, anxiety, depression and suicidal thoughts, for developing a healthy lifestyle and dealing with home and workplace stress.

I will now talk about the criteria for excluding patients from our programs.

The nurse must complete an assessment...

[*English*]

The Chair: Excuse me. We're down to 30 seconds. We'll have to wrap up quickly.

[*Translation*]

Ms. Nancy Dussault: ...over the phone. The exclusion criteria are: high-risk alcohol withdrawal, where 20 or more drinks are consumed a day; imminent risk of suicidal, homicidal or violent threats; severe psychological instability, such as psychosis; aggressive behaviour during assessment or refusal to follow the centre's rules.

In terms of the percentages of use of our services, from 2013 to 2015, military personnel accounted for 22% of our clientele, veterans, 19%, other uniformed positions, 42%, and civilians, 17%.

So far, for 2016, military personnel have accounted for 12% of our clientele, veterans, 29%, other uniformed positions, 47%, and civilians, 12%.

Ninety-four per cent of our customers report that they are satisfied with the services received at La Vigile and that they achieved their treatment objectives.

This concludes our presentation.

We are ready to answer any questions you may have.

● (1545)

[*English*]

The Chair: Great. Thank you very much.

Next is the Veterans Transition Network, for 10 minutes.

Mr. Oliver Thorne (Director, National Operations, Veterans Transition Network): Thank you very much.

Hello, everyone. My name is Oliver Thorne. I am the national operations director for the Veterans Transition Network, which is a registered Canadian charity and service provider to Veterans Affairs Canada.

Our mission as an organization is the delivery of our 10-day veterans transition programs across Canada. Our mission is to make those programs as accessible as possible to any veteran across Canada who may request them.

Essentially our program, as I said, is a 10-day group-based program with the mission of helping Canadian Forces service members and veterans to identify and overcome barriers to transition back into civilian life.

We break up those 10 days into three phases, or what we call three workshops, and each workshop has a particular focus. In the first place we're looking at building a cohesive group of those veterans so they can do this work together, so trust-building is very important in the initial stages.

We're then looking to teach communications skills, which we're encouraging the participants to use throughout the program, the idea being that by the time the program comes to an end, these skills will be second nature to them.

The whole basis is teaching skills and competencies that can be used in the transition back into civilian life, so phase one—the focus of the communications skills—is very much around reconnecting with family members and loved ones, perhaps after returning from service overseas or in that transition period on leaving the military.

Of those three workshops, there is a two- to three-week break in between each one. That's specifically designed so the participants are taking these skills back to their lives at home in between the program days and rehearsing those skills, and then returning to the group, reporting on what's working and what's not, and picking up new competencies along the way.

As the members return to the second phase of the program, the next four-day block, we are working on trauma education, psychoeducation, and providing any skills that we can to help them manage symptoms they may have of operational stress injuries or post-traumatic stress.

As we near the end of that phase, they would then return to their day-to-day life again to practise those skills and return for the final two days of the program on phase three. At this stage we're looking at long-term planning for life after the program, connecting them to continuing resources, such as one-on-one counselling or perhaps a career transition they may be looking at, and helping them make long-term plans for life after the program.

As a little bit of background about our program, it was developed first in 1997 at the University of British Columbia by Doctors Marvin Westwood, David Kuhl, and Tim Black. Over the next 15 years or so, it was researched and developed at UBC with funding from the Royal Canadian Legion in British Columbia.

In 2012 the Veterans Transition Network was incorporated as a not-for-profit, and is now a Canadian charity with the mission of taking that program across Canada and making it accessible to veterans. In the same year, Veterans Affairs reviewed our research and reviewed our program and accepted us as a service provider. We've been seeing Veterans Affairs clients now every year since, and we're up to roughly 50 clients who have now taken our program through Veterans Affairs funding.

For about two-thirds of the clients we see, we raise funds from the community in order to put them through the program, because they have either not accessed Veterans Affairs funding or the funding they do have with Veterans Affairs does not cover their attendance on the program.

Again, with our mission as an organization to make this program accessible, a large part of our day-to-day activities is raising the funds to put those members through who would not otherwise be able to access the program.

Since 2012 we've expanded from one province into six. By the end of the year we'll be in seven provinces. We're working to train both psychologists and clinical counsellors across Canada, as well as regional staff, such as retired Sergeant Doug Allen here, who is our man in Atlantic Canada.

We are working to create programs in both French and English, so we're currently training bilingual clinicians local to Quebec, and we anticipate that by the end of next year we will have delivered our first program in French. Really, that is the bulk of our mission, which is to make sure that we make this program as accessible as possible to Canadian veterans.

I'll hand it over to my colleague Doug to talk a little bit about his work, both as a coordinator and now in training with us as one of the clinicians who helps to deliver our program.

● (1550)

Mr. Doug Allen (Program Coordinator, Atlantic, Veterans Transition Network): Thanks.

My name is Doug Allen. I'm a retired infantry soldier, and now I have a master's degree in social work. My relationship with the Veterans Transition Network is that I graduated from the program myself. Like many veterans, I decided to make sure I was advocating for everybody else, and I wanted to make sure this program was good to go for my troops. What I found was that I needed more help than I thought, and I got it from the veterans transition program. Since then, I joined the team as a coordinator for Atlantic. I have been the para, and now I'm also a clinician in the program.

One of the differences with the veterans transition program is that it uses camaraderie, the same thing that soldiers need to do their job when they go into combat or tough situations. The veterans transition program re-creates that camaraderie, which they need in order to identify their triggers and their stuck points in life. They utilize that camaraderie to get themselves out of that. That's what the veterans transition program does.

When Oliver was talking about it, he broke it down into three phases. It's one of the most important components of the veterans transition program, because it enables us to get out of that safety bubble that was created by the program itself. We leave the safety bubble and we go back into what's essentially the unknown, civilian life. That is what scared us, because we're not used to it, and that's usually where our troubles occur. It's not while we are on a mission; it's when we're at home.

Using the space in between the phases, we're able to go back to where we feel unsafe and use the skills we learned where we did feel safe, which was within the veterans transition program. With how we developed the program, we're able to see what works and what doesn't. We know we're coming back into that bubble in the next phase, and we're able to say what worked. Then we're able to tailor what has to happen the next time. Instead of it not working and having no answer, individuals are still part of the program when they come back in. We can work with them on that so we can fine-tune it for success in the next phase. That is one of the key components to the success of the veterans transition program.

The Chair: Great. Thank you.

We'll start off with questions from Mr. Clarke for six minutes. When we get down to about 30 seconds, I'll motion to wrap up the questioning or answers.

Go ahead, Mr. Clarke.

[*Translation*]

Mr. Alupa Clarke (Beauport—Limoilou, CPC): Thank you, Mr. Chair.

Thank you all for being here with us today.

[*English*]

To the Veterans Transition Network, I visited your installation in Vancouver when I was there last May.

[*Translation*]

I am very pleased that representatives from the Maison de la Vigile came to meet with the committee. I live near the Maison de la Vigile in Quebec City and I can say that you are doing a great job. Thank you very much.

We may have to interrupt you sometimes because we have a number of questions for you. Do not be taken aback by that.

Inevitably, you work with veterans very often. In fact, you work with them every day and I imagine that many of them express their discontent, rightly or wrongly, with case managers and with the way the Department of Veterans Affairs operates.

