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Chair

Mr. Neil Ellis

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● (1805)

[*English*]

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

We will continue our comparative study of services to veterans in other jurisdictions. We have in front of us today the Department of Veterans' Affairs from Australia.

Good morning—or good evening in Canada—and thank you for appearing.

There won't be opening statements, so I will give the analyst the floor for a couple of minutes. Then we'll flip into questions.

Mr. Jean-Rodrigue Paré (Committee Researcher): Good morning.

I want to give members a general overview of how the system works in Australia.

I will probably say something wrong. So you can correct me later on.

The system generally works in a very similar fashion to the Canadian system. The main difference is in how the permanent impairment compensation is paid in Australia. Since 2006 in Canada it's been paid as a lump sum, based on the level of disability, up to 100%. It's a lump sum of up to $360,000 now. Australia, at about the same time, decided to continue with a monthly life pension—I believe it's actually paid twice a month—but veterans can decide to have that monthly payment turned into a lump sum. The maximum amount is around $1,500 a month.

If I'm wrong on that, please correct me later.

The advantage of that is that the amount of the lump sum, if the veteran elects to be paid the lump sum, takes into account the age of the veteran at the time of disability. If a veteran is injured at age 30 or earlier, the amount will be the same, but then the amount of the lump sum will be a little lower as the veteran ages. That's the general idea.

Again, you can correct me if I've said something wrong.

Most of the other elements of the system are the same. One distinction, though, is that Australia sent a significant contingent to Vietnam. As we know from our travel to the U.S., that population of veterans might have some specific issues concerning mental health that did not appear in other contingents. That would be an issue to inquire about. The contingent was about 8,000, if my information is right.

They have a similar rehabilitation program for physical and mental health problems, as well as vocational rehab. Something that Australia has and that doesn't exist in Canada is housing aids. They have subsidized loans, depending on the condition, age, and other criteria. They also have their Veterans and Veterans Families Counselling Service, which is very similar to the phone line that Veterans Affairs Canada administers here.

I won't go into the details of all of that, but you have a general idea. The main thing is that the system is very similar to the Canadian system. The difference is the payment of the monthly pensions. That is very specific to Australia.

Thank you.

The Chair: Thank you.

Deputy Secretary and Chief Operating Officer Liz Cosson will make a few opening remarks, and then we'll flip into questions.

Thank you to all, and welcome.

Go ahead, Liz.

Ms. Liz Cosson (Deputy Secretary and Chief Operating Officer, Department of Veterans' Affairs Australia): Thank you, Mr. Chair.

My name is Liz Cosson. I'm the deputy secretary and chief operating officer. I have a team here that is very happy to take questions from the committee.

By way of a brief introduction, as a department, we are approximately 2,000 people who are spread across Australia in delivering our services and support to our veteran community. I'll give you some statistics in relation to that community shortly. Also, as part of the department, we have a Repatriation Commission and a military rehabilitation and compensation commission. Joining me is the deputy president of the Repatriation Commission.

We work collaboratively to look at how we can best serve our veterans and the broader community. We have around 300,000 clients, and 174,000 of those are veterans with an average age of about 65. We have about 154,000 clients who are dependants of an average age of about 79. Of those, 120 are widows of World War I veterans.

Our numbers are reducing. We see them reducing to about 240,000 by 2020, but what we as a department are identifying is that the younger veterans, our new veterans, are presenting with quite complex claims, and they require a different approach in managing their circumstances.

We have a budget of just under $12 billion Australian. About $6 billion of that goes to compensation and support, as outlined. About $5 billion goes to health and well-being. We also have a commemorations program of about $66 million.

Over the last couple of years, and in a dedicated effort in the past 12 months, what we have been doing is listening to our veteran community to identify how we can change our programs to improve our service and best serve our younger veterans, because we are hearing from them that they are not as satisfied as our older cohort of veterans. We've been working in collaboration with the Department of Defence to look at what our future operating model will be. Ms. Pope, who is with me, is leading that transformation.

Among the key things we are hearing is that we need to change from just focusing on claims to improving the transition from service into the community, and to moving a lot of our ADF members from a life of being dependent on the ADF community to a life of independence. We also have heard that a few of our veterans have not been happy with our claims processing times and the way they have to approach the department. We have been placing a lot of effort on our time taken to process, and in the budget we received just over $13 million to support us in improving the processing activities.

What we've also heard about is the importance of families. You referenced our Veterans and Veterans Families Counselling Service. We also receive funding in the budget to extend the eligibility of our veterans counselling services to pick up more broadly the family members.

You mentioned our commitment to Vietnam. We had about 60,000, including our nurses, who deployed to Vietnam, but unfortunately we only know one in three of those veterans, and from recent conflicts, we only know one in five. Our efforts are really focused on how we can connect to those veterans and that broader community where they do have eligibility for our support and services.

In addition to what I've mentioned and your interest today, I'll conclude my opening. That was just by way of introduction on what we're doing as a department. I'm very happy to open it up to questions from the committee.

● (1810)

The Chair: Before we start, maybe we could just take a minute and get a quick introduction by each member of your staff, and then maybe we'll have some questions. I see that you have legal staff and some others there. Could we just go around?

Ms. Liz Cosson: Carolyn.

Ms. Carolyn Spiers (Principal Legal Advisor, Department of Veterans' Affairs Australia): I'm Carolyn Spiers, the principal legal advisor.

The Chair: Thank you.

Ms. Kate Pope (First Assistant Secretary, Transformation Division, Department of Veterans' Affairs Australia): I'm Kate Pope, first assistant secretary of the transformation division.

