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● (1545)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): I call the meeting to order.

We waited a few minutes because we know that one of our colleagues, on crutches, is a little slower on his feet than normal.

I'll give a little update to the committee before we get into hearing the witnesses today. We were successful in getting the funding back for our trip to Afghanistan. I understand it was just approved in the House.

Let's get down to business. We're here to continue our hearings on the health of our Canadian Forces members, with the emphasis on post-traumatic stress disorder. Today we have some expert witnesses, and we're anxious to hear from them.

I'll explain that we can't go overtime today. The bells will ring at 5:30 for a vote, and then at 5:45, I believe, for another vote.

Go ahead.

Mr. John Cannis (Scarborough Centre, Lib.): Congratulations, first of all, for getting the money. Thank you very much.

Are we going to allot some time to discuss dates, etc., at a future meeting?

The Chair: Yes. The first meeting back, on April 1, will be a subcommittee meeting on future business. We'll be able to deal with that then.

Mr. John Cannis: Thank you. I appreciate it.

The Chair: I've asked the clerk to start us off that way in April.

Today we welcome, from Veterans Affairs, Doug Clorey, director, mental health policy directorate; Rachel Corneille Gravel, executive director, Ste. Anne's Hospital; and Raymond Lalonde, director, National Centre for Operational Stress Injuries.

I understand that each of you has a short presentation to start. Then we'll get into questions.

Whoever wants to start, the floor is yours.

[*Translation*]

Ms. Rachel Corneille Gravel (Executive Director, Ste. Anne's Hospital, Veterans Affairs Canada): Good afternoon. My name is Rachel Corneille Gravel. I am Executive Director of Ste. Anne's Hospital. I want to tell you that we are very pleased to be here today and to be able to answer your questions. We are not clinical specialists, but we will nevertheless try to give you a good idea of the work we do and of what we can do for our clientele.

I'm accompanied by Mr. Doug Clorey, who will take the floor after me. As Mr. Casson mentioned, he is Director of the Mental Health Policy Directorate. He is also responsible for the Veterans Affairs Canada Mental Health Strategy. Mr. Raymond Lalonde is Director of the National Centre for Operational Stress Injuries at Ste. Anne's Hospital.

I'm going to talk a little about Ste. Anne's Hospital, which was founded in 1917. It is the last hospital administered by Veterans Affairs Canada, the last hospital under federal jurisdiction. It is a long-term care centre specializing in geriatrics and psychogeriatrics. It currently houses nearly 415 veterans of World War II and the Korean War. Obviously, we no longer have any patients from World War I.

The hospital also specializes in mental health. The first Veterans Affairs Canada clinic for operational stress injuries was established at Ste. Anne's Hospital in 2001. An enormous amount of work has been done since then. As part of the modernization of programs and services offered to clients through Veterans Affairs Canada, Ste. Anne's Hospital was assigned a national clinical leadership role in 2005 for all matters pertaining to operational stress injuries, OSIs.

Today, the National Centre for Operational Stress Injuries at Ste. Anne's Hospital has three sectors.

The OSI clinic employs psychologists, psychiatrists, social workers and nurses. It offers specialized outpatient services to more than 300 new-generation veterans. There's also the clinical expertise sector, the main role of which is to develop and promote best practices across the country and to provide consulting services, particularly through our other OSI clinics. Lastly, the network coordination and development sector, which is more administrative in nature, is responsible for developing and coordinating clinical mental health services across the country to ensure that all clients, regardless of where they live, can receive the clinical services they need.

Veterans Affairs Canada has a very specific mandate to provide care and services to individuals who have served in the Canadian forces and are now veterans, whereas National Defence is responsible for active military members. Although our mandates are different, our purpose is to develop, coordinate and harmonize care and services in areas of common interest, such as mental health.

For that purpose, Veterans Affairs Canada, the Department of National Defence and the Royal Canadian Mounted Police signed a memorandum of understanding a few years ago. That MOU defines a framework for putting a joint network of clinics in place. Veterans Affairs currently has six clinics, and will soon have 10. The Department of National Defence also has its own clinics. I believe there are five of them. This synergistic and partnership effort is seen in a very good light; it represents a commitment by two departments to assist this clientele.

That was a very brief introduction to tell you who we are and what we do. I now turn the floor over to Mr. Doug Clorey, who will tell you about his area of expertise.

[*English*]

Mr. Doug Clorey (Director, Mental Health Policy Directorate, Veterans Affairs Canada): Thank you, Rachel.

As Rachel and the chair have mentioned, my name is Doug Clorey. I am the department's director of mental health policy. In that capacity I have the overall responsibility for overseeing the implementation of the department's mental health strategy. There are some details on this strategy in your deck, and perhaps we can refer to some of the slides at some point during our discussion.

The strategy essentially consists of four elements. The first one is to ensure that the mental health services required by still-serving members of the Canadian Forces and by veterans are there. It covers the whole gamut from health promotion to assessment, treatment, rehabilitation, and ongoing care.

The second element of the strategy is to build capacity. Building capacity is about ensuring that when we are not satisfied the resources are available, we take steps to initiate those resources, particularly in the local communities where the veterans are located.

We think we also have a role in terms of leading in this area, so there's a leadership component to our strategy.

Finally, we recognize that none of us can do this particular work on our own, so partnerships are key to being able to achieve.

Those are the four elements of the strategy. We can talk more about that as time unfolds this afternoon.

I also have overall responsibility with my team to develop the business processes and the policies associated with the delivery of mental health services to veterans and other clients within the department. This is all to say that I am ready, willing, and hopefully able to speak with you this afternoon on the mental health strategy of the department, on the mental health framework that constitutes how we go about delivering services to our clients, and also a little bit on the lessons we've learned over the last number of years.

Finally, I want to recognize the work of this committee as I suppose part of the work we do in partnership. We really look forward to what will come out of this committee in terms of recommendations, because we would like to think we're all working towards the mental health and well-being of veterans and those who have served our country.

Thank you.

● (1550)

The Chair: Thank you for those comments. We appreciate that.

We will start the seven-minute round with Mr. Coderre.

Hon. Denis Coderre (Bourassa, Lib.): Mr. Lalonde would like to respond.

The Chair: I apologize, sir; take all the time you need. We'll keep Mr. Coderre on hold. It's not an easy thing to do, but we'll try.

Hon. Denis Coderre: Take your time.

[*Translation*]

Mr. Raymond Lalonde (Director, National Centre for Operational Stress Injuries, Veterans Affairs Canada): Thank you very much.

As Ms. Gravel said, the National Centre for OSIs, which I direct, is part of Sainte-Anne Hospital. We have a three-part mandate: to provide clinical services at the hospital for OSIs, to provide OSI expertise to the department and on an outpatient basis, and to develop access to services across the country.

One of the major characteristics of this last component is the establishment of a network of clinics. The Department of Veterans Affairs offers no direct service to its clientele, except at Ste. Anne's Hospital. The services covered by Veterans Affairs are offered through provincial health services and private service providers, the cost of which is reimbursed by the department.

We also have networks of private service providers across the country that offer specialized programs, such as comorbidity programs for PTSD and substance abuse. As regards the OSI clinics, apart from that in Sainte-Anne, we've entered into agreements with institutions under provincial jurisdiction. Under those agreements, we provide the provincial institutions with funding so that they can establish clinics for our veteran clientele. However, those clinics are also accessible to members of the Canadian Forces and the RCMP.

So the department's only OSI clinic is located at Ste. Anne's Hospital. Our other clinics were established under agreements reached with the provincial institutions. I think that's an important difference, having regard to the fact that the Canadian Forces are responsible for their own clinics, which are operated by their personnel.

I wanted to be sure to clarify that point.

● (1555)

[*English*]

The Chair: Thank you.

Mr. Coderre.