What do you think of the administrative process and the organizational practices of Veterans Affairs Canada? What is your relationship with case managers? How do you see the department's way of operating? Are the administrative processes followed properly? Are there things that need to be replaced?

Ms. Nancy Dussault: Mr. Chair, if I may, I will answer the question.

In terms of the administrative process before the Maison La Vigile receives a call from a case manager, we unfortunately cannot say because we don't really know what is happening up there. However, our relations are excellent from the time we receive a call from a case manager. As I explained, the admission process is often initiated in less than 48 hours and the veteran's date of admission is set. Our relations with all the managers are excellent.

Mr. Alupa Clarke: You say that veterans talk to you. I am not blaming the department but, very often, veterans complain to the committee that their relationships with the department are quite horrible. Those are usually complicated cases.

What are the comments you most often hear from veterans about the problems they are experiencing, about the documents they have to complete and, in some cases, about the transition steps they need to take?

● (1555)

Ms. Nancy Dussault: Most of our veterans, our clients, have post-traumatic stress disorder, one of the symptoms of which is anger. We have heard some comments about veterans. It is important to understand that people diagnosed with depression are often going to be haunted by the past whereas people with anxiety will be haunted by the future. Our role is to bring people back into the present. We don't really dwell too much on comments they may make.

We also see that, for some veterans, returning to civilian life is difficult. Simply getting things done, like going to an appointment for a blood test or to see a doctor, can be very difficult and cause a lot of anxiety. For some, simply picking up the telephone and making a call disorients them. They often need the help of a professional in our organization just in order for them to do that. So you can imagine that, for a veteran who has to call Veterans Affairs Canada, starting all those steps and filling in all those documents for various procedures can be a major source of anxiety.

Mr. Alupa Clarke: Are you and your colleagues prepared to help veterans to fill in forms or do paperwork?

Ms. Nancy Dussault: At La Vigile, our role is to develop people's independence. So we are there for them, but we do not do the work for them. For example, if they have appointments, we can do part of what needs to be done, but the goal is really to develop their independence and not to act for them.

Mr. Alupa Clarke: Along those lines, do you believe that it would be a good idea for the department to fill in forms for veterans or, conversely, do you believe that it is good to leave that task to them, even those with sometimes complex mental health issues?

Ms. Nancy Dussault: The role of a support worker is to develop independence. If we adhere to that principle, I would say that it is better for them to do it themselves, but some veterans are not capable of doing so. So, perhaps for some clients, it is necessary to help them, but for others, the goal is to develop their independence.

Mr. Alupa Clarke: Your document points out that veterans' family members do not necessarily have easy access to the department's case managers. This committee has, on several occasions, come across that problem of family members' lack of access to case managers. Does that complaint come up often?

Ms. Nancy Dussault: We have heard those comments from some veterans. Some would have liked their family members to have access to La Vigile's services too. We have also heard that on occasion.

Mr. Alupa Clarke: Speaking of La Vigile's services, at what point do you feel that they really should be available on a broad scale? Clearly, there is a need. Is the department having discussions with you about possibly expanding your services?

Mr. Jacques Denis Simard: There are no plans along those lines yet. We are ready to do it. In fact, two policewomen from the city of York, Ontario, have shown a lot of interest in starting a "Vigile 2" in that province for everyone in uniform. We are ready to expand our services.

Mr. Alupa Clarke: Thank you.

Ms. Nancy Dussault: I can perhaps add that, when a veteran is diagnosed with post-traumatic stress disorder, depression or alcohol problems, the consequences are felt by the entire family. So it becomes difficult for the wife, the children and so on. In fact, the family needs help as well.

Mr. Alupa Clarke: Thank you.

[*English*]

The Chair: Thank you.

Ms. Lockhart is next.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you, everyone, not only for being here today and giving us your testimony but for the work that you are doing for veterans. We appreciate it.

Mr. Allen and Mr. Thorne, being from New Brunswick, I'm quite interested in what your footprint is in Atlantic Canada.

Mr. Doug Allen: I have gone out to New Brunswick—I think it was last year—and we did speak to Veterans Affairs at the two offices there, one in Moncton and one in Saint John. It was very well received. We did have a couple of members go on to a program from that.

Right now I am actually looking for a facility we could use to run our program out in New Brunswick. We haven't found one yet that is suitable; we're still working on that.

One thing about the Atlantic region is that when we run a program there, anybody in the Atlantic provinces can attend. It's part of that one-stop shop kind of bill. If the member is in Atlantic, we'll bring that person to where it is. If we're running the program in Nova Scotia and they're in Newfoundland, we'll bring them. We'll bring them from New Brunswick. That hasn't been an issue thus far, but we are trying to expand so that we can get it as close to where the members are looking for it as possible.

● (1600)

Mrs. Alaina Lockhart: For your program, you don't require a permanent infrastructure, per se. You run the program in the community for periods of time.

Mr. Oliver Thorne: I can speak to that from an operational perspective as well.

As Doug was saying, we are keen to keep that program accessible. If somebody who may not be in an area where we're consistently delivering requests the program, then we will, as a charity, eat the cost of bringing them down, whether it's flying them down, paying for their travel, and paying for a ferry or a taxi, or whatever it may be. We will cover their costs to attend the program.

We keep our eyes on those areas, and when we hit the critical mass for a local program, that's when we would look at finding a local centre where we can deliver the program. When we hit the magic number—and for us it is six to eight, because each of the programs we run is small and has six veterans attending for the first time—we start to look seriously at expanding in that area.

As well, speaking about local resources, our mission as we grow across Canada is to train clinicians locally. That includes registered psychologists and registered clinical counsellors or their equivalents. We're looking to train them in local communities, so that not only do our costs of delivery go down and become more sustainable, but we're also training psychologists and clinicians in local communities in working with veterans so that better care is available in those communities at large, as well as through our programs.

Mrs. Alaina Lockhart: I noticed when we were talking about career transition.... We've been focused a lot on the transition in the service delivery study. Are you finding that veterans are coming to you without a sense of purpose? Is that part of the issue? Could you talk a bit about that?

Mr. Oliver Thorne: I will give that to Doug to speak about the experiences in the program and what people are saying.

One of the things I've found.... As an operations director, my direct contact with clients is limited these days, because I'm overseeing our program expansion. What I have heard in the past, especially working as a coordinator, is that people are not necessarily always struggling with unemployment, but they're struggling with under-employment. I think there is that lack of purpose and not feeling invested in what they're doing, or not feeling as if they have a future or a career in the area where they're working.

That's something we try to focus on in the program, which is to find out where their interests may lie and perhaps what their long-term goals could be. Yes, I think there is a lack of investment sometimes, and a lack of purpose in that sense.

Mrs. Alaina Lockhart: You mentioned as well communication skills—and I'm working backwards—with family and loved ones.

Can you tell us again a bit of what happens or why that's required?

Mr. Doug Allen: We teach soldiers how to listen and speak all over again. It's something that probably even civilians could learn.

When we use it with veterans, of course, they have their own culture and their own way of speaking. They're also dedicated to learning how to get things done, so they're dedicated to learning how to speak and how to listen.

When they practice it on the program with each other, that then carries over to their family. What happens is that initially there is a bit of a shock because when they go home after phase one they're speaking differently and they're listening. When a veteran says to his wife, “What I hear you saying is...”, then the wife is thinking, “What...?” That comes from the program. They've tested it on some hard-core stuff with their comrades in the program, so they've already gone deep. Now they're able to say, “Okay, I've gone pretty deep here. I'm going to go back out into the real world and try it with my loved ones at home”, and they're able to do that.

