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Chair

Mr. Neil Ellis

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● (1105)

[*English*]

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

Pursuant to Standing Order 108(2) and the motion adopted on Thursday, February 25, 2016, the committee resumes its study of service delivery to veterans.

Today, for our first hour, we have Mr. Ferguson, Auditor General of Canada. Also present are Mr. Martire, principal, Office of the Auditor General; and Ms. Campbell, director, Office of the Auditor General.

Good morning, everyone. Thanks for coming today.

We'll start off with your 10 minutes.

Mr. Michael Ferguson (Auditor General of Canada, Office of the Auditor General of Canada): Mr. Chair, thank you for this opportunity to discuss our audit work relating to the committee's study of service delivery to veterans.

Joining me at the table are Joe Martire, principal, and Dawn Campbell, director, responsible for audits of Veterans Affairs Canada, and National Defence and the Canadian Armed Forces.

For the benefit of new members, I would like to briefly explain the types of audits we are presenting to you today, which are performance audits.

Performance audits examine whether government programs are being managed with due regard for economy, efficiency, and environmental impact. We also look to see if there are means in place to measure the effectiveness of programs. However, while we may comment on policy implementation, we do not comment on the merits of policy, itself.

Since 2012, we have conducted two performance audits that focused on selected services and benefits provided to veterans. Veterans Affairs Canada was also part of a third audit that examined the delivery of online services by federal organizations.

[*Translation*]

In the fall of 2012, we reported on how National Defence and Veterans Affairs Canada managed selected programs, services and benefits to support eligible ill and injured Canadian Forces members and veterans in the transition to civilian life. We did not look at whether Canadian Forces members and veterans had received all the services and benefits for which they were eligible. Neither did we examine the fairness of departmental services and benefits available, nor the quality of medical treatment and care provided.

There are a variety of support programs, benefits and services in place to help ill and injured members of the military make the transition to civilian life. However, we found that understanding how the programs worked and accessing them was often complex, lengthy and challenging.

The lack of clear information about programs and services, the complexity of eligibility criteria, and the dependence on paper-based systems were some of the difficulties expressed by both clients and staff.

[*English*]

We also found inconsistencies in how individual cases were managed, as well as problems in the sharing of information between the two departments. As a result, forces members and veterans did not always receive services and benefits in a timely manner, or at all.

We found that the interdepartmental governance framework to coordinate, harmonize, and communicate the various programs, services, and benefits available to ill and injured forces members and veterans needed strengthening.

National Defence and Veterans Affairs accepted all 15 of our recommendations, which included streamlining their processes to make programs more accessible for ill and injured forces members and veterans.

In our fall 2014 report, we reported on mental health services for veterans. As of March 2014, about 15,000 veterans were eligible to receive mental health support from Veterans Affairs Canada through the disability benefits program. The proportion of the department's disability benefits clients with mental health conditions had increased from less than 2% in 2002 to almost 12% in 2014.

[*Translation*]

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

For eligible veterans, the department paid for various mental health services that were not covered by provincial health care plans. These services included specialized psychological care, residential treatment, and some prescription medications.

We found that Veterans Affairs Canada had put in place important mental health supports. These included operational stress injury clinics, a 24/7 telephone service, and the Operational Stress Injury Social Support Program. However, the department was not doing enough to facilitate veterans' timely access to mental health benefits and services.

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

[*English*]

The disability benefits program provides lifelong access to benefits and requires that veterans provide evidence that they have a permanent mental health condition that was caused or aggravated by military service.

We found from the veterans' perspective that about 20% had to wait more than eight months from the first point of contact for the department to confirm their eligibility to access the specialized mental health services paid for by the department.

As in 2012, we found that a complex application process, delays in obtaining medical records from National Defence and the Canadian Armed Forces, and long wait times to access mental health care professionals in stress injury clinics continued to be some of the factors that slow down the decision as to whether veterans are eligible for support provided through the disability benefits program.

In addition, we noted that 65% of veterans who challenged denial-of-eligibility decisions for disability benefits were successful. While the department knew that most successful challenges rely on new information or testimony, it had not analyzed how the process could be improved to obtain this information prior to rendering decisions upon first application.

Mr. Chair, Veterans Affairs Canada agreed with our recommendations, and following our report, produced an action plan with implementation deadlines ranging from December 2014 to March 2016.

● (1110)

[*Translation*]

Lastly, in the fall of 2013, we examined whether the online services offered by some federal organizations, including Veterans Affairs Canada, were client-focused and supported by service delivery strategies with defined and measured benefits. We did not audit service standards.

We found that the government had introduced services to enable individuals to interact online with departments securely. However, multiple steps were required to set up a secure account and then enrol in a program. For example, a retired veteran wishing to interact with the Government of Canada online to access benefits and report taxes first had to set up a secure account and then follow different enrolment processes with Human Resources and Skills Development Canada, Veterans Affairs Canada and the Canada Revenue Agency, or CRA.

While a veteran would have had immediate access to a Veterans Affairs Canada account, the wait time to receive separate security codes in the mail from Service Canada and CRA was 5 to 10 days.

[*English*]

Mr. Chair, we hope the findings in these audits will be useful to the committee in its study. I should note, however, that we have not done other audit work since our reports were presented to Parliament; therefore, we cannot comment on progress the departments have made since then. We encourage your committee to ask department officials what progress they have made toward implementing our recommendations.

Lastly, the committee may be interested to know that on May 3 we will present a report to Parliament on the drug benefits program provided by Veterans Affairs Canada.

This concludes my opening remarks. We would be pleased to answer any questions the committee may have.

Thank you.

The Chair: Thank you.

We'll start with Mr. Kitchen, for six minutes.

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

Thank you, Mr. Ferguson, for coming to us today. Please bear with me; I still have this mind that when I hear “auditor”, I'm thinking financial all the time. I'm hoping I can coordinate and make sure I don't dabble in questions that go toward financial versus the other way.

One of the recommendations that was made was to update the outreach strategy, including for family physicians. In particular, I'm wondering if you might want to comment on the issue of hosting workshops with family physicians and general practitioners and trying to get that information out to the practitioners. I assume we would provide these services across the country.

Likewise, when we talk about family physicians, there are other practitioners that the veterans deal with. Those can be chiropractors, physical therapists, occupational therapists, counsellors. Is the suggestion in this recommendation that those are also included in these workshops that we're providing that service for, and that we're getting that information we need for the veterans?

Mr. Michael Ferguson: I'll ask Ms. Campbell to provide us with some more details, but I'll just start off by saying fundamentally what we were looking at was, first, understanding that the department realized they had to do outreach, that they had to get in touch with family members and with other stakeholders in order to help identify veterans who were struggling with mental health conditions. I think we identified that they needed to do a better job of understanding how successful those outreach activities were being. Part of that was the types of people they should be reaching out to.

I'll ask Ms. Campbell perhaps to provide some more details.

Ms. Dawn Campbell (Director, Office of the Auditor General of Canada): If we refer to paragraph 3.52 in the report on mental health, it indicates that the reason we focused on the family doctors is...and here's a sentence there that's particularly pertinent:

> According to the Mental Health Commission of Canada, "People are more likely to consult their family physician about a mental health problem or illness than any other health care provider."

That doesn't mean others are not important. I think probably—

● (1115)

Mr. Robert Kitchen: No, I understand, but a lot of times, especially in rural communities, the family physician may not be the first access they might have. Speaking as a chiropractor who has dealt with a lot of veterans over the years, oftentimes I've had those individuals in my office dealing specifically with what I deal with in mechanical issues, but the reality is oftentimes they are expressing other things to me that would be of benefit to me as a practitioner because I might be the sole source they have.

There was a time in Estevan, Saskatchewan, when we had five doctors, so I was seeing medical situations that were outside my scope, but people were coming to me because I could get those people to where they needed to be, they had an avenue.

In a lot of rural communities, those aspects are there, and the practitioners who are there whether they are occupational therapists or physical therapists have some of that background and some of that training that they can utilize those skills. Those skills, if they had that outreach to them, would be of great benefit for our veterans so they could expand on that, and maybe get them to where they need to be, and assist them in those programs.

I'm wondering if that was consulted on or discussed, or is it something that could be looked at?

Mr. Michael Ferguson: Mr. Chair, again I think that's a very good point of discussion to have with the department.

What we were looking at here was primarily their approach to stakeholder outreach, which identified that it had primarily focused on family members and people very close to the veterans. Of course, it's extremely important for family members to be able to identify signs of mental illness.

We then said we felt they needed to put some more emphasis on family physicians, because as Ms. Campbell identified, a family physician is often a person who somebody will confide in.

We didn't take it a lot further than that to identify other types of stakeholders, but I think what you're asking is certainly something that could be put to the department to try to identify how they consider which types of stakeholders veterans might be in contact with could be in a position to identify signs that a person may need some direction with some mental health issues.

