HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 037 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Thursday, December 8, 2016

Chair

Mr. Neil Ellis

Standing Committee on Veterans Affairs

Thursday, December 8, 2016

● (1530)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): Good afternoon, everybody. I'd like to call the meeting to order.

Pursuant to Standing Order 108(2) and the motion adopted on September 29, the committee resumes its study on mental health and suicide prevention among veterans. Today we have witnesses from the Department of Veterans Affairs: Dr. Courchesne, director general, health professionals division, and chief medical officer; and Michel Doiron, assistant deputy minister, service delivery branch.

We'll start off with your 10 minutes, and then we'll go to questions.

Welcome again, and thanks for coming.

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

Good afternoon, Mr. Chair, vice-chairs, members of the committee, ladies and gentlemen. As mentioned, I am Michel Doiron, assistant deputy minister of service delivery at Veterans Affairs Canada. With me today is our chief medical officer and director general of health professionals, Dr. Cyd Courchesne. As you may recall, Dr. Courchesne oversees the VAC team of health professionals.

It is our pleasure to be here this afternoon to talk about mental health supports and transitional services for the CAF, RCMP, and family members. This is very timely given that last week members of the Veterans Affairs Canada team participated in the 2016 Military and Veteran Health Research Forum in Vancouver, British Columbia. I believe some of the members attended as well. The forum was co-hosted by the Canadian Institute for Military and Veteran Health Research, or CIMVHR; the University of British Columbia; and the University of Victoria.

The annual conference is a key event for sharing knowledge among our researchers. This year attendees explored a variety of research topics related to the health of military members, veterans, families, and first responders, with presentations by leading Canadian and international researchers and experts. Themes included mental, physical, and social well-being; advances in trauma care; health technologies; the transition to civilian life; occupational health care; care ethics; and gender differences in health.

As mentioned, I'm aware that some of the members did attend the forum. I encourage members to attend when possible, because it is a very good sharing of information.

[*Translation*]

Much has happened since my last appearance in April, and I was here with you on Tuesday.

As of November 2016, Veterans Affairs Canada has hired more than 300 new frontline employees to ensure veterans and their families have the support they need, when and where they need it.

We have also hired additional case managers—to better support and serve veterans and their families and help veterans navigate a successful transition to civilian life. With the new staffing levels, case managers will serve, on average, 25 individuals each.

● (1535)

[*English*]

We have successfully implemented the increase to the earnings loss benefit from 75% to 90% of a member's pre-release salary. The earnings loss benefit supports a veteran financially as he or she undergoes physical rehabilitation, vocational retraining, and counselling, giving them peace of mind financially as they work towards physical and mental well-being. The goal, of course, is to ensure that military personnel have the support in place for an optimal transition to civilian life and that veterans and their families know they have ongoing resources to help them overcome life challenges.

[*Translation*]

A large part of our focus is on mental well-being. Veterans Affairs Canada is committed to ensuring eligible veterans, retired Royal Canadian Mounted Police members, and their families have the mental health support they need, when and where they need it.

[*English*]

I am proud of the wide range of mental health services, supports, and information VAC provides to veterans and their families. The document you were provided with earlier, which was also shared with our stakeholders at the last stakeholders summit, lists VAC's mental health services, supports, and information.

In particular, Veterans Affairs funds a network of 11 operational stress injury, or OSI, clinics across the country, 10 outpatient and one in-patient as well as satellite clinic service sites closer to where the veteran lives. I think some of you have visited some of our OSI clinics. These clinics are complemented by the Canadian Armed Forces network of seven operational trauma and stress support centres that mainly serve still-serving military personnel. This network continues to grow. More OSI clinic service sites will open across the country.

Each OSI clinic has a team of psychiatrists, psychologists, social workers, mental health nurses, and other specialized clinicians who understand the experience and unique needs of veterans. To further improve accessibility, each OSI clinic provides services through telehealth, or distance health services, to support those living in remote areas.

Our clinics also are using specialized software, called the “client-reported outcome measuring information system”, or CROMIS, that has been developed and implemented within these clinics. This system is used to track veterans' mental health outcomes by ensuring timely access to psychological and psychiatric assessment and treatment. CROMIS speaks to how well a given veteran is actually responding to the treatment. It tracks and reports client-reported emotional distress and satisfaction with social and vocational function on a week-by-week, session-by-session basis. When used in accordance with published guidelines, it significantly improves clinicians’ ability to identify those at risk of deterioration and/or premature termination and also to significantly improve outcomes.

[*Translation*]

We also have a well-established national network of around 4,000 mental health professionals who deliver mental health services to veterans with post-traumatic stress disorder and other operational stress injuries.

Our Veterans Affairs Canada assistance service offers a 24-hour toll-free help line, short-term face-to-face mental health counselling and referral services, to military and RCMP Veterans, and their families.

[*English*]

The operational stress injury social support, or OSISS, program offers confidential peer support to CAF members, veterans, and their families impacted by an operational stress injury. The support is provided by trained peer support and family peer support coordinators who typically have first-hand experience with these injuries.

We have collaborated with a number of partners in developing a series of free online and mobile applications that can be used by veterans and their families. PTSD Coach Canada and OSI Connect are mobile apps that provide valuable information to CAF members, veterans, and their families impacted by an OSI. The operational stress injury resource for caregivers is a self-directed online tool for caregivers and families of CAF members and veterans living with an OSI. It provides self-care, problem-solving, and stress management techniques for managing the challenges of being a caregiver. “Veterans and Mental Health” is an online tutorial designed for anyone who is wanting to learn about service-related veteran mental health issues or who is supporting a loved one with a service-related mental illness.

Medically released veterans and their families have access to seven military family resource centres, or MFRCs, across the country, as well as the family helpline and familyforce.ca website as part of the veteran family program. This program is part of a four-year pilot to provide veterans and their families with access to the MFRC supports and programs, traditionally only available to still-serving members of the Canadian Armed Forces.

The Government of Canada has launched a Canadian veteran-specific version of the mental health first aid in partnership with the Mental Health Commission of Canada. This program provides mental health literacy training for veterans in the community.

The government is also providing funding for the Mood Disorders Society of Canada to provide skills development training and support services to unemployed veterans with mental health conditions, to assist them in establishing a new career.

A partnership between VAC and Saint Elizabeth Health Care has also recently been established to design, develop, and deliver, in the summer of 2017, an online caregiver training program to support informal caregivers of veterans with an OSI.

Naturally, we continue to collaborate with the Department of National Defence to create two new centres of excellence in veterans care, including one with specialization in mental health, post-traumatic stress, and related issues. We're also collaborating with our partners at DND to develop a joint suicide prevention strategy for Canadian Armed Forces and our veterans.

These mental health services and supports are examples of how VAC is delivering on the commitment of care, compassion, and respect for our men and women who have served their country, and their families.

Thank you again for the opportunity to address the committee. Dr. Courchesne and I look forward to your questions.

Merci. Thank you.

● (1540)

The Chair: Thank you.

We'll start off with Mr. Kitchen.

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

Thank you both for being with us again.

As you may be aware, I did go to CIMVHR. It is an excellent program. There is so much information, and so little time to sit in. It was a pleasure to be there, and I learned a significant amount.

Interestingly, what I took home from it was that oftentimes we're dealing with a moral injury. A moral injury is a brain injury, and recognizing that moral injury is often the biggest challenge we have to deal with. In reality, in order to focus on repairing it, we need moral repair to make that happen. I just wanted to say that this phrase resonated with me very well. Basically what happens to these soldiers is a violent contradiction of moral expectations, and they're dealing with that aspect of it.