It's a bit of a shock and a little bit of a shake, but what happens is that it's successful. How does it translate back to family and friends, and back into the community? They're taking the skills that they're learning in speaking and helping each other through what their sticking points are in the program and carrying that over into their home life. That makes home life better, because the family is involved as well.

Mrs. Alaina Lockhart: Do I understand from your testimony that you're an independent charity, and that you're not a third party provider to Veterans Affairs?

Mr. Oliver Thorne: We are a registered service provider for Veterans Affairs Canada. We're designated as a multidisciplinary clinic, but we are independent in that we are a non-governmental organization. We have our own board of directors that oversees and directs our activities, and we are a registered charity.

● (1605)

Mrs. Alaina Lockhart: How much time do I have?

The Chair: You have 15 seconds.

Mrs. Alaina Lockhart: Thank you very much.

The Chair: Go ahead, Ms. Mathyssen.

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

Thank you very much for being here and providing this information.

I want to ask a few questions in a different direction. There was discussion about the injuries that veterans exhibit and come to you with. Are you seeing any emotional injuries among women? I'm thinking in terms of women who have suffered sexual assault or sexual harassment. Is this something you're dealing with?

I'd like to hear from both groups, please.

Mr. Oliver Thorne: I'm in pretty regular contact with our clinical director, Dr. Mike Dadson. He oversees all of our training and all of our clinical protocols as they relate to the program. He is the clinician who's really been at the head of translating our programs and bringing them to female veterans and to female service members. The program initially, when it began, was for men. That was the focus of the three doctors and psychologists who had really built the program. Our focus was to bring this to everybody and make sure it was accessible. That did require some tweaks to the way in which we delivered the program.

The unfortunate reality is that so far, a large number of the women veterans who have requested our program have suffered some level of either sexual harassment or sexual trauma in the military. We are seeing that. We're seeing it in the majority of the clients at the moment who are requesting our programs.

Mr. Doug Allen: One thing we're doing to enable them to speak up about this is that we're training women clinicians. When we run a program, we're running a men's program and we're running a women's program.

Initially there is a lot of push-back from women veterans. They say, “We're used to being in a male-dominated society and culture. That's the military.” We ask them to give it a chance, and when they do give it a chance, they find that because they're among women who have similar experiences, they're able to open up in a much different way.

Now, whether or not that's because of sexual assault, I can't tell you, because I'm a man and I'm not a clinician on their program. What I can say, though, is that they're very grateful for being provided an all-women clinical team and an all-women group with the veterans transition program.

[*Translation*]

Ms. Irene Mathyssen: Go ahead, Ms. Dussault.

Ms. Nancy Dussault: Our clients are more than 95% men. We have seen a few military women, some of whom have been victims of harassment, even sexual assault, not only in their military careers but also in their personal lives. They are still a very small part of our clientele. In the consultations, the reasons they bring up are not about the abuse. They came for other reasons but they talk to us about the abuse they have suffered.

[*English*]

Ms. Irene Mathyssen: Do you think there's a reticence among women to talk about what's happened to them? As you were saying, Mr. Allen, they come from a man's world, where you have to be tough. Do you have a sense that they're not able to break through that? Is that a barrier to being well?

Mr. Doug Allen: I don't think they're not able to; I think in our approach we provide an ability to. We provide an all-women clinical team and an all-women group that provides an open window and an opportunity for them to actually explore those things that they perhaps wouldn't otherwise.

Ms. Irene Mathyssen: *Merci*.

Madame Dussault, you made reference in your brief to the absence of support for families. We've heard that families very often are left on the fringes because they can't access the services from Veterans Affairs. Are you hearing from the families of veterans? Are they coming to you and saying they need more support than what they're getting, and what are you able to do in that regard?

● (1610)

[*Translation*]

Ms. Nancy Dussault: Those comments did not come directly from the families, from the wives or the children, they came rather from the veterans who have stayed at La Vigile and who said that they wished their families had access to those services.

[*English*]

Ms. Irene Mathyssen: If families were treated together, would the veteran heal better, faster, or would the families be able to heal better than currently is the case? I throw that out to both of you.

Mr. Oliver Thorne: I think I would defer to Doug on that a little bit, as I tend to do in this situation, but I do know that one thing we hear a lot of feedback on in our program—it's the reason the program is structured the way it is—is that very often the experiences that veterans or service members may have had in the military are so profoundly traumatic and so difficult to speak about that they won't talk about them with their family or in front of their family. The term they often use is that they don't want to put it on them.

When we put them in a group of their peers, they can air these things. They can talk about them. They know they're not going to hurt the person in the group across from them because they've had similar experiences. I think there's absolutely a place for veterans to work with their families to heal and to improve the family relationship, but I think there also needs to be a place for the veterans to do their work separately. There are some things they simply won't want to put on their families.

The Chair: Thank you.

Mr. Bratina is next.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): Thank you.

First, thank you for your service to our country.

You were an infantryman. Are there any quartermasters and chefs, the people who.... It's easy for us to understand someone who's been in the heat of battle, but are there also pressures that relate to illness from the non-combatants in the forces?

Mr. Allen can go first.

Mr. Doug Allen: Absolutely, yes. There's no script for trauma. Trauma is something that happens in the body, and there's no unit of measure that you can use. It doesn't matter if you're a combat soldier or a cook or a clerk. It doesn't matter. Trauma occurs.

With the veterans transition program, I've worked with more non-combat military members in the Atlantic because they're predominately navy and air force. However, you're also dealing with things like the Swissair crash, which has had a profound effect on non-combat military members, but nobody seems to think that, because they say, "Well, you're not in combat, so what's wrong?" There are so many things that our men and women in the military have done that people don't necessarily see, but it has a traumatic effect on them.

Yes, I do see them coming in, and they have a need, and the program works really well. It also works really well with different experiences. You can have a combat veteran and you can have somebody who's never been in combat come together because of trauma, and the shared experience is the fact they have gone through trauma and they can help each other through.

Mr. Bob Bratina: Madame Dussault, would you comment on this question of non-combat—

[*Translation*]

Ms. Nancy Dussault: We have had military medics who were not directly involved in combat, but who had to look after their comrades. They had been diagnosed with post-traumatic stress disorder after providing that care to their comrades.

[*English*]

Mr. Bob Bratina: Thank you.

You stated in your information that you have seen an increase in psychological distress among veterans over the past three years or so. Do you have any thoughts about why this increase is occurring?

[*Translation*]

Ms. Nancy Dussault: The main reason why veterans come to the Maison La Vigile is that they are suffering from post-traumatic stress disorder. Fifty per cent of those diagnosed with post-traumatic stress disorder develop dependency problems. A lot of members of the military and veterans with that diagnosis have problems of dependency on alcohol or drugs.

Abusive consumption of alcohol and drugs leads to family problems, and the entire family suffers the consequences. The symptoms of post-traumatic stress disorder can also become aggravated. Very often, they are hypervigilant, they have nightmares, they are easily startled, they experience avoidance. They withdraw; that leads to all kinds of consequences for the family and the distress increases. That is what we see with veterans.

● (1615)

Mr. Jacques Denis Simard: If there is a marriage breakdown, the pressure increases even more and it can lead to a suicidal distress situation.

[*English*]

Mr. Bob Bratina: To compare the two organizations, Mr. Thorne and Mr. Allen are using therapeutic enactment role-playing; I believe in the case of La Vigile there are other therapies that are basically trying to get at repressed behaviours from the past.