Mr. Robert Kitchen: I agree, and thank you. It's something we need to pursue to make certain because in those areas where we don't have those services, we do have qualified people who can assist in that manner.

On the issue of the VAC mental health action plan, it talks about opening some new operational stress injury clinics. Do you know how many of those have been opened?

Mr. Michael Ferguson: Again, that would have been outside of the time we were doing the audit, so I think that's something the department would have to tell you.

What we were looking at was how they were operating during that period of time rather than whether they have opened any of them.

Mr. Robert Kitchen: Thank you.

A lot of what we've heard around the table over the last couple of months has been talk about when we're dealing with injuries in the sense that someone, for example, who might be in the artillery and is going to have hearing loss, we anticipate that a parachuter who is jumping out of planes and jarring his knees is continually having issues that deal with orthopaedic injuries, be it to his knees or the discs in his spine, or a trooper who jumps off a tank continuously can have issues with his back.

The Chair: Sorry, we've run out of time.

Next is Mr. Bratina.

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

Perhaps I'll follow up because in the 65% of veterans who challenged their denial of eligibility, the department knew that the most successful challenges rely on new information or testimony. Would some of the new information be, as Mr. Kitchen suggested, old information, which is the reason that my knees are bad is because I made 400 parachute jumps? It seems that this information wasn't captured or was not available on your initial denial.

Are you satisfied, because this is from your 2012 report I understand? Have you followed up on the remedies for things like that?

Mr. Michael Ferguson: The reference to the 65% is actually in the 2014 report on mental health, but that's all right because it's fundamentally the same issue.

The issue we were raising was that, once somebody gets turned down for access to these types of long-term mental health services, they go through appeal and then they are approved for it. It's because somewhere in that appeal process what we've referred to as new information has come forward, but you're right, it may simply be that new information may be information that already existed but was not brought forward during the original evaluation.

Really the point of this, I think, is to understand why 65% of the appeals are successful. If there's information that can be learned from that, it says that if people brought forward this type of information early on, then they would have been approved originally and wouldn't have had to go through the appeal process.

That's exactly the issue that this is raising, for the department to be able to analyze the reason that they're overturning appeals and to feed that back into their original process to try to make the original process more efficient for the veterans trying to access the services.

● (1120)

Mr. Bob Bratina: Often you'll hear when you call somebody, “This call may be monitored for quality control purposes.” My concern in many of these kinds of cases and issues is burnout by the staff, so I wonder if you actually monitored the intake in a direct way, whether it be by phone call or.... How did you audit that performance in terms of how the veterans were being dealt with by the staff?

Mr. Michael Ferguson: We weren't really looking at all of those individual interactions per se, but what we looked at was the length of time the process took. Originally, we were looking at how long it took from the point in time that an application came in until they made the first decision.

In fact the department had in place a standard for how long they would take to make that original decision, but part of what we also identified was that, in measuring that time period from when an application comes in until when a decision is made, that doesn't take into account how long it takes a veteran to complete the application in the first place. We found that the application was complex and it was difficult for them to complete.

So you can end up in a situation where the department, because they are measuring the time period from application to decision, is saying that they have met their standard, but the veteran is frustrated because the veteran had to try to navigate all of the time to prepare the application in the first place. That's really the issue that we're raising in that.

The Chair: Ms. Lockhart.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you, and you actually led right where I was going.

First of all, I appreciated reading the report. It really put a lot of analysis around a lot of the anecdotal stories that I've heard from veterans that I spoke to, so thank you for that.

In that period, knowing that it's taking up to 32 weeks from the time someone identifies as needing mental health services to an application being approved or disapproved, are there any interim services? Is there any safety net for these people in the interim?

Mr. Michael Ferguson: I'm glad that you raised that, because when we're talking about that time period, it's in the disability benefits program, which is the access to the longer-term services. They also have the rehabilitation program, where I believe the decision was being made within two weeks, which was for shorter-term services.

I'll ask Ms. Campbell if she wants to add anything to that.

Ms. Dawn Campbell: Sure. Thank you, Mr. Ferguson.

In addition, there are certain other services the department does provide, such as a 24-7 hotline that is actually administered by Health Canada. They have an OSISS program, which is operational stress injuries social support program. There are certain other programs that they have. Generally speaking, the services provided by case workers would be for those who have been deemed eligible for one of the programs, as Mr. Ferguson said.

Mrs. Alaina Lockhart: Can you just clarify for me, when someone is discharged due to mental health, are they automatically qualified for some of these programs, or do they start the process again?

● (1125)

Ms. Dawn Campbell: There is eligibility criteria that must be met for either of the programs we have looked at. There is the disability benefits program and then there is the rehabilitation program. For the rehabilitation program, the criteria to be met are not as high.

The Chair: Ms. Mathyssen.

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

Thank you, Auditor, for your report. It is certainly very thorough and very helpful.

I have a couple of questions and I wanted to go back to the Veterans Review and Appeal Board. You talked about the fact there were fewer appeals granted in 2015-16 than in the previous year. What I took from that is the quality of the interaction between a case worker at VAC and the veteran had improved slightly. There was less need for an overturning of the VAC decision. Is that accurate?

Would you say there has been some improvement with regard to the interaction between the veteran and VAC, or were you able to discern that?

Mr. Michael Ferguson: That really wasn't the focus of what we were looking at in this area. Really, we were looking at the appeal process, so that if the original decision gets overturned, how the department learn from that process to improve its original process, as opposed to specifically the angle of the question you are asking.

Ms. Irene Mathyssen: Is there any sense that the department did in fact learn? Are you feeling more positive about that process?

Mr. Michael Ferguson: Where we are feeling positive is that the department has taken all of our findings and recommendations very seriously. When we presented to them and discussed with them the results of the audits, they understood these were things that needed to be fixed and that they needed to change how they were operating this program.

In terms of this audit, the thing we identified here was that they needed to have a better feedback process to learn from the appeal decisions to make the original application process better.

Ms. Irene Mathyssen: One of my concerns with regard to the appeal process is the stress it puts on veterans. When they go to the Veterans Review and Appeal Board, they are asked a lot of questions and it can be a very intimidating kind of process, so I'm glad you investigated that and have offered that support.

In your letter of February to our chair, you said that although the department had developed a mental health strategy for veterans, it had not put performance measures in place.

Could you explain why those measures are so important? What do they accomplish? Why should VAC be pursuing those?

Mr. Michael Ferguson: Whether it's Veterans Affairs and this program or it's any other program, performance measures are important to understand whether the intended outcomes, the results of a program, are being achieved or not. Having a way of knowing whether the program is doing what it's supposed to be doing is very important.

One of the issues in this audit, in particular though, about performance measures is that they had a performance measure in place around processing the application, how long it took to process the application. They were pretty close to meeting that target, but it was only measuring one part of the process. It wasn't measuring all of these other parts, including the appeal or how long it takes to fill out an application.

Matching up performance measures with the entire intended outcome of a program is not easy to do, but that is really what performance measures need to do. It's whether the program is achieving what it's supposed to be achieving. It is good to measure individual activities, but those individual activities need to somehow get into an overall measure of whether the program is achieving what it's intended to achieve.

● (1130)

Ms. Irene Mathyssen: Certainly, we are dealing with human beings here, and our objective is to deal with them as faithfully as we possibly can. Thank you.

The Chair: Thank you.

Mr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you for the presentation. It was very helpful and very enlightening.

I'd like to quickly follow up on one of the questions that was asked before regarding when people are waiting. They asked about interim services. I can tell you from my professional medical practice experience, one of the interim services that people end up using because they have nowhere else to go is emergency departments. A lot of them, first of all, don't have family doctors, or they'll end up in a crisis situation at hours that don't enable them to get in right away.

Has there been any thought given to an outreach program, or getting some resources out to hospital-based practices in emergency departments where records can be readily accessed, or the department could instruct them on where to go further, or the emergency department could send information that might tell someone up the line, “We can't wait much longer, can you please expedite this?“

Mr. Michael Ferguson: Again, it's really the department that needs to sort of speak to the overall design of the program, but I think what you're identifying is similar to the first question. It's about all of that outreach, isn't it?

The department needs to make sure it identifies all of those places where veterans with mental health conditions are in contact with various types of service providers, and how those service providers know how to interact with the veterans with a mental health condition, but as well, how all of that information could also come back to the department. As you say, to say there's an individual here now.... I mean, Ms. Campbell talked about some of the other services that the department has in place—the hotline, outreach, and some of those other things—but I really think the department should explain to you how all of those services fit together, how they do their outreach to the various stakeholders and people who are touched by this whole program, and how they draw information from people who would know something about individual veterans as well.

Again, I think it's really the department that needs to explain all of those different points of contact.

Mr. Doug Eyolfson: Thank you.

Something that really strikes me is the fact that when you're applying for disability, you first of all have to go through this application process and you have to collect all these records, records that should all be readily available through your national defence service. The fact that so many of the people who appeal are successful in their appeals suggests that those who are not legitimate applicants are outliers. Therefore, what I'm seeing here is the fact that you have to go through this application and prove that all of these things are going on, and it gives me the impression that when someone applies there's the unspoken consideration that they are faking it until proven otherwise.