[*Translation*]

Hon. Denis Coderre (Bourassa, Lib.): I'd like us to go off the beaten path. Hearing talk about leadership, partnership and offer of service, I got the impression—and I mean this quite respectfully—that I was reliving the years when I was studying for my MBA. It was all well and good, but I would like us to go a little off the beaten path. I know you aren't clinical specialists, but we're trying to get a clear understanding of the environment in which a person who most of the time feels alone and has to go through trying times is confined. In addition, it wasn't so long ago that anything called mental health wasn't taken seriously. No doubt you've often preached in the wilderness.

When someone is in need, how do things happen, in concrete terms? Do you offer services, and so on? Do you work with other organizations? Another organization offers support through peers. It tries to reach those who have experienced the same problems, to oversee them, and so on. I know that you're doing quite outstanding work at Ste. Anne's Hospital, but it's a tough and difficult job, and it has to be linked up with other clinics. How is that done? How are you going to go after people, or how do people come to you when they are in need?

Ms. Rachel Corneille Gravel: I'll start, and Raymond or Doug can add their comments.

People in need can be referred to Ste. Anne's Hospital, for example, in various ways. That can be through the Montreal district office. Normally, eligibility is one of the set of rules. These people are referred by the veterans assistance system so that they can receive care and services, for example, at Ste. Anne's Hospital. That can also very well be done through peer support. We also work very closely with a group called the Operational Stress Injury Social Support Program. It's a peer support group, people who have suffered from various mental health disorders and who establish strong ties with their companions in the armed forces. A person in need will be referred to us. The deadline for seeing that person is very short for us, among others, at the operational stress injury clinic. We have to ensure that there is an assessment and treatment plan. That person will be seen by the nurse, by the social worker and, if necessary, by the psychologist or psychiatrist, because, in many cases, a diagnosis has already been made. Obviously, we'll trigger a treatment plan. There are various types of treatment—group therapy, individual therapy—and a lot of work is also done with the families since the family is an integral part of the life of that person. That especially should not be forgotten in the treatment process. It is possible that we may refer them for detox treatment because we work in partnership with other groups, other institutions. The person has to be referred to the right place, depending on his or her situation.

Of course, someone living in an urban area, near an operational stress injury treatment clinic, has better access than someone living in a remote region. In general, I believe we respond to most of the needs of people across the country. We're obviously developing. We have contacts and we're trying to build a network. Some service providers can meet these people where they live. We're also developing a telemedicine system to put people in touch with remote specialists, in another way.

Perhaps Raymond wants to add something.

Hon. Denis Coderre: After speaking with certain soldiers privately—and we'll be hearing from others—it appears that one of the problems is that these people very often feel somewhat trapped in the system. The system may be beneficial and help them —when they've gotten to you, perhaps they'll be saved—but there's a confidentiality problem. They're afraid that things will be known. Obviously, that also depends on whether they have been relieved of their duties or not. We also have the feeling that there's a lot of bureaucracy, because people often give up at some point.

How are you experiencing that? You said you had worked with the organization that we met, which moreover is doing quite outstanding work. How do you ensure follow-up? How do you ensure that you can treat these people humanely and not as statistics or within too bureaucratic a framework? I say that respectfully, of course.

● (1600)

Ms. Rachel Corneille Gravel: The people we meet have been discharged from the Canadian Armed Forces. The Department of National Defence has taken charge of a part of their lives, with emotional consequences. When they are discharged from the armed forces, they become part of our clientele.

I think the approach is very humane. The work that is done very closely with the peer counsellors and health professionals consists in trying to restore their dignity and a sense of belonging to a community. One of the objectives moreover is to be able to do everything to help them find their place in society. The follow-up that we do includes clinical follow-up, for which the clinicians are responsible. However, we also do follow-up with these people and their family through surveys and individual meetings. We have a way of taking the pulse to see if they are satisfied. We have a whole quality control system for finding indicators that give us a faithful representation of a certain degree of success. This system is obviously evolving.

Hon. Denis Coderre: Are you finding that patients are younger and younger? There are World War II and Korean War patients at Sainte-Anne-de-Bellevue. Do the missions we are taking part in give you the sense that there are increasing numbers of people?

Ms. Rachel Corneille Gravel: Yes, the clientele is much younger. It's an out-patient, non-hospitalized clientele. We only admit the hospital veterans who have served overseas in a war. The really much younger clientele, between 30 and 50 years of age, is the one we see on an outpatient basis.

[*English*]

The Chair: Thank you very much.

Mr. Bachand.

[*Translation*]

Mr. Claude Bachand (Saint-Jean, BQ): Thank you, Mr. Chairman.

Welcome. My first question is for you, Ms. Corneille Gravel. Have you been Executive Director of Ste. Anne's Hospital for a long time?

Ms. Rachel Corneille Gravel: Yes, since 1996. I've worked at Ste. Anne's Hospital since 1974.

Mr. Claude Bachand: Your face is familiar. The members of the Standing Committee on Veterans Affairs visited the hospital a few years ago. We were very impressed.

Ms. Rachel Corneille Gravel: That's it.

Mr. Claude Bachand: I even remember having lunch—

Ms. Rachel Corneille Gravel: —a lunch for dysphagics—

Mr. Claude Bachand: —with mashed carrots in the shape of carrots.

Ms. Rachel Corneille Gravel: That project was commercialized not very long ago.

Mr. Claude Bachand: Has that generated profits for you?

Ms. Rachel Corneille Gravel: Not for us, no, not at all. We granted the designer a licence.

Mr. Claude Bachand: That's very good.

I'm going to talk a little more about administration. You told us about a memorandum of understanding, about a joint network of clinics. Is that MOU accessible? Can you send it to the Clerk of the Committee so that we can examine it?

Mr. Raymond Lalonde: With your permission, I'll answer because I am responsible for that MOU at the Department of Veterans Affairs.

The memorandum of understanding signed between the Department of National Defence, the RCMP and Veterans Affairs Canada provides for the framework under which we will establish a network of clinics for the purpose of providing a set of similar services in all clinics across the country accessible to veterans, military members and members of the RCMP. That network is currently being developed. The Department of Veterans Affairs is to open new clinics. We are to open four more to ensure that we have national coverage. We are establishing the financial and administrative operating rules, for quality performance indicators and financial standards. That will enable us to ensure that the three clienteles have access to all clinics in Canada: the on in Sainte-Anne-de-Bellevue, those under our responsibility and that we've negotiated with the provinces, and those of National Defence.

● (1605)

Mr. Claude Bachand: I have another question on standardized services. If I understand correctly, the National Centre for Operational Stress Injuries establishes, for example, the type of treatment that will be provided fo all OSIs. Incidentally, are the letters “SC” in the acronym “OTSSC” there to identify those that are directly under military responsibility?

Ms. Rachel Corneille Gravel: That's correct.

Mr. Raymond Lalonde: The OTSSCs are those of the military.

Mr. Claude Bachand: All right. You're telling us that there is coordination and an MOU with all these people.

Mr. Raymond Lalonde: There is an MOU establishing that we are going to work together to develop and harmonize... It's not yet complete. In some cases, veterans have access to the Defence clinic, and it's different in other cases. For example, there's a clinic in Winnipeg, and we have an agreement with Deer Lodge Hospital, which accepts a lot of military members from the Shilo base. It's already working; we're developing the mechanism, because there aren't enough clinics in the country, and we're working out the details of the services that will be offered.

Mr. Claude Bachand: Can we talk about standardized services? Are there the same services in Montreal and on the west coast, in Esquimalt, for example?

Mr. Raymond Lalonde: When you talk about mental health services, the mandate of the operational stress injury treatment clinics is first to conduct assessments. We use the best practices, those that are recognized by researchers, in the clinics of both the Department of National Defence and the Department of Veterans Affairs. There may be different terms and conditions for military members, but they are nevertheless quite similar. For treatment approaches, clinicians sat down together. The health professionals sat down with those of the Department of National Defence and those of the Department of Veterans Affairs to establish what the best practices should be. Once that's done, health professionals use their professional judgment to use, from among the recognized best practices, those they consider most suited to the client or patient they are treating.

