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Chair

Mr. Neil Ellis

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● (1635)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): Good afternoon, everybody.

I'd like to call the meeting to order. Pursuant to Standing Order 108(2) and the motion adopted on February 6, 2017, the committee is resuming its comparative study of services to veterans in other jurisdictions.

Today, we have a one-hour panel, including a 10-minute statement via video conference from Wellington, New Zealand.

Via video conference we have Ms. Mackenzie, the head of Veterans' Affairs New Zealand; Ms. Povey, manager of veterans' services; Colonel Clare Bennett, chief mental health officer, New Zealand Defence Force; and Steve Mullins, director of integrated wellness, New Zealand Defence Force.

We'll start with a statement by the group and then we'll go into questions.

Welcome, everybody.

Thank you for taking time via video conference from New Zealand. Hopefully today we can get some knowledge of some issues about services for your veterans, the men and women who have served.

We'll open up the panel now for your 10 minutes, and we'll go from there.

Thank you.

Ms. Bernadine Mackenzie (Head, Veterans' Affairs New Zealand): *Tena koutou katoa*. *Bonjour*, and good morning.

Thank you for offering us the chance to talk to you about veterans affairs in New Zealand. My name is Bernadine Mackenzie. I'm the head of Veterans' Affairs New Zealand and will be saying a few words to set the scene before welcoming your questions on how we in New Zealand support our veterans.

A few words first to set the scene. We are a small agency composed of 68 staff, and we operate a unit within the New Zealand Defence Force. We are located in central Wellington and cover all of New Zealand from there. We have no regional offices.

Our budget for the past financial year was $136 million to deliver a number of outputs, and another $177 million for the payment of veterans' pensions. As of April 2017 we had 7,600 veterans on our books and approximately 4,500 spouses, partners, children, and dependants.

We target support based on need. At present, about 3,300 veterans are actively managed by 18 case managers. The majority of our veterans have service prior to Vietnam. We are starting to see more contemporary veterans coming forward with different needs, and we recognize the importance of being proactive in responding to the changing needs of our veteran population.

The legislation under which we operate is the Veterans' Support Act of 2014. This act replaced our previous legislation, which dated back to 1954. It was brought in to modernize the support available to veterans and their families, and it has a new focus on rehabilitation, rather than simply paying pensions and providing financial support to veterans. This change recognizes the changed veteran community we are serving—a declining number of older Second World War and Korean War vets, and younger veterans looking to establish a life after they have left the defence force.

An independent review of the legislation is under way to see how it is operating now. That has been in place for two years. The review is seeking input from veterans around New Zealand, and we are contributing to this as well.

Veterans' Affairs is a funder and facilitator, not a service provider. This means it is key for us to have effective partnerships with other organizations. We work with a number of other government agencies including the Accident Compensation Corporation, a comprehensive no-fault personal injury insurance scheme for all New Zealanders; the Ministry of Social Development, which administers payment of veterans' pensions on our behalf; and the Ministry of Health, which supervises an excellent public health system through which veterans can access quality medical services.

We also work very closely with veteran groups, including the Royal New Zealand Returned and Services' Association, and a recently formed advocacy group that represents younger, contemporary veterans, No Duff. Having effective working relationships with these groups is very important to us in connecting with the veteran community because, as I have already mentioned, we have no regional offices.

It is important to state that the legislation under which we operate does not cover all those who have ever served in New Zealand forces. The act defines clearly those who come under its provisions. This means all who served in New Zealand armed forces before 1 April 1974. This was the date when the Accident Compensation Corporation came into being. ACC covers personal injury from accidents from 1 April 1974 onwards, so all veterans, as New Zealanders, would have cover from ACC for injury, illness, or death from accident during service in that period.

We also cover veterans for illness, injury, or death related to qualifying operational service in the period from 1 April 1974. The easiest way to explain "qualifying operational service" is that this means war-like service, when veterans are put in harm's way in the service of New Zealand. Veterans may have cover from both ACC and Veterans' Affairs, in which case we top up the cover received from ACC. Most forms of support that we offer would require a veteran to have service-related injury or illness, although there are some exceptions.

To turn now to what we provide for veterans, this covers both entitlements and services. Pensions and lump sum payments are available to some qualifying veterans, and we will be happy to answer your questions about what is available and to whom.

Services that are funded include treatment, social and vocational rehabilitation, and reimbursement of travel costs associated with treatment and rehabilitation. We also have in place a veterans' independence programme. This is designed to help qualifying veterans to live independently in their homes, and it can also be paid to their surviving spouse or partner for up to 12 months following a veteran's death. It can help with the cost of house and window cleaning, lawn and garden maintenance, home care, medical alarms, podiatry, and home adaptations such as ramps and rails.

We had almost 3,500 veterans or spouses or partners receiving more than 7,000 individual VIP services at the end of March this year. This was an increase of 33% over the previous 12 months. Those who received the services include more than 50 New Zealand veterans living in Australia.

We have simplified the way we deliver these services to veterans, moving from over 20,000 individual contractors to seven master service agreements, covering both VIP services and pharmaceuticals.

