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COMMITTEE

ON

VETERANS AFFAIRS

Thursday, November 8, 2012

Committee Room 1

Organizational Meeting

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VETERANS AFFAIRS COMMITTEE

Gary Burrill (Chair)
Jim Boudreau (Vice-Chair)
Michele Raymond
Howard Epstein
Lenore Zann
Hon. Wayne Gaudet
Harold Theriault
Alfie MacLeod
Chuck Porter

In Attendance:

Kim Langille
Legislative Committee Clerk

Gordon Hebb
Legislative Counsel

WITNESSES

Veterans Affairs Canada

Glenn Craine,
Case Manager

Stephanie Adams,
Acting Manager, National Appeals and Issues

Derek Cannon,
Case Manager

House of Assembly
Nova Scotia

HALIFAX, THURSDAY, NOVEMBER 8, 2012

STANDING COMMITTEE ON VETERANS AFFAIRS

9:00 A.M.

CHAIR
Gary Burrill

VICE-CHAIR
Jim Boudreau

THE CHAIR: Good morning, everybody. We want to draw our meeting towards order. We want to welcome our guests here from Veterans Affairs Canada this morning, who are going to be presenting to us on PTSD-related matters.

You will see on your agenda that after that we have a number of administrative matters to do with the committee, too. I'd also like to add to that agenda - with everyone's agreement - that Mr. MacLeod would like to raise a matter to do with the proposed changes of the VAC office in Sydney. With that adjustment, does this agenda meet with everybody's approval? Agreed, okay.

Perhaps what we'll do is introduce ourselves to you and then I'll ask you to introduce yourselves to us and then proceed with the presentation and then after that we can have a conversation based on it.

[The committee members introduced themselves.]

THE CHAIR: The floor is yours.

GLENN CRAINE: Good morning everybody, my name is Glenn Craine and I'm a case manager with Veterans Affairs working at Canadian Forces Base Halifax. I would like to introduce two other people who have come today.

On my right is Stephanie Adams - Stephanie currently is the acting manager with the first level appeals unit based in our regional office in Dartmouth. She's previously worked as a case manager with Veterans Affairs as well. On my left is Derek Cannon - Derek is a case manager with Veterans Affairs, working at the Halifax district office. Derek worked for a number of years at Canadian Forces Base Halifax as well as CFB Gagetown.

I'd like to acknowledge the significance of this appearance before your standing committee during Veterans Week 2012. From November 5th - 11th, hundreds of commemorative ceremonies and events take place across the country to remember the achievements of our veterans and honour those who have made the ultimate sacrifice.

Our objective today is to provide you with information on how Veterans Affairs Canada supports veterans who have mental health conditions. An operational stress injury is defined as any persistent psychological difficulty resulting from operational duties performed while serving in the Canadian Forces or as a member of the Royal Canadian Mounted Police. It is used to describe a broad range of problems, which include diagnosed medical conditions such as anxiety disorder, depression and post-traumatic stress disorder. The symptoms and injuries themselves vary according to the individual and the nature of their experience. The earlier help is sought, the better the rate of recovery.

PTSD symptoms usually start soon after the traumatic event but for some people they may not happen until months or years after the trauma. Symptoms may come and go over many years. Some of the symptoms would be things like reliving the event, for example - nightmares, flashbacks, triggers that cause the person to relive the event through such things like smells or sounds. The second one would be avoiding situations so they would avoid crowds. They may avoid driving or watching movies that are related to war. Feeling numb is another one, this can be things like lack of interest in activities or hard to experience emotions. The last one could be hyper-arousal, so difficulty sleeping, concentrating, jittery, on the lookout, angry or irritable.

People with post-traumatic stress disorder may also have other problems. These can include things like: feelings of hopelessness, shame or despair, depression or anxiety, drinking and/or drug problems. Physical symptoms are: chronic pain, employment problems and relationship problems, including divorce.

Treatments for PTSD fall into three main areas: psychotherapy, medication and other types of treatment. Psychotherapy treatments are things like cognitive behavioural therapy, cognitive processing therapy, prolonged exposure therapy, or eye movement desensitization and reprocessing therapy. All of these therapies generally attempt to get the client to confront and reframe the traumatic event.

Medications such as Prozac, Paxil, Zoloft and Celexa are all anti-depressants and regularly used. Other types of treatment could be group treatment, family therapy or

intra-inpatient treatment programs such as the ones that are available through St. Anne's Hospital in Montreal or Homewood in Ontario, which treat not only the PTSD but any associated substance abuse issues.

This slide gives you a feel for the numbers that Veterans Affairs is dealing with. Between 2002 and September 30th, 2011 the number of Veterans Affairs clients who were approved for a mental health disorder related to their service, increased from 2,000 to more than 14,000; 2,500 Veterans Affairs clients with an operational stress injury identified as serving in Afghanistan. Locally, as of June 30th, 2012 there have been almost 1,500 individuals who have been diagnosed with a psychiatric condition, living in Nova Scotia.

The Veterans Affairs Mental Health Strategy is being revised at this time, but until that is complete, this is the way that we are going to proceed. Our Mental Health Strategy provides access to a continuum of programs and services across the country to meet the mental health needs of veterans and their families. The programs and services are based on the five determinants of health, which are: personal factors, social environment, physical environment, economic environment, and the availability of health services. This will become clearer in a moment.

The goals of our Mental Health Strategy are: (1) to provide the capacity in the continuum of services across the country; (2) to exercise leadership in the field of mental health; and (3) to nurture collaborative partnerships.

If you take a look at the small circle on the left of the screen, these are the five determinants of health, which I referred to a moment ago. For instance, in the area of health services, they list: access to health services, treatment of health condition, rehabilitation of the health condition, maintenance, and specialized services.

If you look at the larger circle on the right, it lists off services that are available through Veterans Affairs for each one of those health determinants. So for instance, the operational stress injury clinics, pharmaceuticals and telemental health, to name a few. At the bottom is a sampling of services that would be available to clients in the community, which would be in addition to what Veterans Affairs provides. If we follow the same theme of health services environment, you can see that there are such things as employee assistance programs, walk-in clinics and family doctors.

The new Veterans Charter introduced a suite of programs and services tailored to the transition needs of the modern-day veteran and their family, including such things as comprehensive case management, health benefits, career transition services and financial benefits. Personalized case management services ensure appropriate co-ordination of services. This was enhanced in 2007 with the addition of 70 case managers and assistants to improve our case management services.

The Veterans Affairs Assistance Line is a toll-free, 24-hour access to professional counselling. This service was introduced in 2001. The OSISS, or Operational Stress Injury Social Support program, is co-managed by Veterans Affairs and the Department of National Defence. It's a network of trained, peer support coordinators and trained volunteers who provide peer support to CF members, veterans and their families, who have been affected by an operational stress injury. It also provides bereavement support to families who have lost a loved one due to military service.

There is a joint network of 16 specialized clinics. Nine Veterans Affairs Operational Stress Injury Clinics across Canada provide assessment and treatment of operational stress injuries. They complement the seven Operational and Trauma Stress Support Centres, which are operated by the Department of National Defense. This graphic shows the locations of the Operational Stress Injury Clinics, which are operated by Veterans Affairs, as well as the Operational Trauma Stress Support Centres, which are operated by the Department of National Defense, across the country. In Nova Scotia, there is an Operational Trauma Social Support Centre at CFB Halifax. The closest Veterans Affairs Operational Stress Injury Clinic is in Fredericton, New Brunswick.

Veterans Affairs contracts with community-based mental health service providers such as: psychiatrists, psychologists, social workers, mental health nurses and occupational therapists, through Medavie Blue Cross. There is a network of approximately 2,000 therapists across Canada.