Mr. Claude Bachand: How do you go about putting that together, since health is a provincial jurisdiction? Of course, you retain some responsibility for the soldiers, veterans and so on, but does the MOU establish a standard that must be met by British Columbia in Quebec, or are the MOUs instead segmented by province?

Mr. Raymond Lalonde: Even though I direct the National Centre for Operational Stress Injuries of the Department of Veterans Affairs, we have established agreements with the provinces and we're working on a collaborative basis. We don't have all the knowledge, all the experience or expertise in this area, since it's new and evolving. We're working with all the managers and professionals of the clinics to establish the best practices.

Consequently, this year, we worked to establish jointly what should be the best assessment tool or evaluation form, the one that should be used in all the clinics. We work a lot on a collaborative basis and by consensus instead of imposing standards, because this is a field where we need everyone's contribution. It's often said that we aren't the expertise centre since the expertise centre is the entire network of clinics working together.

Mr. Claude Bachand: Does that include the budget agreement as well? The Deer Lodge Hospital reports to the Government of Manitoba.

Mr. Raymond Lalonde: Yes, but we finance the clinics 100%. According to the agreement we've reached with the institutions, they use our model. This is a highly specialized, level-three interdisciplinary model that includes the best practices, case management, and so on. So we ask that certain criteria be met. In consideration of that, we fund the clinic's operation entirely.

Mr. Claude Bachand: My next question is for Mr. Clorey.

Mr. Clorey, you have the title of Mental Health Policy Director. Does that mean that you establish the entire mental health program of the Department of Veterans Affairs? In other words, are you the brains of the entire system that is then implemented in the OSIs? How do you work?

● (1610)

[*English*]

Mr. Doug Clorey: As Raymond has said already, everything we do around mental health is done in collaboration. So I would certainly not assume responsibility for all of this, or even my team. The department has organized itself with a group of people who bring expertise from all areas of the department to actually develop these policies. But you are correct, in that out of the directorate for mental health policy will flow the policies and business processes for how we will serve clients with mental health conditions.

[*Translation*]

Ms. Rachel Corneille Gravel: I'd like to add something. He handles strategy, and so ensures that all the pieces fit together well. However, it's really the expertise centre of Ste. Anne's Hospital—with the help of the clinicians and the interaction with the clinicians of the other clinics—that is responsible for developing and influencing policy. In a way, it sends that to Doug's box.

[*English*]

The Chair: Thank you.

Ms. Black.

Ms. Dawn Black (New Westminster—Coquitlam, NDP): Thank you very much.

Thank you for coming to the committee. We had people here on Tuesday who were part of this and were peer support counsellors. I found it very interesting to hear about it from their perspective as well.

You say that your facility, Ste. Anne's, is the national centre. I guess this follows up on Mr. Bachand's question on how that spreads out across the country. When I look at your slide I see there's something listed for Esquimalt, but that's all I see for British Columbia, which is my province.

At one time there were veterans hospitals in B.C. as well, but there aren't any more. How do veterans in British Columbia access the same level of service you're talking about in your facility in Montreal?

Mr. Raymond Lalonde: All veterans have access to their services through the provincial health systems. There's also a series of private providers and private programs.

Ms. Dawn Black: Are they funded by Veterans Affairs or the province?

Mr. Raymond Lalonde: If the client is entitled to the services, we will reimburse the costs. For example, in British Columbia we have two providers of comorbid programs on Vancouver Island. One is in Nanaimo and the other is in Victoria. So there are services.

In budget 2007, funding was approved to establish five new clinics across the country. We are looking for hospitals to partner with us to establish OSI clinics, so there will be more clinics out west.

Ms. Dawn Black: If I understand you correctly, it would be a cost-shared program, but the province would have to bill you or seek reimbursement from you before they received money for veterans. Am I correct?

Mr. Raymond Lalonde: If we are talking about OSI clinics, we pay the full bill. If we are talking about services from private providers, the service provider bills Veterans Affairs directly.

Ms. Dawn Black: So they take it down to the individual then.

Mr. Raymond Lalonde: Yes.

Ms. Dawn Black: If a soldier returns from Afghanistan and is out of the military, they come under Veterans Affairs Canada, right?

Mr. Raymond Lalonde: Yes.

Ms. Dawn Black: If they lived in Kelowna in the interior of British Columbia, would they have to go to Esquimalt or Nanaimo on Vancouver Island to access the services, or are you contracting out to mental health providers in that community? Are there problems for returning soldiers, who now come under Veterans Affairs, in accessing services in different regions of the country?

You've said you're going to commit to five new clinics across the country. Where are they going to be?

Mr. Raymond Lalonde: There are 900 services providers that meet our standards and are registered with us to provide services across the country. So around Kelowna there will be providers of trauma therapy for our Veterans Affairs clients. That's not a problem.

The clinic locations have yet to be finalized. The Minister of Veterans Affairs will announce the locations as soon as he can in the near future.

● (1615)

Ms. Dawn Black: My next question concerns the chart in the kit you put out. It talks about numbers of clients. In Charlottetown you're treating 42 clients for post-traumatic stress disorder, and 89 clients for psychiatric conditions. Am I understanding the chart correctly that these are people who've been diagnosed and are now receiving services from Veterans Affairs Canada?

Mr. Doug Clorey: This chart breaks out the previous bar charts that describe how our clients are distributed. If you take a look at the chart on page 4, in 2006-07—and those numbers reflect until the end of March 2007, so they're almost a year old—10,250 clients had received favourable decisions for psychiatric conditions.

Ms. Dawn Black: Does that mean they've been diagnosed?

Mr. Doug Clorey: They have been diagnosed with a condition that's pensionable, under the regulations of Veterans Affairs, in a psychiatric or mental health condition.

Ms. Dawn Black: Thank you.

Mr. Doug Clorey: The chart on page 6 breaks that down in terms of each of the areas of the country. The second column is all of the conditions, so it adds up to the 10,250, the same figure. The first column is the actual numbers of clients who have been diagnosed and assessed and have disability pensions for PTSD.

Ms. Dawn Black: And the cumulative total would be other psychiatric illnesses, including the PTSD?

Mr. Doug Clorey: That's correct. It would be things such as depression, anxiety disorders, social phobias, addictions—any of those other conditions.

Ms. Dawn Black: And are these all people who have left the military now, or are they people who are also in the military?

Mr. Doug Clorey: It's a combination of both.

Ms. Dawn Black: Okay.

So the numbers are really growing.

Mr. Doug Clorey: They have grown.

Ms. Dawn Black: It looks quite dramatic to me.

Mr. Doug Clorey: If you look at the bar graph, you can see the dramatic increase over the period of 2001 to 2007.

Ms. Dawn Black: There's been anecdotal evidence given—or people have talked to me, and I know they have to other members of this committee or other members of Parliament—of people who are now out of the military and moving on to Veterans Affairs having difficulty moving from the umbrella of DND to the umbrella of Veterans Affairs.

What challenges would you talk about in that area? Am I correct? I'm hearing this from individuals. Are you looking at ways to meet those challenges when people are leaving the forces?

I guess my question is, is there room for improvement?

Mr. Doug Clorey: I can start, and my colleagues can add.

We would call this the transition from the military to civilian life. Yes, of course there are many challenges. There are challenges inherent in the very fact that you have people leaving a particular culture and lifestyle and going to something that is very different.

What we have tried to do on the mental health side is focus on that piece of time when the individual is still in the military but is about to be released. We have tried, and there's always room for more improvement, to engage our area counsellors, who are basically our case managers, at the bases so that information can be provided to the people who are leaving the military, particularly those who are being released for medical reasons.

There's also a link, then, with the department through this area counsellor even before they leave. We try to provide as much information as we can to them about the programs that are available. Very often the issues come later, but at least they've had a first pass at what the department is able to provide to them, and it eases the transition.

The goal is to be seamless, at the end of the day. We're not seamless yet, but that's what we aim for.

The Chair: Thank you.

We're out of time on that slot, so we'll have to come back to this.

We go over to Mr. Blaney.

[*Translation*]

Mr. Steven Blaney (Lévis—Bellechasse, CPC): Thank you very much, Mr. Chairman.