Tell us a little about the kind of therapy that goes on at La Vigile for these same problems.

[*Translation*]

Ms. Nancy Dussault: Actually, the goal of the Maison La Vigile is not to provide psychotherapy or to work directly on the trauma. You have to understand that, when a person is living through an experience, it triggers thoughts and interpretations of the event, which lead to the particular behaviours. It's often those initial interpretations that are false.

At the Maison La Vigile, we use the cognitive behaviour approach. We are interested in the interpretation of the thoughts, whether it is realistic, whether it can be countered, in order to lead the person to change their behaviours when they realize that the thoughts are not accurate. Our involvement is based on the cognitive behaviour approach that is widely used by psychologists.

[*English*]

Mr. Bob Bratina: When measuring success—and Mr. Allen, you're a measurer of the success, I suppose—do you do continual feedback? Do you come back a year later? Tell me about how you measure your success.

Mr. Oliver Thorne: The program has been fairly well researched since 1997, which is when the first group was run by Dr. Westwood and Dr. David Kehl. In 2012, we brought on a researcher from the U. S., who's now based at the University of British Columbia, Dr. Dan Cox. He's now conducting the outcome research, essentially, on our program. We deliver questionnaires pre-program and afterward, at three, 12, and 18 months after the program.

We're using a suite of different diagnostic measures. In 2012, we switched to using the OQ-45—outcome questionnaire 45—which is in line with what Veterans Affairs is using, but we're also measuring depression through Beck's depression inventory—a PTSD checklist, essentially—and other measures of quality of life.

We've just recently performed the analysis on our 18-month data because we run small groups, so it takes a while to get to a significant sample size. We've seen significant reductions in post-traumatic stress and depression symptoms and the frequency and severity of suicidal thoughts, and we see an increase in quality of life.

The Chair: Go ahead, Mr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair.

Thank you all for coming today. My first question is for the Veterans Transition Network.

We discussed at length many of the difficulties that veterans face and how your program has helped with them. Can you touch on how these difficulties can be addressed, say, before someone is released from the Department of National Defence, while they're still in active military service? Is there something that can be done at that end that could help to prevent some of this?

Mr. Oliver Thorne: Essentially we'd like to have services like ours available to those who are preparing to transition out or are in the process of transitioning out. We have found that for those who transition out, initially perhaps the experience was good, but then they begin to find that they're having difficulties with family or they're having difficulties with career, or whatever it may be. If they don't have services available at that point, in the early stages, they can very easily slip into negative coping strategies, such as isolation, alcohol or drug abuse, or self-medication.

In terms of preventing that and having to get them when they're far down the road and do reparative work, we believe that if services —not just ours, but like ours—were available to those who are releasing or preparing to release, we could prevent them from falling into those negative coping strategies. To that end, we've recently submitted an application to the Department of National Defence asking to be considered as a service provider.

● (1620)

Mr. Doug Eyolfson: Thank you.

For Maison La Vigile, would you agree, or do you have anything more to add to that statement?

[*Translation*]

Ms. Nancy Dussault: Unfortunately, we are not really familiar with that transition period.

Mr. Jacques Denis Simard: I have heard veterans say that the transition period was an obstacle for them because they were no longer in the military. They were forced to leave the armed forces because they were psychologically or physically wounded. The result was a sense of failure. It was difficult for them to except their status as a veteran.

[*English*]

Mr. Doug Eyolfson: Thank you.

Now, for Maison La Vigile, for veterans within Quebec, would you say that the process is different for transition in the rest of Canada? Is there a marked difference for the Quebec veterans?

[*Translation*]

Ms. Nancy Dussault: Unfortunately, we are not aware of that process at La Vigile.

Mr. Jacques Denis Simard: For the people referred to us, the transition process is already done, is already under way. Case managers refer them to us and we take care of them at La Vigile. However, we are not aware of the differences between Quebec and the other provinces in terms of the transition.

[*English*]

Mr. Doug Eyolfson: Thank you.

To the Veterans Transition Network, I'm impressed by the high level of satisfaction you have with the people who go through.

Are there any recommendations you have for the individuals who come through and don't see the positive changes they were looking for? Is there another avenue that you tend to recommend to them?

Mr. Oliver Thorne: Absolutely, and I'm sure Doug can speak to this, too.

One of the things we've always tried to stay rather open about is that we know we're not a silver bullet and we know that we're not the ideal program for everyone. We're one of the many available programs that are out there. We believe that we fill a particular niche, and we do that quite well, but we recognize that not everybody is going to get as much benefit from our program as someone else might.

It's sometimes the case that we find somebody who is not engaging well with our program and chooses not to return, for whatever reason, or perhaps drugs or alcohol are a bigger factor, and we have to ask that person not to return, which, fortunately, rarely happens. We have about a 95% completion rate. When that does happen, we work with the psychologists on the program to get them linked to other services.

For those who come to us who are not with Veterans Affairs, we're often trying to refer them back and get them other services because we're aware that it's not going to work for everyone.

Does that answer the question sufficiently?

Mr. Doug Eyolfson: Yes, it does.

For Veterans Transition Network again, in your annual report there are some impressive numbers. The report shows how your donor funding has increased dramatically since 2012. Congratulations on that.

What would you attribute that success to? Would this be an increase in the awareness of veterans' needs, or is there some other factor that's contributed to it?

Mr. Oliver Thorne: I think it's across the board. We worked hard to expand the areas that we're applying to for funding. When we started, we were mainly funded by places like the Royal Canadian Legion and grassroots organizations. We've tried hard to expand. We're now funded by True Patriot Love and Wounded Warriors. Veterans Affairs coming on board was an enormous help to us in having those clients covered by government funding, so we could free up the money for more programs for more veterans who weren't covered.

We've tried to diversify where we draw funds, but I think a big part of it is because of the awareness. More people are aware of veterans' issues and, I think, donating to military organizations. Just this year, with the 22 Push-Ups—22 Days Challenge, I know that Wounded Warriors aimed to raise $22,000 by the end of the year, and they made $30,000 in the first month.

There's a lot of awareness out there, which is translating into more community funding for programs like ours.

The Chair: Thank you.

Go ahead, Mr. Kitchen.

[*Translation*]

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Ms. Dussault, Mr. Simard, I do not speak a lot of French, but I am learning. I learn a new word each day. Thank you for your presentation.

● (1625)

[*English*]

That's as far as I'm going to go, because if I do, then we'll never get any questions in.

What we've talked about a lot in our committee has been about dealing with family members, and in your presentation I see there's some talk about family members.

If I understand you correctly, there are not a lot of family members who are participating in your program. Is that correct?

[*Translation*]

Ms. Nancy Dussault: Actually, families are not part of the programming at La Vigile. Just the veterans.

[*English*]

Mr. Robert Kitchen: As I think has been alluded to by others, often when family members participate in a program, there seems to be a better success rate with more acceptance and understanding.

When you accept people into your program, they come through various systems, but can family members come up and say they think a spouse needs to be part of this program? Is there an opportunity for that?

[*Translation*]

Ms. Nancy Dussault: I am sorry, but I did not hear the question very well.

Mr. Alupa Clarke: Can a member of the family call you to say that someone needs your services, for example?

Ms. Nancy Dussault: The request must always come from Veterans Affairs Canada. If the wife of a veteran ever calls about an admission, we refer her to Veterans Affairs Canada. The request cannot come directly from a family member or from a veteran. It must come from a case manager at Veterans Affairs Canada.