I mentioned earlier that our 2014 legislation marked a move away from payment of pensions and introduced a focus on rehabilitation. This gave us ways to provide medical, social, and vocational rehabilitation that can restore a veteran's health and independence after a service-related injury or illness. A major initiative for us at the moment is the development of a rehabilitation strategy that will involve the whole of sector, all those who have some input and support for veterans. This includes us, veterans, the New Zealand Defence Force as a whole, general practitioners, the ACC, the Ministry of Health, and others.

We recognize that effective rehabilitation is not something we can do for our veterans on our own, so we are working with others who all have a part to play on shaping a shared vision that will be effective in what it achieves, and will deliver something very meaningful for our veterans.

We are committed to making sure that our services meet the needs of these veterans, and we conduct client satisfaction surveys to measure this. Our most recent client satisfaction survey had a response rate of 63%, and 93% of the responses indicated they were satisfied with our services. That gives us room to improve, and we plan to do so.

We are conscious that we need to simplify processes and be able to work effectively with our changing veteran population. We have made changes, and we are going to make more. Some of these include implementing a new information management system; reorganizing staff functions to allow more end-to-end processes to be managed in one team, so that veterans and their families have one point of contact; a communications change program, again, aimed at reaching the changing veterans demographic; and making sure our communications are clear and understandable to all veterans.

I know you are particularly interested in management of mental health issues. We can only speak to the types of mental health issues that we see in our current client base. By far the most common accepted mental health condition we see among our current clients is PTSD, followed by depressive disorder, alcohol or substance abuse disorder, and anxiety. We work with medical practitioners, qualified specialist psychiatrists, psychologists, and counsellors to offer individual one-to-one counselling.

Treatment for PTSD is managed on an individual basis; Veterans Affairs does not run established veteran-specific programs. PTSD is also a key focus of the New Zealand Defence Force for serving and transitioning service personnel. Like you, we are looking at how our counterparts overseas are managing veteran-specific programs for this, and any evaluations that become available about the outcomes of these programs.

● (1640)

You are also interested in transitions. We see the transition process, moving out of the military service, as a significant and challenging milestone in our serving member's life. One of those whom I have with me today, Steve Mullins, heads a directorate with the New Zealand Defence Force. It has transition as one of its pillars, and all that this entails. Both he and I will be happy to answer any questions you have on the challenges and opportunities that this process involves in New Zealand.

With that, I conclude my opening remarks.

Steve, Pat, Clare, and I will be happy to talk now on any particular issues you'd like to raise with us. I will note that Clare needs to leave in about 20 minutes. If there are questions about management of mental health issues that you would like to ask her, you might like to deal with these first.

Thank you.

● (1645)

The Chair: Thank you.

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

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

Thank you very much, all of you, for being here.

I see by the clock on your wall it's nine o'clock in the morning, and it's tomorrow for us. Thank you. Hopefully, we will be able to catch up.

As you mentioned, we have spent a lot of time looking at mental health. Thank you for your comments on that. It is a continuously evolving issue, and becoming more and more prevalent. By the sounds of it, it has become more and more prevalent for you.

I'm wondering if you could indicate to us the percentage increases you're seeing—if you have those numbers—in PTSD issues, or any type of mental health issue.

Ms. Bernadine Mackenzie: Are you talking within the service or with Veterans' Affairs?

Mr. Robert Kitchen: With Veterans' Affairs.

Ms. Bernadine Mackenzie: Okay.

We have seen increasing numbers. The specific numbers I don't have on me. Significantly, in our younger contemporary veterans, that certainly is coming forward more prominently.

I have to say that also in our older veterans, in those over 70, we are starting to see where this has been identified as well.

Mr. Robert Kitchen: I want to go back to your very first statement. I missed the numbers.

I believe you said that you had 68 staff. Is that correct?

Ms. Bernadine Mackenzie: Correct.

Mr. Robert Kitchen: You service how many veterans?

Ms. Bernadine Mackenzie: We service about 3,000 active veterans, and we pay about 12,000 pensions.

Mr. Robert Kitchen: Thank you very much.

You mentioned a bit about travel costs. As I'm sure you're aware, Canada is a huge country. I come from Saskatchewan, which is in the middle of the country. We are very rural. We have a lot of veterans who are dealing with issues of how to get the services they're provided.

One concern that some of our veterans have expressed is the big challenge they face if they have to go somewhere. They have to get approval. They have to get everything done. By that time, it seems like a nightmare administratively for them.

I'm wondering—again, just ideas—how you would handle that, and what sort of administrative nightmare it might be for your veterans.

Ms. Pat Povey (Manager, Veterans' Services, Veterans' Affairs New Zealand): I'll respond to that.

With our veterans who need to travel for treatment outside their local area, all we require is a phone call. They have a case manager they will ring and explain that they have an appointment. We make sure that their pre-approval is in place so they can go ahead. Once they have finished their treatment and their travel, they submit a travel request cost, and we reimburse them—into their bank.