Mr. Craig Orme (Deputy President, Department of Veterans' Affairs Australia): I'm Craig Orme, the deputy president of the Repatriation Commission that Liz mentioned.

Ms. Lisa Foreman (First Assistant Secretary, Rehabilitation and Support Division, Department of Veterans' Affairs Australia): I'm Lisa Foreman, first assistant secretary of the rehabilitation and support division.

Ms. Veronica Hancock (Acting First Assistant Secretary, Health and Community Services Division, Department of Veterans' Affairs Australia): I'm Veronica Hancock, assistant secretary of the policy branch in the health and community services division.

Colonel Stephanie Hodson (National Manager, Veterans and Veterans Families Counselling Service, Department of Veterans' Affairs Australia): I'm Dr. Stephanie Hodson, national manager of our Veterans and Veterans Families Counselling Service.

The Chair: Excellent. We have a wide range of knowledge here.

We'll start with Ms. Wagantall.

You have six minutes.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): First of all, thank you so much for being part of this with us this evening. I've been very excited about this opportunity to study what other countries are doing. It's interesting that regardless of the number of veterans involved and the scenarios we've been in, transition and mental health seem to be significant issues all over the world.

I just want to draw attention to an issue that I think Australia has been doing a wonderful job on. In an article in *The Guardian* on June 2, 2017, the Australian Minister for Veterans' Affairs, Dan Tehan, spoke about the progressive outreach services that his office is providing to veterans exposed to the malaria drug, mefloquine, who are potentially experiencing side effects or are concerned about what these side effects are.

He was quoted as saying:

> Over the past year defence has had direct contact with more than 250 concerned individuals about the use of [mefloquine] and has provided information on the trials, how to request individual medical records, and the mechanisms in place through which to seek help.

I just want you to know that our veterans in Canada are very encouraged by these moves you are making, which they see as being very proactive. As we also have veterans who have been exposed to mefloquine, can you advise us how these rollouts have gone about and whether there are other veterans services being considered in this area?

Ms. Veronica Hancock: This is Veronica Hancock, from the health and community services division.

Mrs. Cathay Wagantall: Hi, Veronica.

Ms. Veronica Hancock: In Australia, for our defence forces, mefloquine has been used only as a third-line drug for malaria resistance. The the majority of our forces who are serving in malaria-prone areas are actually receiving other drugs. The numbers involved in Australia who have had mefloquine are very small.

For us, reaching out to individuals is quite feasible. Most of that activity is done by the Australian Defence Force as opposed to the Department of Veterans' Affairs, but we actually have a collaborative effort in place at the moment. That's the work that Minister Tehan referred to in his media release, as part of which we ran a workshop in a city called Townsville, in the far north of Queensland, where a number of the people who are most concerned about the administration of mefloquine currently live, to provide information about the services and the supports available for people who have concerns about their mental or physical health, whether as a result of their exposure to mefloquine or from other causes.

● (1815)

Mrs. Cathay Wagantall: I appreciate that, and your outreach is, I'm sure, much appreciated by those individuals. As you said, it's not a large number, but there is a concern there and you're meeting that need.

I also noted that the Australian Department of Defence has set up a mefloquine web page to further educate soldiers and veterans on mefloquine toxicity. How has this effort been received? Can you tell what kind of action it is receiving?

Ms. Veronica Hancock: I'm not sure how many page views, for example, that information has had. As you noted, it's administered by our colleagues in the Department of Defence, but we do get informal feedback from people that the information provided there is helpful in addressing some of their concerns, and we certainly direct people. We don't have competing information on our website. We refer people who are looking for information to the ADF site.

Mrs. Cathay Wagantall: Okay, so there is co-operation there between Veterans' Affairs and the Department of Defence.

Ms. Veronica Hancock: Yes, definitely.

Mrs. Cathay Wagantall: How much time do I have?

The Chair: You have two minutes.

Mrs. Cathay Wagantall: Okay. I'll try to do this quickly.

This is an issue that is very important to our veterans, so I want to just carry on a little bit with it. *The Guardian* article also quotes Professor Jane Quinn, a pharmaceuticals researcher at Charles Sturt University. It reads:

> Originally from the UK, Quinn's husband, Major Cameron Quinn, was an officer in the British army and was given mefloquine during a training exercise in Kenya in 2001.
>
> He suffered depression and nightmares immediately after taking the drug,...and he eventually took his own life in 2006.

I am sure you're familiar with those reactions.

Professor Quinn now works with military veterans exposed to antimalarial drugs, including mefloquine, to study neuropsychiatric conditions that arise from taking the drugs. She said that while the number of personnel given mefloquine today is minimal, that has not historically been the case—and this is what we're experiencing in Canada, as well—particularly for those individuals taking part in clinical trials in the 1990s.

She goes on to state the need for a study to:

> evaluate and untangle all the different things that might be causing these symptoms and ascertain what is being caused by the drug and what is being caused by...other factors that can impact an individual over their lifetime.

With the proactive work you guys have already been doing in this area, we really feel there is a need for an independent study, and since we have the same concerns, do you think there would be scope for an international collaboration with the Canadian government and Canadian veterans to deal with this issue that's clearly something that's on the forefront with our allies?

Ms. Veronica Hancock: Potentially there is, Ms. Wagantall. We're very interested in doing some research in this area.

We have an investigation under way through our Repatriation Medical Authority, the statutory body that sets the rules under which compensation claims are determined. They're doing a literature review, basically, and presently looking at and checking the current evidence for whether there is a need to have statements of principles in respect of chemically acquired brain injury caused by mefloquine or the related drugs. That report is due to come out within the next couple of months.