That said, in the conference there was a lot of talk about dealing with families as well. I'm wondering if you can expand on whether, in a lot of the services we're providing, they are being resourced to families.

Mr. Michel Doiron: Thank you for the question, Mr. Chair.

First and foremost, under the various acts, Veterans Affairs is for the veteran. Most of our services, disability awards or pensions and things like that, are aimed at the veteran. That said, we strongly encourage family members to attend the OSI sessions, peer support, and various other programs. It's been proven that having the family involved in treating the illness usually works better.

The other thing we've learned is that often the member may say they're doing okay, but the family member may not be quite in agreement with the diagnosis of the member.

However, that being said, there is a full range of services that we provide to the family, without going through the veteran. As an example, the 1-800 phone number is 24/7. A family member, a child, or a veteran may call there and get help online immediately and/or, depending on the severity of the situation, be referred to a psychologist or a mental health care provider for up to 20 sessions. Veterans Affairs pays for this, regardless of whether it's service related or not service related, or whether the veteran is a client. A lot of the apps I just mentioned are available to family members.

As we're advancing in our program, we are looking at how to have better programs for families. We have the family caregiver program, but again that is through the members themselves to help the caregiving side.

● (1545)

Dr. Cyd Courchesne (Director General, Health Professionals Division, and Chief Medical Officer, Department of Veterans Affairs): To reinforce what the ADM has said, all the OSI clinics offer services to the family members of the clients they see. Whether it's immediate family, the spouse, or the children, they're all included.

The MFRCs also look after the families. As well, outside the more acute care of the OSI clinics, we have mental health first aid, which is available to everybody in the veteran's circle, as well as the online caregiver module. We're developing educational tools for people to self-help. It goes all the way to the OSI clinic, where they can participate in the veteran's treatment as part of their treatment.

Mr. Robert Kitchen: Thank you.

In your report you mentioned two new centres of excellence, and we talked about this a year ago. Can you update us as to where we're at on that, what locations are being looked at, and what research will be done? In other words, what sort of structure will be implemented?

Mr. Michel Doiron: We are still working on the centres of excellence and where they're going to be.

The first one we know will be on mental health and PTSD. I'll let Dr. Courchesne provide more information on that, but we're still working on some of those details. I can't share a lot of those details, because we're going to be proposing something in the budget, and the budget's confidential. I can't relay a lot of information, and I apologize, but we are working on it.

However, the first one will be on PTSD and mental health. We like to say "mental health" because it encompasses a lot more.

For the second one, we're working with our research group to determine what the best second centre of excellence would be. We have a couple of proposals in front of the minister for a final decision. It will be for the health of the veteran, absolutely, but we want to make sure we have the right one. That one is to come.

Dr. Cyd Courchesne: For the centre of excellence on mental health and PTSD, we've been consulting with the minister's mental health advisory group as to what they see being needed in that centre.

What we want out of that is to better understand mental health, operational stress injuries, PTSD, because there's still a lot to learn there. We want to be able to develop innovative practices and best practices, advance and build on what we're doing already, and provide education, and not just education internally for our own OSI network. This will generate knowledge that any care provider in the country who's looking after a veteran or someone dealing with PTSD can come to as a resource. It will be a centre of excellence that will generate that level of knowledge and expertise.

The Chair: Thank you.

Mr. Eyolfson.

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

Thank you, again, for coming.

Mr. Doiron, we've heard a lot about veterans transitioning out of the military and finding what's referred to as the "new normal". We've heard about the complex system at VAC. Navigating the services and benefits can be a burden. It can weigh heavily on some of these veterans.

What's your department doing to help veterans in this regard, from the navigation standpoint?

Mr. Michel Doiron: Thank you, Mr. Chair, for the question.

It is true that our system is hard to navigate. There are a lot of policies, programs, and processes. There are a couple of things we are doing to address that.

The first thing we've undertaken is something called the service delivery review, which is looking at how we can simplify our processes and improve transition, because it is a mandate of the minister, as associate minister of National Defence, to eliminate that seam to the extent we can. However, more concretely, what we are doing, and we're piloting it right now, is looking at something we're calling “guided support”, but I like your term of “navigator”.

What we're realizing is that when a soldier gets ready to release, they don't know our programs. They may start talking to a military case manager and they may start talking to one of our case managers, but they don't know the programs. This guided support would be meeting with a Veterans Affairs employee during transition, and that employee would go through their entire file, what we think they're entitled to, and even trying to get the cases adjudicated before they're release from the armed forces.

It does not mean they would not come back five, 10, or 50 years later. We have people who show up 50 years after release, but at least if you're moving to a certain part of the country and you have special needs and maybe you'd have a hard time receiving the specialized medical help you need, you would know if you eligible for a disability or what type of employment opportunities there are. That's why we're calling it “guided support” or the “navigator”. It's to get them better suited for transition, because we know that 27% of the people transitioning have a hard time. Most of them transition well, but 27% do not.

The reason we're concentrating on this is that we've concentrated a lot on the medically releasing individuals. We've been doing a lot of work in transition in eliminating the seam for the medically releasing individuals. We just realized, because our researchers had done some work on it, that of that 27%, 60% are actually non-medically released people who are having a hard time. We've been concentrating on the medically releasing, and now we have to make sure we're taking care of the non-medically.

Most of them want to be released with their head high, no stigma, but then they realize when they get into the Canadian population, it's a little different.

● (1550)

Mr. Doug Eyolfson: All right. Thank you.

Mr. Kitchen had asked about the centres of excellence. I know you've said there's a lot that you can't talk about right now because of the situation. Is there anything that you can share with us at this point on the types of centres or how these centres would assist veterans?

Mr. Michel Doiron: We have a lot of centres presently helping veterans. There are the OSIs, and my colleague on Tuesday night was talking about Ste. Anne's and some of the expertise we have.

I think the OSI clinics are actually recognized even internationally. I thank the member for her comment, I believe it was yesterday, about Parkwood. It's true; we have very good OSI clinics that have very specific expertise.

In addition, we partner with CAF. I think we all know that CAF has a partnership with the Royal Ottawa, and we're going to piggyback on that to ensure that expertise is not lost.

Dr. Cyd Courchesne: Again, we work closely with our CAF colleagues. They have a chair in military mental health at the Royal Ottawa. We have our OSI clinic at the Royal Ottawa. They have an institute of research and several chairs looking at sleep and PTSD, and suicide. We want, through our CAF partners, to be able to tap into that expertise.

Nonetheless, we're exploring all options, again, in consultation with the veteran stakeholders and the minister's mental health advisory group, which has representation from national mental health organizations, like the Mental Health Commission of Canada, to make sure that what we propose is going to capture the most expertise.

Mr. Doug Eyolfson: All right, thank you.

VAC has a partnership with the Canadian Institute for Military and Veteran Health Research. In your opinion, what are the areas of research that you think need the most attention?

Mr. Michel Doiron: I think mental health absolutely. This committee has been studying mental health. There's a lot more we can learn on mental health, and its entire complexity. I'm not a psychiatrist or a doctor, but it's clear to me that there's still a lot of work do to. I know Public Safety is working on the first responders also, and we're collaborating with them to ensure that is not lost.

I also think there are issues on the pain management side. Often we see mental health issues related to pain, and how we handle pain. I don't know if there's any research right now.