Mr. Robert Kitchen: I've never been to New Zealand. I'd love to go there some day.

To get from one end to the other, how long does it normally take?

Ms. Pat Povey: Our veterans wouldn't normally need to get from one end of New Zealand to the other.

Mr. Robert Kitchen: Okay.

Ms. Pat Povey: Probably the longest distance they would have to travel for treatment not in their local area is perhaps two to three hours. It's not significant.

Mr. Robert Kitchen: That doesn't even get you through my riding.

Ms. Bernadine Mackenzie: Most of our veterans are located in populated areas of New Zealand.

Mr. Robert Kitchen: I've been led to believe that in your decision-making structure, you utilize an expert medical panel.

I'm wondering if you might comment on how you avoid veterans saying that this medical panel is speaking on behalf of the veterans services organization, versus being independent on behalf of the veteran.

● (1650)

Ms. Pat Povey: We have a team of decision officers who make decisions on entitlements for our veterans. If a veteran comes to us and says they have a medical condition linked to their service, then the decision officers who are part of Veterans' Affairs make those decisions using the statements of principles and balance of probability and so forth in looking at their service.

We're very clear that if a veteran requires some sort of support, they will have a case manager. That case manager doesn't discuss their claim at all with them, apart from perhaps some administrative sort of things. It's kept very separate, and it hasn't been an issue that we've come across that I'm aware of.

Ms. Bernadine Mackenzie: It's not a medical panel, so it is using decision officers and a methodology that is completely independent from our case managers.

Mr. Robert Kitchen: Thank you.

I'm glad to see that you include a lot of family support in providing these services for veterans and helping them with home window cleaning and cutting the grass. I'm assuming that's what you're alluding to.

One of the things I'm also interested in is the following, which you may have a process in place at this point or may not. Have you looked at service dogs and the value they might have for your veterans, especially for veterans with PTSD?

Ms. Bernadine Mackenzie: We've had one service dog in New Zealand. The RSA has provided that support. We are watching the evidence base with regard to service dogs. That's on our agenda.

Mr. Robert Kitchen: Thank you very much.

The Chair: Thank you, Mr. Kitchen.

Mr. Fraser.

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

Thank you all very much for joining us today. It is greatly appreciated. Hopefully some of these answers will give us an insight into how you do things in your country, and that we can share best practices to make sure we're doing what we can for our veterans here in Canada. We really appreciate your time.

You mentioned that there are no regional offices. Your main office, or the only office, is in Wellington. How do you make sure there is outreach to smaller communities across your country, engaging in outreach to veterans right across your country without physically being in each community? Do you use technology? Can you share some ideas that you may have for a country as vast as Canada, where we have rural areas and have a hard time making sure we're engaging our veterans in smaller communities?

Ms. Bernadine Mackenzie: We work a lot with the Royal New Zealand RSA. They are out in local communities. They do have field officers who work with local veterans. We're very much working with them to ensure that veterans know what services can be provided. They act as that key contact.

We also have it within our communication plan that we make visits to the local RSAs, where we take our case managers. That's an opportunity for veterans to come together to be able to talk about any specific issues with our individual staff. We have the expertise to be able to respond to them.

The other way is obviously through our technology, our website. That has information on how to contact us. We run an inquiry line within Veterans' Affairs so veterans and others in the community can have a direct link to get the right information very quickly so they don't have to go through other channels.

We're looking at other ways we can develop in this area. We are looking to also involve social media by the end of the year. We believe this is key when we're starting to look at our contemporary veteran.

Another advocacy group that we have a very good relationships with is No Duff. Again, as I stated, this is a very new group here in New Zealand that certainly has context for the contemporary veterans. We have built those relationships to ensure that when they find veterans who need further support and treatment and rehabilitation, we are able to work together to ensure that it is provided.

Mr. Colin Fraser: What feedback are you getting with regard to the online services you mentioned? Are veterans happy with the online service you provide, and is there a lot of uptake?

Ms. Bernadine Mackenzie: While their ages range from 19 to 105, by far the majority of our veterans are over 70. Their preferred lines of communication are through email and phone, and also through postal letters. Those are the mediums we use because that is what they've told us they need. When I talk about social media, that's a move to be able to meet the needs of what we consider our future client, the contemporary veteran.

● (1655)

Mr. Colin Fraser: You talk about contemporary veterans having different needs. I suppose your last answer kind of identifies that as an issue moving forward, to try to address those contemporary veterans and adapt your services to their needs.

With regard to peer support, you mentioned some of the activities that are happening on the ground in local communities. With peer support for contemporary veterans, are you seeing that a way for you to have outreach to contemporary veterans is through members who have served and have gained the confidence of fellow veterans?

Ms. Bernadine Mackenzie: Absolutely. Certainly, No Duff, as an organization that is run on peer support, is able to match veterans with the right peer as well. They have seen probably about a hundred veterans in the last year in the contemporary age range. That's where our link is important. They are building the organization and the relationship with us to ensure that they can link back, because they are the first responders, if you like, and we certainly count on them with regard to providing the secondary support.