Mr. Jacques Denis Simard: The training that the Maison La Vigile provides is given by a criminologist who, after being a corrections officer for 15 years or so, became a criminologist and then took charge of an assistance program. He is now retired and works for us. He provides our training. He is a psychotherapist and a member of the Ordre des psychologues du Québec.

That aspect of our program is expanding rapidly at the moment. We have adapted our training programs to the requests we have received from police forces and paramedics associations. We have not yet received any requests for training programs from Veterans Affairs Canada.

Mr. Jacques Denis Simard: Up to now, we have not had any family members coming to the Maison La Vigile, because we have no funding.

[*English*]

Mr. Robert Kitchen: I assume when you're talking about training, you're talking about training your staff. How long does that training program take? Does it include veterans who might be able to take up some of those positions? I ask because we often hear that when certain services are provided, there is a better response when a veteran is there because the veteran understands. Mr. Allen spoke to it a little earlier too, on the reality. A veteran understands the language, and if a veteran is part of your training program, he or she understands what's happening there and might be able to be of a little more assistance.

[*Translation*]

Ms. Nancy Dussault: In terms of staff training, a lot of training programs on personality disorders are given by psychologists. As for the nursing staff, we have a veteran who works nights as a nurse. We also have a nurse who was previously in the military.

Mr. Jacques Denis Simard: We have set aside quite a considerable amount in our budget for staff training so that the staff is always able to respond appropriately to our clients' needs.

Mr. Robert Kitchen: Thank you.

[*English*]

Mr. Allen and Mr. Thorne, I appreciate your being here today. Some of us had the privilege of seeing *Contact! Unload*; it was a very powerful and inspiring presentation, and your support of it is tremendous. A lot of what you talk about, I think, is very evident in the presentation and in the play. As l said earlier, I think Canadians need to see that so that Canadians get a better understanding. We see the one young gentleman in the play who is suffering, and he is suffering not because he was in combat, but because he was on a radio and had to make an order for something that transpired. We see those things, and it's very powerful.

You said you're in a number of provinces, and I'm from Saskatchewan. We have veterans there too. I think this is a very powerful thing, and your treatment is impressive. Do you anticipate going to Saskatchewan in the future?

A Voice: Or are we already one of the seven?

● (1630)

Mr. Oliver Thorne: Unfortunately, not yet. We're almost there. As I said, in line with our typical process, once we hit that kind of critical mass with a sufficient number of people for us to deliver a program locally, we will. For our wait-list for western Canada at the moment, we have two or three names that are from Saskatchewan, so we're not very well known there at the moment. At the moment we are bringing those people from Saskatchewan who can attend a program in B.C. If they are available, we will cover their travel costs to bring them over. Again, making sure that the program is accessible is goal number one.

If you know anyone who can introduce us in Saskatchewan, then I'd be happy to talk to them and set something up.

Mr. Robert Kitchen: Thank you.

Can we get a copy of your research, as in the research references?

Mr. Oliver Thorne: Definitely. If I can get some contact information for who to send that to, I'd be—

Mr. Robert Kitchen: Thank you.

The Chair: We'll get that contact information to you. Thank you.

Next we have Mr. Fraser, who is going to split his time with Mr. Rioux.

Mr. Colin Fraser (West Nova, Lib.): Thank you very much, Mr. Chair.

[*Translation*]

Thank you all for your presentations. Thank you also for the great work that you are doing with veterans day after day.

[*English*]

I want to start by asking a question to the Veterans Transition Network, and I'll be brief because I'm sharing my time.

Can you explain how a veteran or a soldier about to release would actually get involved with your network? How do they find you, or do you find them?

Mr. Doug Allen: Typically we operate in a grassroots format. We work with members talking to other members, and it seems to work the best. Most veterans and most members releasing don't trust the system—I'm sure that may come as a shock—but they do trust each other, so we try to keep that grassroots approach as much as possible.

What has to happen is that as a coordinator.... Somebody asked if the wife or the family can contact us. I have had wives contact me and say, “My husband needs your program”, and I say, “That's great; have your husband call me.” One of the things we need is for them to make that contact and for them to initiate, which tells us they're ready to do the treatment and they're ready to go through the program to get the work done.

What happens then is that we work with them. The first things I will ask are, “Are you with Veterans Affairs? Do you have a case manager? Did you open the door for discussion with your case manager? Do you have a therapist? Are you seeing a social worker or a psychologist?” I open the door for conversation. Why? It's because we're not here to do anybody else's job. What we're here to do is to help empower them in their own care plans.

When we do that, then all of a sudden we have so many people, and we bring everybody together to work on this one individual to come to success. That's how we do it. We keep it low key, and it's totally up to them. When they contact us, they're telling us they're ready to do the work, and that's key for us.

Mr. Colin Fraser: My other question is, what follow-up is done after somebody has gone through the programming and received the services you offer? What follow-up is there to make sure they're doing well and to make sure the good work you're doing is being reflected in the research?

Mr. Doug Allen: There are a couple of things.

We have what's called a calling list. When we start our program, we do a fan-out list, as you would do in a typical conventional military unit. You would have a fan-out list of everybody's name and number so that you can contact each other. We do that, and it's like the buddy system. While we're in the program, we use that call list to instill that buddy system that they had before. They call each other in the interim. They call each other just to do a check-in, and they practise their communication skills.

Those numbers don't disappear at the end of the program, and quite often the veterans stay connected for years and years afterwards, so they are well connected. We do the research, and we're always back there. Three months later or six months later or 18 months later, they get a call from us, and they say, “Oh, yes, I remember now.” It helps them to go back to say, “Yes, I remember that program. Where am I from that program, and what am I doing right now? How far have I come since that program, and how successful have I been?”

Mr. Colin Fraser: Thank you. That's excellent.

I'll turn it over to Mr. Rioux.

[*Translation*]

Mr. Jean Rioux (Saint-Jean, Lib.): Thank you.

My thanks to the witnesses for joining us.

I have two questions for the people from the Maison La Vigile. I will ask them together so that the person answering can put the focus where they see fit.

The number of Veterans Affairs Canada's clients increased by 19% between 2013 and 2015. In the first part of 2016, that figure went to 29%. In Quebec, are the services available to veterans sufficient to meet the needs?

You mentioned that one of the main problems for veterans is alcohol and drug use. Do veterans also have difficulty in getting into the labour market after their military careers? How do they adapt to their new lives? Is it a widespread problem that veterans, after their careers in the military, have difficulty finding jobs and getting into the labour market? How are they adapting to their new lives?

● (1635)

Ms. Nancy Dussault: Veterans tell us that they have difficulty getting into the labour market because they have had no closure on their military careers. It is very difficult for them to accept that they no longer have a military career. Only about 30% of the veterans coming to the Maison La Vigile have jobs.

Can you remind me of your other question?

Mr. Jean Rioux: You have seen an increase in the number of veterans, your clients. As you perceive the market, are the needs being met? Are there sufficient resources and services available in Quebec to meet the needs of veterans?

Ms. Nancy Dussault: The service that we provide is summed up in the six programs we have mentioned. The grey area is when Veterans Affairs Canada makes a request for a person who takes substances 20 times a day and poses a serious risk in terms of withdrawal. We have criteria that can exclude cases like that.