I'd like to welcome our witnesses. I hope the road here was good and that it will be on the return as well. A storm has been forecasted. I apologize for missing your testimony. Whatever the case may be, I have seven questions, and we have seven minutes. I hope we can get an overview of the subject.

Ms. Black, looking at your chart, I wondered what distinction there was between CF members and War Service members?

● (1620)

Mr. Raymond Lalonde: The people who are in the War Service category are those who fought in the world wars and the Korean War. Those appearing in the CF category are those who served from 1945 to the present, with the exception of those who fought in the Korean War.

Mr. Steven Blaney: I thought these statistics concerned members of the regular forces, in other words active members of the RCMP and veterans. Is that correct?

M. Doug Clorey: That's correct.

Mr. Steven Blaney: Is there a distribution between active members and veterans?

[*English*]

Mr. Doug Clorey: If you take a look at the chart on page 4, the bars show the different combinations of war service veterans, Canadian Forces veterans, and RCMP. The blue bar in the middle is the increase in Canadian Forces veterans. The top one in the greenish colour is the war service veterans, and the RCMP is at the bottom. That's how the numbers are divided.

If we look at 2006 and 2007, of the total number of clients we have receiving disability pensions for psychiatric conditions, we have 3,125 who are war service veterans—that's World War II and Korea, essentially—we have 5,872 Canadian Forces veterans who are receiving benefits that are basically peacetime in Afghanistan, and 1,253 from the RCMP.

Mr. Steven Blaney: Okay, so they are veterans. They are not still active in the forces. None of them are still active?

Mr. Doug Clorey: Some are. We don't have the breakdown there. I can actually give you the breakdown for Afghanistan, if that would be of interest to you.

Mr. Steven Blaney: Yes, sure.

Mr. Doug Clorey: It is not in your slides. It gives you a sense of how they break out.

This is as of the end of February this year, so for most of 2007-08. We had a total of 3,500 clients in the department who have served with a special duty area of Afghanistan, of which 2,150 are still serving, and 1,350 have been released.

Mr. Steven Blaney: That's good.

Mr. Doug Clorey: It's 1,350. I can also tell you how many of those, if you have an interest, have psychiatric conditions.

Of the total 3,500 who are clients of the department who have served in Afghanistan, 681 currently have disability benefits with a psychiatric condition, of which 412 are still serving and 269 have been medically released.

Mr. Steven Blaney: Wow. Those are large numbers.

As you mentioned, you expect those numbers to grow within five years. Have you made any projections? Because I guess you have to plan on there being an increase.

[*Translation*]

Mr. Raymond Lalonde: I'd like to answer.

If you rely on the table showing the increase in recent years, you may think that this will continue to increase. It's very hard to make forecasts, in view of the fact that we don't know how long our military members will be deployed, on the one hand. On the other hand, you also have to consider the improvement in mental health services in the Canadian Forces. Much screening is done before, during and after return. The Canadian Forces have significantly increased their mental health resources. We hope this improvement will have an impact that will mean that the number of veterans with mental health problems will decline. So it's hard to make forecasts.

Mr. Steven Blaney: What's the average length of a stay? When someone's referred to you and is taken in charge, how long does that person take advantage of your psychiatric services?

Mr. Raymond Lalonde: He may have them all his life. That depends on the client. The intensive phases of post-traumatic stress, for example, can last a year or two. However, many of our clients will need services throughout their lives and will remain our clients. That's not the case for the majority of them, but, unlike members of the Canadian Forces, some have been in hospital since the war.

● (1625)

Ms. Rachel Corneille Gravel: What we hope—and that's what we're working toward—is that they can return to the community, have a paying job and regain their dignity and self-sufficiency. That doesn't prevent the fact that they may occasionally need to come to Ste. Anne's Hospital, for example. Ideally, an operational stress injury clinic works toward giving people their discharge, even if it means them having follow-up in the community or, if necessary, with a psychologist. That could be done at Ste. Anne's Hospital, for those living in the region.

Mr. Steven Blaney: All right.

Ms. Rachel Corneille Gravel: This is still new; we're still laying the foundation.

Mr. Steven Blaney: These people aren't placed in an institution, are they?

Ms. Rachel Corneille Gravel: No one is.

Mr. Steven Blaney: All right.

Do you ever decide to remove someone from the active forces? Do you make that kind of medical decision?

Ms. Rachel Corneille Gravel: Not at all.

Mr. Steven Blaney: It's not you who make that decision.

Mr. Raymond Lalonde: No.

Mr. Steven Blaney: Do your statistics take into account those who receive outpatient treatment and who do not call on the Canadian Forces? I imagine your statistics don't take into account those who go to see their family doctor or who go to a civilian hospital to receive psychological treatment.

Mr. Raymond Lalonde: Are you referring to military members or veterans?

Mr. Steven Blaney: I'm referring to both.

Mr. Raymond Lalonde: Our mandate doesn't cover military members. We don't monitor them. We're concerned with veterans. These figures show those who file a claim for compensation for a disability that is recognized as related to their service. That concerns only those who come to see us and whose disability has been recognized. Some of those 10,000 individuals will subsequently receive the services of a psychologist or psychiatrist, or will receive medication. There are others who will simply receive the services of their family doctor, because their condition is less serious.

[*English*]

The Chair: Sorry, Steven.

[*Translation*]

Mr. Steven Blaney: Thank you very much. It's a whole world.

Thank you, Mr. Chairman.

[*English*]

The Chair: Thank you.

That finishes the opening round. We'll now get into a five-minute round, starting with Mr. Rota.

Mr. Anthony Rota (Nipissing—Timiskaming, Lib.): Thank you, Mr. Chair.

Thank you for being here today.

I'm going to just use one case study in particular. An individual was in my office. He's a young man. He came back from Afghanistan, and he was getting treated. He went to see a psychologist he was referred to. He's with Veterans Affairs now. He's no longer in the military. He sat down with a psychologist and the psychologist looked at him and said, “Well, I really don't know how to treat post-traumatic stress disorder, but we'll go through this together and we'll see what happens.” This leads me to chapter 4, page 3, of the Auditor General's report, when she reported that mental health work is being contracted out to civilian workers who don't have the experience or knowledge to treat injured individuals. That has to do with the military, with DND. I'm sure a lot of it spills over. I'm not sure exactly what the division is. That's one question.

The real question is how do you choose health care providers? What criteria do you use to assess their capabilities? When you have a psychologist or a psychiatrist or a mental health care provider, where do they get their training? Is it mainly through school? Do you look at what training they have afterwards? Is it a combination of all?

[*Translation*]

You may answer in French if you wish.

Mr. Raymond Lalonde: As I explained earlier, 900 service providers across the country meet our criteria. Clients are free to go and see the service provider of their choice, provided that provider meets our criteria. We then reimburse for treatment expenses. In one sense, that's very different from what is done in the Canadian Forces. In their case, contracts are established with service providers, and forces members are referred to them. In our case, it's a matter of free choice.

To be a service provider, you have to meet training and experience criteria. We don't have any contractual relationship with those suppliers. We can't impose practices. Our role is to ensure that clients are satisfied and to improve the training and supervision of those providers. Since we don't have any authority, the practice of those providers is the responsibility of their professional order, in the province where they are located. We're in the process of improving training for service providers. In addition, the OSI treatment clinics have a role to play in training.

Our role is also to improve our relations with service providers so that they can work with the specialists at the OSI treatment clinics. The objectives is to enable them to improve their practice. To do this, they can discuss the best approach to adopt with the professionals and experts. We also aim to further standardize reports and information that we want to receive when we are asked to approve a series of treatments.

Clients may consult the therapist of their choice, but they must seek pre-authorization from us where they exceed a certain number of treatments. In that respect, we're working to improve our policy and our instruments, particularly with a view to offering the right answers and asking the therapist the right questions and to ensuring that the treatment heads in the right direction.

Mr. Anthony Rota: I don't understand. Individuals choose where they want to go, but I imagine that criteria have been set in the matter.