Mr. Colin Fraser: Is that group you mentioned—sorry, I didn't catch the name of it—funded by the Veterans' Affairs department? How do they operate?

Ms. Bernadine Mackenzie: No, it is independent. It is a voluntary group.

Mr. Colin Fraser: I have one other quick question, if I have time, Mr. Chair.

The Chair: You have one minute.

Mr. Colin Fraser: All right.

With regard to service attribution of injury and illness, and the determination that is made, I understand that there are now two evidential standards employed in New Zealand: the presumptive list and the statement of principles. I'm wondering what you have seen since this evidentiary standard has been in effect with regard to appeals: whether there are more appeals, whether they are more successful, and how that system works.

Ms. Pat Povey: Since the new act has come in and we have started using those statements of principles, what has happened is that some veterans who were declined conditions under the old act have been able to reapply under a clean slate and have actually had the conditions accepted. It's a much clearer guideline for our decision officers.

In terms of appeals, we take a very close look at any appeals now to make sure that we have the right information up front, and we try to circumvent their getting to that point. We've had some success in that area. Had we gone back in the first place, looked at the information, and found that the veteran perhaps did have more information but it wasn't submitted in that first application, it wouldn't have got to that point.

Mr. Colin Fraser: Wonderful.

Thank you very much for your time.

The Chair: Ms. Mathyssen, go ahead.

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

Thank you for this opportunity to talk with you and perhaps pick your brain and see if we can come up with better services for our veterans here.

I wonder if we could talk about military sexual trauma. That's something that came up during our review, discussion, and research into injuries and the mental stresses, the mental health issues that subsequently come from operational stress injuries. Do you offer military sexual trauma survivors access to case managers who would have experience in dealing with sexual assault, and a certain sensitivity, I guess, to a victim who has been assaulted?

Colonel Clare Bennett (Chief Mental Health Officer, Defence Health Directorate, New Zealand Defence Force): Steve, do you want to talk about sexual assault?

Mr. Steve Mullins (Director, Integrated Wellness, New Zealand Defence Force): Good afternoon.

Yes, it's a good question. From a New Zealand Defence Force perspective, there has been a very strong emphasis on a campaign towards operational respect, which addresses sexual assault among other behaviours that would be deemed inappropriate. That campaign has included our recruitment of personnel with expertise in case-managing sexual assault. They are internal personnel who are being employed on a permanent, full-time basis. The attitude toward that is that eventually, as the potential number of cases diminishes, those practitioners would move toward education-based services to ensure that, from a cultural perspective, the New Zealand Defence Force is well on top of those aspects.

● (1700)

Ms. Irene Mathyssen: Thank you. I'm aware that you're interested in increasing the percentage of women in the armed forces, and I applaud that. I think that makes for a stronger and better force.

I also have read that you have town halls or training programs. You were just mentioning them and the specialists who lead them. Could you elaborate on the restricted disclosure system? It's alluded to in the literature. Has it been successful? Have you made any changes to it? How do you see it working?

Mr. Steve Mullins: Obviously there are some sensitivities around this information, but since the respect campaign, we have found that we have opened up dialogue and the confidence of our staff, especially our female staff, who know they are able to come forward knowing that their information will be treated professionally and appropriately within the Privacy Act, and also knowing that the issue will be dealt with through the chain of command, but in a way that would be managed appropriately, so that retribution or any remedial action would be taken through a natural justice process.

Ms. Irene Mathyssen: Do you follow up? Is there any emphasis on treatment for mental health issues that could result from sexual trauma?

Mr. Steve Mullins: Yes, absolutely.

Internally, we also have a number of support service medical-related practitioners. So they would be internal to our health directorate, and we also utilize the services of professionals within the New Zealand public sector. Those would be with other government agencies or other non-governmental agencies in order to assist with that treatment aspect.

Ms. Irene Mathyssen: Thank you.

I also wonder about the ratio of case managers to veterans. You said that there are 68 case managers who look after about 3,000 veterans, or did I hear that wrong?

Ms. Pat Povey: Sixty-eight is our total staff at Veterans Affairs. We have 16 case managers, and each case manager will be responsible for an average of 200 veterans, depending on the level of care required. We have many more veterans who are not actively case-managed. We are aware of them. We may have case-managed them in the past, but at the present time they don't need anything from us. They're coping quite nicely at home, but as soon as anything changes for them, they will be actively case-managed, and they will go back to that same case manager they had previously, so there is always that one point of contact. That helps us to manage those good relationships with our veterans, and even though we're not meeting up face to face on a regular basis, they have formed a relationship over a period of time with that veteran.

The actively case-managed veterans are those who either require some support at home at the moment or some form of treatment, whether it be physical, surgical, or counselling and mental health types of treatment. Those are the veterans we actively case manage, and the level of risk and need determines how often we are in contact with them. So for perhaps our younger contemporary veterans who have mental health issues and who are high risk, we could be having weekly contact or more, depending on the situation at that time.

● (1705)

The Chair: Great. Thank you.

Ms. Lambropoulos.