In light of whatever evidence is revealed in that investigation, we propose to develop a research proposal jointly with the Department of Defence, and we'd be absolutely open to an international collaboration on that. In fact, we have had conversations about our mutual research interests with our colleagues in the Canadian Veterans Affairs department on a regular basis anyway, so we're very happy to add that to the list of things that we would consider.

Mrs. Cathay Wagantall: Thank you very much.

The Chair: Thank you.

Mr. Eyolfson.

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

I'd like to talk about transition from active military service to becoming a veteran. Our experience in Canada is that somewhere in the vicinity of 77% of veterans will transition very well to post-military life, but about 23% do report difficulties in that transition. One of the things we've noticed is that it isn't always related to being ill or injured. Sometimes these people are healthy when they're discharged, but they still have trouble transitioning. How do those kinds of numbers compare with the Australian experience?

● (1820)

Ms. Liz Cosson: Thank you.

I'll start. I'd like to then invite Kate Pope to talk about the transition work she's doing and Lisa Foreman to talk about our Prime Minister's employment program, which is supporting our transition.

Certainly those numbers do resonate with us. We have about 5,500 who separate from our Australian Defence Force each year, and about 20% of those are separating for either medical or administrative reasons.

We have been undertaking interviews with veterans and their families over the last 12 months. We have established a transition task force to help better inform what we need to do to assist with transition. What we are finding is that those who are not leaving voluntarily find it extremely challenging and difficult to make that step from their service life into civilian life.

We're putting in place a number of initiatives to support them during transition. We're working closely with the defence department and the Australian Defence Force in looking at how we can ensure continuity of care for those who are separating for medical reasons. Our Veterans and Veterans Families Counselling Service has some programs to support the veterans and their families to make that step and to understand what their experience might be post-transition. As I mentioned, Lisa Foreman and her team are leading a program for employment, which was launched by our Prime Minister last year.

That's just by way of introduction. Maybe I can open it up. Do you want a little more detail on the employment program, or counselling, or on the transition task force? Then I can coordinate the answer.

Mr. Doug Eyolfson: Yes, we don't have a lot of time, but maybe it could be just a brief overview on the elements of what the transition involves.

Ms. Liz Cosson: Okay.

Kate.

Ms. Kate Pope: I'm Kate Pope, and I'd be happy to answer that question.

We are looking at all elements that really comprise a successful transition being about a full life after leaving the military and moving into civilian life. There's a focus on employment and on health and medical well-being, and access to the Australian medical system in the usual way once people leave the military, in which all medical services have been provided for them. It's about housing. It's about social connections. It's very crucially about their families. And, certainly, when we hear of the struggles with transition, the families' experiences are very similar to what you were describing. Families struggle in that environment as well. It's about employment for spouses, education for children, and basically reintegration into civilian life. When we talk with veterans, similar to the way you described it, those who find it difficult can face some significant challenges, and transition always comes up.

We also had specific consultations with female veterans, and they have also very much emphasized the challenges here. So the work we're trying to do, as Ms. Cosson was describing, is to smooth that transition. One of the ways we are working to do that is through our early engagement program. We would like to consider serving personnel to be clients of Veterans' Affairs from the day they enlist right through to the end of their lives, so that the transition is not this sudden drop and they contact us only when they're in crisis, but instead that they have a relationship with us and they know the services we can provide and it's a whole-of-life continuity of a caring relationship, which is what we're working to develop now. Our hope is that we can make it a positive experience and smooth that challenge at the point of transition with a focus on healthy and productive lives and then healthy aging. We really want to focus on early intervention for medical conditions so that we treat early, we get the best results we can for the veteran, and we save money for the government as well.

Ms. Liz Cosson: One of the key things for us was that information sharing with Defence, so 12 months ago we initiated a program so that we would know everyone who enlists in the Australian Defence Force now. We have visibility of everyone who enlists and we also have visibility of any injury sustained during service, which the Department of Defence notifies us about. So we start to bring them into the Department of Veterans' Affairs before they need us.

Mr. Doug Eyolfson: All right. Thank you.

I have only about 30 seconds left. Among those who have difficulty transitioning, what would you estimate would be the most common defining factors?

● (1825)

Ms. Liz Cosson: The most common factor for me would be their getting into employment. They don't recognize the skills that they have. They're unable to translate their experiences to their CV for civilian employment. We have programs to help them do that and to get back into employment so they don't rely on welfare.

Ms. Lisa Foreman: The other thing I would add is about the way that they're discharged. Have they gone voluntarily? Those who leave voluntarily, who choose to discharge, seem to be in a much better state of mind and state of health compared to those who are discharged medically. They often fight it right until the very end because they want to stay in Defence. So when they're discharged and they come to us, they're angry and actually grieving because they've lost their career. I think that's a problem and I would add it to the previous answer.

Mr. Doug Eyolfson: Thank you.

The Chair: Thank you very much.

Ms. Mathyssen.

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

To the Australian Department of Veterans' Affairs, thank you very much. We're extremely grateful to have access to your expertise.

I was very interested in what you said about the potential for a co-operative study between Australia and Canada's Department of Veterans Affairs in regard to mefloquine. I'm sure you know that this committee has been working on a study in regard to mental health and suicide prevention, and mefloquine has come up. It's been referenced by both experts and veterans with regard to the veterans who were given mefloquine during deployment. I have some concerns about our ability to finish this study. We're very close to the end of this session, and we'll be going away for the summer. If we prorogue, this study will be lost. But we'll see when the time comes.