Clinical care managers are clinicians who provide temporary, non-clinical support and guidance to veterans with mental health conditions, and their families. This service is designed for clients with complex mental health conditions, who are having a hard time coping and not functioning well within normal, departmental, case-management services.

The Mental Health Strategy in 2006 was developed and implemented based on the five determinants of health. A major review is currently under way to update our strategy and ensure that it meets the needs of our current veterans.

Strengthening case management - working with rehabilitation and case managers to ensure that mental health expertise is applied to case management, including the support for the development of core competencies for our case managers.

We are working with the Canadian Forces to ensure that Veterans Affairs is appropriately positioned in mental health policy and service delivery to respond to the changes occurring within the Department of National Defense and the Canadian Forces, as well to better understand the mental health profile of the Canadian Forces still serving population. Veterans Affairs continues to work to expand partnerships in the area of mental health, building upon the model used to put in place the Operational Stress Injury Clinics, which was done in collaboration with the provinces.

We are in the process of developing specific strategies to deal with difficult issues like addictions, rural access, and homelessness. The suicide prevention framework and ongoing suicide prevention activities - for instance, in 2007, we implemented a staff protocol in suicide awareness, prevention and intervention. In 2009 all of our front line staff were provided with applied suicide intervention skills training. In 2010 a full review of Veterans Affairs suicide prevention activities and approaches was conducted in order to make significant changes and improvements, which would further strengthen suicide prevention for our veterans and families.

We're in the process of simplifying policies and processes in the areas of referrals to OSI clinics, ensuring families have access to services, better use of clinical care managers, and ensuring access to related health services such as counselling from licenced registered providers.

We have completed a mental health environmental scan to identify partnerships. Examples include - with the Correctional Service of Canada, we're identifying opportunities to tracking veterans who are within the correctional system. Our case managers will work together with the Correctional Service on rehabilitation plans for veterans releasing into the community. The Canadian Institute of Health Research - we're creating partnerships for mental health research with them.

Veterans Affairs supports federal-provincial, non-governmental organizations and community projects, which will improve awareness, access, co-ordination and delivery of mental health service to veterans and their families, in the communities where they live. Mental health and the successful transition of veterans and their families is a priority for Veterans Affairs. Veterans Affairs is modernizing health care, strengthening case management and harmonizing policies with the Department of National Defence.

Veterans Affairs is investing in strategies for high risk demographics including rural areas, addictions and homelessness. Suicide prevention is a priority of Veterans Affairs. Our approach is working. Today Veterans Affairs is helping more than 14,000 veterans and their families with their mental health conditions. Nearly 3,500 have been treated in our specialized clinics. We appreciate the opportunity to make the presentation on this very important topic and we would be happy to take questions now.

THE CHAIR: Thank you very much. So we'll be open to a discussion then of the presentation. Mr. Porter.

CHUCK PORTER: Thank you, Mr. Chairman. Mr. Craine, and the folks with you today, thank you for being here and taking the time to give us a presentation and maybe answer a few questions for us. Oh, where to start? I'm going to touch on a couple of different areas; I only have a few minutes. A good presentation, a good program offering lots of stuff, I can see that.

I think back though to veterans of yesterday - I'll call them our older vets, who have been through world wars. The Korean conflict comes to mind given my wife's grandfather was there and, like many, he came back a changed person - as did others, as do our veterans today, come back a little bit changed people. I have family members who have been to Afghanistan more than once who, I can tell you firsthand, are not the same, and they don't talk about it, that's for sure. Every once in a while they may discuss something. It's interesting, my brother-in-law tells me, when he leaves that conflict area, they go somewhere for a couple of days, they do some bit of a debriefing, and as far as I know - and I'll use him as the example - that's it, he doesn't go anywhere else. Maybe that's just him and his way, he deals with that a different way.

It's good that we have a program now that we are dealing with these things and I think we need to continue to build on that. We're always going to have this issue and we need to make sure that it's strong and the supports are there for our families, but what about prior to going in? I've always been a bit curious about that. They know what they're going there to do. The reality of that is very simple; they know what they're going there to do. I'll use Afghanistan as an example and certainly, I don't know for sure, if our older veterans knew as much about. Times were different and the world is this big now - it's a click, we see what's going on. These guys and gals know what they're going there to do. What do we do, preventatively, before going in? Is there a program that you're involved with there as well?

GLENN CRAINE: Well, as a department, of course, we're not heavily involved when people are going in, when people in the Canadian Forces are going to Afghanistan, although we do provide some presentations, some information, so that they have the information available before they go. We do presentations with some groups before they go to make sure that they know that if there are injuries, they need to come and see us when they're done - you know, what sort of services we provide to them. So there are pre-deployment seminars, yes.

STEPHANIE ADAMS: In partnership with the Canadian Forces.

GLENN CRAINE: Absolutely, yes.

STEPHANIE ADAMS: They invite us to come.

CHUCK PORTER: And the reason I ask that question, obviously, is knowing full well that you are going to have cases coming back. It's amazing to see the number of cases you're dealing with, specific to all kinds of different things I guess and not just one of anything; you list them all off with regards to post-traumatic stress disorder. A very good presentation.

I spent 16 or 17 years as a paramedic and I can tell you, in the early days there was no such thing, but in the latter years it has been very good and very well defined, what

you're dealing with there. That's real, that stuff is real. I don't think people realize that and I don't know - the reason I asked the question about the preventive side was, yes, they're in the military, they're going, and especially first-timers, do they really know what they're going into? But it's good that we're providing something prior to their going. Sorry, I didn't mean to interrupt you - go ahead.

STEPHANIE ADAMS: No, I was just going to say we do continue to partner very closely with the Canadian Forces and support whatever programs they have.

CHUCK PORTER: I think that's very important. I know a couple of guys locally in my area - I come from Hants County, the Windsor area - who have served and who have gone through some very serious problems and continue to battle those, they don't go away easily. It's amazing to see through services being provided how well they've come, they are doing very well. I can't imagine myself being there. You see it on occasion, as a paramedic on the street, you may see things, serious things, but on a regular basis, a steady basis, I'm certain it's awful to deal with.

So I'm glad that you're there doing what you're doing and I thank you for that. Whatever we can do or I can do, this committee can do, to help support that, I think it's important and I know that we do.

Thank you, Mr. Chairman, I'll pass it on. I know there are other questions.

THE CHAIR: Thank you. Might I ask a specific treatment question related to this condition, PTSD-related bruxism? If I understand this right, is it not the case that it is possible under the present regime to be granted a disability award entitlement for PTSD-related bruxism but in fact to not be able to receive any benefit for that because there is some limitation about the coverage of dental-related conditions within what's available to members of the service? Are you familiar with this problem?

DEREK CANNON: On the dental side of things - I think there have been some issues in that area but what you're talking about is a consequential condition related to PTSD.

THE CHAIR: Exactly.

DEREK CANNON: Consequential conditions, of course, do have coverage. I know through our dental program it's a little bit different, but I'm not 100 per cent familiar with all the details of it. I've had a lot of my clients where I've tried to assist in that area and there has been some success, but there have been other issues that - and I'm not 100 per cent certain as to why that is the way it is. What you're saying is correct. There are some issues when it comes to coverage for those.

Some individuals have indicated in the past where an individual may be grinding their teeth and breaking their teeth.

THE CHAIR: Exactly, that's the condition.

DEREK CANNON: The best way for me to respond to that is there are different criteria to access our dental program. How that's done is sort of beyond what I get involved with. That's just some of the experience that I've had. Usually what I do with my clients when I end up with that situation is I explore other resources for them to access treatment, because that's our responsibility as case managers. If, for some reason, there is not eligibility for a benefit through Veterans Affairs, our responsibility is, well, where is that benefit that you may be entitled to, to get treatment or assistance?