Ms. Emmanuella Lambropoulos (Saint-Laurent, Lib.): Hello. Thank you for being with us today and for answering our questions.

You mentioned that you help veterans and their families with transition, and you manage an independence program that helps them in their homes. What other programs do you offer veterans and their families to help with transition?

Mr. Steve Mullins: As was alluded to earlier, the defence force in New Zealand has really recognized the importance and significance of providing holistic transition support. In theory, we have come to the conclusion that transition begins on the very first day of employment.

So we are now taking a bit of a different perspective, knowing that we would be treating our members as being in a transition stage from day one, meaning that we would be looking at giving them the life skills, giving them the support, giving them awareness of what may be happening outside of the defence force, so that when they are prepared, or do decide that they wish to exit, they are much better equipped and able to manage some of those challenges that might present themselves.

Ms. Emmanuella Lambropoulos: Is it mandatory for all veterans to get these services, starting from day one?

Mr. Steve Mullins: Yes, as far as internal staff are concerned. In the future, we will absolutely be looking at building a framework around this. There will be a number of policies and initiatives. We're looking at a holistic view of how we can go about addressing some of the educational awareness perspectives of it, including what we would deem the *whanau*, the indigenous word for family. A lot of our offerings go much broader than just our employees; they're almost community-related activities.

Ms. Emmanuella Lambropoulos: Would you say that, at this point, the largest number of veterans is quite young? Would you agree with that?

Ms. Pat Povey: In terms of the veterans who come to Veterans Affairs once they're no longer serving, at the moment the largest group we look after is older veterans.

Ms. Emmanuella Lambropoulos: Older veterans, okay.

Ms. Pat Povey: Yes, over the age of 70 and to 100 years old.

Ms. Emmanuella Lambropoulos: Do you have a plan in place to reach the younger veterans?

Ms. Bernadine Mackenzie: Yes, we have.

As I was talking about before, particularly about communications and linking with others, I think the biggest issue we have is people recognizing they are veterans. That recognition is really important. We are linking with our advocacy groups and others. We're also linking with government agencies, because a lot of the time they might have the first interaction with a veteran. General practitioners in the community, who are primary carers, link back with us as well.

Part of our rehabilitation strategy is to have them at the table and to look at what information they need to get. What capability do they need in their workforce to be able to deal effectively with veterans when they come to them? What specific issues come from the service?

Ms. Emmanuella Lambropoulos: This is my last question, if I have time.

The Chair: You have three minutes.

Ms. Emmanuella Lambropoulos: What would you say is the biggest problem, the thing most veterans have the most difficulty with, when it comes to transition? When they're transitioning, what's the most common difficulty among veterans?

Col Clare Bennett: I'll comment on that.

It does range for people, but commonly when people have served for many years, it's around their loss of sense of identity. The transition to civilian life and civilian employment is quite difficult for many people. Historically, we have provided housing, health services, and so forth. The challenge for many people is being able to establish debt in the civilian world.

One of the things we have focused on and are thinking about is how we do more of a soft handover between [*Inaudible—Editor*] and Veterans Affairs so that they are hooked up. If they opt out of being on the books with Veterans Affairs, we ensure that they are connecting with their GPs and so forth as part of the transition program we're putting in place.

We are very much drawing on learnings from what other nations have been doing in this space, including Canada and the Canadian Forces.

● (1710)

Ms. Emmanuella Lambropoulos: Thank you.

The Chair: Mr. Bratina.

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

When friends of mine in high school—and that's a very long time ago—were travelling, they stopped in New Zealand and never came back—

Voices: Oh, oh!

Mr. Bob Bratina: —because, apparently, you have beautiful beaches and it's a great place. It may be a great place to retire as a veteran as well.

My first question is about the Vietnam experience. We talked with our American friends, and their highest suicide rates are in the Vietnam cohort.

Are there special issues related to the Vietnam group for New Zealand?

Ms. Pat Povey: Yes, there have been. Historically, there was a feeling that their service wasn't valued Zealand when they came back, settled back into the community, and so forth. It was quite a difficult period for them. What the New Zealand government did was to make a public apology. We had a welcome home, and a memorandum of understanding was put in place. It has gone a long way in helping those veterans feel like they are valued and their service was valued.

We now have a presumptive list for a number of conditions related to service in Vietnam. If a veteran has a particular medical condition, and it's on that list, they don't have to prove that it's linked. We will just accept that it is linked because of the research that has been done around that. Yes, that has gone a long way.

There are still some veterans who struggle with the public perception when they came back to New Zealand. Certainly, in terms of Veterans Affairs' helping, the experience become more positive for them. We have seen over years, as the one-on-one case management service has been provided, that they feel there is value in their service and that we recognize its value to New Zealand.

Mr. Bob Bratina: Yes. That, then, leads to qualifying operational service when soldiers were in harm's way. Is there any controversy about that designation, that someone was in harm's way or that “I should get the same benefit or opportunity”? Does it work okay?

Ms. Bernadine Mackenzie: It works okay. It's difficult, particularly going back and looking at service records and at the qualifying factors. It is something we continue to try to simplify for the veteran, but it's probably the one area in which they would like to see change in this country.