There are a lot of nice things out there—and VAC has been really investing in this—that people say help. They seem to help, but I think the research is not always there behind them. I know it's been in the media this week, but there are things like the entire service dog issue. We absolutely know it helps, but let's make sure we have the right evidence. That one is more advanced, but there's equine therapy and things like that. Those are all areas I think CIMVHR could be looking into.

● (1555)

Mr. Doug Eyolfson: Great. Thank you.

The Chair: Thank you.

Ms. Mathyssen.

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

Thank you very much for noticing the comments about Parkwood. We are very proud of it in London. I don't think a day goes by without someone indicating how very significant it is as a facility in their lives to help them and their families. We're very lucky to have Parkwood.

Thank you for being here.

I wanted to ask a few questions in regard to veterans who, unfortunately, have committed suicide. I wonder, do you track the suicide rate at all in regard to the veterans who are served by Veterans Affairs?

Dr. Cyd Courchesne: Thank you for your question.

I just wanted to add that your comments were a great morale booster for the clinic. We had lots of feedback from them, so thank you very much. It's good for them to hear some good recognition.

With respect to suicide in the veteran population—and this more in the realm of our directorate of research—if a veteran is in our care and they commit suicide, we know about that, so we can track that part of the population that we serve, which is about a third of all the veterans who are in Canada. What we have difficulty tracking is those who are not in direct receipt of our services. That doesn't mean that we can't; it's just that it's difficult. Our researchers work with the Canadian Armed Forces and with Statistics Canada to try to capture that information.

That information is not available on a punctual basis. They have to do it over several years to try to track and report. The next report on the CAF and veterans mortality study is going to be released in 2017. Right now we have rates up to 2013. They go in three- to four-year cycles to gather that data, but it's difficult for us to track it because, unlike the Canadian Forces, we're not a health care system. They're not our patients, so it happens a little bit outside of our reach.

Ms. Irene Mathyssen: Right. You would need those external experts, like psychologists and psychiatrists, to help to understand if there was a pattern or something significant that you could learn from in terms of knowing what's going on out there.

Dr. Cyd Courchesne: Because veterans receive their health care in their communities, under their own provincial health authorities, we don't have access. We have no right to have access to that type of information unless it's shared with us. Our review and analysis is only based on what we know of the veteran, but it's an incomplete picture, unlike for our colleagues in the Canadian Forces, who have the entire medical record and can go more in depth. But, again, with the help of Statistics Canada and with the CAF, we can paint as complete a picture as we can.

Ms. Irene Mathyssen: I imagine that would be very useful in addressing that tragedy among our veterans.

The figure of 4,000 professionals providing mental health care has been utilized. Is that 4,000 enough? Do you need more?

We tend to think of psychiatrists being the first group that we go to. Has the department looked into other providers, like psychologists?

I ask this because I had a meeting very recently with the London Regional Psychological Association and they said very clearly that they would love to be of assistance to our veterans but they didn't know how to reach out and provide that kind of support.

● (1600)

Dr. Cyd Courchesne: The 4,000 providers in the community are a mix. There are psychologists and social workers. We have occupational therapists who work in clinical care manager roles, so they're not just psychiatrists. It covers a wide range of services because, as you said, everybody doesn't need to see a psychiatrist. If they have a mental health condition there are many more professionals out there who can assist.

With respect to if we have enough psychologists, the CEO of the Canadian Psychological Association is on the mental health advisory committee and they communicate with their entire membership. They know that our third-party administrator, Medavie Blue Cross, registers providers, so there is no limit to how many people can register to become a provider in communities across Canada.

The Chair: Thank you.

Mr. Bratina.

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

I'm intrigued by the percentage of non-medical releases. Is it 61%?

At which point in their service would they typically make the decision to leave? Are they 10-year guys, 20-year guys, or 40...?

Mr. Michel Doiron: They're all over the place, if I can use that terminology. It depends. For some of them it's usually when they can no longer meet universality of service they leave the forces, and that could be by injury, by health issue. There are various issues. You could have a person with two years' experience, or one with 35 years. Once they've reached universality of service....

You're talking about the non-service-related. They're also all over the place because if somebody comes in for five years and decides they want another life.... I don't know the statistics of the releasing per age. CAF probably has that; we don't. We see the average age of release as around 36, which I believe was the last number I saw, so probably more mid-career.

Mr. Bob Bratina: These would be deployable individuals who could meet universality of service but have just decided they want to move on.

Mr. Michel Doiron: Yes. That's the 60% I was talking about.

Mr. Bob Bratina: Do they get the full scope of veterans' programs available to them at that time?

Typically I would see that the people with some traumatic reason for departure would be up to speed, but if somebody says they've had enough of the army, then....

Mr. Michel Doiron: All regular forces are offered and are supposed to have a transition interview. I'll put the reservists aside for a second.

Regular forces are offered and they are supposed to have a transition interview. Last year the number who got one was in the high nineties. That's what we've done in the past. That is more of an "are you doing okay?" The person says he's doing fine and you go through the check marks, asking if he has a job and, "yes, he has a job he's going to", etc.

We're realizing that they're not disclosing. They're leaving the armed forces for whatever personal reason. Maybe they don't even know. Sometimes they don't know. They just don't want to do it any more. They arrive outside the armed forces and realize that they have an issue. The new guided support we're offering is that transition interview, but much further. It's spending the time with the healthy soon-to-be veteran to make sure things are covered and to make sure that if they were injured.... It could be a bad knee. Sometimes it's not always mental health. I know that today we're talking more about mental health, but we ask, "Have you applied for a disability award?", "Is your medical record up to date?" They come to us and if the medical record is not up to date, it takes time to release, medically or non-medically.

We do all that while they are still in uniform, prior to releasing, regardless of whether it's service related or if they're walking out regularly.

● (1605)

Mr. Bob Bratina: To our topic today of mental health and suicide prevention, were you suggesting that when someone leaves and says, "I did my service to my country and I'm gone", and then two, three, or five years later a depression sets in or there could be...?

Mr. Michel Doiron: I'll let the doctor take that one.

Dr. Cyd Courchesne: What our research has shown is that for the people who medically release they come to us right away. We do a warm transfer. After that when we look at the trends of when people come to us for services it's anywhere from two years after release to 40 years after release. It's possible that we'll see someone who has been released for 30 years and all of a sudden, because they're hearing a lot about Bell Let's Talk and mental health, and the stigma of mental health, they might realize, wait a minute I think I have that.

They come to us at any time. There are no spikes. After those medical releases come to us immediately in the first 18 months after release, they can come back at any time from two to 40 years. They could develop a depression or they could just realize late that perhaps there's something wrong with them and then they'll come to us.

Mr. Bob Bratina: In the quick facts on your handout, there's reference to awards, disability benefits, and so on. Are they able to access mental health services prior to the award being presented?

Mr. Michel Doiron: For some of the services, absolutely. Some of our services are linked to the disability award, but for all the services I mentioned you don't even have to be a client. They can have access to all of that.

On the PTSD side, or mental health side, we try to accelerate the evaluation or the determination of the award quicker. According to the last stats I saw, 94% of people coming to us with mental health issues are being approved on first application, and a lot of them are within the 16-week standard. We're actually doing quite well. That's our average for mental health. When you hear it's a bit longer than 16 weeks on the mental health side, we typically are lower. The only thing is that we need to have the diagnosis and that sometimes can be an issue.

Mr. Bob Bratina: I wonder when the families would become eligible.

Mr. Michel Doiron: With the 1-800 numbers, they can go anytime.