I'm very concerned that this work will go astray, particularly in light of the fact that you said Veterans Affairs Canada has indicated an interest in co-operating with your department to look at the impact of mefloquine. First, can you give us a sense of what has been determined in regard to that co-operative study? Second, obviously there was something that compelled you to look at mefloquine. Was it the anecdotal reports from veterans? Was it concern from the medical community? What precisely prompted the decision to look at a potential study?

Ms. Veronica Hancock: Thank you, Ms. Mathyssen.

Just to correct the record, our discussions with Veterans Affairs Canada have ranged across our mutual research interests. We haven't at this point specifically discussed mefloquine, but I certainly would like to convey the impression that we are very willing to consider adding it to our list of mutual research interests. The issues that we have primarily focused on in relation to our mutual research interests to date include transition, mental health generally, homelessness, and suicide, but as I said, we'd be very open to considering some joint work on mefloquine as well.

The interest in Australia has very much been sparked by some concerted lobbying efforts from affected individuals, including Professor Quinn, to whom your colleague referred earlier. Those concerns have been raised for some time now. There has been some research internationally. Mefloquine is used across the Australian community as an anti-malarial. Outside defence circles, it's still being used, and it has been used for quite some time.

One of the reasons we're interested in the literature search currently being undertaken by our Repatriation Medical Authority is that they're looking at the consequences of exposure across the whole population, which gives potentially a much better idea of numbers. From a research perspective, in Australia the number of people who have taken mefloquine as an anti-malarial is so small it's very hard to get robust evidence. We're hoping that by looking at numbers across the broader community we'll be able to get a better picture of the situation.

● (1830)

Ms. Irene Mathyssen: Thank you.

I'm assuming that other drugs were used instead of mefloquine in regard to anti-malarials.

Ms. Veronica Hancock: Yes. In Australia the first-line drug is doxycycline. That's by far the most widely used.

Ms. Irene Mathyssen: Thank you.

There has also been discussion in this committee on military sexual trauma, and we are hearing from both men and women as it pertains to their experiences in the armed forces.

I see you have support for individuals who have experienced sexual or physical abuse in the Australian Defence Force, and that you provide counselling and special services, case management, and group programs to about 20,000 current and former Australian Defence Force members and their families each year.

Can you describe the process for how those who have suffered sexual trauma come forward and how their evidence is treated? How do they get into these counselling sessions? I'll be very frank. Here, concern has been expressed that the counselling sessions that are offered are not particularly tailored toward those who come from a military background and that culture.

Is that part of how you put together your programs? Could you simply describe the process and the program?

The Chair: I apologize, as we're about 30 seconds over time. I'll give the member another 30 seconds, if you can answer that quickly.

Ms. Lisa Foreman: I'll take 15 seconds.

We've just had a royal commission into abuse of children by institutions. Defence was one of those institutions. We have changed our rules for how members who have suffered abuse claim compensation. I'll leave it at that. That's what we've done. At one end, we've made it simpler for those members who have suffered abuse to come forward and claim compensation.

I'd be happy to talk about that some other time, but I'll pass to Stephanie to talk about the counselling aspect.

Col Stephanie Hodson: Very briefly, I think the big points are that they can start counselling immediately. We don't require them to apply for compensation. Often we will get people through our telephone line, and then they are put into face-to-face counselling.

We do a lot of effort. We consistently provide free training to a network of 1,400 counsellors. A lot of the counsellors in our network are actually ex-military mental health professionals, but importantly it is about keeping a very free and readily accessible service that is military aware.

We have put a lot of work into making sure that our counselling service is military aware. Anything to do with sexual assault will be handled very carefully, and we work very carefully with the specialists in the area as well. Sometimes we need to refer....

The Chair: Mr. Bratina.

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

I would like to direct my questions to Mr. Orme.

Sir, you are the deputy president for the Repatriation Commission.

Is that correct?

Mr. Craig Orme: Yes, sir.

The Repatriation Commission is the statutory body set up to oversee the respective acts, the Veterans' Entitlements Act and the Military Rehabilitation and Compensation Commission, which was established to oversee the act and to work in concert with the department very closely on behalf of veterans.

Mr. Bob Bratina: Would you just explain your primary responsibilities?

Mr. Craig Orme: Effectively, we have our legislation, which covers the legal entitlements enshrined in law for determining veterans benefits. It's beneficial legislation, which means we try to interpret the considerations in the veterans' favour. The legislation outlines the range of benefits that veterans are entitled to and are enshrined in law.

The role of the commission is to then oversee the department's implementation of the legislation, and, if you like, to also adjudicate around issues of policy interpretation. Where the law needs interpretation, and needs to have policy effect and a response to contemporary issues as they arise short of legislation, the commission acts as the authority to interpret those changes. Through the departments, through the delegates of the commissions who make the decisions on individual claims, there's a range of things that come up that don't require changes in legislation but do require interpretations.

Where the interpretation goes beyond simple interpretation of policy and requires changes in legislation, we go back to government, and the government then changes the legislation.

The commission effectively sits between the law and the implementation of the policy on a day-by-day basis.

● (1835)

Mr. Bob Bratina: I gather you had extensive military experience. Is that correct?

Mr. Craig Orme: Yes, sir. I spent 37 years in the Australian army. I'm a tank officer, and I'm very proud of that. But more importantly for this role, I spent significant periods of time as the director of senior officer management, as director general of personnel for the army, and as head of defence people capability, which is the senior military personnel officer across the Australian Defence Force. That gave me a good sense of these issues.

Mr. Bob Bratina: Your young soldiers, like our young soldiers, may encounter the current ISIS situation. Whatever the case, years from now, they'll be veterans. From your experience, I am wondering whether the training and preparation for combat of young soldiers is being modified in anticipation of the kind of things they may experience in these kinds of theatres.