Ideally, for a person who takes substances more than 20 times, the withdrawal process should be done in hospital, but our health care system does not do prevention. It focuses mainly on healing. So people like that are not automatically hospitalized for withdrawal. The treatment period for them is longer. We cannot have them at the Maison La Vigile because their consumption is too great and there is a risk of major episodes like convulsions, delirium and even death.

At that stage, our suggestion to Veterans Affairs Canada—this is not ideal, but it is still a solution—is that the person should progressively reduce consumption for a few weeks until they reach 19 or fewer per day, after which they can be admitted to the Maison La Vigile, with a detox protocol and with specific medication to deal with the symptoms.

So that is one criterion under which a person cannot be admitted to the Maison La Vigile. Another is when there is a risk of suicide, homicide, or excessive violence, as was the case recently when a very psychologically unstable person with aggressive tendencies communicated with our organization in order to be admitted. It was impossible for us to do so.

So there is a grey area in which the Maison La Vigile cannot accept a veteran. A hospital may evaluate him but will not automatically admit him. So he leaves hospital after a few hours without really feeling better. Sometimes, people like that need closer supervision, but they end up at home very quickly, without having received the psychological assistance they need.

[*English*]

The Chair: Thank you.

Ms. Wagantall, you have five minutes.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): I want to come back to the short discussion we had about dealing with things in a more preventive way instead of having to deal with them after the veterans have been released and having to find them and all this type of thing.

We're responsible for studying service delivery, and a big part of that would be finding ways to need less of it on the more difficult end of things. In the Canadian Armed Forces we have VAC and this seam that we're trying to close. You talked about basically teaching them to listen and speak again, I'm assuming, because you've gone in.... There's a responsibility in the armed forces. You respond. You're part of a team. It's a different dynamic.

I'm so pleased that there's a possibility for this treatment much sooner in this whole process. Would you see it as important for us as a committee to recommend that these types of services be available? The responsibility is more on the armed forces side of it, before they're released, so that they have that understanding of their new value as they're going into a totally different lifestyle.

● (1640)

Mr. Doug Allen: Absolutely.

When people are being medically released, especially for mental health conditions, it is because they're dealing with trauma. They're already dealing with something.

They were in a profession where they were above reproach. When you are in the military, you are trained that you are better than.... You are the ones who go into the fire when everybody else is afraid. You're trained that way, and that's what you believe. Then in a split second, you're told you're disabled, so then you have to deal with the fact that you're disabled and that you are unemployed. Not only are you dealing with the trauma of being disabled, but you're also dealing with the trauma of what to do with your life. The whole entire culture is telling you to leave, and you only have this much time on the clock until it happens. You're dealing with two traumas. If you were able to deal with one trauma first and you were shown how to work with that, then when you were released, at least you'd have the skill sets and the mindset to be able to handle that transition a lot better.

Mrs. Cathay Wagantall: I appreciate that you mentioned the navy as well, because I did spend one night on the *Fredericton* learning about what they do and what they do on our behalf, and the potential. It's not like the movies. I didn't know how a ship is destroyed by a submarine. They were explaining all of this to me, and I just asked, “How do you deal with that? You're out here in the middle....” It was interesting, because there was a sudden quietness, and one of them just said, “We try not to think of that, ma'am.”

That's trauma to me already. Mentally, you're dealing with the knowledge that there's always that possibility. We need to make their transition easier from being taught to try not to think about that. That transition is really important, I think.

Thank you; that's huge.

There's one more thing. You mentioned about needing places to set up. Of course, Saskatchewan's dear to my heart. I've met veterans. I know they're veterans, but they're very quiet. They don't have that camaraderie that you're talking about in our province, because they're spread out all over the place. We're fine with travelling. We travel for everything, and we don't get mail delivered to our door. However, a place called the Thorpe Recovery Centre approached me. It's a phenomenal place. They're right on the border between Alberta and Saskatchewan. They called and said they had empty beds. They had had two veterans come to them because the Legion had paid for them to go there. They asked, “Is there not a way that our services could be used more?” I would encourage you to check them out. They're not quite as into Saskatchewan as I would like, but if we have opportunities to share those kinds of things with you, that's really positive.

Mr. Oliver Thorne: We'll absolutely look them up. Thank you.

The Chair: We'll have Ms. Mathyssen for three minutes.

Ms. Irene Mathyssen: Thank you, Mr. Chair.

I want to get back to Monsieur Simard. You were going to answer the question in regard to families. I noticed in your recommendations that you say that Maison La Vigile recommends that both residential and out-patient services for veterans be extended to their immediate family members. I wondered if you could explain that recommendation, and perhaps you have other recommendations.

Then, if there's time, Mr. Chair, I'd like to ask a little about funding, particularly to the folks from Veterans Transition Network, but first, I'd like to hear from Monsieur Simard.

[*Translation*]

Mr. Jacques Denis Simard: Thank you for your question.

I said that, because veterans' families have no access to the services provided at the Maison La Vigile because of funding. When case managers call us, it is for a veteran, a former member of the military with veteran's status. However, families coping with stress, coping with marriage difficulties, or other difficulties being experienced by the spouse, have no access to the Maison as residents. There is nothing specific we can do for them.

I think there are external services, but internally, in our residential situation, there are none. We haven't received any requests about it.

● (1645)

Ms. Nancy Dussault: You are aware that a number of veterans receive services at the Maison La Vigile, but they also receive psychiatric services at the OSI clinic. So all the veterans do not come to the Maison La Vigile. Sometimes, family members or spouses can also develop dependency issues or depression, and the family atmosphere begins to take a heavy toll. It could be a great opportunity for a wife, if she also had in-patient access for withdrawal, or for psychological assistance for depression.

[*English*]

Ms. Irene Mathyssen: To the Veterans Transition Network, you talked about the money that you received from VAC and the support you get from True Patriot Love and other charitable NGOs. Do you ever find that your resources cannot possibly meet the needs? Are you ever in the terrible situation of having to say to veterans, “Sorry, we can't help you now?”

Mr. Oliver Thorne: At the moment we have wait-lists in every province that we're delivering in, essentially. I wouldn't at all classify it as a crisis financially, but if somebody puts a hand up and says, “I want to take your program”, we want to be able to provide it as soon as possible. We know in particular that a lot of people who are requesting our programs have not, for whatever reason, engaged with some of the services that are available. Some of those people are fairly far down the road, as we say, with negative coping strategies. We know they're at risk, so we want to provide that service as soon as we possibly can.

We plan our years very carefully, based on our budgets. We receive financial oversight from our board of directors to make sure that we're never overstretching ourselves so that the organization is at risk, but the veterans are at risk, and they are who we're trying to help, so any more money that we can bring in will go into program delivery and will be used by veterans. We have wait-lists in all those provinces where we're delivering.

Ms. Irene Mathyssen: I wondered if the need outstrips the availability of resources, because that would be of profound concern in regard to our veterans.

Either group could comment.

The Chair: It will have to be short.

Mr. Oliver Thorne: Yes, absolutely.

I think we could certainly utilize more money. The need is there, and we can't provide service to all of those who have asked for our program. The risk isn't to the organization financially, but to the veterans who need our services.

[*Translation*]

Mr. Jacques Denis Simard: We support what has just been said.

[*English*]

The Chair: Great. Thank you.

This ends the round of questioning. What we can do is let each group wrap up. We'll give you a couple of minutes each for a summary, if you wish. From there, we will break for a few minutes and come back with a motion Ms. Lockhart has, and then after that we'll have to go in camera to discuss committee business.