Mr. Bob Bratina: Right. Thanks.

The Chair: Mr. Rioux.

[*Translation*]

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

I would like to thank the witnesses for being here today.

My questions might not be as sophisticated as those of my colleagues who have more experience here than I do, as I am a new member of this committee.

In a document, it says that the proportion of serving members suffering from PTSD tends initially to be close to that of the general population, and so forth. Does the same apply to mental illness?

Dr. Cyd Courchesne: Yes.

Mr. Jean Rioux: So the same applies.

Dr. Cyd Courchesne: The same applies. One person in five will suffer from a mental health condition in their life, and it will affect everyone around them. In short, we can say that nearly all Canadians are affected by this reality in one way or another. The statistics are the same.

Mr. Jean Rioux: Thank you.

When candidates are recruited, is there some assessment of their mental health? Some people experience crises while they are serving. When it is determined that they present a potential risk in this regard, either initially or later on, and that they must be relieved of their duties, does Veterans Affairs Canada immediately look after their transition to civilian life? Does it happen in a natural way?

Dr. Cyd Courchesne: Earlier in my career, I was responsible for recruiting medical personnel into the Canadian Forces. That said, this is perhaps something that you will have to ask the Canadian Forces, because Veterans Affairs Canada is not responsible for recruiting medical personnel. If I had not had that job, I would not have been able to tell you that because I would not have known it.

I don't know if there have been changes since I left my job with the Canadian Forces. You would really have to ask the Canadian Forces how their medical personnel goes about identifying mental health problems among recruits.

● (1610)

Mr. Michel Doiron: I will talk about the transition to civilian life.

We work closely with Canadian Forces health professionals to facilitate the transition of members to civilian life. Whether the person has been with the Canadian Forces for two years or 35, when a member has a mental or physical health problem, we are contacted.

The Canadian Forces would of course like to allow the member to continue serving. Their first goal is to reintegrate or retrain that person, because training a soldier is expensive. Regardless of the person's occupation, it is a major investment. The Canadian Forces invest a great deal in their personnel.

Once it has been determined that the member cannot be reintegrated into their unit, we are contacted and we work closely with the member to provide guided support. We have to assist the member and support them throughout the process. This person's goal in life, their career, is to be a member of the Canadian Forces. As a result of psychological or physical injury in combat—there are different kinds of injuries—from one day to the next, the person can no longer be a member of the Canadian Forces. That is traumatic. Suddenly the person has a lot of forms to fill out and has to make some decisions. In addition, their mental health may be suffering. At that point, we work closely with the Canadian Forces to facilitate the member's transition to civilian life. The guided support is a way of working even more closely with that person.

The changes proposed by the committee in the last session have allowed us to intervene much earlier in the process. Thank you for that. Under the previous act, our responsibilities began the day that the member was no longer in uniform. We still work with the Canadian Forces, but as a result of the changes proposed by this committee, we can play a more effective role in this process.

My deputy minister always says not to say six months, but often we become involved from six months to a year before the person leaves the military, working with Canadian Forces health professionals. We work as a team to ensure a smooth transition.

Mr. Jean Rioux: There are 11 major centres in Canada for people suffering from operational stress injuries.

How many are there in Quebec? Can you describe the services offered in Sainte-Anne-de-Bellevue? Does that facility treat people from Quebec only or are there also people from all over Canada there?

Dr. Cyd Courchesne: We have a clinic in Quebec City. Our clinic in Montreal is located at the Ste. Anne's Hospital. This clinic primarily serves people from the Montreal area, but the residential program is open to anyone in Canada.

Mr. Jean Rioux: So the clinic in Sainte-Anne-de-Bellevue primarily serves people in the Montreal area.

Dr. Cyd Courchesne: Yes.

Mr. Jean Rioux: Thank you, Dr. Courchesne and Mr. Doiron.

I have finished, Mr. Chair.

Thank you.

[*English*]

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

Mr. John Brassard (Barrie—Innisfil, CPC): Thank you, Mr. Chair.

Thank you both for being here. Michel, it's good to see you again.

I want to focus on the issue of best practices. In your earlier comments you spoke about the need to better understand PTSD and mental health issues with respect to some of the best practices. You also mentioned the fact that the advisory group is studying best practices in mental health.

I guess this question is for the doctor.

Surely, there have to be examples of best practices in other countries, namely with our allies in the United States, Britain, or the European Union, because PTSD and the issues of OSI are very human conditions. I'm sure that other countries have studied these.

Why aren't we engaging in or following some of their best practices? I don't see the need for us to take the lead or further study some of these conditions.

Dr. Cyd Courchesne: Thank you for your question. It's an excellent question.

We do in fact work with our allies. We work closely in the military with our NATO allies, and through the network of other veterans affairs organizations in the United States, Australia, the U.K., and New Zealand, we exchange. People look to Canada for the best practices. We are recognized for our leadership in mental health. I think if someone had found a magic bullet out there, we would be all over it and we would be implementing and adopting it.

I think what we see through our discussions at forums, such as the Military and Veteran Health Research Forum, where it's becoming more and more international—at the beginning it was more Canadian—is that people are exchanging. We're all struggling with the same issues. We're all using the same practices to treat. We're all looking for the same answers to questions and recognizing the need for further research.

● (1615)

Mr. John Brassard: If Canada is seen as a leader on these issues by other countries, then what more do we need to study to ensure we're taking care of our veterans who suffer from PTSD and occupational stress injuries? What more can we do, if anything?

Dr. Cyd Courchesne: There are lots of advances in research through brain imaging, and again I'm going to turn to your colleague, who is from the London area. The University of Western Ontario is doing some leading-edge research. Dr. Ruth Lanius is using imaging techniques to look at the brains of people affected by PTSD.

Advances are being made in genetics, where now we can do little saliva tests that tell us that this medication is not going to work for this patient with PTSD and we have to go to this class of medication. There is still a lot to be done in research to understand this, so we can increase our better outcomes in treating it.

Mr. John Brassard: The thing that's frustrating to me—and I've only been in this role for six or seven weeks—is that I hear of a lot of studies going on. I know there are currently some best practices in place, as I mentioned earlier, and as you agreed.

Michel, you brought up the issue of service dogs and I'll bring that up again today. I know I brought it up with the minister the other day.

In terms of studies and the evidence, the Americans have studied this issue. They've studied service-dog issues, equine therapy issues. My understanding is that for those who suffer from epilepsy, blindness, and diabetes, there were no studies that were done with respect to those service animals. For veterans who are suffering from PTSD, what more do we need to study in that area that we can't get elsewhere?

Mr. Michel Doiron: Thank you for the question.

We use the information that's available. I want to be very clear that our researchers.... Dr. Pedlar may have appeared in front of you at one point. He was on a scholarship to work on mental health and health of veterans. His group leads a lot of research. We read what the other groups are doing and we talk to them.

I was in England three weeks ago talking to their veterans affairs organization. It was interesting, London was mentioned, even in England. No pun intended, I just realized what I said...London, Ontario. We do read what's going on. The other thing we have to make sure is that, often we say “research”, but it's not just having a dog, because some people out there may try to give you a dog that is not well trained.

Mr. Cousineau, as an example, has an excellent dog, very well trained, top-notch. I've met Medric, and his dog is top class. But you have to make sure that the tool—the dog, the horse, or the program—is going to help the veteran. We recognize dogs, but that dog must be well trained and trained for what it is supposed to do. It's not just somebody working somewhere who says, I can.... A lot of the work we're doing right now is certification. It's not necessarily studying the dog.