Mr. Bob Bratina: You mentioned veterans who don't know they're veterans. It sounds strange, but we have the same experience here. When you stop someone on the street and ask, “Are you a veteran?”, they may say no, and if you say, “Were you ever a member of the Argyll and Sutherland Highlanders Regiment?”, they may say yes. So they were a veteran.

In terms of veterans choosing to not receive, do you have a very large group of veterans who just walk away from the service at the end of their active duty and don't report or don't have case management? Is that a very common thing or not?

Ms. Bernadine Mackenzie: Yes, it is, if you look at the possible numbers of veterans in this country. Let me say that we have an excellent public health system here in New Zealand, and so many of these veterans, through their general practitioner, are also linked to secondary services. Our ACC system for accident and injury is fantastic as well, as it also provides for that population.

Mr. Bob Bratina: Yes. We have what we call “universality of service”, which means that the active-duty member has to be able to deploy on a day's notice. Should they not, for mental, physical or other reasons, they may well find that they're at the end of their career and all of that stuff that you talked about: they're no longer a member of the team and are rather excluded.

Can you comment on the situation in New Zealand regarding universality of service, as to whether there are ways to keep active service members within the ranks until their issue has been overcome? Or is that something that you deal with at all? I may not be asking the right people, but perhaps you could comment on this.

● (1715)

Mr. Steve Mullins: Yes, it is a real issue when we have what we would deem downgrades; in our terminology, we would downgrade from a medical perspective. There's been some debate and some conceptual thinking around how best to manage those members who are downgraded. In theory, the attitude that we're leaning towards is keeping them within the team environment. The other side of the story would be to take them away from the team environment and put them into what we would deem a rehabilitation unit in order to increase their rehabilitation aspects and try to get them back into service or operational readiness.

At the present time, we're grappling with the issue, but we believe that the answer lies within having a really good care plan, and so a wrap-around, medically-related, evidence-based time frame whereby command are quite aware of how treatment is progressing, in order to get the operational readiness aspect back as quickly as possible. The majority of our members are very passionate about getting back to their full capacity, so we're obviously dealing with a cohort who are trying their hardest to get back to their physical or mental best.

Mr. Bob Bratina: Yes.

The Chair: Mr. Brassard.

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

Thank you for joining us today.

I want to focus on three areas, if we can. The first one is the case-managed situation. It works out in New Zealand to about 1:200. In Canada, we try for about a 1:30 ratio, from a case management standpoint.

Do you find that in a 1:200 situation your case managers are in fact overwhelmed with the demand of those cases, or are they able to manage appropriately and effectively?

Ms. Bernadine Mackenzie: I'll just start by saying that the numbers sound high, but it comes down to the needs and to when there is an intensive need for the person to be case-managed. In fact, we have rehabilitation advisers too who support that process. Then, as I said, we have veterans who are being managed within the mental health services and the public health system of New Zealand as well. We will liaise there with the psychiatrist, for instance, who would be the primary caregiver. The majority of our cases are not at that extreme level; we absolutely have a reduced caseload there.

Pat, do you want to talk about the...?

Ms. Pat Povey: When a veteran comes into our case management service, we clearly look at what their need is and whether they're high risk or not, in terms of mental health, or they might have high surgical needs or mobility needs, so we prioritize those. With every veteran who comes into our case management service, they would have someone assigned within a week, and a phone call will be made and a full needs assessment done over the phone. We have a tool that we use that gives us a full picture of the veteran's need.

A lot of the veterans who are sitting on a caseload have the services in place while they are actively case managed. They might not need a lot of actual intervention, because we've got the things in place. It might be just a matter of a phone call once every six months just to make sure that everything is working. We have master service agreement providers who provide a lot of those services around the home for our veterans to help them maintain their independence. If there are problems, the veteran can contact them straight away and they will work it out. So we might not be the sole provider of something, but might be signposting or putting those services in place, and those providers have to manage the delivery of that service.

Ms. Bernadine Mackenzie: While that's the current situation, we're also looking to the future because we do believe that we're going to have more intensive case management than what we have now. We're trying to look at modelling what will that look like going forward and what operating costs we will need to cover. That points in the direction of a reduced caseload—

Mr. John Brassard: Perhaps related to mental health issues, PTSD, for example.

Ms. Bernadine Mackenzie: Absolutely.

Mr. John Brassard: The second area I want to focus on is the pension issue, because I noticed that pre-1974 those veterans who served then received a monthly income, and post-1974 they received a lump sum income. How have those changes been received?

Ms. Pat Povey: That's not quite correct. If a veteran pre-1974, under the old act, had a medical condition that was accepted as related to service and a pension were paid, it might be dependent on the level of disability, and that would affect the decision on the dollar amount. With the new act, the first thing that we're looking at is rehabilitation and treatment. So if a veteran comes to us with a medical condition, the first thing we will look at is whether it's related to qualifying operational service and how we should treat that veteran to get them back to fitness.