THE CHAIR: Such avenues as what?

DEREK CANNON: An example would be the Public Service Health Care Plan, or other types of health plans that the individual may be eligible for.

STEPHANIE ADAMS: We probably don't have a lot of specifics on the entitlement part of bruxism for you today but we can certainly bring that back and see if we can . . .

THE CHAIR: Well, it does seem to be an issue, people are granted awards because it's a PTSD-related condition but then access to dental work, one of the avenues is not bruxism . . .

STEPHANIE ADAMS: The treatment benefits related to that, right.

THE CHAIR: . . . so the overall system acknowledges the condition and then the service delivery system won't provide the fulfillment of the award. If this is in fact true, it's a pretty serious problem. If you are able to provide any further information, that would be very helpful.

STEPHANIE ADAMS: Absolutely. The other part of our programs with the release of the New Veterans Charter is the Rehabilitation Program. If you have a service-related condition that stops you from living your life essentially, then you would be able to make application for a rehabilitation program, and part of that could be some of the effects or the disabilities that are related - anything related to PTSD, so that could be another avenue to look at in terms of being able to provide somebody some support with that on a short-term basis. The rehabilitation program doesn't replace the treatment benefits program but still is meant to complement it and augment it while the veteran is continuing to improve and move on with their lives.

THE CHAIR: Thank you. Any information clarifying this would certainly be important.

Mr. Morton, please.

JIM MORTON: Mr. Chairman, I have just a couple of questions. I'm not sure if you are the right people to ask these, and you can tell me if not. I really appreciate the information you've provided so far. As we've learned a lot more about post-traumatic stress disorder over recent years, I'm curious about what - this may seem like an unusual word to use, I guess - what is being done in relation to prevention? Are we learning things? Are you beginning, and is the system beginning, to understand things about how people might deal better with certain kinds of traumatic experiences, so that screening for enlistment and other kinds of factors like that might be taken into account in advance? Is that something that you're familiar with?

GLENN CRAINE: Well, again, a lot of that would be done through the Department of National Defence, but my understanding is that they do some screening before people go. How extensive that is, I don't know, and how they do it, I can't tell you, but there is not only the physical screening but some mental screening as well prior to people getting in and also prior to them being deployed to situations such as Afghanistan.

STEPHANIE ADAMS: The part that Veterans Affairs - I think the role that we play is getting involved as early as we can, as that partnership with the CF continues to grow and we continue to improve on that. We've committed to trying to be there with screens - yes, after the fact, but still as quickly as we can, to help that seamless transition. That's where some people end up with a lot of difficulties. Changing from the life they know in the Canadian Forces back into civilian life is a major transition, so we try to be there before that happens.

JIM MORTON: Just switching gears a little, I was pleased to see in your presentation that there's a family therapy component that is built into the treatment programs. Do you have any detail as to how that works, or the approaches it takes?

GLENN CRAINE: One of the things that we now have the freedom to do is, if a member has a mental health issue and their family - whether it's their spouse or their children - are experiencing difficulties related to it, we can provide them with treatment as well, much as we can with the veteran. That's one way that we're able to approach it.

STEPHANIE ADAMS: It can take any form. It could be couple's counselling, individual therapy, family therapy.

JIM MORTON: I think it's positive, because it seems to me that a lot of mental health symptoms, including PTSD, occur in a current context, and where most people live is with family members.

DEREK CANNON: I can add something to that aspect too, with a case manager - many of my clients are in the Veterans Affairs rehabilitation program. That's part of the changes the department has made that I really like: the fact that they basically delegated authority down to our case managers in order for us to be able to immediately action something. So instead of us having to go through the approval processes, I can meet with one of my clients if there's a family issue, and if they're willing, I can immediately approve and authorize treatment for the family and children. That was a huge change, and a huge benefit to me working with my clients.

THE CHAIR: Mr. Epstein.

HOWARD EPSTEIN: Thank you, Mr. Chairman, and thank you very much for coming to talk with us about this issue. It's very important.

I wonder if I could ask a bit about the interaction of military personnel and veterans with RCMP members who might also be subject to post-traumatic stress disorder. I noticed in your presentation that you make mention of the RCMP, and I'm wondering if you can tell us anything about the extent to which the services are shared or the professional expertise is shared or whether the treatment is shared amongst the different branches of the federal government represented by the RCMP and the military.

GLENN CRAINE: As a department, we do provide services and benefits to released members of the RCMP.

HOWARD EPSTEIN: Sorry, is the answer simply this is a completely integrated service and it's not offered separately depending on where people are serving?

GLENN CRAINE: No, it's integrated. They have access to the same treatment benefits as people in the military. Am I not answering your question?

HOWARD EPSTEIN: A benefit sounds to me like monetary benefits. Are you talking about treatment?

GLENN CRAINE: I'm talking about treatment.

HOWARD EPSTEIN: So, in fact, an RCMP officer and a military person would go to the same centre, would have access to the same personnel and so on, is that right?

GLENN CRAINE: Yes.

HOWARD EPSTEIN: Okay, that was exactly what I meant so my apologies for not asking the question in a crisp way at the beginning; that's really what I wondered. If it were otherwise, it would seem to me that it would be an unnecessary silo. Okay, so that's great.

The next question I have has to do with something on Page 12 of your presentation. There is reference to something called an Operational Stress Injury Clinic and then other things called Operational Trauma and Stress Support Centres. I don't think I heard what the differentiation was. Can you just explain what those two things are?

GLENN CRAINE: The major difference is that the Operational Stress Injury Clinics are managed by Veterans Affairs; the Operational Trauma and Stress Support Centres are operated by the Department of National Defence. They provide similar services to clients whether it's still serving, released or RCMP in treatment assessment, that sort of thing, for operational stress injuries.

HOWARD EPSTEIN: Does that mean in practice that the Operational Trauma and Stress Support Centres are located on military bases and the others would be somewhere else?

GLENN CRAINE: That's correct, yes.

HOWARD EPSTEIN: Okay, when I look at the map that you have on the next page you've identified on it all of the stress support centres and then there are other indicators, or icons I guess, on this map that aren't identified as stress support centres. What are they, are those stress injury clinics or are they something else?

GLENN CRAINE: Stress injury clinics, yes.

HOWARD EPSTEIN: I see, okay.

GLENN CRAINE: They're managed in partnership with the province, so for instance the one in New Brunswick, in Fredericton, is co-managed with the Province of New Brunswick.

STEPHANIE ADAMS: River Valley Health.

GLENN CRAINE: River Valley Health, yes, I'm sorry, right.

HOWARD EPSTEIN: And the entities that are the stress injury clinics and are operated by Veterans Affairs - are they inside regular public hospitals or are they independent entities?

GLENN CRAINE: The one in River Valley Health is.

HOWARD EPSTEIN: Is what?

GLENN CRAINE: I'm sorry, is part of a hospital. The other ones, I'm sorry, I don't know. If I had to guess the Royal Ottawa probably was, there is a Royal Ottawa Hospital, but I'm not familiar with those ones.

HOWARD EPSTEIN: When I was noticing the kind of therapies that were on offer - this is back on Page 6, I think, of your presentation - you started out broadly characterizing them as psychotherapy and then medication and then other types of treatment. I'm wondering if the services that are offered, the treatments that are offered come from psychiatrists or from psychologists, or whether there's a team approach and if so whether it's always a team approach. Can you tell me a bit about the different services in terms of the professionals that are available?