Mr. Raymond Lalonde: Yes, suppliers must meet our training and experience criteria in the area of the therapy.

● (1630)

Mr. Anthony Rota: If someone wants to try something different, such as acupuncture, for example, or another unofficial treatment, does your system have some flexibility or is it rigid?

Mr. Raymond Lalonde: The treatments for which we provide reimbursement are those offered by health professionals.

Mr. Anthony Rota: That's only one example. That's the first idea that came to my mind. If there's something new, a new treatment—

Mr. Raymond Lalonde: It must be studied and recognized in the research field. We don't accept just any treatment, especially where it isn't offered by health professionals. That's a really important criterion. And we've previously been asked to approve a treatment offered by people who weren't health professionals. In that kind of case, we don't give our approval, and we don't reimburse for treatment.

Ms. Rachel Corneille Gravel: Veterans can choose to go and see whomever they want. However, their treatments won't be reimbursed by Veterans Affairs Canada if they aren't part of the protocol that we apply.

That's an unfortunate situation for your client. We've never heard about that. This is the kind of situation that can occur, I imagine. It may involve people who are replacing others, but the fact remains that it's unacceptable. The fact that a client who was supposed to see a person experienced in the field of PTSD winds up with someone inexperienced in the area should immediately be brought to our attention. That is indeed unacceptable.

[*English*]

The Chair: Thank you.

Mr. Hawn.

Mr. Laurie Hawn (Edmonton Centre, CPC): Thank you very much, Mr. Chair.

Thank you all for coming.

Your approach is interdisciplinary, and some of the people you treat are suffering from addiction as well as operational stress injuries. How do you go about approaching those kinds of situations? In the cases you deal with, is there a number of how many are suffering from both an addiction and a stress injury? Do you have an idea?

Mr. Raymond Lalonde: The numbers are quite high. Research says probably someone with PTSD will have 50% or more chance of having a substance abuse problem. The way we treat it, our clients have an OSI with the substance abuse problem. The issue is first the identification, because a lot of our clients will not admit they have substance abuse problems, so screening is very important. We're looking at training the Veterans Affairs staff on that, OSI clinics. This is one thing.

Then the engagement means that someone can have a problem but doesn't want to do anything about it. We have service providers, so we could refer clients and pay for sessions with service providers. We also have six providers across the country who offer in-patient service for up to two months' comorbid PTSD and substance-abuse programs. So we have them across the country, and they are very effective. They are working well.

● (1635)

Mr. Laurie Hawn: Are you telling me that—on page 5—of the 6,500 people you are treating, 50% of those would have an addiction problem as well as a stress injury?

Mr. Raymond Lalonde: The 6,500 is the number of clients who have recognized conditions. It doesn't mean that we treat them all, because some may have a condition and may not come to us for services. The literature says that someone who has PTSD would have 50%—

Mr. Laurie Hawn: So that's a reasonable assumption, okay.

The VAC clinics and DND clinics, are they all the same with respect to services provided and so on?

Mr. Raymond Lalonde: They are fairly similar. The context is quite different, but assessment, treatment, interdisciplinary approach, and group programs are similar, yes.

Mr. Laurie Hawn: In your deck here, you talk about capacity challenges, which you obviously have, just from the increasing numbers. How are you coping with that? You must be setting some priorities, prioritizing patients. How much difficulty are you having with that? Do you have a level of comfort that you're reaching the higher-priority folks appropriately?

Mr. Raymond Lalonde: Of course the priority is decided by the clinic staff upon their analysis of the condition of the client, so it's not first arriving, first in. The wait time that we're trying to achieve within the clinics is to have 80% of the initial interviews with the patient or client within 15 working days. We have a phone contact, so it will be faster if we're told by the referring organization that this client really is in need.

The way we deal with the issue of capacity is that the 2007 budget allowed us to open five new clinics, so it's going to double our capacity across the country. In each of the clinics, if there's a need, we will increase the capacity of the clinic by funding the province with new resources.

Mr. Laurie Hawn: We can open those five new clinics, but do you have enough service providers to man those five new clinics? How difficult is that?

Mr. Raymond Lalonde: Do you mean the staff for the clinics?

Mr. Laurie Hawn: Yes.

Mr. Raymond Lalonde: They will be hired by the provinces. So far it has been going well. It's not that easy, but so far we're getting the resources in those clinics as needed.

Mr. Laurie Hawn: I know you can't give me a finite answer to this, but in terms of ramping up the increase across the board, a lot of that is probably due to awareness, much better awareness, and some obviously is due to increased activity.

Can you give me a feeling for how much is simply awareness, versus increased activity?

Mr. Doug Clorey: One of the issues we deal with, particularly with Afghanistan, is that it can take up to two years before a member is released, essentially before they become our client. We know that's going to cause some issues in the not too distant future, because more and more are going to reach that two-year period and be released. The extent of that we're estimating. We don't have fixed numbers, because we don't have the release numbers. However, we do know that we're just seeing the tip of the iceberg, I would say, in terms of the clients who will come to us as a result of service in Afghanistan.

I think that's probably as much as I can say on that question.

The Chair: That's it, Laurie, sorry. We're out of time.

Mr. Laurie Hawn: Thank you.

The Chair: Mr. Bouchard, and then Mr. McGuire.

[*Translation*]

Mr. Robert Bouchard (Chicoutimi—Le Fjord, BQ): Thank you, Mr. Chairman.

Thank you for coming to testify before the committee.

One can readily see an upward trend in the tables on pages 4 and 5. However, sometimes statistics also say something else. Can we say that there was a need and that it developed, or that people were embarrassed at first and then expressed the wish to be treated? Is that the main cause of the increase? Otherwise, is it a real upward trend?

Furthermore, are these all people who are treated at outpatient clinics? Are there any hospitalization cases? Do they spend a morning, a day or two at an outpatient clinic? How have these figures been distributed?

● (1640)

Mr. Raymond Lalonde: It's extremely hard to attribute the increase to any one factor in particular. The knowledge we have of post-traumatic stress disorder has increased thanks to General Dallaire. The support of peer counsellors and information have encouraged more veterans to seek services. But there is also an increase in needs related to the types of missions facing the Canadian Forces. So it's very difficult to know what's what.

Clients may go to an outpatient clinic to get an assessment, which may take one, two or three hours. That isn't a full day or a half-day; in general, this involves shorter periods. Clients go to an outpatient clinic to meet a counsellor, either in an individual session or with their spouse, to take part in various therapeutic techniques in a group consisting of eight to 10 veterans.

The veterans who are in crisis, who need to be hospitalized, have access to all the beds and all the public emergency services across Canada. So we're responding to this needs segment. We also have internal programs, which are offered by private providers whom we reimburse for costs incurred. For example, with regard to the post-traumatic stress disorder program and substance abuse, we'll reimburse providers who care for our clients internally for two months. In the Quebec City region, we refer clients to CASA. We also have some stabilization beds at Ste. Anne's Hospital. We hope to start up a new hospital program to increase capacity.

[*English*]

Mr. Doug Clorey: I might add that I think you're correct in saying PTSD in general has received a greater acceptability in terms of coming forward. We're seeing members of the Canadian Forces and war service veterans, for that matter, and Korean War veterans coming forward with PTSD symptoms and receiving the treatment they should receive.

What's interesting is if you look at the previous slide, PTSD is reported as being the fourth most common within the Canadian Forces, yet we are seeing that two-thirds of our clients with psychiatric conditions have PTSD. Again, it's speaking to the tip of the iceberg. I don't think we've seen the depression, which is number one. Alcohol dependency we're seeing mostly in comorbidities, and we haven't seen the social phobia yet. I don't think society and the military are yet at the point where it's as acceptable to come forward with these other conditions as it is to come forward with PTSD. That's another factor that plays into this equation.

The Chair: Thank you for that, Doug.

I just want clarification before we go to Mr. McGuire. These two graphs you have on page 4 and page 5 indicate that they're cumulative. Does that mean the 1,760 on page 4 in the second column is included in the 5,872 in the last column?