For some of the other stuff that people say helps, anecdotally they say it helps, but where's the evidence? Where are the clinical trial? Does it work for any case? What cases does it work for?

● (1620)

Mr. John Brassard: I know we're out of time, but that's my point. There is evidence that exists elsewhere that we can tap into without having to reinvent the wheel as a country.

Mr. Michel Doiron: We absolutely do.

The Chair: Thank you.

Mr. Eyolfson.

Mr. Doug Eyolfson: Thank you.

We've talked about the earnings loss benefit, the increase. Now I'm unsure, have we decided that's going to be increasing or has it been implemented?

Mr. Michel Doiron: It has been. It was implemented October 1.

Mr. Doug Eyolfson: Okay. Thank you.

Has there been any reported impact on veterans and their families at this point or would you say it's too soon to tell?

Mr. Michel Doiron: I would say it's too soon to tell. The 6,000—and I round off the figures—who we have as clients have been processed, so they're in pay. They're eligible for all their programming and that has been done, but as to the impact on the family, on the person, we'll have to see.

Mr. Doug Eyolfson: Sure.

We've talked about the importance of peer-to-peer support with other witnesses in this committee. How could VAC best facilitate these relationships in how they can provide help?

Dr. Cyd Courchesne: We partner with the Canadian Armed Forces and their OSISS program, the operational stress injury social support. We assist in training peers to be good peer supporters, and all of our OSI clinics have OSISS peer supporters and they're very well appreciated in the clinics. When I go around and visit them, I always make sure I meet those one or two individuals who work there. As for the OSI clinics, they could not function without that important partner.

I think it's well used. It's well established. It is a Canadian Forces-led program. I don't know how well they use it, but I know that in our system it's very well used, very well appreciated.

Mr. Doug Eyolfson: All right.

There are some other peer-to-peer support systems or organizations we've heard of that are more or less volunteer-run and independent. Do you see a role in partnering these organizations with VAC?

Dr. Cyd Courchesne: I think for all our stakeholders, all the stakeholder groups, the Legion, Canadian Veterans Advocacy, they could all be considered peer support groups. They all do excellent work at representing the needs of the veterans and providing support. We see it through the members who are on the mental health advisory group. They're a great support to each other.

Mr. Michel Doiron: We work very closely with many of these stakeholder groups. For example, the Legion, I think most people know the fantastic work they do. We don't necessarily call them peer support. I guess you could say they're a type of peer support, but they are also a very good service provider.

Mr. Doug Eyolfson: Thank you.

We've heard from some witnesses about how transition is that pivotal moment. In regard to making sure that veterans are aware where mental health services are available, where would you say VAC should be involved in the transition? At what point should they get involved in plugging them into the awareness of mental health services?

Mr. Michel Doiron: We should be involved as early as possible in the transition process, because once the decision is made, there is a series.... I gave you some, but I didn't even talk about pastoral services. There are all kinds of other services available and sometimes it's not service related, but you can get these services there. As early as VAC can get involved in the transition of the individual and make the individual and the family aware of the services available, because people don't often.... That's why I handed out that document earlier. I think the clerk circulated it. There is a series of programs for mental health available to our veterans, and we very rarely hear about the programs.

The committee is studying suicide and studying mental health. It's proven—and I'm not a clinician—that the faster you can get them into treatment and get them help, the better your chances of success.

It's important that we get out to the Canadian public, to our veteran population, and that's why we gave it to the stakeholder groups, that here are the services available. It doesn't matter if you're service related or not. Yes, there may be a box that's more for the service-related injuries, but if your injury is not service related, here's a whole other series of services that VAC has out there that we'll pay for and you can have access to.

I think it's important that the Veterans Affairs organization, and the government as a whole, get that message out there, that the services are there.

Sorry, I'm passionate about that one because often—

● (1625)

Mr. Doug Eyolfson: No, that's okay. It's a very good answer. Thanks.

We talk a lot about PTSD. It's something we still don't understand completely, despite the fact that it's been around for a long time. Do you believe there's a role for any specialized centre of excellence that would concentrate on PTSD?

Mr. Michel Doiron: I believe there is. I think there's more we can do on that. Don't forget, if we study PTSD and mental health, that information will be made available to first responders. We share information. My first career was as a paramedic first responder. We can help more people than veterans. But I think there is more we can do—because science advances in early determination, early detection, how to treat it, what works, what doesn't work—to make sure the veteran gets to what we like to call the “new normal” as early as possible. Maybe they'll never be able to work again, but at least we can take care of them.

The Chair: Thank you.

Ms. Wagantall.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you, Chair.

Thank you for being here again today. This is very helpful, and all these programs show a significant concern and care for our veterans. When I look at the full list, the reality is that something is still not working for a cohort who struggle significantly. That is what we're trying to deal with.

There's a new VAC office opening in Saskatoon, correct?

Mr. Michel Doiron: It's open.

Mrs. Cathay Wagantall: It's not fully operational, but it's open and it's there. Will an OSI clinic be part of that dynamic? Reply really briefly.

Mr. Michel Doiron: Yes, we're opening a sub in the Saskatoon area. I don't have dates.

Mrs. Cathay Wagantall: I have to tell you that this is huge because we can't find our veterans, but when they have something they want to be found for, they're pretty accessible. It's good to hear this is happening because obviously we have veterans there who have suffered because they have to travel and they don't want to leave home and all those dynamics. I hope that's going to be significant for them.

You mentioned that 4,000 mental health professionals are available. We hear this a lot. How many of those are psychiatrists at any one time? Can you say that this month we have this many registered?

Mr. Michel Doiron: I can get you that. I don't have that with me, but we do have the breakdown of who they are.

Mrs. Cathay Wagantall: Do we know where they are? Then you can be able to say that this many are here, this many are there, that type of thing?

Mr. Michel Doiron: Yes. The way it works is that the mental health professionals register, as the doctor said, with Medavie Blue Cross. Essentially, we pay the mental health professional to provide the service to the veterans in their location. As you've mentioned, OSI clinics aren't everywhere. Even though we do telehealth and other stuff, sometimes we need somebody to do an assessment on site, so we have them across the country.

Mrs. Cathay Wagantall: Again, this is a huge issue we hear a lot in Saskatchewan where no psychiatrist is available.

Mr. Michel Doiron: Absolutely, and I met with their minister of health, and I was told exactly what you're telling me.

Mrs. Cathay Wagantall: Good, we're on the same page.

I also hear from a certain segment of veterans that they cannot get in to see a psychiatrist. What are the barriers to their being able to be treated by a psychiatrist?

Mr. Michel Doiron: In terms of barriers to being treated, the access is pretty good for our OSI clinics. They may have to wait two weeks but generally speaking.... We report on our accessibility, following an OAG report. We're doing pretty well. Can we do better? We can always do better everywhere, but I think we're doing pretty well there.

Certain areas of the country lack psychiatrists. As an example, we had to delay the opening of the OSI clinic in Halifax by maybe a couple of months because we could not get a psychiatrist.

● (1630)

Mrs. Cathay Wagantall: That's not too bad—a couple of months—in light of the bigger picture.

Mr. Michel Doiron: It isn't, but it is when you have the money and you have the commitment and you want to do it and you can't open because....

Mrs. Cathay Wagantall: I want to move on from there.