GLENN CRAINE: My understanding is that there is a team approach in most cases. I don't know if it would be in every case but in most cases there is - whether there's a psychiatrist who is involved in meeting with the client periodically, the psychologist or social worker would meet with the client on a more regular basis. The psychiatrist would have control over medications - either that or through the family doctor, but it's the psychologist or social worker who does the bulk of the therapy with the client. It would mean meeting with them on a weekly basis or every second week or whatever schedule they determine, but they would work as a team to try to provide the assistance for the client.

HOWARD EPSTEIN: I think it's wonderful that there is now a recognition of these difficulties and there is an offering of professional services. The key thing is outcomes, however, and I'm wondering if you can tell us anything about the outcomes of the treatments.

STEPHANIE ADAMS: The clients really have a choice in accessing treatment, and further to what Glenn had said with the first question, it depends on the case whether a client will see a psychiatrist regularly or a psychologist regularly - depending on their own treatment outcomes and their own treatment plans and where their goals are. In terms of goal-setting and treatment outcomes, we get regular updates from the professionals as part of the ongoing treatment benefit to be able to provide those services.

In order to continue to see a psychologist, for example, they would submit documentation to us to say, these are the goals we worked on, these are the achievements to date, and this is our next plan. That would help us to continue to make sure that a client is continuing to improve. Other clients may be in a maintenance phase where they just need to see somebody every month or so to check in, to make sure everything is okay.

HOWARD EPSTEIN: Just to be clear, I'm certainly not asking about any individuals. What I'm asking for is statistical information, and I would have thought outcomes would be measured by things like whether there actually were numbers of suicides - whether people were judged fit to go back into active service if they were still a member of the force or a member of the RCMP, or whether their lives have basically fallen

apart and they've become unemployable or homeless or maintained addictions, if that was a problem, whatever.

I'm just wondering if there are studies about the effectiveness of the treatments and where we stand with this. For example, I heard you mention in passing that concern about suicide was a very high indicator, but I don't think I heard any stats on suicides. Do you know anything about that?

STEPHANIE ADAMS: We didn't bring any today, but we could look into that further. We certainly are keeping close tabs on the rates of suicide, for example, like you say, or the return-to-work stats for people who are successfully reintegrating and moving on and perhaps going back to work. We didn't bring those kinds of stats today, but we certainly could.

HOWARD EPSTEIN: I think it would be useful. If there is any kind of study that's done on the effectiveness of the treatment and the outcomes, if you could draw it to our attention as a committee, that would be very helpful. Thank you.

DEREK CANNON: If I could just add - part of your question is about returning to active duty. In other words, individuals getting treatment while they're in the CF and then, are they capable of going back and fulfill their duties? Ok.

When I was working on the base from 2005 to 2008, I remember discussing some things with the OTSSC and one of the - I guess you could say - myths, in a sense, that they said to me was that treatment does work for a lot of individuals who are in the CF. We aren't totally part of that, because the OTSSC does a lot of that treatment - psychologists, psychologists, mental health workers. Based upon some of the information I've received from the mental health professionals - they had indicated we do have a lot of our service members who get treatment, they get better and they go back to active duty.

Stat-wise, I don't have the stats, but I have had the information given to me that it does work. Actually, I would have to say that I've talked to many clients who were still on active duty even though they were diagnosed.

HOWARD EPSTEIN: That's very helpful. Thank you.

DEREK CANNON: That would definitely be a question toward the Department of National Defence in terms of that kind of information.

HOWARD EPSTEIN: Good point - thank you.

THE CHAIR: Thank you, Mr. Epstein. Mr. MacLeod?

ALFIE MACLEOD: Thank you for the presentation. I guess one of my questions is, how many case managers are involved in Nova Scotia?

GLENN CRAINE: I believe we have 22; that is the number that we have in Nova Scotia, but that includes Halifax and Sydney. I think there are three in Sydney, and then the rest would be in Halifax.

ALFIE MACLEOD: And what would be the average number of cases a case manager would handle?

GLENN CRAINE: The average number of cases that a case manager is assigned, or case-managed clients, would be in the area of 30 to 40 at the current time.

ALFIE MACLEOD: You say that there's three located in Sydney and the rest are located here.

GLENN CRAINE: Yes.

ALFIE MACLEOD: So if we have somebody in the other end of the province that needs to access your help, how would they go about doing that?

GLENN CRAINE: Well, there's various ways that people get in touch with us: we have toll-free lines, we have contact centres that those toll-free lines ring into, there's Web sites that have information on things that we provide. In addition to that, the case managers do travel the province so we have case managers who cover from Yarmouth to Sydney and everywhere in between. They're out there regularly - not daily but they are out there regularly. You can contact us through the Legions - quite often we get contacts through the service officers and some of the Legions, so that's another way.

ALFIE MACLEOD: That was one of my questions, the relationship of your organization with the Legions.

GLENN CRAINE: Absolutely. I've worked primarily in Dartmouth in my number of years with Veterans Affairs and have had numerous contacts with the service officers at the Centennial and the Somme Branch. As well, I used to work at the Eastern Shore and in Truro. The service officers there were great. They were contacting us on a regular basis about people who were involved with their particular branches so it's a good source of communication.

ALFIE MACLEOD: If somebody were to come into any one of our offices, is there a number or a contact person that we should have or should know about who we could pass the information on to your organization, to make sure that individuals get their proper assistance when it is required?

GLENN CRAINE: Normally we prefer that people go through our toll-free line.

ALFIE MACLEOD: I understand that but I know like in the case of workers' compensation we have a contact that we, as MLAs, can identify an issue and then the department takes over from there and they continue on. I just think that when you're in an area that may not have a case manager and somebody comes in - I'm no professional but I just know that sometimes you can tell by how a person is portraying themselves that there might be an emergency situation that we would want to pass on to you.

STEPHANIE ADAMS: If a client is being case managed then we would already have that relationship established with that particular client. So they would be able to get hold of us fairly quickly in any cases - always with a toll-free line, on an emergency basis, but we would have that relationship already established.

When there are new people who show up with crises, the first line is always going to be the toll-free line because that's the best way to get somebody as quick as possible. We've made a lot of improvements in that line to get somebody on the phone right away.

In terms of a key contact throughout Nova Scotia, for us here locally, I wouldn't have that for you today but it's certainly something that we would keep in mind for you. We wouldn't be able to talk about the client; we'd have to be able to say: call us.

ALFIE MACLEOD: If there is such a contact, that would be helpful. What I'm looking for - and I can't speak for anyone else - is to identify someone who comes into the office that I believe, as a novice, is in need, somewhere that I can pass that on in a hurry so that there would be some kind of action taken.

GLENN CRAINE: One of the things I'm going to do is I've got some business cards that I'll give out to you. Although I am a case manager, I work on the military base so I provide case management services to people who are still serving in the military, as well as outside. I'll give you one of my cards. I'm in the city so you can contact me if you want to.

DEREK CANNON: I'll just add one thing to your question. Glenn had mentioned, and I'm not sure where it was here, the OSISS program - Operational Stress Injury Social Support program. I'm just going to try to find it here. OSISS - this group is former members of the Forces running this program for the Department of National Defence.

I've had issues where, let's say the client is out in the community, they don't know who to go to. Sometimes if somebody gets them in contact with this group and they were a former member - and we're talking in the realm of mental health, right, we're seeing there's a potential mental health stressor issue that's going on with an individual and you know they're a former member and there appears to be stress issues going on. Sometimes

these individuals are a great source for that, too, because they can immediately go see those individuals right in their homes, sit down and talk with them.

It's more on an informal basis to kind of get a gist of what's happening and those individuals are quite linked in with our organization. So the gentleman who runs this program here locally, there are times where all of us here have gotten phone calls from him to say, hey, could you maybe touch base with so and so, because some people may not want to pick up that phone and call the 1-800 number. Maybe they want just a face to face with somebody.