If, at the end of the period of treatment, there is a permanent condition that has been identified or it's reached a stable state, a decision is then made, depending on when the injury occurred, and a fortnightly independence allowance is given, or a lump sum payment is made. And there are the dates around that, so between April 1974 and April 2002, an independence allowance would have been given —and that aligns with our ACC, which Bernadine has spoken about —while post April 1, 2002, if the injury is permanent, a lump sum payment is made based on the level of disability.

● (1720)

Mr. John Brassard: Okay. Who determines that level of disability?

Ms. Pat Povey: It's our decision officers, and they base that on specialist reports, so they don't make a determination just themselves; we get specialist medical reports.

Mr. John Brassard: How much time do I have, Mr. Chair?

The Chair: A minute.

Mr. John Brassard: Okay.

The last area I want to focus on—and I am glad to have been able to get all three questions in—is the area of transition and specifically the employment of veterans or existing members who are transitioning out.

In Canada, for example, I would call their employment rate in the public service abysmal.

What's been your experience in helping or assisting those members of the armed forces transition into other areas of employment, perhaps the public service or private sector? What's the experience been like there and how successful has that been, in your opinion?

Mr. Steve Mullins: If I could answer, I would suggest that we have a similar issue. The way we differ a little bit is that a lot of our civilian-related employment opportunities in the New Zealand Defence Force are actually being filled by veterans, meaning that veterans are actually coming back into the defence force into our civilian-related work or employment opportunities.

We are also leveraging a number of other opportunities within the recruitment labour hire markets, trying to have corporate partnerships within New Zealand to promote the value-add of ex-military personnel within the private sector or other government agencies.

But it is a work in progress.

The Chair: Thank you.

Mr. Fraser, I believe you're splitting your time. So you're up.

Mr. Colin Fraser: I am indeed. Thank you, Mr. Chair.

I'm just sticking with the transition piece. I'd like to hear a bit about when forces' members are being released from the military and becoming veterans. How well integrated are they and how much co-operation is there between the Ministry of Defence and the veterans' affairs department in this transition. What level of co-operation is there and can you explain how that looks in New Zealand?

Ms. Bernadine Mackenzie: Well, we are a unit of the New Zealand police force. We're part of the family, if you like, although we have some quite specific accountabilities in regard to our veterans. There are good relationships there. As always, there are privacy issues, and we have worked through these with the health directorate within the New Zealand police force. We are always looking to see how we can do that soft handover better, which Clare Bennett talked about, and taking a proactive response to this. For instance, at the moment, when you exit the New Zealand police force you have to opt in, if you qualify, as a veteran within our service. We are now being proactive with new policy to enable that. You are opted in, and then you have to opt out. We are trying to make that easier for the veterans because, obviously, once you've left the defence force and something happens, you see the world a lot differently and it becomes a lot harder to connect back. So this is trying to make it as easy as possible and a smooth transition.

Mr. Colin Fraser: Would you say that forces' members are aware of the benefits and services that are available to them upon their release? Is it common knowledge, or is there some kind of information given to folks as they are transitioning?

● (1725)

Ms. Bernadine Mackenzie: There is information and we pass off some of the transition programs. We're looking to improve in that area and are mobilizing ourselves in bases, for instance, to ensure that the current proven members actually do know what is available. So we're trying to get the information out and communicate it continuously. Part of it comes back to the recognition of being a veteran as well. It seems that if I'm hitting retirement, I might actually quite like to be a veteran. But before that, for veterans in this country there is an issue around recognition.

Mr. Colin Fraser: Thanks very much. I'm going to turn it over to my friend now, Ms. Lambropoulos.

Ms. Emmanuella Lambropoulos: Hello again. We've found here in Canada that a lot of the veterans only seek services later on, unless they've been released on injury. A lot of them come back when they realize that they have post-traumatic stress disorder or depression, as you mentioned earlier. I was wondering if you know approximately what percentage of veterans you serve or are currently being monitored or receiving some kind of service from one of your partnerships?

Ms. Bernadine Mackenzie: No, we don't.

Ms. Emmanuella Lambropoulos: No, okay.

Is it really up to them to reach out, or is there a way of keeping track of who is receiving services or where the veterans stand down the line?

Ms. Bernadine Mackenzie: I think that going forward it will be easier with the change in policy I'm talking about. But at the moment, when a person transitions out of the New Zealand Defence Force, they go out into the community of New Zealand, and unless they come back through another avenue, we don't know where they are.

Ms. Emmanuella Lambropoulos: Okay. I think that's all for me. Thank you.

The Chair: Ms. Wagantall, you have five minutes.

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

I really appreciate the opportunity to talk about things with you today. I would be remiss if I didn't bring up the issue of mefloquine. As you know it's an issue around the world right now, an anti-malaria drug that was used significantly in the past. However, New Zealand has an amazing record in regards to this drug, in being so proactive in ensuring that it wasn't used only as a drug of last resort and that it was monitored. Ground trials were done and if it were approved for use in the operational context, the personnel receiving it were followed up and monitored as well. So you've had very little issue with veterans suffering from the side effects of that drug. I see that you've worked with the United Kingdom defence study on that. It was very exciting for me to see how proactive you were in that. It shows a real concern for your veterans.