Mr. Craig Orme: I'm speaking on behalf of the Department of Defence, which is outside my lane, but certainly the issue of resilience is something that we've been working on for quite a deal of time. Dr. Hodson is also ex-military, a psychologist, and can probably speak to some of the issues. We are building this into our programs and drawing on some of the experience of the U.S. with resilience training.

We find resilience to be necessary regardless of threats, theatre, or operations. The trauma of military service can exist even in our humanitarian assistance and disaster relief, particularly in the experiences we had in Banda Aceh. It can be present in border protection and in the whole sweep we expect our soldiers, sailors, airmen, and airwomen to operate in. All these missions can be intensely stressful for a range of reasons, not the least of which is ISIS and the uncertainty of that threat.

Mental and physical resilience are key issues. Our defence force is working very hard in that space—both in our recruitment and initial training and also in our predeployment training and in the continuum of service—to provide people with the skills they need to cope with these issues.

Mr. Bob Bratina: You mentioned Banda Aceh. Was that was the tsunami relief program?

Mr. Craig Orme: Yes, our soldiers, sailors, airmen, airwomen, and civilians were exposed to significant trauma in that environment. I raise this as an example of trauma outside the traditional operational environment. We focus on stress. In our case, our Viet Nam veterans have experienced significant mental health issues, such as PTSD, much later on. You mentioned ISIS as a new threat, but there is a range of threats that our veterans have covered for generations. The mental health issue, I think, has been undercooked and now we're starting to understand its importance and the effect it has, not only on the veteran but also on their families, immediate and extended. We're trying to come to understand those things in a much better way. It's very much in concert with our allies and our coalition partners that we've fought with over many years.

Mr. Bob Bratina: How serious is malaria in terms of your having to offer preventative drugs? For a soldier in the field, how serious is malaria?

Mr. Craig Orme: When we deploy our soldiers across a range of environments—and I actually served with Canadians across a range of environments—it's more the environmental threat, actual and potential, in Asia, the Middle East, and a range of places where malaria is prevalent. We use a range of drugs to prevent malaria. Depending on the theatre of operations, particularly in the Asian region, malaria can be of concern, so we take the preventative approach of putting people on a course of drugs. We administer inoculations for a range of issues, and we make particular drugs available for specific theatres of operation.

● (1840)

Mr. Bob Bratina: Thanks for your comments.

The Chair: Mr. Badawey.

Mr. Vance Badawey (Niagara Centre, Lib.): Thank you, Mr. Chair.

With respect to the different demographics, are you experiencing difficulties in reaching younger generations of veterans, particularly those who may have mental health or PTSD issues? That's my first question.

Second, how does the DVA reach out to veterans and their families with mental health concerns?

Ms. Liz Cosson: I'll lead in responding to that question.

Certainly, as I mentioned earlier, we only know one in five of our younger veterans, those who have served from 1999 onwards. Yes, we only know one in five.

So we rely on our ex-service organization community, veterans' service organizations which are non-government organizations, to connect with those younger veterans to bring them into the mainstream, to help ensure that they're receiving the support and services that they're eligible for through the Department of Veterans' Affairs.

We have, I think, about 3,000 ex-service organizations, with a lot of them registered as charities. Sometimes they are not as helpful as they could be, but where they are helpful and work with the department, we try to reach those veterans. Certainly we did, as I mentioned, from 12 months ago...we refer to it as “closing the door”. So we now know everyone who enlists in the Australian Defence Force, and through the transformation work that Kate Pope is leading, we're identifying ways we can reach out so that we can connect with those who aren't aware of the support and services we have available.

One other thing that we have done is work with our Commonwealth Superannuation Corporation and data analysts to do some geospatial mapping to work out where those younger veterans are, when they've transitioned from the ADF, where have they gone to live, so that we can see what is available to them in those remote communities, in a lot of instances, across Australia. A range of efforts are under way to try to connect with them.

Ms. Veronica Hancock: We also have made a substantial investment over the last five years or so in online resources, primarily directed at our younger veteran cohort. We have a website, which is the main go-to place for information about mental health support and services. It's accessible from the Department of Veterans' Affairs website, but it's very specifically about mental and social health support and resources. We've produced a number of mobile phone apps, some quite specifically directed at people who have symptoms. There's one called PTSD Coach, which is our most downloaded app, but we also have another one that is targeted at helping people moderate the amount of alcohol they drink to healthy levels. We have a whole series of web-based and phone app resources to support people who may be experiencing suicidal ideation, and to help build resilience.

Ms. Liz Cosson: Perhaps I can add one final thing to that. In the budget this year we received funding to extend treatment services to anybody who has served in the Australian Defence Force for one day, for all mental health conditions, so that they don't need to put in a claim. They can just seek the support they need without having to demonstrate it was service-related. So any mental health condition now will receive treatment.

Mr. Vance Badawey: That's a perfect segue to my third question with respect to those living in Australia who may have actually been with allied or foreign armed forces. Are they offered the same services?

Ms. Lisa Foreman: You have to have been a member of the Australian Defence Force to qualify. We call that non-liability health care. You need to have been a member of the Australian Defence Force under the legislation to qualify for that.

● (1845)

Ms. Carolyn Spiers: We do have an arrangement whereby we act as an agent for Commonwealth and allied countries, for service people from those countries who reside in Australia, to administer the compensation systems of those countries for their benefits. So there is that arrangement, but the services we provide are predominantly to Australian-based service personnel, or ex-service personnel.

Mr. Vance Badawey: Great. Thank you.

Thank you, Mr. Chairman.