ALFIE MACLEOD: I think that would be helpful. I guess what I'm looking for, and hoping that I never have to use it, but I'm looking for some kind of a way that if somebody comes into our offices, we're able to contact someone right away who could put some of this into effect because I know different times we get people - and when they want to come in and talk to a complete stranger, then you know there's an issue and so you want to be able to point them in the right direction right away, and not say I'll get back to you because that may not suit what's going on in the situation.

So if there are any kind of contact numbers that you could supply as a group to the chairman who would then distribute them, not only to this committee but probably to all members of the House for such a matter, I think that might be helpful.

STEPHANIE ADAMS: Just to add to Derek's point, the contact information for the OSISS program is www.OSISS.ca and everybody's phone number is written right in there. If you want to get that, and just for that part of it - we're still going to look into that key contact, but Dave McArdle's number is right there.

DEREK CANNON: The family peer support coordinator has a handout that has their contact info in it. That might not be a bad thing and I'll give that to you, and then he can provide it to the group.

THE CHAIR: Thank you, Mr. MacLeod. Mr. Boudreau.

MR. JIM BOUDREAU: Yes, thank you, Mr. Chairman, and thank you for your presentation. One of the areas that I had some questions around, and they were brought up by MLA Epstein, was the idea of outcomes and, you know, where you're at. So it will be nice to see some of those things if it's available.

I guess sort of a follow-up to that is, where do you see yourselves now because when I listened to your presentation, I heard a lot of words like development of, and in the process, new protocols, investing in strategies, building capacity, and so on. So I guess what I'm trying to just see if I can get a handle on is where do you see yourselves now in this process, you know, at what stage are you at? I don't know if I'm making myself clear.

GLENN CRAINE: No, I understand what you're saying, you know, and it is an interesting question. One of the things that I tell people about, and I've worked at Veterans Affairs since 1998, when I first came to work there, we didn't know anything about mental health issues. We had no idea. We had people showing up at our door with issues and we didn't know what to do with them. We've made huge strides in the last 15 years in terms of our staff being able to respond to them and I think you're right, we do have some things like that in our presentation saying that we're working on things. We have strategies in place but we're refining those strategies and making them better. So there are ways of responding to things now but we're trying to get better and we're always in a development process.

STEPHANIE ADAMS: I think we're in the middle.

GLENN CRAINE: Yes, I agree, but huge strides. Derek had mentioned the OSISS program and it's a program that's co-managed by Veterans Affairs but they have a former CF member who has a mental health issue running the program. When we had our first one show up in the office, we didn't know what to do with him. I mean we were scared of him because he was, you know, something new for us. That's not the situation today. The man who works with us now is a man who has worked with us for a number of years and everybody knows him, everybody knows what he can do and he knows what we can do, and it's a much better situation now than it was 15 years ago. We've made huge strides as a department.

JIM BOUDREAU: Very good, thank you, and I hope you didn't perceive the question as being sort of negative.

GLENN CRAINE: Oh, no, no, it's a good question.

JIM BOUDREAU: Okay, I was just trying to get a handle on, you know, where you're at and where you see yourselves going.

Maybe we can talk about some of the strategies that you're implementing or trying to move toward with regard to the high-risk demographics. In particular, I come from a rural area, and like my colleague across the way, there are always some special challenges there. I'm just wondering if you might like to speak for a few moments on some of the things you're doing there.

GLENN CRAINE: And again, a good question. In terms of rural access, the ideal situation for us is to have people deal with mental health therapists in their home community, but of course, in the rural areas that's just not possible. We will pay for people to come into bigger centres. If they are coming to Sydney, for instance, and there are therapists in Sydney, or if they are coming from a rural area in the mainland, coming into Halifax, we will subsidize their transportation in and out.

Another area that we are in the process of dealing with is telemental health, where they can do it by telephone or by video conference. They can do their treatment that way if it's not possible for them to come into a larger centre for whatever reason. So there are a couple of initiatives that we're able to work on right now, or that we are working on right now.

JIM BOUDREAU: Just out of curiosity, with telemental health, you're talking about - the province put a Telehealth system in place. Is that something you use now? Is that what you're doing, using that system, or do you have your own?

STEPHANIE ADAMS: I can't give examples, but that would be the idea - that we would partner with whoever had the system locally. I know that there are few private clinics that have it as well, so if we could connect their psychologist in Halifax with another centre, be it hospital based or provincially based or privately based, then that would be able to link them together that way.

JIM BOUDREAU: Yeah, I'm sort of pushing that, because I see that as something that we don't really utilize well in the province right now. I'm just throwing it out there.

STEPHANIE ADAMS: And with the developments in Web access, people may even be able to access it from their own homes, right? That would be the ideal - to get the services they need right there on their own laptop.

Another one Glenn mentioned earlier in the presentation was clinical care managers, which are kind of an extension of the client's current treatment team - with their case manager, their treating psychologist or their treating professionals, and then we could also put in place a clinical care manager who might be able to meet with them more regularly and may actually be based in their area.

JIM BOUDREAU: Well, thank you very much. That's great.

THE CHAIR: Mr. Theriault.

HAROLD THERIAULT: Thank you for your presentation. Through that presentation, what opened my eyes was Page 7, the numbers. That truly amazed me. Of that 14,600, what percentage would that be of our forces?

GLENN CRAINE: I don't know how big the Canadian Forces are. It's not 14,000 people still serving. It's 14,000 clients of Veterans Affairs. Some of them could be serving, but I don't know how many. I can't tell you.

STEPHANIE ADAMS: No, I don't have those numbers.

GLENN CRAINE: No, I don't have that number.

HAROLD THERIAULT: Why do you see such an impact? It's amazing from 2002 to 2012 where - I can understand the 2,500 in Afghanistan, but here are 10,000 other people in the forces who have been under this system. Do you see that growing?

GLENN CRAINE: You know, I was thinking about the numbers this morning, and one of the things that occurred to me was that between 2002 and 2011 tracks the time period that Canada was in Afghanistan, but in addition to that . . .

HAROLD THERIAULT: That's only 2,500 people, though.

GLENN CRAINE: But in addition to that, the issue of operational stress injuries has become much more open in the military, but also outside of the military. We're seeing people come to us from Swiss Air, from people who were in Bosnia and Croatia, from people who were involved in the Kootenay in 1969 or 1967 - I can't remember which it was. Those are people that are coming out of the woodwork who have suffered for x number of years, who are coming to us now because it's more acceptable for them to come to us, whereas in the past it wasn't.

HAROLD THERIAULT: So every year you've seen it growing in the past 10 years?

GLENN CRAINE: Yes.

HAROLD THERIAULT: Do you think it will continue to grow?

GLENN CRAINE: I think there are still people out there that are going to come to us, yes.

HAROLD THERIAULT: That's amazing.

DEREK CANNON: There's more information out there now, like we're advertising it better, the CF is more accepting of it. An example would be the OSISS program. I like that program because it's former members helping former members and sometimes that's the very first step somebody might take, they might talk to a former peer and say, you know what happened to me years ago and I never really dealt with it. Now they want to deal with it and they understand maybe there's more acceptance for me to come out and talk to somebody about it. That's what I've seen in my own personal experiences the past 10 years.

STEPHANIE ADAMS: It's the awareness programs, right? We see we're removing the stigma of mental health all over, across every age group, every province.

HAROLD THERIAULT: Thank you.

THE CHAIR: Ms. Zann.

LENORE ZANN: Thank you so much for your presentation, I've been looking forward to this one. I've had a lot of curiosity about it over the years. I would love to get some statistics as well; some statistics on suicide, homelessness and domestic violence. I know just from hearing and reading different things that that's also a problem, also with the RCMP, with the police forces as well. Could you talk about that a little bit, your experiences of people coming back and how they are showing their symptoms in a domestic violence-type situation?