You have your veterans advisory board and I understand that members are appointed by the Minister of Veterans Affairs'. I'm just wondering about the process for that. You have seven members and one serving veteran on that board. What kind of an opportunity or input do the veterans themselves—disabled veterans, the ones that you service most—have into who might be considered to sit on that board?

Ms. Bernadine Mackenzie: The RSA would be one mechanism. The board is very new. It's only been going for a couple of years, so if you look at their work program over the last year, it's mainly been focused on the repatriation policy changes that have been made here in this country.

We're getting back into the swing of things. Veterans, and certainly those who are on that panel, are very supportive of the people who have been appointed.

Mrs. Cathay Wagantall: That's excellent. Thank you.

We have an issue here with our case managers being under a lot of stress, and we're trying to make their load more reasonable.

How are your case managers trained, and are they veterans themselves or do they have some kind of national defence background? Also, can you tell me anything about their longevity of service, because expertise becomes so important?

Ms. Pat Povey: Our case managers have a wide range of backgrounds. When we are looking for recruits, we always look for someone who has had experience in a case management role in a previous life, because we understand that they need to be able to manage a number of things quite intensely for our veterans.

We've had some ex-service personnel, an ex-mental health nurse, and occupational therapists. Yes, we have quite a wide variety. We have some who have worked with the ACC in the past, so they are aware of dealing with those sorts of injuries and managing them.

We have a very good retention rate with a lot of our case managers. Some have been there for 10 years and so they really enjoy their jobs. We've had some quite significant changes within the department over the last couple of years and over half of the case management team are new recruits, just because of the change of where we were sitting. This means that we now have a lot of younger case managers, who have interacted and fitted in very well with what we call our “classic” case managers, the ones who have been here for a while.

● (1730)

Mrs. Cathay Wagantall: Do you have specific training when they come to this new job?

Ms. Pat Povey: Yes, we do.

The training is specifically around the act in the first place and the policies now, and we have peer review of all our work. They sit and listen to our conversations with our veterans. We have our team of rehab advisers who talk to them about any conflict issues or conflict cases. They all sit on the same floor with them, so it's a very interactive and a very supportive environment for them.

One of the things we have recognized with the new contemporary veterans coming on board now with more mental health issues and more intensive case management required is the need to safeguard our staff so they don't become overwhelmed. We are certainly taking that into consideration.

Mrs. Cathay Wagantall: I have a quick question—

The Chair: Thank you.

Mrs. Cathay Wagantall: I'm done?

The Chair: Yes, I'm sorry.

Ms. Mathyssen.

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

I have a couple of follow-up questions. You talked about the challenges of finding veterans once they're discharged, particularly if they don't seem to have specific needs. Again, I want to come back to those who have experienced military sexual trauma.

I wonder if there is a special effort to find those discharged survivors and support them, because clearly this is an OSI that could be very problematic for the rest of their lives.

Mr. Steve Mullins: Yes, you're absolutely correct.

We haven't attempted at this point in time to identify those individuals. We'd be relying on their coming forward for historic-related issues. In any contemporary or current situations, we would absolutely be doing a wraparound for those individuals if they couldn't continue in service. We would make sure that was well recognized within the Veterans' Affairs handover within the Privacy Act and Health Information Privacy Code, with their consent to share the information.

Ms. Irene Mathyssen: Thank you.

I was quite interested in Ms. Wagantall's question with regard to mefloquine and the fact that you did not use mefloquine aggressively. Obviously, you have veterans who were in Vietnam who were exposed to malaria. Have you any idea why the New Zealand Defence Force chose not to use that particular drug?

Ms. Bernadine Mackenzie: My understanding of some of that was the linkages with Australia. I'm sorry, but we don't have the details here amongst our group.

Mr. Steve Mullins: To add to those comments, the New Zealand Defence Force is well advanced within their occupational health strategy and policies, both historically and at present. Even as of last year, there was an independent external review into the manner and method within the New Zealand Defence Force around occupational health and safety.

That's really put this organization in good stead in understanding the risk, and mitigating the likelihood of any issues via effective controls. This means that if elimination was one of the controls, that would obviously be where—from a health and safety perspective—the defence force would aim to eliminate all potential risk.

● (1735)

The Chair: Thank you.

That ends our hour.

On behalf of the committee, I would like to thank all of you for helping us today. If there were any questions that you felt you wanted to elaborate further on, or that you didn't have answers for, please email your response to our clerk and he will get them to our committee members.

On behalf of the committee, I invite every one of you to visit us. We would enjoy hosting you.

That said, I have to switch to a bit of committee business here.

Next Monday's meeting includes a video conference from the U. K., so the time change is 11 o'clock until 1 o'clock. We will be serving lunch.

No meeting is scheduled for next Wednesday.

We have a motion to adjourn from Mr. Bratina.

(Motion agreed to)

The Chair: Thank you.