Starting with La Vigile, you have two minutes to wrap up.

[*Translation*]

Mr. Jacques Denis Simard: I would like to conclude our appearance and wrap up the questions we have been asked with this comment.

Mr. Rioux briefly touched on the subject, but I would like to finish it. Those experiencing episodes of suicidal distress go to hospitals. Here's how it works in Quebec. They are seen by a doctor and, less than 12 hours later, they are sent home. They have no safety net. That is when the idea of suicide can occur again. They may then commit or attempt suicide. That is a grey area that really upsets me.

I would like people like that to have access to emergency beds. The Government of Quebec's crisis centre cannot respond to their needs because there is a problem with the culture. Police, former military, veterans and members of the military will not turn to a resource that is not familiar with their culture.

That, in a nutshell, is our problem. I hope that solutions can be found to the problems that this grey area causes.

● (1650)

[*English*]

The Chair: Thank you.

Next is the Veterans Transition Network.

Mr. Oliver Thorne: I'd like to close by saying thank you so much for being invited here today. We're a small organization and we're a growing organization, but we're aware that our scope of operations is dwarfed by an organization such as VAC, with their resources and reach.

If I can provide any lessons learned from what we've done, it would be to use their peers to reach out to those veterans who are isolated and those veterans who are not engaging, because it's a contact point they trust. I would just echo that. Also, it would be to create as low an access barrier as possible for those who are in crisis.

I'll hand it over to you.

Mr. Doug Allen: I'll say thank you very much for allowing us to come here to speak as well.

One of the things with Veterans Affairs and with our program is that we've been working to get the members into our program, and the case managers become enablers. They become enablers in a most powerful way. When they see their members come back, the members want to talk to their case managers. The members want to come back and engage with VAC because VAC has helped them get to the place where they are after the program, which to me brings them back and invests them back into the community, back into the resources, and back into the system, if you will. The trust is reinstated when they do that. I've seen that with the case managers in working with them.

I just thought I'd put that out there as well. Thank you very much.

The Chair: Thank you to both organizations on behalf of the committee for all of the great things that you do for the men and women who have served.

I would also like to note that if there's anything you want to add to the discussion or if you want to expand on any of the questions that were asked of you today, you could send the information to the clerk, he will get it to all the committee members.

Now I would like a recess motion from Ms. Lockhart for three minutes. I'm sure some of the group would like to say goodbye to you, and then, as I said, we'll come back with Ms. Lockhart's motion and go in camera for a discussion of business.

Thank you very much.

● (1650)

(Pause)

● (1700)

The Chair: We have a motion that was presented about a week ago. I believe everybody has a copy of the motion, and I will turn the floor over to Ms. Lockhart with her motion.

Mrs. Alaina Lockhart: Thank you.

Based on a lot of the witnesses we've heard and conversations we've had about priorities, I'd like to propose a motion, and the analyst just pointed out a word that's missing.

I move:

> That the committee undertake a study on mental health focused on improving the transitional support (closing the seam) between the Canadian Forces and Veterans Affairs, and including recommendations which can ultimately be used in the development of a coordinated Suicide Prevention Program.

Thank you.

The Chair: The motion is on the floor.

For discussion, we have Mr. Kitchen, and then we'll go with Ms. Mathyssen.

Mr. Robert Kitchen: I'd like to see about making an amendment to that and add, following “suicide prevention program”, the words “that includes a suicide prevention hotline”.

The Chair: In the process, it could be a motion or a friendly amendment, and I guess that's up to you. We could put it as a motion and vote on it as procedure.

Did you want to put it as an amendment now, and then we'll discuss it and then vote on the amendment? I guess that procedure would be proper. That would be a motion.

You'd have to read it. We could discuss it first.

Mr. Robert Kitchen: I'm just wondering about that.

The Chair: As a process, we could go around in discussion and then make any amendments if anybody wants them. Then we could vote on the amendment or we could put the motion on the floor, talk about the amendment, vote on the amendment, and then vote on the motion at the end. I think that's the process.

Mr. Robert Kitchen: I may have to talk about the amendment, if you want to do that first.

Mr. Colin Fraser: I don't know, Chair, how formal we have to be.

The Chair: We're still an open session, so it's probably formal.

Mr. Colin Fraser: Do we need a seconder for the motion, then?

The Chair: We don't need a seconder.

Mr. Colin Fraser: The motion is on the floor, and then the amendment is being sought.

The Chair: The motion is on the floor. Mr. Kitchen's is an amending motion. We'd talk about the amending motion first. Would that be your motion, Mr. Kitchen—to add "that includes a suicide prevention hotline" as your amendment?

Mr. Robert Kitchen: Yes.

The Chair: That would be the amending motion.

Mr. Colin Fraser: The only reason I asked is because it seems like a specific thing to include in there. We haven't heard any evidence as to why that might be a good thing. There might be lots of ideas that we will hear about, and that may be one of them. It sounds like a good idea on the face of it, but why that specifically? Do you not think that could be dealt with by hearing evidence and then making a recommendation based on what's already there with "suicide prevention program", for example?

Mr. Robert Kitchen: I agree with you. That was part of, when I saw the motion. This is okay, but we have all these other aspects we can look at, such as homelessness, etc.

If we put something in the motion to say we're looking at this specifically and then when we deal with suicide prevention, there are all sorts of angles to it. We can look at different things that we've heard today about alcoholism and drug abuse, etc. Then there are the steps that would lead to that and PTSD. I'd like to have at least one specific part of it saying that this is the intent, so that at the end we can say there is a suicide hotline. I think we've all discussed that and I think we all are fairly well in agreement that this is something we need to consider. I'd like to make certain that we have some specifics on it.

● (1705)

Mr. Colin Fraser: If I may, Chair, my only concern would be that if we're adding one specific thing like that, then I don't want anyone to think that there's an exclusion of other specific things we may be considering.

Mr. Robert Kitchen: They've done it in a number of committees. They've taken a thing and they've broken it down into sections and said that they want to look at this. The reason I'm saying that is so that we at least have one.

We've had a huge number of meetings. We've gone here, we've gone here, and we've gone here. I'll use an example of heritage: the heritage committee now has a section of four meetings strictly on women and sport.

I'm looking at that and saying this all falls under suicide prevention. I say we could break it down and say that we can look at a suicide hotline as one part, homelessness as another part, and then drug addiction, alcoholism, and PTSD—I'm just throwing those out off the top of my head as four spots—when we sit down to do the study. We've now said we're going to allocate four meetings to this and four meeting to that. I'm just throwing out numbers arbitrarily, but it's to say that we have an answer and we can answer those questions specifically.

The Chair: Mrs. Lockhart, go ahead.

Mrs. Alaina Lockhart: Mr. Kitchen, I certainly appreciate where you are coming from. I know you want to have direct action come from the recommendations and I agree that we should have specific outcomes. I think the motion covers that, though, including recommendations that can ultimately be used in the development of a coordinated suicide prevention program, and a hotline would possibly be part of that prevention program.

I want to speak to the fact that the service delivery study we are doing now is very broad, but it is very broad by design. If you think back to the conversation when we were deciding where to go first, you'll see that we decided to keep it very broad instead of picking a priority without hearing from anyone.

Now that we've heard a vast number of witnesses, to me there is a recurring theme and a recurring sense of urgency around mental health, which is why I am putting this motion forward.