Considering that so many of these appeals are successful, should we not be developing more of a policy that turns that around into a sort of negative option that says, “If you are applying, it must be assumed that this is legitimate unless the department can find information that proves that you're not eligible”?

Mr. Michael Ferguson: Again, I think the department will need to talk to the approach they take to each individual application coming in. But I think a couple of things you mentioned that are important are, number one, we did identify that the sharing of information between National Defence and Veterans Affairs was not being done in a timely manner. That showed up in both of the audits, the audit we did on the transition of ill and injured military personnel to civilian life, and also the audit on mental health services. It's a matter of having a way of making sure that this information is shared.

The other thing, though, that we found in the audit of the transition of ill and injured members to civilian life was that when we looked at the Veterans Affairs' rehabilitation database—and remember this was in 2012—we found there were significant errors in the data that had been transferred. If you're starting out with a database that has errors in it, that's going to cause problems throughout the process of considering what types of benefits somebody might be eligible for.

Certainly, making sure there's timely sharing of information, I think, is something that is critical to improving these types of services, but then also it's making sure that there are sufficient quality-management steps around the data to make sure the data being shared is accurate.

● (1135)

Mr. Doug Eyolfson: One of the difficulties they identified in the report was the long wait for referral to a mental health professional. I know much of that must be due to the fact that there aren't as many. Has there been any identification as to why we can't attract more mental health professionals to serve in this capacity?

Mr. Michael Ferguson: I guess the short answer is that this wasn't part of the audit, so we didn't actually look at that.

The Chair: Thank you.

Next we have Ms. Romanado.

Mrs. Sherry Romanado (Longueuil—Charles-LeMoyne, Lib.): Thank you.

I have a couple of questions. In terms of the overturned eligibility, one of the recommendations was to capture more systematically the reasons for the overturning of decisions. There's no indication that training was offered to ensure that these kinds of decisions that should have been approved.... People are learning from past mistakes. I want to know if you were able to capture any of that, if training went along with it, and if so, you could let us know.

I also have a follow-up question on that.

Mr. Michael Ferguson: Again, I think what we were looking at was whether the information got fed back in. I'll ask Ms. Campbell to elaborate whether there was anything done on the training side.

One thing, and it's outside of this audit, we also recently released an audit on Canada pension plan disability and access to that. We actually found a very similar thing. Something I think a number of government departments need to start to build into their processes is that when they have a process that includes this type of an adjudication and appeal process, learning from that and feeding it back into the process should be a really important part.

I'll ask Ms. Campbell if there is anything else she'd like to elaborate on.

Ms. Dawn Campbell: No, we didn't look specifically at what you're asking.

Mrs. Sherry Romanado: In terms of the data integrity that you talked about in the transfer of records from DND to VAC, were these errors human errors or system errors?

Mr. Joe Martire (Principal, Office of the Auditor General of Canada): As was mentioned, it's very important that the information is shared in a timely manner but that it's also accurate and reliable.

Back in 2012, most of the records that were being transferred were being done manually. They had an initiative to work on electronic data transfer, I'm not sure where that's at now. But the types of errors that we're talking about included things like the release dates and included even the type of veteran. Was it a member of the Canadian Forces? Was it a member of the reservists? These things affect eligibility of programs. They also talked about whether someone served in a special service area. Again, that may entitle someone to certain benefits.

We found 24% of the service numbers were actually in error back in 2012 in the databases.

Mrs. Sherry Romanado: You may not be able to answer this, but I'm curious.

Are employees' compensation based on performance? Are you aware if they are, in fact, based on performance?

Mr. Michael Ferguson: Do you mean in the Department of Veteran Affairs?

Mrs. Sherry Romanado: Yes.

Mr. Michael Ferguson: I think they would have to answer that question. I can't answer that.

Mrs. Sherry Romanado: Okay.

In terms of the transfer of data from DND to VAC, would you recommend what I would call a one-stop shop, rather than a service member having to fill out all of this form and then DND having to transfer all of this information to another department? Would it not make more sense that the case worker who's with the active member of service in DND remain with the now veteran to ensure that there's a continuity in service? It seems to be “Oh, it's no longer my problem. The person's a vet” or “They're not ours yet. They're still an active member”.

There's this gap of “it's not my problem”, so I'm simply trying to see where the “not my problem” is.

● (1140)

Mr. Michael Ferguson: In the 2012 audit on the transition of ill and injured members, we made a recommendation that National Defence and the Canadian Forces and Veteran Affairs Canada should ensure that their databases contain reliable information and that Canadian Forces and Veteran Affairs processes are managed to facilitate the timely and efficient sharing of authorized information. That's in paragraph 4.28 of that audit and there's a response from each of the departments there.

We recognize that trying to start from scratch and put in place a comprehensive system that's going to cover everything, that type of thing, takes a long time. Recognizing that, they still need to find ways of making sure they are sharing information in a timely fashion and that the information that's being shared is accurate, and if the information has to be re-entered into another system, that there's a way of making sure that it is re-entered properly.

Certainly, we made a recommendation that they should facilitate that efficient sharing of information.

Mrs. Sherry Romanado: In terms of the data integrity you were mentioning, we have a problem with sharing information. We have a problem with the information that's actually there. As the old saying goes, garbage in and garbage out. Who's accountable? How come this keeps happening?

Mr. Joe Martire: Thank you for that.

In 2012, in the chapter when we looked at the transition, we also looked at the governance process between the two departments to ensure that information about benefits and programs is coordinated, harmonized, and shared.

As mentioned in paragraph 4.69 of that report, we found that there were gaps in the steering committee between some senior officials. They were charged with addressing the issues that you're raising, one of which was information sharing. What we found was that they had these priorities, but they weren't really tracking whether they were being accomplished and whether they had timelines for their completion, so there were gaps.

The good news was that there was a mechanism to coordinate and harmonize, but it wasn't being tracked and there were gaps in that process.

The Chair: Thank you.

Mr. Clarke.

[*Translation*]

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

Mr. Auditor General, Ms. Campbell and Mr. Martire, welcome to the committee. I am happy to see you here today.

I will preface my first question.

I would like to come back to what my colleague Mr. Eyolfson said earlier. He felt that it was taken for granted that those who were submitting applications were faking, as they had to provide records to support their application if they wanted to receive specific services or benefits from Veterans Affairs Canada.

Mr. Auditor General, military members are under extreme pressure every day. It's an environment where people have to constantly prove themselves to their peers and their superiors. In a way, that's completely normal, as the government asks the Canadian Armed Forces to carry out missions despite sometimes insufficient resources. In addition, senior army officers have to ask their members to meet that requirement.

Here is what I think military members find difficult. The culture of military members having to constantly prove themselves is perpetuated, in a way, when they deal with Veterans Affairs Canada. For example, they have to do research to access their documents in order to prove that they have a service-related injury. I don't know whether this is true, but according to what I have been told, in the United States, the burden of proof lies with the Department of Veterans Affairs, and not the veterans themselves. Mr. Eyolfson also talked about that earlier.

My question is simple. Did you look at the burden of proof system in the United States in your audit? If so, what did you find out? If you did not look at it, what do you think about the burden of proof right now?

● (1145)

Mr. Michael Ferguson: I want to begin by pointing out that our audit examines the way the department processes applications for services. It focuses only on how the department handles those issues. Our audit did not look into what other countries are doing.

Generally speaking, I think the burden of proof is problematic for military members. It is especially important in mental health, as the audit shows. It is difficult for a member of the armed forces to admit that they are having mental health issues and to ask for help. That is an obstacle in the program in general.

The veteran must begin by deciding that they need help. Then, they have to prepare their application properly and perhaps file an appeal in case of a refusal. That is a cultural aspect of this kind of a program.

Mr. Alupa Clarke: Thank you.

Should you soon have an opportunity to carry out a study on Veterans Affairs Canada's services, I strongly recommend that you look into how the burden of proof is handled in the United States. That burden is actually assumed by the U.S. department in charge of veterans, and not by veterans themselves. I would really like to see the results of that study.

In your audit, you made a recommendation on the mental health hotline. That recommendation has been implemented.

Have you considered the option of having a hotline for suicide prevention? That also exists in the United States.

Many veterans have told me that it was good to have the mental health hotline, but in situations of extreme crisis, they would like to be able to call experts who could manage their situation and help them avoid committing suicide.

Mr. Michael Ferguson: I think that is another consideration for the department. During this audit, we identified the various types of services available, including the hotline. However, it is up to the department to decide whether specific services for veterans should be implemented. That was not something we covered in our audit.

Mr. Alupa Clarke: You said that it was easier to have access to the rehabilitation program than to the disability benefits program. Do you think that is a matter of money?

Obviously, disability benefits require considerably more financial resources. Do you think this could explain the difference in eligibility between the two programs?