The Chair: Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair, and thank you, ladies and gentlemen, for getting up early to talk with us. I really appreciate it. Thank you also for the DVA fact sheet that gives us a little bit of information about what you provide for your veterans, and thank you for your service.

I'm just going to go quickly back to the mefloquine issue. We've heard a lot of things on the issue, one of them being about your Returned and Services League. They've looked at sponsoring a neuroimaging study, looking for the correct diagnosis of mefloquine. We had a presentation here by a Dr. Merali, who is also sponsoring a neuroimaging study. I'm just throwing that out there for you to look at that name should you investigate that further. We would appreciate that consideration.

Mr. Orme, it's good to hear that you're a tank man. I grew up with tanks. My father was a major-general and he was the CO of our number one tank regiment, the Royal Canadian Dragoons, so I appreciate hearing that. That said, much of what we've heard through our studies and talking about mental illness is that a lot of times our soldiers are seeing a lack of recognition.

One of the things that tend to be beneficial to them is to be able to talk to somebody and have that person actually understand the language. Having grown up that way—not to say that I understand it completely—I understand it better than most civilians. Can you relate to us how your services integrate that in providing service for your veterans?

Mr. Craig Orme: Mr. Kitchen, it's a great question; it's wonderful. I'd like to catch up with your father. Of course, the Royal Canadian Dragoons are a remarkable regiment and well known around the world.

In terms of ranking veterans, I think the fact that we have a Department of Veterans' Affairs is probably the key aspect. We have a remarkable universal health system in Australia called Medicare. We have a wonderful country that looks after all of our citizens and delivers services to them, health and welfare, and a range of departments that do that. But we have a separate, single-standing Department of Veterans' Affairs, and its role is to acknowledge that special place our veterans have in our society, those men and women who put their lives on the line on behalf of the rest of our community. Notwithstanding the great work that first responders do —our police, our emergency services—these are the men and women who go to fight our country's wars, or do things that are dangerous and hazardous that no one else can do.

So we have a Department of Veterans' Affairs, which, when initially established, delivered services through through repatriation hospitals and through in-house, if you like, models of service delivery to our veterans. But we've moved now to a model where most of our service is delivered by other agencies—the state and public health systems, private doctors, specialists, all those sorts of things. We work with other departments to deliver some of our income-support payments in an increasingly shared service model.

That said, fact that we have a standing department for veterans' issues is the recognition you speak about. We work very hard to determine and establish the role of the department, and what it may be in the future, to ensure that veterans have a voice, that their specific concerns are recognized, and that on behalf of our nation, we respect their service and deliver services to them.

Ms. Liz Cosson: I would add, Mr. Kitchen, that we have a couple of programs as well to help staff who perhaps haven't had direct military experience to understand what military experience is like.

One is the It's Why We're Here program that we run within the department. We also have an arrangement with Defence. We have defence familiarization visits where we send our staff out to military bases to understand how military operations occur. Finally, we are working very closely with our special forces community to do a proof of concept on how we can better connect with our special forces members so that they understand us, and we understand them better. We're doing a lot of activities so that we can relate better with our veteran community.

● (1850)

Mr. Robert Kitchen: Thank you.

I noticed in your document that you have various cards, levels of carding, for your veterans for health care. Are they based on the number of years of service? I did hear that if someone served one day, they'd have recognition of it. From a pension point of view, are there certain levels in terms of where their pensions may go? Does it lead up to a lifetime pension? Is it a set amount?

Could you explain that a little bit more for us?

Ms. Lisa Foreman: It's essentially based on whether or not you've been injured. What I was talking about before is non-liability health care. You only need to have served one day to be able to access mental health support. For what we call our “gold card”, you need to have had an illness or an injury. The level of illness or injury will decide whether you get access to a gold card, which gives you access to free health care and a range of other services.

The only age-related issue for the gold card is that if you've had what we call “operational service”, which essentially means that you've fought in a conflict of some description very broadly, when you turn 70 you will get a gold card just for that reason. Regardless of your income, assets, injuries, or illnesses, you will get a gold card, which is a very valuable card to have. It's so good that everybody would like one.

Voices: Oh, oh!

Ms. Lisa Foreman: We're under a lot of pressure to give more people gold cards.

Mr. Robert Kitchen: Thank you.

The Chair: Thank you.

Mr. Eyolfson.

Ms. Emmanuella Lambropoulos (Saint-Laurent, Lib.): I'm going to take the question.

The Chair: Okay, Ms. Lambropoulos.

Ms. Emmanuella Lambropoulos: First off, what percentage of veterans would you say are on your radar and receiving benefits and services? Then, once we know that answer, what steps do you take to ensure that all veterans have access to your programs and, more specifically, to health care?

I know that you've already mentioned a mobile phone app for younger veterans, but just in general can you give us more options?

Ms. Liz Cosson: At the moment in our community of veteran clients, we are supporting about 170,000 veterans. As I mentioned, we know about one in three from the Vietnam conflict. We're getting to know more of them as they age because they're actually needing our services and connecting with us. From 1999 onwards, we only know about one in five.

We have a couple of initiatives in place. One is to know everyone who now enlists so that we won't have this problem in the future. We are going around the country and inviting veterans to come and speak to us. It's an outreach activity to try to bring them into the mainstream with the department.

Unfortunately, a lot of our younger veterans don't trust us. Social media is quite active, as you know, and if someone has had a bad experience, they jump on social media and they say not to go to the DVA. What we're trying to do is correct that perception of us, and to say that we're here, we want to support them, and they do have this eligibility for support and services. Also, it's so we have the early engagement, as Kate was referencing, and early intervention. If we can get our younger veterans into treatment earlier, then, as you know, that would save things in the longer term and would help them lead healthy and productive lives.