● (1645)

Mr. Doug Clorey: Yes.

The Chair: It looks to me that if there were 1,760 in 2002 and it went up by....

It's not going up more per year; you're getting about the same number of people, but you're just adding them on.

Mr. Doug Clorey: That's an interesting observation, because in general—

The Chair: Mr. McGuire's going to ask this question. He'll have to use his five minutes for something else. I apologize.

Mr. Doug Clorey: In general, over this five- or six-year period we've seen about 1,600 new clients with psychiatric conditions. That's essentially the bottom line. It's a little less earlier, and a little more later. What's interesting—and you don't see it in your chart, as this data was hot off the presses as of this morning—is that as of the end of February, it appears we will have a total of 779 for this fiscal year, which is a significant drop from what we've seen over the last five to six years.

I'm not sure what that means yet. We'd like to think people are recovering and have less need to come forward. But there's clearly a drop in the numbers in 2007-08.

The Chair: Thank you very much.

I will now turn it over to Mr. McGuire to ask the same question.

An hon. member: Give him just two minutes.

Hon. Joe McGuire (Egmont, Lib.): You can understand why the numbers for the Canadian Forces have been growing for the past five years, but in the case of the RCMP, the veterans of the Second World War and the Korean War, and maybe the Suez peacekeepers, is it because you're finally treating these people that you're getting these numbers? Is word spreading, particularly among the veterans?

They were suffering these conditions for decades, and all of a sudden they're coming into the picture as statistics. They are near the end of their days. Whether they had pensions before they were diagnosed with mental illness I don't know, but it seems totally unfair that these people spent fifty years being untreated, and now all of a sudden they're coming out of the woodwork.

As well, to what would you attribute the clearly dramatic increases in the RCMP numbers?

Mr. Doug Clorey: On your first question, I think the observation is very valid. I'd just make a couple of points.

There was a recent research initiative in Australia that came out with some really interesting statistics around Korean veterans. They found that there was indeed a very significant increase in the number of Korean veterans coming forward with mental health conditions about fifty years after the conflict. These were individuals who had returned from Korea, had married, had successful business careers and successful family life, and apparently no issues, but they reached a point in their life, perhaps when they started to reflect back on their life, and suddenly PTSD started to appear in fairly significant numbers. That's one point.

The second point is what we're seeing in our OSI clinics as well, which we thought would be primarily the Canadian Forces veterans. We are seeing a fairly significant number of war service veterans, and Korea veterans as well, coming forward with very complex mental health conditions, very late in life. That's a reality that we are living at this point.

I'm not sure, Raymond, if you want to add anything to that.

Mr. Raymond Lalonde: Some have been living with it all their lives and kept it to themselves. But some, as they grew older and retired, started to have nightmares again at 70 or 80 years of age. They were okay, but it came back. As you probably know, there are a lot of war vets who had never, in all their life, talked about what happened.

Hon. Joe McGuire: So a lot of these people weren't on pension before they started getting treated for mental illness. They lived completely normal lives.

Mr. Raymond Lalonde: Yes, exactly.

Hon. Joe McGuire: What about the RCMP? Is it because of the Alberta massacre and because of the shooting of the young RCMP officers? Is that part of it?

● (1650)

Mr. Raymond Lalonde: There, the issue of awareness is probably a big thing, a big reason we've been working closely with the RCMP over the past year, to ensure that the members know about our programs. But also, since the 1990s they have been deployed much more across the world—for example, in Haiti. So some of it also comes from having been in those operations.

Mr. Doug Clorey: The RCMP people we are specifically referring to in this chart are people who have received a disability benefit as a result of their service with the military.

Hon. Joe McGuire: Concerning the families of the RCMP, I know in particular a sister of one of the RCMP officers, who basically had to quit one of the best jobs in Queen's Park as chief of staff to one of the ministers because she couldn't deal with the death of her brother. Is she getting any kind of assistance through your clinics? Is there any outreach to the families?

Mr. Doug Clorey: I can speak in general terms of the services we provide to families.

The families of individuals who are clients of the department have access to a variety of services. The one that's most confidential is a 1-800 service, which provides confidential counselling to family members who either have themselves experienced a mental health condition or are living with someone who has a mental health condition. We also have services for individuals who have applied for a variety of our programs, particularly in rehabilitation. The recognition there is that the family member also is part of the treatment of the client.

Hon. Joe McGuire: It's left to the RCMP to do their own outreach.

Mr. Doug Clorey: Correct.

The Chair: Good; you're right on time. Thank you.

Mr. Lunney, and then Mr. Cannis.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you very much, Mr. Chair.

I appreciate the discussion so far and the valuable information you've been providing.

As an observation on the numbers you mentioned just a moment ago, it seems to show a decreasing trend, which might be very encouraging if it isn't too early to draw conclusions. There have been some significant changes made in the last couple of years with the decompression, which seems to me to be a very valuable exercise, as well as the peer support program that has come in, and education, just the fact that soldiers know there is help available and can talk it over with their colleagues on the way home. It may be early to draw conclusions, but does it seem likely that these programs are having an impact?

Mr. Raymond Lalonde: It is very hard to discuss. Actually, it's the first time that I've seen those numbers dropping.

What happened with Bosnia, Croatia, Somalia, and Rwanda is that we had major increases in requests at Veterans Affairs about five years after each conflict. So as Doug Clorey was saying for Afghanistan, we will see the results at Veterans Affairs in a few years. Now, most of the people are still in the Canadian Forces. We may see a drop for a couple of years, and there may be an increase again, but it's very, very difficult.... But it's positive to see the trend slowing down. It's still growing; it's still almost at 700 out of 1,100. It's still a good percentage of our increase.

Mr. James Lunney: Can I come back and ask you something about the beginning of your presentation, when I thought I heard you say that Veterans Affairs has six clinics, expanding to ten, and that DND has five? I'm just trying to rationalize that, or compare slide 17, with the chart here, which shows a network of clinics across the country. If I count them up, I just see eleven there.

Are these all Veterans Affairs' clinics? Are these existing ones, or ones that are coming into being? Could you please explain this?

Mr. Raymond Lalonde: There's an error on the map.

Among the ones that exist right now, we have a clinic in Quebec City; one in Sainte-Anne-de-Bellevue; one in London, Ontario; one in Winnipeg; one in Calgary; and we have signed an MOU for a clinic in Fredericton, and we're looking at four new clinics across the country; and you have the five DND OTSSCs. So there's an error.

Well, I'm not sure we have the same map.

● (1655)

Mr. James Lunney: This is on page 17 of the deck we have here.

Mr. Doug Clorey: I think the chart you have there is meant to indicate that we had five OSI clinics prior to budget 2007. Those are the ones in Calgary, Deer Lodge, Parkwood, and Sainte-Anne in Quebec. Those were the five original ones. The five at the bottom are the Canadian Forces' operational trauma and stress support centres; so those are the DND ones. And also, you will see that Fredericton is one of the first of the additional five that came out of budget 2007.

Mr. Raymond Lalonde: Yes, exactly, and we'll have four more open by the end of March next year, probably.

Hon. Denis Coderre: Can you tell us where?

Mr. Raymond Lalonde: Well, the minister will announce the location as soon as we have finalized the agreements with the provincial institutions.

Mr. James Lunney: Thank you.

Jumping back to the beginning of the presentation, I believe Madame Gravel mentioned that there are clinical best practices clinics. Does that comment relate to all of the clinics, or are some of the clinics particularly investigating best practices with comparative studies, or what might work better?

Ms. Rachel Corneille Gravel: Well, I would say that the centre of expertise will ensure leadership in looking at what's being done in the U.S. and Australia and California. There's a lot of research going on, and a lot of expertise has been developed all over the world. But, definitely, we have experts in those other clinics under Veterans Affairs, and the centre of expertise will work very closely with those experts in the different clinics too.

Mr. James Lunney: Is that a physical centre, the centre of expertise?

Ms. Rachel Corneille Gravel: The centre of expertise is at Sainte-Anne.