Ms. Dawn Campbell: The requirements are not the same for the two programs. The problem with the rehabilitation program is really a temporary one.

[*English*]

There has to be a more permanent disability in order for one to be eligible for the disability program.

The Chair: Mr. Fraser.

[*Translation*]

Mr. Colin Fraser (West Nova, Lib.): Thank you for coming to meet with us today and for making your presentation.

[*English*]

I would like to ask about the Veterans Review and Appeal Board. I know that one of the recommendations was that Veterans Affairs work together with the Veterans Review and Appeal Board on a number of items. I'm wondering if you can comment on any delay that you noticed in the Veterans Review and Appeal Board in matters coming before a hearing, and then also whether there was a delay in a decision actually being rendered.

Ms. Dawn Campbell: I'll respond to your question. We really were taking a look at the process globally, in terms of how long. We stepped back and took at look at, for every veteran who had a successful decision, how long it took and whether or not there was a component of that that was taken up in terms of the review and appeal process at the appeal board. We didn't really look into the nuts and bolts or the subcomponents of that, but more how that added to the timeline overall.

● (1150)

Mr. Colin Fraser: Okay, thank you.

With regard to an outreach strategy, did you take a look into how there was maybe different outreach needed in larger centres or more rural areas, where Veterans Affairs was to try to engage veterans who do not have access to services that maybe some folks in larger centres did or where there were service centres?

Mr. Michael Ferguson: I would go to the overall finding that we had on this item in paragraph 3.50 in the audit on mental health services for veterans, where we said, "Overall, we found that Veterans Affairs Canada's mental health outreach strategy is not comprehensive enough." We didn't get down to the rural-urban type of issue or those types of things, but what we felt was that the strategy needed to do some more in terms of areas like outreach to family doctors and families of veterans. There was still more that they could do. The types of things that you are talking about are maybe other things that perhaps they had considered or that they should consider. The department would have to go to that detail, but fundamentally, what we felt was that their strategy wasn't comprehensive enough.

Mr. Colin Fraser: Okay. In one of the responses to the recommendation, I think it was recommendation 6, there was a commitment by Veterans Affairs to improve the My VAC Account portal. I'm wondering, was that in effect when you were doing the audit, and if so, did you look at what is included as services in the My VAC Account portal?

Mr. Michael Ferguson: I believe that was the recommendation we made about providing mental health outreach. The department has said they will use online tools such as a My VAC Account, and they will continue to invest in the online environment to help veterans and their families find information quickly and easily. Through budget 2014 the Government of Canada committed $2.1 million to make further improvements to the My VAC Account.

That was the response we got after this audit. They said they had received more money to put into it. But what's happened since then I don't know because again we haven't gone back to see what they've done. They made a commitment to make those improvements to the My VAC Account and they had committed $2.1 million to do that.

Mr. Colin Fraser: I think you mentioned this in your comments. With regard to the complexity of support programs, benefits, and services for those making the transition to civilian life, and the current commitment by the government to reduce the number of veterans to the ratio of 25:1 for each case worker, do you believe that would be helpful in managing the complexity of these support programs, benefits, and services that you identified as an issue?

Mr. Michael Ferguson: When we are doing audits we always focus on a way of measuring outcomes and performance. That is a change to the inputs, the resources going into a program. The natural expectation is that if more resources are going into a program there will be better outcomes, but those two things don't necessarily always go hand in hand. I think it's important that whenever there is a change like that or a commitment to do something else or invest more in a program, there needs to be a good way of measuring if it is having the intended outcome.

Making sure there's that performance measurement attached to that increase in resources, I think, will let us know whether it's having the effect it's supposed to have.

Mr. Colin Fraser: Thank you.

Those are my questions, Mr. Chair.

The Chair: Thank you.

Ms. Wagantall.

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

Thank you very much for being here today.

When I look at your 2014 report, number 12 in your results, you focused on timely access, timely decisions, and mentioned that you didn't audit whether your decisions were appropriate or the quality of care. I'm looking on this sheet of your sticky notes this morning.

The big question here is whether you think it would be good for us as a committee to recommend an audit in those areas that you didn't audit.

As someone who doesn't have people in my own family involved in the military, when I look at the mandate to improve the seamlessness between DND and veterans, I'm beginning to learn about the culture and the reality. In some ways that very much mirrors professional athletes where you take it for the team and you have to work as a team in spite of the circumstances you're in.

I think a lot of times that's why that ask for help with mental illness takes so long, or to even recognize that they need help.

I've heard over and over again whether or not more should be done preventively or educationally to prepare our soldiers to deal with mental health issues as a possibility in circumstances where they're facing direct combat.

Years ago when I was scuba diving, I faced a very bad situation way down there and survived. I still think about it. That's nothing compared to what our veterans face in combat. We know parachutists will have trouble with their knees. Those who hit a mine or watch their friends die or face a serious injury, can we not assume they need help? Is that help there in advance? Because to me this is one of the things that's the greatest barrier in achieving the ability to transition to civilian life.

● (1155)

Mr. Michael Ferguson: I think what your question is leading to is that there are, I'll call it, three stages, and what we looked at was two of them. We looked at once somebody has been discharged, they're a veteran, they're in civilian life, and now they're facing mental health issues, how do they get access to that?

The audit we did in 2012 was looking at people who are about to come out of the military, how they make the transition to civilian life, and what types of supports are there to help them make that transition. Part of that might be to identify that they might need some help with some mental health issues.

You're talking about even before those two things. When somebody is a serving member and they are going through incidents that could have an impact on their mental health, how do Canadian Forces and National Defence manage that? I can't speak to that because that wasn't the aspect we looked at.

The way you started the question was whether there's another audit that could be done. Something we could consider looking at is how National Defence and the Canadian Armed Forces look at managing the experiences that Canadian Forces members go through.

We would have to consider that, I guess. I'll let Mr. Martire add to that.

Mr. Joe Martire: Thank you for that.

Although, as the Auditor General said, we didn't look at that specifically as a separate audit objective, we did look at the services available within the Canadian Forces if someone becomes ill or injured. We spent quite a bit of time explaining that process.

As you pointed out, the context when you're in the military is much different from when you're in civilian life. In the military, the medical system is there. It comes to you. Once you're out, you're making that transition, you're basically a private individual, so it's a help to have those services.

People who are diagnosed as having medical limitations have to go through a process. If they have mental illness, there are trauma units that are available, and there are case workers. They have a whole system. Those services were there. It's what happens when you have those issues and you're identified, how you're supported, and then what happens to you when you transition to civilian life. That's where we found some of the issues back then were problematic, because of the movement from one system to a different type of system.

● (1200)

The Chair: Thank you for that.

Next is Ms. Mathyssen, for three minutes.

Ms. Irene Mathyssen: Thank you very much.

I understand that you've gone in, and you've audited the delivery of services. In that process, obviously based on your recommendations, you must have seen where there were problem areas, and hence your recommendations.

I'm thinking particularly of recommendation six where at the bottom you have recommended a pilot project to provide veterans' families with access to military family resource centres and hiring 15 new peer support coordinators.

Obviously there was some kind of deficiency or you wouldn't have made that recommendation. What were you hoping would be achieved in that recommendation in terms of the resource centres and new coordinators? What would they look like? What was the objective of that recommendation?

Mr. Michael Ferguson: I guess we're all struggling to figure out exactly which recommendation.

Ms. Irene Mathyssen: The analyst is going to explain where I've gone wrong.

Mr. Jean-Rodrigue Paré (Committee Researcher): You're quoting from the action plan from the department, after the auditor's report. What you're mentioning is the action plan of the department, following the report.

Mr. Michael Ferguson: If I may, based on our recommendations we have had responses from the department. The department has put in place an action plan to try to deal with those issues.

I think to the more general point of your question, what we tried to do in both of these audits was to put ourselves in the shoes of the individual, in the shoes of the veteran, in the shoes of the Canadian Forces member who was making the transition to civilian life. We were trying to look at all of the things the person has to go through to get those services or to make that transition. I think there are some things the department needs to do, and the action plan that you're referring to lays out a number of steps that they're supposed to take.

Fundamentally, at the end of all of this, the intention is that there should be a better experience for the veteran with the types of services they are getting. That's what all the recommendations are aimed at, so it's less important. Sometimes what happens is that departments get focused on trying to do something to say they dealt with our recommendation, but what they need to be doing is to be making sure they're putting the focus on the end service, and the end experience of the individual, as a much better experience.

Ms. Irene Mathyssen: You talked in your remarks, in paragraph 15 and following, about the rehabilitation program for veterans experiencing that difficulty transitioning, and the treatments and benefits, and once the veteran completes the program.

I want to go back to the experience and whether that's something we should be concerned about, because very often you can complete a program but there hasn't been the positive end result.

The Chair: I apologize, we'll have to have a three-second answer on that.

Mr. Michael Ferguson: Well, the rehabilitation program is designed as a short-term program, but the disability program is designed for longer-term issues.