STEPHANIE ADAMS: I wouldn't have any examples of that.

LENORE ZANN: Have you had any of those kinds of examples yourself?

DEREK CANNON: Not necessarily domestic violence, more along the lines of just dysfunctional families, like families not functioning correctly, like typical. That seems to be what brings out the call for help. Sometimes it may come from a spouse who will come to us and say my husband is not - things aren't working out well and can you talk to them? That does occur. I haven't run into a lot of that in the past 10 years, just the functioning of the family is definitely not well. This is where I've mentioned before about what I liked about our rehab program; I can go into that home and that day I can tell the family member: I can help you out now, I can do it now.

LENORE ZANN: So when people come back from service of duty do they self-identify in order to come to you or is there a screening program that each soldier goes through when they come back and then they are identified by somebody else possibly as being someone with these possible problems?

GLENN CRAINE: The issue of identifying them from somebody else is a touchy issue because we're working across two different departments that have two different sets of information. They are not allowed to do that unless the client says they can do it. If you look at it that way, it's the client self-identifying and they would come to us and say that they have been dealing with somebody, they've been diagnosed with the condition and they'd like to deal with it with Veterans Affairs now.

I think that probably us having people on the base makes it much easier for people to do that, for the people that are still serving in the military to do that. Having the same people around for a certain number of years or in certain locations makes it more comfortable for people to come to us and that could be part of the reason why our numbers have exploded over the last 10 years. I'm not sure if I answered your question or not.

STEPHANIE ADAMS: What about transition interviews?

GLENN CRAINE: Actually, that's a good point that Stephanie just mentioned. One of the things we do with everybody who gets out of the military is we have an interview with them; whether it's medical release, voluntarily, it doesn't really matter.

What we used to find - and Derek and I used to do them together a number of years ago - is that people had gone through their service for many years in the military, suffered with an injury - it didn't matter if it was a physical or mental health injury - they suffered with an injury for many years. When it came to the end of their career and we offered them the opportunity to deal with that issue, they would take that opportunity and they would apply for the injury and we would help them with that, or they would go and get the diagnosis or get access to the professionals that they see. We are able to do that through the transition interview with everyone.

LENORE ZANN: Yes, so that's part of my question, the transitional interview. When someone comes back from a tour of duty, do they automatically get that interview?

GLENN CRAINE: Oh, no, the transition interview is done when they're making the transition from being in the military to being a civilian. It is when they are leaving the military. Some people leave when they come back from their tour but for most people it's when they actually leave the military, at the end of their career.

LENORE ZANN: Right, so like they've come back and either they've had an injury or they are done, then do they automatically get an interview and a psychological assessment?

GLENN CRAINE: Oh, I'm sorry, we don't do a psychological assessment, no. The military does some screening when they are - if we use Afghanistan as the example, they had a decompression for a number of days when they came back. Some of that is information about what they are going to face when they come back, some of the issues, some of the services, all that sort of thing.

There is screening done for each one of them by the military when they come back, some mental health and some physical screening. How extensive that is, I don't know. That's something that the Department of National Defence does. In some cases they would pick up people who have mental health issues. In some cases they may not show up for 10 years.

LENORE ZANN: I would personally suggest that it would probably be good for them to interview them on a psychological assessment basis as soon as they come back, but then follow it up at maybe six months and even a year later, to see how they're doing. That's the whole thing with post-traumatic stress disorder - it doesn't necessarily show up right away, does it?

GLENN CRAINE: That's correct.

LENORE ZANN: It's a nefarious little beast. I would also say that the stuff about domestic violence - I mean it's the same as with addictions, they can all kind of go hand-in-hand sometimes, can't they; the way people react and how they self-medicate or how they cope. People's coping mechanisms are all different but I have heard anecdotes from people who have said that when people come back from a tour of duty where they have been used to killing and fighting and constantly on guard - all of these clinical descriptions that we were told earlier can also manifest in domestic violence at times, and that's the same with police and the RCMP as well. Perhaps people are more reluctant to talk about it as well, our society seems like it's getting more and more open these days about people talking about these issues, which is why there are such exploding numbers because, really, it has been going on all along but nobody talked about it, right?

Now the Legions - the other thing is, are there any programs? You mentioned former members helping former members. That is very much like the 12-step program where it takes an alcoholic to help another alcoholic, so to speak, because they have both been in the trenches. Are there any programs available for younger vets to talk to older vets, and vice versa, anything like that?

STEPHANIE ADAMS: I don't know if the Legion has any of those.

DEREK CANNON: I haven't heard anything like that. Sometimes through the OSSIP program that can occur because a former, an older member of the Forces who is released may participate in their group meetings and then talk to the younger veterans as well, that could occur within those group sessions that they have.

LENORE ZANN: Do you find that the older members are still more reluctant to talk or self-identify as having any of these problems?

DEREK CANNON: Yes.

LENORE ZANN: And that's probably because of the way they were brought up right at that era, where it was buck up your chin and come on, sonny, get back to work, this is nothing, it's all in your head, don't be a sissy - that kind of stuff. So is there anybody doing any outreach to these members?

STEPHANIE ADAMS: A lot of those would be our clients. Sometimes their health changes such that we do get in there and do some assessment and other things are brought to light, and we're able to work on any mental health conditions that might surface at that point. That's happened with me a few times, where somebody's physical health tends to deteriorate because they're in their eighties or whatever, and other things come out as a result.

LENORE ZANN: Sure, right.

STEPHANIE ADAMS: They're no longer independent in these areas and therefore other things come out, like the stress.

LENORE ZANN: And that's when they would open up to you?

STEPHANIE ADAMS: Yes.

LENORE ZANN: That's good. Okay, thank you very much.

THE CHAIR: Mr. Morton.

JIM MORTON: One of the things we haven't talked much about is a wait list and demand for the 16 specialized clinics that are across Canada - three here in Atlantic Canada, I guess, if I understand the map properly. As of today, how many people are waiting for admission, and what are the wait times?

GLENN CRAINE: Well, the operational stress injury clinics, aside from the one in Montreal, are outpatient clinics. They're outpatient clinics.

JIM MORTON: Yes, okay.

GLENN CRAINE: And the same thing with the operational trauma centres, I believe, for the Department of National Defence - they're all outpatient clinics. In terms of the contract facilities, the places like Oakwood or Bellwood - there are others and I can't remember what they're called - I don't know.

STEPHANIE ADAMS: My experience has been that the wait lists are not long, because they're private clinics or clinics that are funded for veterans. So my experience has been, it doesn't take very long at all. There's a screening process and the referral process - to get all the information that they need to present to the clinic to say, okay, here's a client, here's a referral - may take the most time, but once that's all received, the client is given an admission or a date of assessment, for example, and they're able to go in. The vast majority of our other clients access private psychological clinics, and so there's not as much wait time for those as there would be if they were publicly funded.

JIM MORTON: So at this point there isn't a backlog of people who are waiting for access to an appropriate service?

STEPHANIE ADAMS: I can't say that unequivocally. I haven't run into any.

GLENN CRAINE: Actually, I had one item in recently that I dealt with. As Stephanie mentioned, it was the information gathering that was taking more time than the

actual admission time. Once we got all the information together, he was offered a bed space within three to four weeks. So it was very quick.

STEPHANIE ADAMS: And we do work closely with the provincial side. For example, think of pain management or psychiatric services, where the client would access provincial resources for those, and that may be where we find more wait times. So we may put other services in place waiting for the assessment or the treatment from a psychiatrist or a pain management clinic.

DEREK CANNON: And your question is centered around the OSI clinics?