Mr. James Lunney: At Sainte-Anne.

Ms. Rachel Corneille Gravel: Yes, but Sainte-Anne will work closely with the expert psychiatrists, the colleges, and the social workers and the other clinics you see here on the map to discuss their expertise and best practices, and they will work together to develop tools and evaluation measures.

The Chair: Thanks, Mr. Lunney. That's enough for you; I'm sorry.

Mr. Cannis, and then Ms. Gallant.

Mr. John Cannis: Thank you, Mr. Chairman.

Guests, welcome.

The questions that have been asked have been primarily around the expertise, the service, etc. You've given valuable information, for which we all thank you. But throughout the responses, the word “budget” has been mentioned, in terms of budget 2007, and I'd like to take it in a different direction.

You mentioned in your presentation the provincial clinics, the services, the jurisdictional responsibilities—I'm just generalizing now—and you said “We finance clinics”, if I may quote you.

How does that work? Other presenters have come before our committee, including some just the other day, in terms of funding difficulties they've had as a result of the Senate committee report—as I believe, Mr. Chairman, was referred to yesterday—and funding being brought forward. You're funded by DND or Veterans Affairs. Could you please tell us how Veterans Affairs and DND tie together? And are there any obstacles that veterans run into because of jurisdictional responsibilities and the referrals that have to be made?

You also talked about how, when you don't have expertise, you “contract out”, as you put it. Where is that? Obviously we've been told by witnesses in the past that in the Canadian Forces, our military persons have a different health program, per se. It's not like I'm covered, for instance, under the Ontario hospital medical association.

Could you somehow join the dots for us there, in the short time we have left, and give us an overview on the services, the finances, the budgeting, and so on?

Mr. Raymond Lalonde: The funding of services to veterans who are entitled to receive services because of their mental health conditions is done through our health program. It is on an entitlement basis. If you're entitled to it as a veteran, we will reimburse you for the services you got from a private service provider.

The majority of our clients get services from those 900 service providers across the country. It's just a matter of entitlement. If you have a mental health condition, you're entitled to ten sessions a year. After that, we need to have it pre-authorized for us to reimburse for the other sessions. As we pre-authorize, we will look at whether the treatment is appropriate and working well, etc.

As for the clinics, we fund the clinics out of our health program at Veterans Affairs, so we finance the full clinic. What we're working on—

● (1700)

Mr. John Cannis: It's the budget allocated through Veterans Affairs then.

Mr. Raymond Lalonde: Yes. Every year we sit down with the clinic and look at their requirements, and we approve every year the full budget for the operation of the clinic.

The issue for us at this point is that we need more clinics. We were really pleased to see, in budget 2007, that we have the opportunity to double the complement of clinics to cover the whole country.

Mr. John Cannis: How much was it, Mr. Lalonde?

Mr. Raymond Lalonde: It was $9 million for five new clinics, and support to Veterans Affairs—

Mr. John Cannis: So $9 million for the clinics. Was that the overall budget?

Mr. Raymond Lalonde: No, it was only for the OSI clinics.

Mr. John Cannis: But was that allocated for the different services?

Mr. Raymond Lalonde: For Veterans Affairs?

Mr. John Cannis: Yes.

Mr. Raymond Lalonde: Oh, it was much more than that. I don't have the exact number, but it was in the $30 million range at that time.

Mr. John Cannis: Okay.

Mr. Raymond Lalonde: I don't know if that answers your question.

Mr. John Cannis: I have one more.

You referred to jurisdictional responsibilities. If you have a veteran who needs a specific type of service and they live in Ontario or in Quebec or in P.E.I., are there any obstacles in getting them that service? Really, the bottom line is getting them the service they need. Have there ever been any obstacles? If so, how do we overcome that?

Mr. Raymond Lalonde: I don't think the provincial jurisdiction is an issue. The provinces offer general public health service to all of the veterans, including our veterans who have mental health conditions. This is done. If they need to go to emergency, they will be taken in. There's really no problem.

So they're covered all across the country in the same way.

Mr. John Cannis: Thank you, Mr. Chairman.

The Chair: Thanks, Mr. Cannis.

We're over to the government, with Mr. Lunney.

Mr. James Lunney: Thank you.

Picking up where we were a moment or two ago, to bounce back, you mentioned in your remarks that there about 900 service providers across the country—I think that was in response to Mr. Rota's comments earlier—and that of course they need to be registered at the service provider, and so on.

I notice that in your remarks you mentioned the psychiatrist, psychologist, sociologist, group therapy, family therapy, detox, but I think I also heard you mention, Madame Gravel, natural caregivers. If I refer to slide 13, “Comprehensive Continuum of Mental Health Services and Policies”, I see that it mentions a “holistic approach... addressing all determinants of health”, and so on. Who did you have in mind when you were talking about natural service providers, and what is meant by a holistic approach?

Mr. Doug Clorey: Perhaps I can start with the holistic approach. I'd draw your attention to slide 14, which has our mental health framework. It's a very complicated slide, or it looks complicated.

By holistic, what we mean is that when our front line staff are dealing with an individual with a mental health condition, they ought to look at those five areas of interest, not just the health services environment but the personal factors. Very often they are ill, they are in pain, they may have diseases or disabilities other than their mental health conditions. We need to look at their social environment, at supporting their family, at connections with peers. You've already been briefed on the operational stress injury social support network.

The economic environment is part of this as well—do they have money to live on, do they have employment?—and also the physical environment, their actual home conditions and home environment.

When we say holistic, that's what we mean by it.

Mr. James Lunney: Okay, thank you.

Madame Gravel, would you care to comment? I think it was you who mentioned natural—

Ms. Rachel Corneille Gravel: The caregivers are really the family, the person who provides care at home—

Mr. James Lunney: The personal support network, you're saying, then.

Ms. Rachel Corneille Gravel: Right.

Oh, no; I talked about the peer support, which is different.

● (1705)

Mr. James Lunney: No, I'm aware of that.

In budget 2008, you're probably aware that we're putting $110 million into some four or five studies across the country related to homelessness and mental health issues and their relation to drug addiction. There's quite a connection between drug addiction—as you've mentioned here, alcoholism and so on—and mental health issues.

Looking at the centre for expertise and best practices, we know that in trying to manage depression, which I think you heard is not what you're seeing primarily as a presenting complaint, but rather PTSD—but often there's a relation, and these parallel or co-existing diagnoses get lumped in—SSRIs as a drug approach are falling under quite a bit of scrutiny these days as hardly better than a placebo.

In terms of non-drug treatments at Ste-Anne, we've heard a bit about a non-drug approach called EMDR. Is that something that's being made available? “Eye movement desensitization and reprocessing” is, I believe, what the acronym stands for. Is it offered at Ste-Anne's and other centres?

Mr. Raymond Lalonde: It is, and also in DND's OTSSC. All of the clinics have staff trained in EMDR.

Mr. James Lunney: I guess you're not doctors; I think we heard that caveat at the beginning. So perhaps asking you to comment on clinical.... I won't go there.

But in terms of the whole question of mental health, there are some concerns that we're missing, some gaps here. I'm wondering whether people in the centre of expertise are looking at the kinds of supports that are available for people who have neurological stress, in terms of extra nutritional support and so on: B vitamins—here we go again, guys—

An hon. member: We knew you'd get there sooner or later.

Mr. James Lunney: —and a whole range of nutritional supplementation and minerals that help people who are under stress. The population is quite interested in this; a lot of people take nutritional supplements.

Is anybody exploring how we might help our soldiers with extra nutritional support? And if not, why not?

Mr. Raymond Lalonde: I have no idea.

Ms. Rachel Corneille Gravel: There isn't any research going on at the centre of expertise in that field.

I'm not able to tell you, but we can find out.

Mr. James Lunney: There seems to be quite an interest, in the orthomolecular medicine world, in identifying factors that contribute to neurological stress and in the idea that many among us may in fact be nutritionally dependent, whether because of a genetic trait, a viral assault, or some other chemical exposures. There's quite a bit of interest in this.