The Chair: Thank you.

That ends our round with these witnesses.

On behalf of the Standing Committee on Veterans Affairs, I'd like to thank you all for coming today and taking time out of your busy schedules. We will now break for about three minutes.

● (1200)

(Pause)

● (1210)

The Chair: For the second part of the service delivery review, we have Mr. Courchesne, director general of health professionals and national medical officer; Mr. Ross, national manager and clinical coordinator of the operational stress injury network; and Mr. Doiron, assistant deputy minister.

Thank you for attending today. We'll start with 10 minutes.

Dr. Cyd Courchesne (Director General of Health Professionals and National Medical Officer, Department of Veterans Affairs): Good afternoon, ladies and gentlemen. Thank you for the opportunity to appear here today and talk to you about the operational stress injury network.

I'm Dr. Cyd Courchesne. I am the director general of health professionals and the chief medical officer for the Department of Veterans Affairs. I've been in this role since October 2014, after serving 30 years with the Canadian Forces health services.

Here with me is Mr. Michel Doiron—you know him—the associate deputy minister for service delivery, who is also my boss. We also brought along Mr. Joel Fillion, who is our new director of mental health. He's sitting at the back here. He's new to the organization, as of just a few months, and he's still orienting to the department. We want you to meet him, but we thought we'd spare his having to.... Also, as mentioned, we have with us Dr. David Ross. Dr. Ross is the operational stress injury network national manager and the national clinical coordinator.

The OSI network that we present to you today is the product of 15 years of development and collaboration with our partners. This is a network that's 100% funded by the department but fully operated by our provincial partners. In my view, this is an exemplary model of federal–provincial partnership.

[*Translation*]

Together with our partners from National Defence, we have accumulated 20 years of experience in the assessment and treatment of operational stress injuries. We have more specifically focused on post-traumatic stress disorder among military members, veterans and first respondents, such as Royal Canadian Mounted Police members. I am confident that no other organization in Canada has more experience in the area than us. When I say “us”, I am referring to our military and provincial partners, as well as us, on the federal level, at the Department of Veterans Affairs. We have worked tirelessly and selflessly over the years to develop our expertise and our treatment methods, carry out research, innovate and measure our results.

[*English*]

The work, however, is never done. It's a journey of continuous improvement and of learning, and we continue to improve and to grow our capability.

Just last week, Mr. Fillion and I had the privilege of being invited to the University of Waterloo for the launch of a new operational stress injury service at the Centre for Mental Health Research in the faculty of psychology, where, in collaboration with the Parkwood OSI clinic in London, Ontario, they're training Ph.D. candidates and clinical psychology residents in the assessment of operational stress injuries.

This is a significant event because, while we've been very present in the health care domain in Canada, now we're entering into the education realm, whereby future clinicians will come to us already educated and trained in military and veterans' mental health issues, and in this case, specifically in the assessment of operational stress injuries.

I would say that the greatest strength of our network is the partnerships. It's said that a chain is only as strong as its weakest link, but we've worked over the years at maintaining and strengthening our partnerships, to the point that from an outsider's point of view they could be mistaken in thinking that we own and run those clinics, but we don't. From the outside, it looks like a very cohesive and high-performing unit, and it is.

● (1215)

[*Translation*]

The additional partnerships we have developed over the years are another strength of our network. Our mental health strategy is based on the information we receive from the Veterans Affairs Canada Research Directorate, especially information and data stemming from the study on life after service, the usefulness and quality of which are matchless. All the information arising from the research conducted by the Canadian Institute for Military and Veteran Health Research—which has a network of more than 40 academic institutes—is invaluable to our network's growth, as is our close collaboration with our Canadian Forces colleagues. Worthy of mention are the Canadian Military and Veterans Mental Health Centre of Excellence and the Chair in Military Mental Health, which were established in collaboration with the Ottawa Royal Hospital.

[*English*]

I'm going to stop my comments here.

I want to highlight the fact that just recently, in January, we started up a new directorate of mental health, which is comprised of all the mental health resources that we had, but now they all report directly to me under the leadership of Mr. Fillion. Later this year, we'll be welcoming our own chief psychiatrist, a former military psychiatrist, with extensive experience in operational stress injuries and PTSD.

Thank you.

The Chair: Thank you.

Mr. Clarke, you have six minutes.

[*Translation*]

Mr. Alupa Clarke: Thank you very much, Mr. Chair.

Thank you for joining us today.

Veteran Affairs Canada's mental health action plan called for quarterly meetings to be held between Veterans Affairs Canada and the Veterans Review and Appeal Board. Two weeks ago, I went to the Veterans Review and Appeal Board, in Quebec City, to find out what kind of cases came before the board. Of course, I did not look into any specific cases.

I saw that one of the issues that came up the most frequently was a lack of access to medical expertise. In many instances, for a case to have a positive outcome, the individual had to provide expert medical evidence. However, some of those individuals said many times to the judge that they had gone to numerous places, be it in New Brunswick, Ontario, Quebec or even as far as Winnipeg, without being able to obtain expert medical evidence.

Can you talk to us about this problematic situation?

Dr. Cyd Courchesne: I will start, and my colleagues can add to my answer if they want.

When it comes to medical expertise, we carry out assessments, establish diagnoses and provide treatments. Those who come before the board are people who do not necessarily agree with the assessment or the diagnosis that has been made either by Canadian Forces physicians or by Veterans Affairs physicians who carry out assessments, or by our OSI clinic practitioners.

If we also provided medical expertise, we would be in a conflict of interest, in the sense that we would disagree with the veteran. In those cases, people have to obtain expertise from outside the Canadian Forces and Veterans Affairs Canada. They rely on the expertise from the Canadian health system.

The department provides veterans with legal assistance, but it does not provide them with medical assistance, as the same physicians would be involved and would find themselves in a conflict of interest situation because they were supposed to establish diagnoses, but not also testify on their clients' behalf.

There is probably a lack of expert resources. No one can force a psychiatrist, a specialist, to provide expertise. We are aware of this problematic situation. It is a difficult one.

● (1220)

Mr. Alupa Clarke: Thank you for your answer. I understand what you are saying. Physicians are not really as available as we would like them to be.

As for conflicts of interest, you do provide legal assistance to veterans, and that really surprised me. I recognize that fact and I think it is fantastic. A veteran can use a lawyer who is under your authority, but is still independent.

Don't you think it would be possible to do the same thing when it comes to physicians?

Dr. Cyd Courchesne: The decisions on eligibility to a treatment or benefits are not made by the same people. Legal assistance is independent from the department in terms of operation, although it is part of it.

There are generalists on the legal side, but when it comes to expertise, an expert is needed for each medical specialty. We could not have such resources.

Mr. Alupa Clarke: How many front-line mental health clinics are there currently in Canada?

Dr. David Ross (National Manager and Clinical Coordinator, Network of Operational Stress Injury Clinics, Québec Regional Office, Department of Veterans Affairs): There are 11 of them.

Mr. Alupa Clarke: When exactly were those 11 clinics created?

Dr. David Ross: The first one was created in 2002-2003, and the last one just opened in Halifax.

Mr. Alupa Clarke: I have one last question. What exactly does your first aid program for veterans consist of?

I understand that the question is broad.

Dr. Cyd Courchesne: I will begin, and will then let Dr. Ross complete the answer.

Those are not front-line clinics; we are talking about third-line care.

Front-line care is provided by family doctors. In this case, we provide specialized and even ultra-specialized care targeting mental health issues among veterans and military members, especially operational stress issues. That is a very specific and specialized service. As I said, those kinds of injuries have been around for over 20 years—in fact, for as long as soldiers have been around.

Front-line care is closer to the clientele. Those are not drop-in clinics, but well-organized clinics that refer people to those services.

[*English*]

The Chair: Thank you.

Mrs. Lockhart.

Mrs. Alaina Lockhart: Thank you for being here today.

With your centres, what outcomes are you looking to achieve?

Dr. David Ross: What an excellent question.

It's interesting. The reason I say, “Thank you for asking the question”, is that all too often in mental health we look at outputs, but we don't look at outcomes. We look at how many hamburgers we put through the door, but are they edible?

We've been concentrating on developing a way to track veteran self-reported outcomes. We have a national server-based system set up, which allows veterans on their way to a session to answer a couple of brief questionnaires. That data goes to a secure server, it's scored, the results are analyzed, a report is generated, and that report is ready for the vet by the time they show up at the clinic. The system is called CROMIS. It uses industry-standard measures that track their overall well-being, but can also track specific outcomes with respect to the identified primary conditions like post-traumatic stress disorder or major depression.

When you're talking about outcomes, that is one of our primary measures. Now it's not the only one. Of course, we're looking at the other domains, social and vocational satisfaction, and their medical well-being as well. That's why the clinics are organized using interdisciplinary teams, so that each person does the assessment, we come together, and we look at the person in as well-rounded a manner as possible. As we intervene, we're trying to iteratively evaluate the outcomes, so that we can make real-time decisions and adjust the treatment plans, so it's really tailored to that particular person.