JIM MORTON: Actually, I was probably thinking that a lot of these services were in-patient services, which was my misunderstanding, so I'm glad I asked the question. I was interested as well, just in terms of what is the wait time for access to service, whether that's on an outpatient basis or on a residential basis?

GLENN CRAINE: I think they're relatively quick. Even to see a psychiatrist or a psychologist in the community is relatively quick. We can set that up within a couple of weeks.

JIM MORTON: Thank you very much.

THE CHAIR: Thank you, Mr. Morton. Are there other queries or comments for our guests on the meeting? Ok.

Well, then, I'm just wondering - is there any kind of concluding comment you might want to offer based on the discussion?

DEREK CANNON: Well, one, just about - I apologize, what was your name again? Yes, you.

LENORE ZANN: Lenore.

DEREK CANNON: Lenore, when you were talking about your questions around the screening, when the member comes back from a conflict area and things as such - again, that falls within the Department of National Defence's responsibility. So they do post-deployment screenings, and I believe that does involve a psychological component. How that's structured and how that's done is within the Department of National Defence's responsibility.

So that frames part of your question about what happens when they come back - the Department of National Defence does that - but like Glenn said, some individuals will come back and they'll put in their release right away and say I'm done, I did my three years and I'm done. That's where we may end up talking to the person, at that point in time. So

the time frame is important in terms of when we become involved. If the member comes back from an area and they're having issues but then they say, okay, I'm going to leave the Forces, I'm going to put my 30-day release in and leave now, we then are tasked to see that person within that 30 days.

If it's a medical release, we're tasked to do a transition interview with that person within the first six months of their release, because they know, six months before, what their date is. That is the point where we become involved - and it's interesting about the transition interview - that's a part that I like that the Department of Veterans Affairs has done, where I've met with people and sent them back to the health services of the CF and said, don't go, and health services brought them back in and said, oh, there was an existing condition here we weren't really aware about and the person was leaving because of such and didn't really talk to us. Sometimes capturing that person at that point does help them. I've had that happen and I know Glenn has had that happen too. Then they bring them back and say, well don't release yet. We'll give you a period of time of treatment and try to help you out before you leave.

THE CHAIR: Is there anything else you want to offer?

DEREK CANNON: No, thank you very much for having us.

THE CHAIR: We thank you very much for coming and for making this whole exchange possible and bringing the information that you have brought. That's wonderful. We'll wrap up this part of the meeting and have a three and a half minute recess while our guests get their material together and then we'll reconvene.

[The committee recessed at 10:11 a.m.]

[The committee reconvened at 10:17 a.m.]

THE CHAIR: That brings us to the three and a half minute mark and we'll reconvene to deal with the committee business here, the first matter of which is the subject of the annual report. So the annual report has been circulated - does anyone have any comment about it? It is in order for us to have a motion.

AN HON. MEMBER: So moved.

THE CHAIR: Would all in favour of the motion to accept the report as it's before us please say Aye? Contrary minded, Nay.

The motion is carried.

The correspondence that is in front of us - the first matter stems from last January's meeting about the Call to Remembrance Program and the letter that the committee

forwarded to the Minister of Education recommending that and her response to that recommendation about that program. Is there anything that anyone would wish to have happen with this correspondence other than it be received for information? Is it then agreed? Thank you

Matters from the February meeting with Veterans Emergency Transition Services - we decided at that meeting to petition the federal government about the request from VETS for charitable tax status and the first item is the response of the federal minister to that request. Is there anything other than receiving this for information? Agreed to receive this? Thank you

We also, at that meeting, agreed to see what we could do on behalf of VETS about finding some available, possible, surplus office space from the province. There is correspondence here from the Department of Transportation and Infrastructure Renewal. I would just add to this that Mr. Langille of the department also called me to explain about the conversations he had about available properties with VETS to assure me that this had been followed up - Mr. Mel Hackett - that this had been taken seriously and followed up, and so that is here. Is there anything other than receiving this for information that we need to do? Agreed to receive this? Thank you.

Following up on that also, we had agreed that we would possibly want to provide information about VETS more widely amongst members. Ms. Langille followed up on that on our behalf. Then there is a response from the organization saying that they are a little reticent about doing that, for the reasons that they explain here. Are we agreed to receive this for information? Agreed? Thank you.

Then following that, an e-mail - we followed up with a thing that had been mentioned at that meeting about the Veterans Transition Program and with Dr. Whalen. First of all, David MacLeod has declined to want to speak about this himself from VETS, and has referred us to Dr. Whalen. That's item 5. Are we agreed to receive that? That's the e-mail from June 25th? Agreed.

Then following that, the response from Dr. Whalen in answer to our question about what happens with the Veterans Transition Program that VETS had mentioned to us, and he has attached there - it's with the e-mail - some further information about that. Are we agreed to receive information from Dr. Whalen's e-mail and brochure? Agreed, thanks.

Then from the March meeting with Canadian Army Veterans, this correspondence has to do with the request that the CAV made of us, that we endorse their project of having part of a highway in Nova Scotia designated a Highway of Heroes. We agreed to endorse that project. There's a copy here, first, of my letter following up and making that endorsement, for members' information. Agreed to receive that? Agreed.

Next is the correspondence from the CAV back and forth from the minister about the proposal from the minister's office to do this in a specific way, naming a section of Highway No. 111. This was communicated to the CAV, and they are very pleased with this proposal from TIR, so that's there in this correspondence. Do we agree to receive this for information? Agreed, okay.

Now there's one matter that stems out of this. The Department of Transportation and Infrastructure Renewal has asked our committee to let them know what our mind would be about - how we think it would be best to actually follow up on the placing of this sign. They've given some thought now to where the sign would actually be placed, to the design of the sign, but there is one thing that they would like to know what we think about, that they would like to have decided, and that is what is specifically being paid tribute to in the sign. This is done in three different ways across Canada - I'm sorry you don't have this correspondence in front of you, but I can summarize it easily.

One way is that the Highway of Heroes sign would be paying tribute to all fallen peacekeepers, soldiers, emergency responders, firefighters, and law enforcement officers from or based in Nova Scotia. This is the way that it is done in New Brunswick, and that's what Highway of Heroes means there.

Another way to do it - there are three such ways - a second way, which is how it is done in Manitoba, is that the sign would be designed in such a way that it would be restricted only to fallen military and veterans, so that emergency responders, firefighters, and so on would not be included. A third way - and this was, in fact, if you'll remember the model from B.C. that Canadian Army Veterans had put before us, that they had been involved with - the way it is done in B.C. is that the sign is designed in such a way that it's specifically a tribute to those who have died in Canadian service in Afghanistan. TIR is asking our direction about what we think, specifically, would be the way to go in having this sign established.

JIM BOUDREAU: Having listened to the three and listened to the presentation that was put forth by CAV themselves, I would be of the mind that we should pursue option number three. I'd be prepared to put a motion on the floor to that effect.

HON. WAYNE GAUDET: But why only limit those?

JIM BOUDREAU: I just think that goes in line with what they were asking for and that would be my logic for it, basically.

CHUCK PORTER: I kind of agree with what Wayne just jumped in there with. Why would we narrow it down to one conflict? We have had soldiers and forces members, men and women, all over the world, in a variety of conflicts, in a variety of peacekeeping measures, as well, and over many years. I don't know that the intent was specific to one conflict but if there is any confusion, and it appears as though there is, perhaps we need to

clarify with that organization what their desire might be. I would move that we do that before we move forward designing any signage that we want to make sure we get it right.

My understanding is we wrote on their behalf and moved on their behalf and their request. I think at the very least we should be going back to these folks and saying we have some options; let's talk about the options and see where they are and then come back. Let's take our time and let's get it right, if we're going to do this. Remember who we are talking about here.