It seems to me, since we're looking at best practices and are aware that perhaps what's out there—I think Mr. Rota mentioned an example of a therapist who wasn't sure how to approach that clinically.... There's lots of room for checking on things that might contribute to better clinical outcomes.

Mr. Raymond Lalonde: At the national centre, one of our areas of research is in mental health and OSI, so there's a lot to do. We just created the centre a couple of years ago, so we're just starting with our research agenda.

Actually this has an influence on the mental health state of our clients, and we may, down the road, do some research on it, but at this point we're focusing more on the research that will help us improve our clinical practice of EMDR and treatment with the families within the clinics with therapies.

This may be like your mention of nutrition as something the department might do down the road, but at the national centre we will be focusing first on how we can improve our clinical practice.

The Chair: Good. Thank you very much.

That ends the second round. We are starting into the third round with the official opposition.

They're good, so we are back over to the government. Okay, they're good, so we'll go to the Bloc.

Mr. Bachand.... No? Okay. And Ms. Black is gone. Well, it looks as though that wraps it up.

Do you have any comments you'd like to make? If you have a recommendation yourselves, you could certainly offer it to us or get it to us in writing.

We're not the veterans affairs committee; we're the defence committee, and our issue is with active service. The mixture you deal with seems to me to be.... I'm not sure how that works; you're from the Department of Veterans Affairs, but you work with active soldiers. Maybe you can get into that a little bit, and then if you do have a recommendation or some issue you think is important to us, go ahead.

● (1710)

Mr. Doug Clorey: There is one area I'm sure you're very well aware of from your work in this committee. It's the whole area of family services. One of the areas we struggle with in that particular domain is that services tend to be offered to family members based on their partner or their spouse being a client of the department.

What we're finding in terms of research is that very often the family member, whether it's the spouse or the partner or the child, has become impacted as a result of living with someone with an operational stress injury, and yet the individual has not come to us. The veteran has not come to us or the still-serving member of the Canadian Forces has not come to us, and it very often ties our hands in terms of what we can do for the family members. So it would be interesting for your committee to delve into that a bit more. We think there needs to be some legislative or regulatory change that recognizes family members as clients in their own right as a result of the service that their partner has incurred in the military.

I'm not sure if you've had that kind of discussion, but it would be well worthwhile to have it. Our needs on the veterans affairs side are different from what the Department of National Defence has around family services, but I think there needs to be a recognition that when someone goes into the military, it's not just an individual responsibility, but a family unit responsibility, and that there are responsibilities on behalf of the Government of Canada to serve the members of the families in a more effective way.

I throw that to you as something for your consideration.

The Chair: Thank you.

Ms. Black, while you were out we went through the rotation list. If you have something you want to ask, there's some time here.

Ms. Dawn Black: No, I'm just interested in the recommendation and whether you had any other recommendations that you would ask the committee to consider.

Mr. Doug Clorey: That's certainly the one at the forefront of my mind. I would defer to my colleagues if they have other recommendations.

The Chair: Well, it's somewhat unfair to.... But if you have something you think of over the next period of time, feel free to get it to us. We'd appreciate that.

Mr. Doug Clorey: Thank you.

The Chair: We travelled a year or more ago out to Petawawa and to Edmonton. Some of the comments we heard from the families of the soldiers were quite remarkable. Some of the things you would just absolutely take for granted become big issues.

For example, perhaps the spouse is at home and the fridge goes on the fritz and she or he is talking to the soldier in the field. It's a big issue at home, and they don't want to bother the soldier over there, and the soldier starts to feel they're being left out, and it just snowballs.

In Petawawa a student, a young child, was called to the principal's office on a school matter. By the time the child got to the office they were frantic, because they thought it was going to be about the parent who was away. All these things—we don't think about them on a regular basis, but they're very important.

Thank you very much. Keep up the good work, and thank you.

Oh, I'm sorry; Mr. Cannis did have a quick question.

Mr. John Cannis: This is for Mr. Clorey, if I may, for clarification.

We've been told that there is variance between the health services provided to the service person and the health services provided to the spouse or partner and the family. Are you, with this recommendation you've made, telling us that should the children or the partner of the service person be going through an experience, they cannot, on their own, seek help? It must be initiated by the service person, by the military person in the family, male or female—is that what I understood?

Mr. Doug Clorey: What I was speaking of was specifically for veterans. I cannot speak for the Department National Defence.

Mr. John Cannis: It is for veterans, yes.

Mr. Doug Clorey: For Veterans Affairs, except for a very high level of service to family members, the member that has served in the military must be a client before we can serve the family members. What I am recommending or suggesting, for your consideration, is that you think about a way we can actually help the family member before the client comes to us or if he or she refuses to come to us. In effect, by helping the family member, we will also be able to help the veteran.

Mr. John Cannis: Mr. Clorey, I can't thank you enough. As the chairman clearly pointed out, this is a committee on national defence, and as the chairman has also pointed out in the past, there's a veterans affairs committee. Yes, we have our political stripes. But 99% of the time we have in mind the best interests of the men and women who do this work we ask on our behalf.

I would greatly encourage you, on behalf of everybody here, if you're not appearing before the veterans affairs committee, or if you haven't been asked, to submit something like this. Because I believe it is an issue.

Cheryl, in your neck of the woods there's a base, and I'm sure you've heard stories as well. This is something they should be made aware of. Thank you.

Thank you, Mr. Chair.

● (1715)

The Chair: You bet.

We passed by the Bloc slot while Mr. Bachand was out.

Mr. Claude Bachand: You passed me.

The Chair: Yes, but you indicated before you left that you had a question. We have a few minutes. Go ahead.

[*Translation*]

Mr. Claude Bachand: I need clarification regarding your table on page 6. You say there were 64 post-traumatic stress disorder cases and 118 psychiatric condition cases in foreign countries. What does that mean? One lady explained to us the other day that there was a common clinic in Kandahar and that sometimes cases were treated there. Is that correct?

[*English*]

Mr. Doug Clorey: No, these are primarily veterans who live outside of Canada.

[*Translation*]

Mr. Claude Bachand: All right.

[*English*]

Mr. Doug Clorey: For the most part, those tend to be people who live in Europe, and in particular, in the United Kingdom.

[*Translation*]

Mr. Claude Bachand: All right.

Here's my million dollar question. I asked it when the committee was dealing with veterans business and that of national defence. You are all veterans. According to one school of thought at the time, the Department of National Defence wasn't doing enough prevention. There are two things. Even the provincial governments, when they provide their health services, tend to focus on the curative aspect, but not enough on prevention. They wonder what has to be done to cure people.

I don't want to start an interdepartmental war, but, according to that school of thought, the Department of National Defence didn't focus enough on providing training that would alert soldiers to psychological conditions such as those we've been talking about from the outset. In other words, the Department of National Defence sent people to the front on the basis that, if things went poorly and those people were released by the armed forces, the Department of Veterans Affairs would take care of them. Does that school of thought still exist? Sometimes don't you get the impression that National Defence creates a problem and that you are subsequently the ones forced to solve it?

Perhaps we should sit in camera to hear that answer, Mr. Chairman.

[*English*]

I'm joking now.

The Chair: I know you are.

Go ahead. Answer if you can or if you wish to. That's a statement.

Mr. Doug Clorey: I won't answer the question directly. I will say that I think the key to successful health for everyone in the military and as they become released and become veterans is to have resilience, not just physically, but mentally. I think that in this area, and I suppose it includes all of us, we need to become more resilient in both dimensions of our lives.

There's a lot of emphasis, as we all know, on physical resilience in the military. You need to be fit physically. I would hope that we reach a day when there will be as much emphasis on being mentally resilient as you enter the military, as you serve in the military, and as you leave the military.

The Chair: Thank you very much. We enjoyed your time here in committee.

Just before we go, keep in mind that when we come back we'll be having a future business meeting, so think about where you want to travel, which bases you want to go to, and who you want to visit so we can proceed.

Thank you.

The meeting is adjourned.

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