We're trying to reach out to families as well. As you can appreciate, someone with a mental health condition may be unlikely to want to reach out for support or service, but their families may. Their families will recognize that something isn't quite right, so what we want to do is connect with the families and let them know that their partner can access our services. We have an active social media campaign now under way, and we're engaging with our younger veterans, who have their own social media platform, to ask them to please pass on the message. We're trying as much as we can to reach out to the younger veterans.

Col Stephanie Hodson: Knowing that many people don't understand what treatment is, one very successful social media thing that we did recently was a community-based webinar with two lived-experience veterans who have been through our mental health system and who talked about their experiences. We were very careful about how we did that. In the first month, we had over 1,000 views of the webinar, and it was seen in 22 countries, which is the bit that surprised us. It's a different way of trying to talk to a younger audience in a safe way, but it's about getting over that barrier of "what is treatment, is it scary, and how do I access it?"

● (1855)

Ms. Emmanuella Lambropoulos: That's awesome. In general, how do you monitor service delivery and ensure a stable and effective service across all programs and benefits? What are the key metrics you use to determine effectiveness?

Ms. Liz Cosson: Would someone like to speak to that?

Ms. Veronica Hancock: For many years now, the primary role of the Department of Veterans Affairs has been to ensure that the treatment services for veterans are paid for. So we now have a lot of data about all the services for a whole generation that were paid for. By and large, veterans have treatment in the broader health system, so they would see a psychiatrist, a psychologist, or a specialist of some kind, depending on what their condition is, and they'll use their DVA-issued gold or white card to pay for that service. We get the data about the services they have had.

There has been far less visibility of the exact treatment that someone is having and good data about its efficacy. We're still working on how we can better monitor health outcomes. It's very easy for us to monitor the amount of service. We have a lot of metrics about how many services people have had, what kind of treatment practitioners they are seeing, data about their hospital admissions, including how long an admission was and what it was for, but it is really challenging to get good data about their health outcomes.

Even if you see a general practitioner, you might raise five issues with the practitioner in the course of a consultation. We can tell what prescriptions someone might have come out with, because we get the payment data for those prescriptions when they are presented at a pharmacy, but we don't know exactly what transpired in the course of the consultation. We know if you are seeing a psychologist, but we don't know what therapy they may have been using.

There are some exceptions to that. For example, the Veterans and Veterans Families Counselling Service has a much more complete set of data about courses of treatment. They require their therapist to use evidence-based forms of treatment for particular conditions, so they have a much richer source of data about the health outcomes of their clients.

The Chair: Mr. Nicholson, you have five minutes.

Hon. Rob Nicholson (Niagara Falls, CPC): Thank you very much.

Thank you for doing this. There are so many similarities between Canada and Australia that this is very helpful to us.

First of all, Ms. Cosson, when referring to the Vietnam veterans you said that one-third of them are lost. They are lost in what sense? Is it that they don't feel the need to interact with the veterans affairs department, or have they passed on? What's behind that description?

Ms. Liz Cosson: In a lot of cases, they haven't felt the need to connect with the Department of Veterans' Affairs. We learn of the veteran, as Lisa Foreman was mentioning, when we issue them with a gold card because of their operational service, or because they've turned 70 and are eligible then for the gold card. Sometimes their mate has said to them "Have you been to the Department of Veterans' Affairs? You'll get this gold card." Then they will connect with us.

Hon. Rob Nicholson: Up to that point, a number of veterans just feel they don't have the need for that?

Ms. Liz Cosson: That's correct.

Hon. Rob Nicholson: One of the things that was mentioned was housing loans. Even even though we don't currently have those in Canada, once upon a time we did for World War II veterans. We used to give them mortgages.

I believe yours is up to $25,000. Is it dependent upon the income or resources of the individual, or is it available to all veterans?

Ms. Carolyn Spiers: Mr. Nicholson, there are a number of housing loans that the Australian Government administers for the military. The older form of housing loan was $25,000, as you've mentioned, called the defence services homes loans. That was a very old scheme. There wasn't an income-based test at all; it was merely when an individual had served three years of full-time continuous service. Over the years, that was replaced by another form of defence service homes loans in which the value of the loan was slightly higher. I can't quite recall the figure, but it was more than $25,000.

● (1900)

Hon. Rob Nicholson: Would there be a lower interest rate for veterans on this money than they might get on the commercial market?

Ms. Carolyn Spiers: Correct. It was a sweetheart rate, obviously, which was to correct the lower—

Hon. Rob Nicholson: I like that term "sweetheart rate". That's good.

Would you register a mortgage against the individual's property?

Ms. Carolyn Spiers: Correct, if a first mortgage were required on the property. There were some rules for those very low loan amounts. Sometimes those payments were allowed to be put toward modifications to an existing house.

Hon. Rob Nicholson: That's fair enough.

Ms. Carolyn Spiers: Those older forms of schemes have since been replaced by a military scheme called the defence home ownership assistance scheme. It's a far more contemporary scheme in terms of the value of subsidization that's applied and more realistic to the value of home loans.

The Department of Defence has responsibility for that scheme, but coincidentally the Department of Veterans' Affairs administers it on behalf of the Department of Defence.

I think it would probably be best if we gave you some things about that because I don't have a lot of it in my head at the moment.

Hon. Rob Nicholson: That would be very interesting to get.

One of the discussions that we've had in Canada over the last couple of years is the whole question of monthly payments to veterans or a lump sum. This was addressed right at the beginning. One of the amounts that was suggested was, I think, a maximum of $1,500 per month. Is that correct?