You were saying what areas we need to have more research in. One of them you mentioned was pain management. In light of what we're hearing right now with regard to the decisions made around marijuana and concerns about the amount versus what they would like to see, that kind of thing, and then the concerns about addictions, which are all valid, do you see value in doing a pain management study comparing what veterans are being prescribed as pharmaceuticals and the effects of that versus the effects of marijuana, and the dynamics of the two?

Mr. Michel Doiron: Our first step will be to do the research on marijuana. We're partnering with our colleagues at CAF to do proper research on the benefits of cannabis for medical purposes.

I'll follow up on your question. I had not thought about doing that type of study at this point. Right now we just want to know if marijuana works and what the long-term effects are, whether it is addictive or not.

We did this about six months ago and we're doing it again now. We looked at the usage of opioids and benzodiazepines among our veterans using marijuana. We do track that. Six months ago, when I asked for that, there was no decrease in the usage of opioids for the people using marijuana.

People say your total usage has gone down. Absolutely, it has because our number of veterans has gone down. However, in the population using marijuana and opioids, it has not gone down. We're redoing that study now to make sure; has there been a change in six months?

Mrs. Cathay Wagantall: Could I suggest that you make sure you put the ask out there to speak to caregivers who are dealing with the treatment of veterans, and talk to individuals as well? Is this the kind of situation, again, where any kind of evidence provided by individuals who should be part of the study, are not part of the study?

The Chair: Give us a quick answer, if you could, please.

Mr. Michel Doiron: Yes.

The Chair: Okay, thank you. Great.

The next is a three-minute round. Ms. Mathyssen.

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

You mentioned the issue that VAC will pay for treatment, and that's very important, but today I saw a report from the veterans ombudsman that veterans have to pay their own expenses while they're waiting for a disability award. We know that pressure, stress, can trigger a mental health breakdown.

These expenses are not reimbursed if they precede the disability approval. I wonder if you could comment on that fact.

Mr. Michel Doiron: Prior to the NVC they were covered. I meet with the ombudsman on a monthly basis. We have a very good relationship. Post-NVC that was one of the issues.

I think we have highlighted, in the reports you've seen, that the department agrees. There's some work we have to do, but it's legislative. It's not just our saying we're going to change this. It's in the timelines in the act. It's a legislative change that has to be done.

Ms. Irene Mathyssen: Are those who are responsible for that piece aware and know they have things to do?

Mr. Michel Doiron: Yes, and Mr. Parent reminds us often.

Ms. Irene Mathyssen: Good. He struck me as an individual who would be very diligent about reminding.

Mr. Michel Doiron: Absolutely.

Ms. Irene Mathyssen: I have a question about service animals. I've gone to events. I have met with organizations that are involved in the training of these animals, and it's a very long, very expensive process. Are you in contact with them? Do they approach you to provide that conduit, to make sure that veterans, those in need, receive the right animal for their needs?

● (1635)

Mr. Michel Doiron: They're not in contact with me, but I know our research group, especially on the dog side, is working very closely with the industry to make sure we have the right standards. They're working with us at Standards Canada, I believe that's the right term, to make sure that a dog that is certified as a service dog has the right certification, that it's not just Michel Doiron in his backyard, training a dog. I'm being a little facetious, but we're always a little concerned about some of the areas that say a lot of stuff, but have they...?

Some organizations are excellent, by the way, but let's make sure that the dog the veteran will receive is able to do what it's supposed to do. It does help, so let's make sure it's well trained.

The Chair: Thank you. That ends the second round.

We'll have time now to do another round. Mr. Kitchen is going to split his time with Mr. Brassard.

Mr. Kitchen.

Mr. Robert Kitchen: Thank you, Mr. Chair.

I would like to go back to the centres of excellence. What I've heard basically is talking a lot about research. Research is one thing in a centre of excellence. We all know that to do a RCT it takes time to get it done and completed, and then take that information and, through knowledge transfer, get it out to the practitioners.

Can you tell me what sorts of treatments would be set up so there's a take-home for our veterans and their families when they go to these centres of excellence?

Dr. Cyd Courchesne: Thank you. I'll take that question.

When we talk about research, we're not just talking about doing RCTs because those are the highest level in clinical research, but we can do some other research, research about what's working elsewhere and things like that.

The research drives the practices that we can then push into all of our OSI clinics, but also to the entire medical community to advance the practice of treating these injuries.

The centres of excellence, yes, there's an essential part that needs to be researched to understand because we need to understand in order to drive the best practices that will be implemented and give the tools to the medical community to deal with that. It's not just research in isolation. It will be to drive new practices to get better outcomes.

Mr. Michel Doiron: If I may—the doctor had mentioned it earlier—it's about the understanding of the issue but also educating our health professionals across the country, not just the ones who work in an OSI. It's to get that education out and actually translate some of that terminology so that people understand, because our OSI clinics are professionals in dealing with our military colleagues.

I'm from Edmundston, New Brunswick. That's where I was raised. I'm not sure how many of our doctors in Edmundston, New Brunswick, have experience dealing with and even recognizing some of the injuries related to PTSD. I think that's the other part, the education and pushing that out.

Mr. Robert Kitchen: I understand that part of it. I realize that's a goal, but is there going to be a component, and if so, what percentage of it will be providing treatment to these veterans so they get some treatment, and their families have some take-home they can use, whether it be a situation of training them with skills on how to care for their loved one with PTSD or that sort of thing?

Dr. Cyd Courchesne: Again, the understanding will drive more education for the caregivers and for the family. It's the entire package. The treatment will continue in our OSI clinic network, which will continue to grow.

The Chair: Thank you.

Mr. Brassard.

Mr. John Brassard: Thank you, Mr. Chair.

I've been trying to eeny, meeny, miny, moe, which question I'm going to ask here because I know I have only a short time, but I'm going to stick with the issue of PTSD.

One of the things I've learned in talking to some veterans is that, when a condition is too complex for somebody they are referred to, if it's post-traumatic stress disorder related, sometimes there are psychiatrists who just can't deal with it because the issue is too complex.

Can you walk me through the process of what happens at that point if it is determined that a person who is suffering is referred to a psychiatrist who can't deal with it. How long of a process does it take to find another doctor? It's something that has come to my attention recently.

● (1640)

Dr. Cyd Courchesne: I would say it would be unusual for a military veteran to not either be connected.... Either they were diagnosed while they were still in the military, and they were put into care in their specialized clinics, which have a different acronym from ours but do the same thing, the same function....

Is it possible there's a veteran who's not one of our clients and shows up to their family doctor who refers them to a psychiatrist? PTSD is not unknown to psychiatrists. If it's with respect to their military service, I think they would know that Veterans Affairs pays attention to this and I would hope they would refer them back to their case manager who would say that they should be going to an OSI clinic.

I haven't encountered cases where people have been prevented from accessing care because their psychiatrist was uncomfortable with treating it.

Mr. John Brassard: If the psychiatrist is uncomfortable dealing with it because perhaps it is too complex a case, how long would it take for them to be able to seek other doctors?

Dr. Cyd Courchesne: It would be as long as anyone who would show up for the first time in one of our VAC offices and said—

Mr. John Brassard: Which is typically two weeks?

Dr. Cyd Courchesne: Yes, it's two to four weeks.

Mr. Michel Doiron: I want to put a *bémol*. That's for our OSI clinics. In some parts of the country—I think we were hearing about the challenges in Saskatchewan, and I'm sure other parts of the country have the same challenges—it may take longer if we're trying to get a psychiatrist who is not in one of our OSI clinics. That is the Canadian health system.