That's very important because people tend to talk a lot about best practices, but all those best practices data are all based on group outcomes. The reality is that in a clinical intervention, you always need to adapt those best practice interventions to the particular needs of that particular person. The best way to do that is to track their vital signs, just like they do in medicine, so it's like tracking blood pressure or body temperature.

We're the only network that uses that. I believe DND is working on starting up their own version, but we actually specifically track outcomes in real time and report the results back collaboratively with the veterans.

● (1225)

Mrs. Alaina Lockhart: I'm happy to hear that you're tracking that as well, because quite often we hear a lot of anecdotal feedback. When you have data to start backing up some of these things, over time we can continue to improve.

Dr. David Ross: If I could, I would like to add one little thing too.

When you look at this best practices literature, it gives you group outcomes, but sometimes those populations are not our people. They're not Canadian veterans.

We set the system up so that we'll be able to speak directly to how we're doing with our people over a set period of time.

Mrs. Alaina Lockhart: What you're telling us is all good stuff, which I think we're looking to hear.

Nonetheless, what are the barriers right now? What are the challenges? Where are the areas that we can be doing better, from your perspective?

Dr. Cyd Courchesne: I'll jump in. I never miss an opportunity to discuss how we can remove barriers.

Of course, people want access. We always hear that accessibility is a barrier. From our own network, which I'll reemphasize that we've been building for the past 15 years, we hear that the barriers are now starting to be physical, the physical space. Our clinics are saying that they have more clinical people who want to work for them but that they have no physical space to put them in.

When we established this network, there was an urgency that we had to start opening clinics. We opened them alongside long-term care facilities, because we already had a relationship with those hospitals. But hospitals are getting old and people are starting to be cramped. We've maximized the physical space. I would say that the biggest barrier today is physical space in our clinics. They want to expand because clinicians want to come and work there. If we could do that then, we could see more people. The capacity issue right now is physical. We would improve our access times and our wait times for all the clinicians, simply by having more space.

Mrs. Alaina Lockhart: So your wait time isn't necessarily associated with an application process; it's physical wait time.

Dr. Cyd Courchesne: Yes, it's really physical space. That is the choke point right now.

The Chair: Ms. Mathyssen.

Ms. Irene Mathyssen: Looking at the Auditor General's report, its first recommendation has to do with what we've been talking about, the barriers to timeliness in terms of helping veterans access psychological and psychiatric assessments.

It takes about 16 weeks after the veteran has gathered and submitted the necessary paperwork, and it takes another 16 weeks before they actually receive the benefit, assuming that there are no delays or glitches. At that point, they are reimbursed for any mental health care received after the date of a positive decision. The preceding 32 weeks in which they still required mental health care aren't covered. What impact does this delay have on care and coverage? If someone is under financial stress, that has to play on that person. Have you looked at the impact on mental health?

How is it possible that it could take eight months for the department to figure out that a veteran is suffering from these mental health issues and that none of that eight-month period is covered?

● (1230)

Mr. Michel Doiron (Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs): I'm going to start and then turn it over to Dr. Courchesne.

I think the first part has to do with when the OAG talked about 32 weeks. We have to recognize that during the first 16 weeks a lot depends on the delay. There is some interpretation that comes into that 16 weeks. Needless to say, there is a delay before we get a completed application and it's entered into the system. We've had lots of discussion with the OAG about the 16 weeks. Some of the data they were taking was from the get-go of the first phone call. It's hard to open a claim when you only have a phone call.

That said, we accept the fact that it's long. We accept the fact that we had to simplify. What we have done since the OAG report is to accelerate our disability process for mental health. We have done it for many other items, not just mental health. But since we're talking mental health, I will specifically talk about it.

If they have a diagnostic and they come in to us and they've served, especially if they've been in any SDAs or special duty areas, they are in the club. To really decrease...whether it's 32 or 16, to me at this point is not important. The important thing is to get that down. While they're waiting for this, there are avenues for them. We can't forget that we have the 1-800 network. We'll give the veteran 20 sessions with a psychiatrist or a psychologist within 24 to 72 hours. We pay for that. There is no adjudication process.

As long as they're a veteran or a veteran's family, we take care of the bill. There is no delay. There is no waiting. You call that number. You need help. Somebody referred to the crisis line earlier. If you need help, we will help you. We'll get you into mental health. It is not the OSI clinic, I agree, but at least you can get help immediately, pending a lot of this stuff. We pay. There's no billing. It's with Health Canada. They bill my division directly and we take care of it.

I'll turn it over to Mr. Courchesne or Dr. Ross.

Ms. Irene Mathyssen: I wonder what the pharmaceutical costs are. What are they and are they covered too? You talked about the psychologist. Are the drugs covered as well?

Mr. Michel Doiron: They're not covered under that program. But if the veteran is accepted into the disability, they are covered by the department.

Ms. Irene Mathyssen: Yes.

Mr. Michel Doiron: They need the diagnostic.

Ms. Irene Mathyssen: The word “if” bothers me a little bit.

I wanted to go back to what you said, Dr. Courchesne, about the barriers, the physical barriers regarding the OSI clinics. One of the suggestions I've heard is to embed psychologists in DND. Now, I understand VAC is different from DND. But the minister is a deputy in DND. It seems to me that this begins to make sense—you identify the problem before it becomes severe. We know that people experience mental health issues, and if they're left untreated, these issues can become catastrophic. I know that the psychological society has been talking about this. Is it something that you've discussed at VAC or with the minister?

Dr. Cyd Courchesne: Our partners at DND have similar clinics, and we consider that we're all partners. They have OTSSC—they have more complicated acronyms than we do. But they're the same. They're the OSI equivalent. They have psychologists in their clinics. I would say that they're stuck with the same problem as us with respect to physical footprints, because they're in older buildings than we are. So on both sides, we have psychologists on staff.

Ms. Irene Mathyssen: I think the suggestion was that they should be part of the military personnel and that this would break down barriers. Was any thought given to that?

● (1235)

Dr. Cyd Courchesne: You'd have to raise that with the CF. I don't think I can speak to that.

The Chair: Ms. Romanado.

Mrs. Sherry Romanado: First, I'd like to thank you for being here today and for the work that you're doing to address post-traumatic stress disorder. I have a couple of questions, but I am going to premise my questions with an apology because it may sound harsh.

We've just heard from the Auditor General, and I have to say that I'm a little concerned when I hear that 65% of cases are overturned, but I hear that in those cases, whether it be because of a lack of documentation or errors, the payments are not retroactive.

My questions are more for the ADM. Currently are there KPIs in VAC, or is there management by objectives with employees? Do employees have a performance-based incentive? What kind of quality control is in place? If there are errors happening, is there training so that these errors stop? If it's a performance problem, are people, are their jobs... I don't want to say that people are making... But they're making mistakes on the backs of the veterans.

Who is keeping track to make sure that if errors are being made, they are being addressed, that training is provided for folks, and that you're capturing the data of what kinds of errors are happening? But what happens to the data? Is it just in a report somewhere? My concern is what's happening.

I'm sure the employees wouldn't feel so great if they were told, “Well, we're going to take 16 weeks of your salary back.” My question is, what's happening?

Mr. Michel Doiron: I can probably answer all of those.

First of all, it is no longer 63%, but an 83.3% approval rate, on first applications. That has increased by 20 percentage points.

I have to back up to answer part of the question.

Army people—and I think a lot of people here have mentioned and Mr. Clarke has spoken of it—have this ethos that when you're serving with your group of people, you do not fill out the famous form, something 98, to say that you've been injured. It doesn't go into your medical file because you want to be a contributing member of your team and you want to support your partners and your colleagues. I think Mr. Clarke spoke to it well earlier.

Our legislation is written in such a way that two or three years ago we would go in to try to find proof that you were injured. That means we had to look over 500, 600, 700 pages of medical files to try to identify when you injured your knee and if you filled out a form that said you had injured your knee.

Now serious injury cases are not an issue. When we are talking serious injuries, there is a medical file. It is more about these injuries that happen over time, so what we've done is undertaken a review. Actually that started before the OAG came in, but we put a lot of effort after the OAG came in to move that from... Somebody at the OAG talked about the burden of proof, but shifting the burden of proof from the veteran to Veterans Affairs in the sense that, for an injury... I'm not talking illness, as I think I referred to last time. I'm really talking injury here. Illness is a little bit more complex.

If you were a SAR tech and you've jumped out of helicopters and planes for 30 years—who knows how many jumps you've had?—you're going to have bad knees. You're going to have a bad back; you're going to have a bad something. So we've done a lot of work with the institute of research that's over at the military site to say what the injuries are related to. Is it a certain trade? And if you come in, you have to have a diagnostic. I still need a diagnostic. A doctor has to say that your knees are gone.