Mr. Robert Kitchen: I understand that, and I don't think anyone here is saying that we are against the issue of mental health. I think it is a great study that we need to do. My thinking is that if we have some specifics, we can at least come out with some specific answers or specific recommendations on those things.

The Chair: Ms. Mathyssen, I think you were not looking to speak to the main motion, so we'll go to Mr. Clarke, then Mr. Bratina, and then Mr. Eyolfson.

Mr. Alupa Clarke: It seems to me it was quite clear all along in our hearings, from the veterans groups we met, that there is no 24/7 line for the crisis situation happening to the individual. I am not sure whether the suicide hotline is a prevention tool. I see it more as a drastic crisis-happening tool. I'm probably not using the right word, but when someone calls a suicide hotline, it's because he is probably going to take the action of suicide.

In the case of veterans, when they call the 24/7 line of Veterans Affairs—because there is such a line, but it is not for suicide—there are no people who are professional enough to deal with those kinds of people, so they will say, "Okay, call back in 12 hours," for this kind of thing.

I think that adding this to your motion will make it so that not only will we have prevention tools that we can decide on after the study, but they will also be part of a suicide line.

● (1710)

Mrs. Alaina Lockhart: I understand what you are saying and I don't think any of us on this side are against having witnesses to talk about the effectiveness of a suicide hotline. It's just that this is only one of the things we would like to study, and I really didn't intend to get specific. I would like to leave it broad. I still see it as part of a prevention measure, in that it is the first line of response.

The Chair: From listening to the conversation here, I think there are two things.

Part of the service delivery review, as the analyst said to me, might point toward a recommendation, or we can talk about suicide and the suicide line in the service delivery. There are two things on that, I guess: whether it would come out in that study, or whether it would be best for this. Service delivery would be—

Mr. Jean-Rodrigue Paré (Committee Researcher): You could make a recommendation on that one as a result of the current study, and then the next study could analyze how it could best be done, or something like that. You seem to be saying that after we've heard all the witnesses, it may be that this would be a good recommendation. If this is the case, it could be a recommendation that the committee would be studying for the current report.

I'm just throwing that out there.

Mr. Robert Kitchen: I see that. My intent here is to make certain that when we focus on where we are going and who we are inviting for witnesses.... Mental health runs a huge gamut, and if we are all over the map with mental health, we can get all sorts of different....

The recommendation in the motion was to develop a coordinated suicide prevention program. I'm just saying that it could be a developed coordinated suicide prevention program that includes a suicide prevention hotline. I am looking at that purely from that last little bit when we are looking at the development of a coordinated suicide prevention program.

The Chair: We have everybody lined up to speak, so I'm going to have bring back the rules here and hold us to them.

We have Mr. Bratina, I believe.

Mr. Clark, have you spoken?

Mr. Alupa Clarke: Yes, I spoke already.

Mr. Bob Bratina: I don't think anybody disagrees with the point, but in my experience simpler motions are better. The motion captures the notion because there are other issues included in it, such as mefloquine and the potential ties to veterans' well-being. I got engrossed in that topic and I have a couple of people whom I could recommend: Canadian military psychiatrist Dr. Greg Passey, a remarkable individual, and Dr. Remington Nevin.

Let me mention Dr. Passey just for a moment. He has treated members of the Canadian Airborne Regiment and understood, in the Somali inquiry, that this mefloquine had been involved in some of the behaviours that subsequently happened. It's such a big issue that I don't think I would necessarily need to ask the mover of the motion to include that wording, because I don't think it would detract from our discussions that would ultimately come up with such things as a suicide hotline. I think the motion is fine as it stands, because it incorporates everything we would discuss, including a suicide hotline, without defining it in the wording.

The Chair: Go ahead, Mr. Eyolfson.

Mr. Doug Eyolfson: I agree. There are many different things that I don't see the advantage of including this one specific thing. There are many ways; it makes sense. We might—although this is extremely unlikely—hear evidence that in fact there wouldn't be any value added to it. We need to keep our minds open on this, and I think this is a broad motion that covers everything. If a suicide hotline were beneficial—which I think it probably would be—then it would be covered. I just think it's an unnecessarily specific addition to a very broad motion.

● (1715)

The Chair: Go ahead, Ms. Wagantall.

Mrs. Cathay Wagantall: In terms of its being complicated, there are actually two trains of thought here.

The first one is doing a study on mental health that is focused on improving transitional support, From what we've heard in committee to date, I think a lot of the mental health issues are related to that problem, but that is very different from the mental health issues related to their coming back with an injury. The second one is more related to the crisis from their experience.

So we're dealing with two different things here already. If you're going to deal with mental health issues, there are mental health issues in our armed forces that are related to moving from DND to VAC, to transitioning. That's the first part. Then you want to include developing a coordinated suicide prevention program, which is more related to dealing with a crisis that occurs because of their military experience.

It's already extremely broad. Those are almost two separate studies.

The Chair: I'm going to call a vote on the amending motion. Did you want to make a closing statement?

Mr. Robert Kitchen: Mr. Chair, I have faith that this committee will study the issues that we want to see expressed and studied, so I withdraw the amendment and we'll move forward.

The Chair: I think we'll get it done.

We have a motion on the floor, and Ms. Mathyssen has been waiting so patiently.

Ms. Irene Mathyssen: I just wondered about the timeline and what Ms. Lockhart envisioned as the number of days for the study and whether it would take up all of the spring.

The Chair: I guess the subcommittee met, and I was trying to go in camera. We have a couple of motions. We'll discuss that in camera.

The motion is on the floor.

Go ahead, Ms. Wagantall.

Mrs. Cathay Wagantall: We could keep it as one study, but have two parts. We could focus right in on mental health with the first part, and then focus right in on mental health with the second part. Do you see the difference between the two sentences here? There's the issue of mental health in transitioning, and then there's the suicide prevention program, which I would think is more focused on the crisis that they're dealing with.

Mrs. Alaina Lockhart: I understand where you see a confusion, and I guess perhaps language isn't always our friend. My thought is that as a committee we won't be developing the suicide prevention program ourselves, but making recommendations based on that transition piece, that gap that we're seeing, that we've heard about so often.

Mrs. Cathay Wagantall: But then you're saying that the program you're going to develop will be a response to transition issues, and I don't think.... I would hope that those transition issues could be dealt with so that those mental health concerns are dealt with by getting rid of that seam. That is a different from people dealing with mental health issues arising from a traumatic circumstance.

I would hope that a coordinated suicide prevention program isn't necessary as a result of people committing suicide because they're struggling with the transition between the two departments. That's definitely something we should be able to fix bureaucratically with the recommendations coming from the ombudsman, or whatever the government decides to do, basically.

Am I making any sense, Mr. Analyst? Do you know what I'm saying?

● (1720)

Mr. Jean-Rodrigue Paré: I'm very discreet.

Mr. Robert Kitchen: Mr. Chair, hopefully I won't confuse this anymore.

Perhaps we can discuss the issues of how we want to approach the study when we go in camera and decide at that point how we want to break it up into sections, how we want to allot certain meetings for this, that, and the other, and maybe identify it at that point.

The Chair: Yes. If the motion does pass, we'll meet with the subcommittee and map that out as we did the last time for the meetings—and you're both on it.

That said, all in favour of the motion?

(Motion agreed to [See *Minutes of Proceedings*])

The Chair: I need a motion to go in camera.

Mr. Doug Eyolfson: I so move.

(Motion agreed to)

We'll suspend to go in camera.

[*Proceedings continue in camera*]