As the doctor said earlier, the Canadian Armed Forces is a health provider; VAC is not a health provider. We use the Canadian health system. Our OSI clinics, as an example, are staffed by provincial health professionals. We pay the province to dedicate the clinic purely to veterans and RCMP members, but they are provincial employees dedicated to veterans. In some parts of the country, if you're not going to an OSI clinic, there could be a delay in the medical health system.

Mr. John Brassard: I see the chair is not in his chair, so I'm going to take advantage right now and ask the other question.

There will be a significant challenge for VAC going forward. This may not necessarily relate to PTSD, but in terms of long-term care for those veterans from Afghanistan, Somalia, how much planning is VAC doing? I know we're going to have to be really quick here.

Mr. Michel Doiron: We are planning. We're doing the demographics, and we're working on the entire long-term care scenario.

The Chair: Thank you.

Ms. Lockhart.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you very much.

Thank you both for being here today.

I understand Mr. Brassard has been talking a lot about the need for research. We are all looking for the answers here.

Do we have a need for research or do we have a need for more information sharing with our allies? Does anybody else have this sorted out?

Mr. Michel Doiron: I think you missed an earlier part on this.

● (1645)

Mrs. Alaina Lockhart: Sorry.

Mr. Michel Doiron: That's okay.

Canada is recognized as one of the leaders in this. Our OSI clinics and the practices and CROMIS are recognized internationally. We work very closely with the other Five Eyes: Australia, United States, New Zealand, and the U.K.

Senior officials, our researchers, and even ministers usually meet every two years. The last one I attended at West Point was on mental health.

Mrs. Alaina Lockhart: We heard testimony not too long ago from Dr. Sareen who estimated about 15% of those transitioning had mental health issues, and he mentioned that was a conservative estimate. When I asked if that's a conservative number, what did he think the real number was, he said upwards of 30%.

Does that reflect your experience?

Mr. Michel Doiron: That sounds higher than our experience. I think we typically see probably around the 20% mark.

Dr. Cyd Courchesne: It's about 23% of our clients who we have right now. It doesn't mean that there are.... We know from our research that another 20% have left the military not for medical reasons. They're not quite so sick that they would become our clients, but they struggle. It's probably an accurate number.

Mrs. Alaina Lockhart: We estimate about 20% to 25% of those we have identified.

Dr. Cyd Courchesne: Of our clients 23% have a mental health disorder diagnosis.

Mrs. Alaina Lockhart: Taking into consideration that there are those who wouldn't be tracked, that is possible.

Dr. Cyd Courchesne: Yes.

Mrs. Alaina Lockhart: Does our lack of a national suicide prevention strategy impact how we're dealing with veterans?

Dr. Cyd Courchesne: Are you speaking about a Canadian suicide prevention strategy?

Mrs. Alaina Lockhart: Yes. Will it be helpful if we have one?

Dr. Cyd Courchesne: I think it will be helpful for everyone, veterans included. It is a public health issue. I think some work is being done. For the two years I've been with the department, we've collaborated with the Public Health Agency of Canada in developing a national framework. The CAF and several partners have also been engaged with them.

Mrs. Alaina Lockhart: The other thing that we heard recently in testimony is about what I think was referred to as “death by a thousand cuts”, so there is a PTSD issue or there is a mental health issue, but on top of that there's a service delivery issue or there are other outside factors like relationships or money issues and what have you.

There are some things that we can't control as a government, obviously, but do you expect the work that we're doing on service delivery to have an impact on suicide prevention?

Mr. Michel Doiron: I look forward to your report on service delivery. I'm not sure when it will be tabled, but I do look forward to it. The last time ACVA tabled a report, there was stuff that we did use and it was very useful, so I'm looking forward to it.

For sure it is known, not just with suicide but in treating mental health in general, that the faster we can get them into treatment, the faster we can get them the care they need and the better it is for the individual. It's probably true for all illnesses. With any delays in approvals or getting them into treatment, there's an impact. That's why we're working so hard on the service delivery review that the department has been doing, but also on how to modernize our systems, get more stuff online—eliminating some of the bureaucracy is maybe the best word to use—to move it forward.

Understanding that we are governed by a multitude of acts and regulations that are laws, I can't just decide that I'm going to do X. There's a law that I have to comply with. That said, we are doing some work on that. The health care provisions are one we're starting to look into, and the financial benefit suite that we have. At the end of the day, where we're trying to go, and we've really undertaken this in the last little bit, is focusing on the veteran's well-being. You'll hear a lot about veteran-centricity, veteran-centric not program-centric, and not just making sure all the boxes in the system are.... What does the veteran need, when, and how? Let's get to it and let's get them trained.

Unfortunately, we're still heavy on the administration, and I don't mean staff when I say that, please. I mean the documentation and some of the stuff that we need to do, and sometimes it's to comply with acts. People like to say, that's what the act says. I am not a lawyer. I've been in the public service a long time, so I ask them to show me in the act where it says that. Often, over time, and this is my eighth department, people start adding requirements because of one bad apple somewhere throughout the years, and all of a sudden that becomes the policy.

Let's eliminate that policy, and our minister and deputy minister have really challenged the department to get rid of these areas, ensuring though that we don't break laws and we follow what we're supposed to. We have to or the OAG will come in and give recommendations, but let's take care of our veterans. The bottom line is care, compassion, and respect, and not just saying those words but getting them there.

In mental health, with 16 weeks, okay, I'm meeting my service standard but it's a long time to get your diagnosis and treatment. We know that and we're trying to do that much faster. For some other stuff, maybe it's acceptable.

● (1650)

The Chair: Thank you.

Ms. Mathyssen.

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

We had the Canadian Forces ombudsman here, and I'm sure you know that he has reported. We've seen the simplified service delivery model for medically releasing members. In that he suggested a concierge service, a web portal that was accessible and enabled veterans to see what it was that was available, and just a general sort of support system.

I wonder if you could comment on how these suggestions might help those suffering with mental health issues.

Mr. Michel Doiron: That was the CF ombudsman? Just to make sure, because our ombudsman has also put some stuff out, and I wanted to make sure I answer the right thing.

I agree with some of the statements from the CF ombudsman. It is really for the CAF to debate or not debate the findings. When I look at Mr. Walbourne's comments, I agree with the concierge service, and that's what we're trying to do with the guided support. Let's make sure we do that transition, not just for mental health but for all transitioning veterans.

His comments about the service attribution being done by the Canadian Armed Forces, that I don't agree with, because what happens to the people who have left? If we know that 60% of the people who are not medically releasing are having issues and they come to us two to 40 years down the road, who will be adjudicating those cases? Who takes care of that population that is already gone? It won't be the CAF doctor.

I have some concerns about Mr. Walbourne's comment on that area. We have met with him, not me personally, but my RDG has met with him and Mr. Butler, who was here, also sat down with him to go through the findings. I agree with a lot of the other ones. Simplify the process. Have it online so somebody can apply online. Let's facilitate the usage of the medical health records, so that we only use what we need to use—and we've done a lot of work on that already, by the way. I talked about the concierge service. Those parts I absolutely agree with. How do we get there?

Ms. Irene Mathyssen: We also heard from veterans who came and talked about the brown envelope syndrome, the fact that this ominous envelope arrives and it says they're rejected. One of the things we did hear from veterans was the need for a more human approach.

Is this something you've considered? Here's a very fragile human being and the news is not good. Can we help them deal with the rejection in a one-on-one situation?