Mrs. Sherry Romanado: I'm just going to stop you because what I'm referring to is performance. We're going to run out of time, so I'd like to have that answer, if possible.

Mr. Michel Doiron: Okay, so first of all, employees in Veterans Affairs are not paid per widget or whatever the right terminology is. They are at salary. They do get overtime and that. Executives, like other executives in the federal government, do have performance pay, but the employees do not.

The employees are held accountable. We have a quality assurance program that ensures that they are meeting the requirements of the program.

The Chair: Sorry, could I just have that clarified? Employees, does that include management and all of it?

Mr. Michel Doiron: Yes, executives and directors have performance pay. That's like all employees in the public service, by the way. But our managers and our employees are not on performance pay. They're on salary and they do get overtime and things like that.

Work is tracked. People are held accountable for delivering their work. There is a quality assurance program that is relatively new, but there is a quality assurance program to ensure that the work performed by the employees is meeting the criteria or requirements of the acts. We have to remember that this is all in law, right? Our stuff is in law.

I forget if I answered all your points.

● (1240)

Mrs. Sherry Romanado: I don't want to single someone out, but it you have an employee who is making errors, is there training involved and, after training is provided, a performance evaluation? Are you managing that performance?

Mr. Michel Doiron: Absolutely, and we have gone even further. We have restructured that division and now have what I call “tech advisers” and managers. That used to be one position. I have split that position now, to have more accountability and to make sure that the performance is being managed.

The technical side—because there are some very technical cases here.... It's on them that the daily learning occurs, and people are held accountable.

The Chair: I think we might have to trim one minute off everybody's time, if we are going to get everybody to their next meetings.

Mr. Colin Fraser: With regard to the operational stress injury clinics themselves, I assume those deal with a variety of different mental health issues. Mental health can be manifested in many ways, including in addictions. I am just wondering how well-equipped these clinics are to deal with addiction issues and if those can be properly addressed on an outpatient basis.

Dr. David Ross: This is an excellent question.

Two years ago we reviewed our competencies using the CCSA competency list. We did a survey across the country and took a look at where we were at.

We guarantee that each one of our teams has outpatient level 2 competencies, which means that they can screen and assess. They can determine the severity of the problem. If the persons have enough control over their addiction problem that they can complete the rest of their treatment—say, for major depression, PTSD, or whatever—then it is treated concurrently and in an integrated fashion, because that is the best practice.

If, however, the persons' condition has advanced to the point where they have completely lost control over the behaviour, then we do what is called “stepped care”. We will refer them to a designated facility with level 3 or 4 competencies, with the assurance that we will take them seamlessly as soon as they come back. We work in collaboration with them so that, as their discharge approaches, we start harmonizing the care plans. That is the best practice, and that is how we operate.

Mr. Colin Fraser: With regard to the clinics themselves, is there much outreach? Obviously, there are centres across the country, but there are places that aren't serviced close by. Is there outreach to those folks, and how is travel arranged for people to come to the clinics?

Dr. David Ross: As a matter of fact, we do as much outreach as we can. We take people by referral.

One of the things we have been trying to do is to bring the services to them as much as possible. Take British Columbia as an example. You know, this is Canada. We have cities along the bottom and a great open expanse. Some of the people who need us the most are not in those cities.

We use Telehealth; we fly people out to points of service where we can deliver services; we do everything we can. As a matter of fact, B.C. was one of the very innovative places where they used a new technology so that they could FedEx a secure Telehealth terminal directly to the person's home. All they had to do was plug it in, and they could do secure sessions that way. This is not a replacement for face-to-face, but if the alternative is driving 300 miles, it's a nice option. It is a serious priority for us.

Mr. Colin Fraser: I have one final question.

With regard to family physicians, are they aware of your services, and do you reach out to them to ensure that they know you are there to help the veterans if they need it?

● (1245)

Dr. Cyd Courchesne: You go.

Dr. David Ross: We are aware of the importance of family physicians. The reality is that family physicians do a lot of Canada's front-line mental health care, de jure or de facto. These people are vital in the care linkage.

We go and identify their communities of practice. We speak to them. What we try to provide, wherever possible, is just-in-time support, because whether or not they take a veteran may depend on whether they know they can pick up the phone and say, “I have this guy, and this is happening. What do I do?” If they know they can speak to us, that can make the difference as to whether they accept them or they say, “You know what, I have 2,000 files. I don't think I can handle any more stress right now.”

That is one area we would like to do more in, and we have been looking at options for that. We have prepared some proposals.

Mr. Colin Fraser: Thank you very much.

The Chair: Thank you.

Mr. Kitchen, go ahead.

Mr. Robert Kitchen: Thank you, Dr. Ross, for your presentation. It helped to fill in some things, especially knowing where these clinics are.

Now, my understanding is that the funding of these clinics is provincial. Am I correct?

Dr. Cyd Courchesne: No, we fund them totally.

Mr. Robert Kitchen: You fund them.

I notice that you have them in a lot of provinces; you don't have one in Saskatchewan. We have some great medical facilities and a teaching hospital, etc. Are there plans for that to happen?

Mr. Michel Doiron: We're looking at it. I was aware that there was nothing in Saskatchewan, and as you know, we're opening a new office in Saskatoon, and we're going to look at all the services and how we can improve those services.

Mr. Robert Kitchen: You realize that Saskatchewan is a huge mass, and the reality is that Saskatoon is in the bottom third of the province. We have a lot of veterans there who are looking for services, and if they have a distance to go, it's very difficult for them. Telehealth is a wonderful thing, but when the technology isn't there.... They don't have the technology; they can't access it. They live in remote areas. They're prepared to go, but they need to know, and they need to be somewhere local.

So thank you for that. I appreciate it.

I'd like to follow up on Ms. Romanado's thought. You talked about there being a quality assurance program. My question to that is, who's supervising the supervisors?

Mr. Michel Doiron: We have an internal audit shop. I call it A and E, and I'm trying to remember what A and E stands for.

Dr. Cyd Courchesne: It's audit and evaluation.

Mr. Michel Doiron: Thank you, ma'am. Audit and evaluation come in and do function audits. I've asked them to come in. I've asked them to audit our case management, do a tiger team, go out and see, and the same with our VSAs, veteran service agents. They also do work within to make sure that we are complying with the rules and following what we're supposed to be following.

Mr. Robert Kitchen: Is this an internal organization or an external one?

Mr. Michel Doiron: No, this is an internal organization that reports directly to the deputy minister.

Mr. Robert Kitchen: Is there any particular reason that it's internal versus external?

Mr. Michel Doiron: External is the OAG. Every department has an internal audit—

Mr. Robert Kitchen: Okay, but to do your audit as we're talking about, on whether we're getting the services provided, if you're going to do quality assurance and know whether these individuals are doing their jobs, then are we asking someone external to verify whether that's being done, versus the people they work for?

Mr. Michel Doiron: In the case here, A and E would come in and do it, and the OAG, when they come in and do an audit, as they did in 2014, will either say yea or nay, right? You're doing it or you're not.

Mr. Robert Kitchen: Do I have time for one more question?

The Chair: You have two minutes.

Mr. Robert Kitchen: Very quickly then, can you possibly answer this question. What's the most pressing issue: opening these service delivery offices, or mental health clinics?

Mr. Michel Doiron: They're both pressing issues, to be honest.

Mr. Robert Kitchen: And we realize they both are valuable, but what is the most pressing issue?

Mr. Michel Doiron: To me, right now it's opening the offices, and I can explain why. I'll try to do it very quickly.

If we don't have somebody to do that first assessment, a case manager on the ground or a VSA to identify and promote that, to actually be able to refer them, there's a step missing in the process. But it does not preclude.... I don't want to sound as if mental health is not important, because absolutely, the mental health component is very important; it's hard to really rank them. But they need somebody to do that initial assessment before they send anyone to our professionals, because it's on a referral basis.

● (1250)

Mr. Robert Kitchen: Thank you.

The Chair: Mr. Eyolfson.

Mr. Doug Eyolfson: Thank you. How long do I have?

The Chair: Five minutes.

Mr. Doug Eyolfson: This is a little complicated. I'll try to put a preamble on this to put it in perspective. There are military personnel who are discharged for disciplinary reasons, but the discipline is substance-related. Military personnel are discharged because they're found driving a tank drunk on the base and crash into a building, something like that. They're just simply discharged, dishonourably, despite the fact that the substance abuse may be secondary to unrecognized PTSD.

So the question is whether someone who is discharged in that kind of situation—not on medical leave, but just simply discharged as a matter of discipline—can access these Veterans Affairs services.

Dr. Cyd Courchesne: Yes.

Mr. Doug Eyolfson: That is much simpler. That answer, I think, made my day. Thank you.

The Chair: We just gained some time.

Mr. Doug Eyolfson: Excellent. It's the simplest answer to the most complicated question I've ever asked.