Ms. Lisa Foreman: Veterans have access to three sources of income from the government if they're injured.

The first is for permanent impairment, which you can take either as a lump sum or as a fortnightly payment, if you elect to do so.

Second, you also get access to your military superannuation scheme, which is a defined benefits superannuation scheme.

Third, if you're injured or ill, you get access to an incapacity payment. Your incapacity payment is matched to the salary and allowances you had when you left Defence. We bring your income up to that level.

Hon. Rob Nicholson: It's a combination of all three then.

Ms. Lisa Foreman: That's right.

Hon. Rob Nicholson: Are any of them based on the assets or resources of the individual, or simply on the condition of the veteran?

Ms. Lisa Foreman: It's on the condition of the individual. They are not income and asset tested at all. They're universal.

Hon. Rob Nicholson: Would Australian veterans who move outside the country continue to get payments and other benefits? Obviously, they wouldn't have access to the Australian medical system.

Ms. Lisa Foreman: Yes, some of them do. We have arrangements in place with a number of other countries so the veterans can continue to access rehabilitation and pharmaceuticals.

Other arrangements depend on the relationship with the country they go to.

Hon. Rob Nicholson: Okay. That's fair enough. Those are my questions.

Thank you very much, Mr. Chair.

The Chair: We have three minutes with Ms. Mathyssen.

Ms. Irene Mathyssen: Thank you very much.

Again, thank you for your expertise.

I noted that you had a consultation with female veterans and their families in December 2016. The objective was to create a line of communication and to give those veterans an opportunity to discuss the unique reality of being a female veteran. You followed up in May of this year with another forum. As a result, you were looking at vulnerable and disadvantaged women and the health conditions of those veterans being perhaps service related. Finally, the objective was to identify new services that were needed.

I recognize that it's early in this discussion, but I wondered what you discovered that was of greatest interest and what new services were identified, if any.

Ms. Kate Pope: Ms. Mathyssen, I can help you with that.

The female veterans policy forum was an election commitment, and it is an ongoing arrangement. You're right: the first forum was held in December last year. It consisted of about 25 female veterans and 25 female family members of veterans. We ran parallel seminars, and then we brought the two groups together for most of the second day, when they shared their issues.

Both groups identified quite similar concerns: transition was one of the top issues, as it is when we talk to veterans more broadly; the impact that service has on families, what it's like to serve as a female member and the effect that has on their families; the intergenerational experience of mental health and the impact on children; and the rigours of deployment if both parents are serving and deploying, and what happens to children and families in those situations.

They reflected on the difference from the Vietnam veteran era, when usually it was the man who deployed and the spouse stayed at home. The children had the stability of their mother, and also the health of their mother to rely on. In families now, very often female veterans are married to veterans themselves, so families are subject to a situation that challenges both parents. There was quite a lot of focus there, and what that means.

There was focus on veteran suicide and the experience of the women who had participated as mothers, wives, and sisters of people who had taken their own lives, and the impact that had on them.

They also talked about the need to support the family—because if you support the family, you support the veteran—and the critical role families play, as we were talking about before, in seeing what's happening to the veterans before the veterans themselves may notice. Families want to be able to talk directly to DVA and to be heard and respected—not just the veteran, but, very importantly, the family.

Those were the main issues they raised at that first seminar.

We are holding that on an annual basis. The next one will be in October this year. As I said, we have four years' worth of funding to continue to run this forum.

We are looking at other things we can do to support them. For example, one of the members there was involved in writing a book for children with parents who have PTSD. The book is called *Do You Still Love Me? Because I Really Love You!* We've been involved in purchasing copies of it, which we are distributing through our veterans and veterans' families counselling service as a way of supporting children in those circumstances.

Since then, we've been engaging, individually and collectively, with the women who participated in the forum, bringing some of them in to see the changes we are making and to help inform us of the direction we should go with the services that we offer. We've held particular engagement sessions with female veterans to get a real focus on what the particular challenges for women are.

There has also been an issue around recognition of the service of female veterans and their access to ex-service organizations. Some of them have faced discrimination and unfortunate commentary, when they are wearing their medals at commemoration ceremonies, that they are not wearing their own medals and have them on the wrong side. There are those kinds of questions. Our minister put out a press release highlighting this issue just before Anzac Day, to draw attention to the fact that female veterans deserve the same respect as male veterans, and their service is just as important and valued.

That's kind of the space we are operating in at the moment. We are working to develop ongoing connections and to help them form a network themselves, because we've discovered that most of them don't know one another. They were feeling quite isolated and alone, and the forum really gave them an opportunity to join together and to recognize that they weren't on their own. We've been encouraging the development of that ongoing network.

● (1905)

The Chair: Great. Thank you.

That ends our time for today. I thank you for staying a little longer.

On behalf of the committee, thank you for taking the time out of your busy scheduled.

I just wanted to add that my father was in World War II, on the *Uganda*. He didn't talk about the war a lot. That was a flagship that met the British fleet in Australia, and the only thing he'd talk about was how nice Australia was.

Voices: Oh, oh!

The Chair: It still is, I guess.

Mr. Vance Badawey: I think the committee should go down there.

The Chair: Having said that, if your politicians were to make a motion to send our committee down to see you, we would accept that offer.

Voices: Oh, oh!

The Chair: Again, thank you. If there is anything our committee can do to help your veterans, the men and women who have served, stay in touch. All the best.

Yes, Ms. Lambropoulos.

● (1910)

Ms. Emmanuella Lambropoulos: I move that we adjourn.

(Motion agreed to)

The Chair: Thank you.