Mr. Michel Doiron: Absolutely. We are piloting one right now in the Montreal office, and we'll see how it works. When they send documentation, they make a phone call to ask five days later if they have received their documentation. We're trying to facilitate, make readable, I guess, the letters we're sending out, to make sure that the veterans understand the content. We're trying to use a language that is understandable, not jargon.

We have to be careful, though. Right now our first application approval rate is 84%, so a lot of people are being approved for what they come in for, but 16% is still not being approved yet. We are working on that. We're looking at how we can make this.... In the adjudications, I have a team who now calls the veteran before sending the letter to say no. They will call and say that based on the information we have, it doesn't look favourable. Is there anything you can add to the file that may help us make a favourable decision?

There are some exceptions. We had somebody claim that we addicted them to cocaine when they were in Afghanistan, and we should pay. When we get a claim like that, we're not going to make the phone call. I apologize. We're going to deal with him in a different way, and this is an actual case. But they call and ask if the veteran is okay, and can something more be provided, because if the veteran doesn't provide anything more, then that's their file.

A lot of that is being done, but we are trying to put a much more human, personal touch, and that's the care, compassion, and respect.

Sometimes the answer is no. Let's be honest. It's not service related. There will always be those letters that say no, but let's do it in a way that is not traumatic for the veteran.

● (1655)

Ms. Irene Mathyssen: That's less adversarial.

Mr. Michel Doiron: That's less adversarial.

Ms. Irene Mathyssen: Defuse that sense that it's us against them.

Mr. Michel Doiron: Yes, and the Veterans Affairs employees are some of the most committed employees I've seen. They believe in helping the veterans. They are committed. They sometimes take abuse. Any worker in the mental health realm would know about this. They are totally committed to helping those veterans, and we just want to make sure that it gets out that we are there for the veterans. We're not there to deny. We're there to help, and even if a veteran cannot get a disability award, there are other programs, and we will put the veteran in touch with other people who can help. Our staff in the field does that.

Ms. Irene Mathyssen: I want to thank you for the fact sheet.

One of the things in the fact sheet is this online tutorial designed for anyone wanting—

The Chair: I'm sorry, we'll have to make it very quick, please.

Ms. Irene Mathyssen: I will freely admit to being technologically idiotic. I wondered how the tutorial was developed to ensure that it was good technology and user-friendly.

Dr. Cyd Courchesne: This is the online caregiver. It was developed by Queen's University, the Royal Ottawa Hospital, and the Military Family Resource Centre. It was tested with actual caregivers who said this is what they needed. This is good. They went through all that process.

The Chair: Thank you.

Mr. Bratina.

Mr. Bob Bratina: That was toward what I wanted to ask you about, the online resources.

When I was mayor, if I wanted to find out something about the city, I would Google it, because I couldn't figure out the city's website. Generally speaking, it's not only with the online resources but with everything you do, and I was encouraged by the remarks you just made.

We're reviewing the programs and processes. What about your internal review? Tell me about that.

Mr. Michel Doiron: We're finalizing one that we're going to start implementing probably in January or February. It's the service delivery review, which is looking at the journey of a veteran in our process. We've done journey mapping, and some of that stuff, to see.... They've looked at 400 veterans, actual cases, and mapped what happened.

It's not always nice in the sense that the service was done, but there are a lot of touchpoints, a lot of letters sent, and a lot of medical exams needed. We're going to be looking to eliminate some of this, to make it simpler. That's the service delivery review. We're also looking at stuff to make our forms easier. It's very practical stuff.

The other review that the associate deputy minister is going to embark on in the very near future is what we're calling a functional review. I think the meeting was called for tomorrow but it may be next week now. As I mentioned earlier, we're noticing the policies. Often there are departmental policies that are not law or regulations, so it's about how we can remove these layers of policies that have morphed.

Veterans Affairs is a very old department. The deputy minister likes to call our legislation and our policies a quilt. I think that's a very good picture of our stuff. Governments add programs or change things, but there are all these rules and regulations that we have to follow. How can we remove the internal policies that have been put in place over time that are not in law and are not in regulations and simplify that?

There are 741 internal regulations and policies, and I stand to be corrected on the exact number. They're not legal. We're going to be embarking on figuring out which ones don't make sense and eliminating them to try to save time, process, and documentation, and advance this. This is ongoing.

We are serious about trying to simplify this. In my mind, I keep thinking about TurboTax, and it may be a plug for a company here. I use TurboTax to do my income tax. I would love to have TurboVAC. I'm very serious about it, because you can go on the web, assuming you're web literate, and if you're not, we'll take care of you, but it won't ask you to fill out 25 forms. It'll ask if you served, yes or no, and you can put out some stuff and our system would populate it.

We are not there, but I had a veteran talk to me the other day who said it was the first time he had a VAC form sent to him that was completed. We put all the information on the form, and he just had to confirm and send it back to us. We're going down that road.

● (1700)

Mr. Bob Bratina: You were a paramedic?

Mr. Michel Doiron: Yes, years ago.

Mr. Bob Bratina: The people we're talking about are in crisis. It's not as if they're asking when they can get their car fixed. In your case, in your previous work, if the phone rang or a light went off, three minutes later you're on the way.

I also like TurboVAC.

We need all the Veterans Affairs staff to remain relevant to the needs of veterans. I know that the head of the Canadian Pacific Railway moved all its people away from the downtown Calgary office to a railway yard and told them to look out the window, because that's what they do.

I'm wondering how you achieve that human, personal touch that you talked about.

Mr. Michel Doiron: First of all, we've hired over 300 new individuals based on budget 2015 and 2016. All these individuals are going through an intensive training program, which is all about care, compassion, and respect. They are going out into the offices across the country with the new philosophies. Come April 1, we're going to bring in our more experienced people and put them through, not quite the same training because they have the expertise, but to make sure they know the new concepts.

For the service delivery branch, for my branch, my directors general and my executives are all tasked to get out to a field office on a very regular basis. Our head office is in Charlottetown, as opposed to other departments, but if you're always in the ivory tower and you never make it to the front line, or to the train yard, you don't really know what's happening on that front line.

It caught me by surprise when a person in a certain position said he went with a deputy to an office, and it was the first time in *x* number of years he'd been to a field office. I was thinking to myself, how do you know what's going on?

I feel it every day.... I field the complaints—not just feel, but field—but it's important that everybody does. Our deputy—you've met him, he was here Tuesday—and the associate deputy minister go to offices, and the deputy probably hits an office every couple of weeks, a bit less now because of his operation. When he comes back, he goes to the senior management table and tells them what he heard and saw.

It's being brought into the entire organization, because care, compassion, and respect has to be believed and lived at all levels of the organization. The staff are living it. I live it every day. The doctor here lives it every day, but we have to ensure the entire department understands it.

● (1705)

Mr. Bob Bratina: Thank you.

The Chair: Thank you.

That ends our time for today, so I'll give you a couple of minutes if you'd like to wrap up, and we'll go from there.

Mr. Michel Doiron: The only wrap-up I would have is that I do seriously look forward to your report on service. I know you've been meeting with a lot of individuals. I read a lot of the transcripts. I hope there are areas in that, that will help us.

The Chair: Our intention is to table the report tomorrow, so you'll have some reading for the weekend.

Mr. Michel Doiron: I spend a lot of time reading.

Thank you to the committee.

The Chair: Thank you very much.

On behalf of the committee, I'd like to thank both of you again for testifying in front of the committee today, and thank you for all you do for the men and women who have served us.

With that, I'll suspend for about four minutes and we'll come back in camera.

[*Proceedings continue in camera*]