I have another question I was wondering about, and I made reference to this in a previous meeting with another group. We've made some reference to this. We have a lot of vets who have injuries that are diagnosed well after the fact, where it could be the sore knee but there's no medical file from when the person was there. It's the same for the person who saw horrendous things and never actually submitted a request for care when he saw his friends being blown up, but later, when he presents, you find out that, yes, he has this serious mental health issue because this, this, and that was happening.

Is there a feedback mechanism to the Department of National Defence where you can say that you are seeing these patients who have this going on, and that you believe you may be able to mitigate this if you take this into account when they're in active service?

Dr. Cyd Courchesne: We work very closely with our partners in health services. We sit on the same committees. We do research together. I work with them. I left the military, but I didn't leave the building where I worked. To their great despair, I still hang around. I walk into the director of mental health's office whenever anything crosses my desk that I think they should know about. We talk to each other on a daily basis. They know that.

To your point, what I would like to point out is that—and this is what our research has shown us, the life after service study—people come to us at different times. Some people come to us strictly, directly from the military. The military hands them over to us. We know they're going to be released. We take them on into our OSI clinics. Some people come to us years after they left because they hear about this, and they say, “I think I have a problem and I think it's related to my deployment”, and they come back to us. They come to us over their lifetime, when they leave. We have 25% who come immediately after service; and 75% over 40 years.

Mr. Doug Eyolfson: How much time do I have?

The Chair: You have one minute.

Mr. Doug Eyolfson: There's something that just occurred to me in response to the previous question, for which, again, there was a much simpler answer than I expected. Let's say we have someone with a disciplinary discharge, which will have quite a lot of implications for a lot of the benefits they might receive. If you're looking after these patients who present later, and find out that the root of their behaviour that caused the disciplinary discharge was in fact an unrecognized mental health issue, is there a mechanism to feed that back and to change their status, change the ruling of their disciplinary process?

Dr. Cyd Courchesne: I'll answer that because in my previous life, we had cases like that.

It used to be that we could. Someone was released. They decided to take a voluntary release rather than wait around for a medical decision, and we found out that it would have been better for benefits and all that, so we used to change it retroactively. Several years ago the lawyers said that was illegal, and I don't know where that is now. I would say that you would have to go back to the CF and to legal people in the chief of military personnel's branch to find out if they can still do that.

Mr. Doug Eyolfson: As a medical professional, would you agree that it would be a good thing to change it back to that system?

● (1255)

Dr. Cyd Courchesne: It's an administrative, legal thing. I don't think my medical expertise in there has anything to do with that.

Mr. Doug Eyolfson: Okay. Thank you.

The Chair: Ms. Wagantall, for four minutes.

Mrs. Cathay Wagantall: I'm beginning to get a grasp of this. OSI clinics are your third line. The veteran has gone through a first and a second line before they get to them. Am I to understand that these are the more serious cases?

Dr. Cyd Courchesne: No. They don't have to go one, two, three. It's just that in medical terms, it's not considered first-line treatment.

Mrs. Cathay Wagantall: Okay, so they've been diagnosed, and referred to you by whom?

Dr. Cyd Courchesne: They come to us from several.... They can come to us directly from the CF, so doctor to doctor; and they can come to us from our case managers, who say, “We have a client here whom we think...”, etc., and they come to us directly.

Mrs. Cathay Wagantall: Okay, but that case manager, that's a critical point, as you were saying.

Dr. Cyd Courchesne: That's the first line.

Mrs. Cathay Wagantall: They're making this all happen.

I'm from Saskatchewan. That tells you a little bit.

Dr. Cyd Courchesne: Go Riders.

Mrs. Cathay Wagantall: Yes. Please go, Riders, go.

The difference between, as you say, your barriers, the physical space, you need more clinics.... We need more mental health clinics. Then we're also talking about the need for two centres of excellence, which are a different animal again, correct?

Mr. Michel Doiron: Yes.

Mrs. Cathay Wagantall: Which one should be the priority?

If we have *x* number of dollars to spend, where are we going to help the majority of our vets?

Mr. Michel Doiron: On the centres of excellence, the mandate letter of the minister mentioned two, right?

Mrs. Cathay Wagantall: I understand that.

Mr. Michel Doiron: One of them was mental health/PTSD. I'll let Dr. Courchesne talk about this, because we think we are very close to having that.

Mrs. Cathay Wagantall: In addition to that, as you answer that question, I would like to know where they are. In relation to where the others are located, would it not be good to have one, say, out west?

Dr. Cyd Courchesne: We have one out west.

Mrs. Cathay Wagantall: In Saskatchewan?

Dr. Cyd Courchesne: We have them in Edmonton, Calgary, and Vancouver.

I like Saskatchewan. My partner is from Humboldt, Saskatchewan. I know Saskatchewan.

When the clinics were established, they were established where there are big bases such as Valcartier and Edmonton. We collocated close to the forces clinics so that we could catch the people coming out. That was the premise at the time. There's also Moose Jaw, which is a training base, with fairly young people there, young people who want to be fighter pilots and all that, but there wasn't that critical mass, so it's not because we don't like Saskatchewan or that they were overlooked. I think it was critical mass that dictated it at the time.

Now in our research, we look at where are the veterans and where is the need. I don't want to leave you with the impression that I wanted more mental health clinics. I think, except for Saskatchewan, which we'll take under consideration—

Some hon. members: Oh, oh!

Dr. Cyd Courchesne: But where we are, we need to expand there, because they already have critical mass there and expertise, and they're well under way. That was my...it was about expanding the clinics in size, not in numbers.

Mrs. Cathay Wagantall: Okay.

Mr. Michel Doiron: I want to emphasize that the services are available. We're opening an office. There will be two, one in Regina and one in Saskatoon. But whether we open an OSI clinic in Saskatchewan or not, I want to emphasize that the services are available. Mental health services from our OSI clinics are available in Saskatchewan. I really want to emphasize that.

I believe that during one of my previous appearances here, you raised the issue of a psychiatrist or psychologist in Saskatchewan, or the lack of—

Mrs. Cathay Wagantall: They're flying in from other provinces.

Mr. Michel Doiron: We take it very seriously, extremely seriously, to ensure that it doesn't matter where the veteran resides: the services are available whether they come from Edmonton, Calgary, or somewhere else.

But I've been given the finger, or the hand, so—

Voices: Oh, oh!

Mr. Michel Doiron: I apologize.

The Chair: Yes, that was my last career.

Last is Ms. Mathyssen.

Ms. Irene Mathyssen: Recommendation 6 from the Auditor General talked about outreach to family in order to ensure that there was that support system. We know that good mental health is best achieved when there is a supportive family.

You agreed to a pilot project to provide veteran families with access through the military family resource centres. I wonder what impact that pilot project could have. How far along are you in making that a reality?

● (1300)

Mr. Michel Doiron: I don't want to presuppose the outcome of the pilot. However, we do know, as it has been proven, that when you involve the family in any treatment, whether it is mental health or anything else, it's more beneficial for the individual. But we'll have to see how the pilot goes.

We have implemented the pilot. The MFRCs are open. There hasn't been a national announcement around it, but there have been local announcements that they're ongoing. We have funded them and are partnering with the CAF to have them running. That is going along, and I am meeting with some of the MFRC managers or directors individually in the near future to ask how it's going, because I'm concerned about whether they're getting the traffic they should be getting.

Ms. Irene Mathyssen: Where are the pilots? Could you tell us?

Mr. Michel Doiron: I don't remember off the top of my head. I probably have it here somewhere, but I can send that to you.

Ms. Irene Mathyssen: How many are there?

Mr. Michel Doiron: There are seven.

Ms. Irene Mathyssen: Seven, and you can send me the locations?

Mr. Michel Doiron: Yes, we can provide that to you. I have it here somewhere, but I just don't remember.

Ms. Irene Mathyssen: I'd also be interested in the level of funding, because I've been to many military family events where they're doing a bake sale or a walkathon in order to provide support for those families, very important support. So I would like to know how much the funding is.

I want to get back to one last thing. It has to do with the recommendation by the Auditor General regarding medical records and making sure there's an effective transfer of medical records. One of the recommendations from the June 2014 report was that when CAF personnel are released, they should have an ID card of all the medical records that pertain to them, so they can use these records whenever they need to in their lives. As Dr. Courchesne indicated, 75% of those going to OSI clinics are there after a considerable length of time.

Is this something you are pursuing? That recommendation is important, I think.

The Chair: We are down to about five seconds on that answer.

Mr. Michel Doiron: Yes.

The Chair: Thank you. We'll wrap this up.

On behalf of the Standing Committee on Veterans Affairs, I'd like to thank all three of you for taking time out of your busy schedules today and for all the work you do for our great veterans.

I have a bit of information for the committee. Tuesday's meeting will be a steering subcommittee meeting. We'll get the location of that out to people.

I need a motion to adjourn. Your name is too hard to pronounce, so I'll go with Mr. Fraser.

Voices: Oh, oh!

Mr. Colin Fraser: So moved.

(Motion agreed to)

The Chair: Thank you.