THE CHAIR: I think what we ought to do is to consider your point Mr. Porter, not as a motion but as an amendment to the motion. Would you be willing to offer that amendment that the motion not go forward until there is consultation with Canadian Army Veterans?

CHUCK PORTER: That would be fine, absolutely.

THE CHAIR: Okay, discussion on Mr. Porter's amendment that this matter be set aside until that consultation takes place.

HOWARD EPSTEIN: I was wondering if TIR had any kind of timetable that they were suggesting to us, what time limits we were working within, if any; and I also wanted to request that their correspondence be circulated to the rest of the committee. I didn't see it. That would be helpful. I'm in support of those points that were raised in support of the amendment.

HAROLD THERIAULT: I was going to say the same thing. We can just write a letter to them with the options and let them do it. It's not up to us to decide what they want on their sign. It's their sign, so let them decide.

JIM MORTON: I don't sit on this committee regularly; I'm here as a substitution for the MLA for Halifax Atlantic this morning. One of the thoughts that occurs to me is, I guess I say this as someone who hasn't had a chance to be part of that earlier discussion, but I think naming a highway in this way does have certain kinds of implications. As we approach Remembrance Day, one of the things I struggle with continuously, is the balance between remembering those who have made tremendous sacrifices and falling into what I think is a trap of glorifying the horror of war.

We've just had witnesses here who have been talking about post-traumatic stress disorder. I'm a social worker by training and I've thought about these things quite a bit. In some ways there's no real mystery as to why people who are exposed to the conditions of war might be experiencing post trauma as an aftermath of that. I guess I continue to have this sense that we need to do everything possible to promote the interest of peace as opposed to inadvertently create conditions that seem to support more of that trauma.

As an observation - in Canada, I'm afraid we've been moving toward a set of conditions that may have been helping us glorify or perhaps militarize our society. Personally I'm uncomfortable with that and so I think there might be some value in being cautious about the naming of highways, the naming of things, because they have a tendency either to support or not support values that we hold as very important. One of the values that I hold as very important is that we find a way to be peaceful. I hope we take that into account as we think this through.

THE CHAIR: Does this have any bearing on your view of the amendment?

JIM MORTON: Speaking personally, I would support naming the highway but limiting the name to those people who have fallen in Afghanistan and Highway No. 107, as I understand it, is the highway on which those who have fallen have been returned to Nova Scotia. However, I think the amendment provides an opportunity for more reflection and insight so I would support that.

THE CHAIR: Thank you, Mr. Morton. The more I think about this, I think I'm leading us, procedurally, in the wrong way. This is probably not best considered an amendment, it really is, isn't it, Mr. Porter, a motion to table? We don't want to get into a situation where we have the amendment saying one thing and the motion itself saying the other . . .

JIM BOUDREAU: I was going to point that out, sir.

THE CHAIR: Right. What you've really offered is an initiative to set the matter aside until this consultation has taken place and I think I've wrongly characterized that as an amendment.

With the agreement of everyone, I would like to have us amend the record so that we treat this as a motion to table this before us. Can we agree to do that?

SOME HON. MEMBERS: Sure.

THE CHAIR: Okay, thank you. Mr. Boudreau.

JIM BOUDREAU: I just refer to the letter that we just received, that we voted to receive just a few minutes ago, which is from the CAV. It just says:

> "On behalf of the 2nd Canadian Army Veterans Motorcycle Unit (CAV) I would like to thank you for support of Nova Scotia naming a section of Highway 111 "**Highway of Heroes**" in memory of our troops killed in Afghanistan."

We're saying we should consult them but I don't know if it's necessary to consult them because they have already indicated to us, in both their presentation and this piece of correspondence, what their preference was. That was the intent of my motion, to follow what the request was, not to put our own spin on this but to absolutely follow what they asked for.

HAROLD THERIAULT: Measure twice, cut once. Check with them.

JIM BOUDREAU: Well, it's right here.

THE CHAIR: Mr. MacLeod has the floor right now, thanks.

ALFIE MACLEOD: Thank you, Mr. Chairman. I understand where Mr. Boudreau is coming from but at that point we didn't know there were options. Now we have laid out three different options by TIR and for the sake of going to the group, identifying the three options with them and letting them come back with whatever their decision might be, it would be, in my opinion, the fairest thing to do and the right thing to do. Although it was their initiative, they may not have been aware that there were other options that could be looked at.

I think that for the sake of doing this and doing it correctly - and to my good friend from Digby-Annapolis, measure twice, cut once - I think that's what we're talking about here.

THE CHAIR: Any further thoughts. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

This then sets aside for another day Mr. Boudreau's motion about how the substance of the matter should be handled. Thank you.

Continuing on with correspondence, items 10 and 11 have to do with requests from the Equitas Society and the Army Museum that they be included in the agenda of the committee, so can we agree to receive those for information and deal with them in the matter of dealing with the agenda, agreed?

SOME HON. MEMBERS: Agreed.

THE CHAIR: Okay. Before we turn to the agenda setting matter, let's then deal with the matter that Mr. MacLeod wanted to bring to the meeting about the VAC in Sydney.

ALFIE MACLEOD: As you heard during the presentation, currently there are two offices of VAC; one is located in Sydney with three case managers and the other is located here. It is my understanding, and I did ask the members for their understanding, that the office in Sydney is proposed to be closed. It would be an added hardship on the individuals, I believe.

I would like this committee to consider at least writing a letter the Department of Veterans Affairs requesting that they leave the office in Sydney intact so that the services that are offered by them can be fruitfully utilized because I would think that they would go up the Strait area and further as part of what they do. There is a significant hardship for individuals if they do have to travel great distances, considering why they require these services.

I would like to make a motion that we send a letter to the Department of Veterans Affairs requesting that the VAC office in Sydney remain open.

WAYNE GAUDET: Just for clarification, has the federal government announced that they are closing the office.

ALFIE MACLEOD: My understanding with talking to the three individuals, I said there is a rumor and they said it is more than a rumor.

THE CHAIR: Are there comments or thoughts about Mr. MacLeod's motion? Mr. Epstein.

HOWARD EPSTEIN: I'm generally in support of this but I'm wondering if we can express it as a matter of concern; that is, that the committee notes this and expresses it as a matter of concern. There are always complicated considerations that would go into any decision like that by any government, and I don't feel in a position to say whether it's the right or the wrong decision - my instinct is that it's the wrong decision. So what I'm hoping is that as a committee we can note a serious concern about it and I'm wondering if that is acceptable to the mover.

ALFIE MACLEOD: I'm certainly acceptable to that. I guess what I want to do is make sure that our committee is on record as identifying this as an issue. How it is worded, I will leave to the very capable chairman and committee clerk.

HOWARD EPSTEIN: Sure, fine, thank you.

THE CHAIR: Any further thoughts. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Turning to the matter of the agenda, I want to propose that we handle this in the way that standing committees have been dealing with this this Fall, that we have this list circulated, of the four categories, ones that have come from external to the committee, ones that have come from each of the three caucus, that the members of the caucus have considered these lists that are being distributed today and that we have a meeting just for the purpose of establishing the agenda - I would think a short meeting on December 13th - and deal with decisions coming from this list.

Is there a motion to this effect.

AN. HON. MEMBER: So moved.

THE CHAIR: Is there any discussion. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Is there anything else that the committee should deal with.

LENORE ZANN: I just have a quick question. Our earlier one about what Jim's motion was to move to the CAV thing forward, you're just going to write a letter to them and give them the three options that have been shown to us as being options?

THE CHAIR: Ask their opinion before we offer our opinion.

LENORE ZANN: And are you going to wait and tell us at the next meeting or are you going to send us an email?

THE CHAIR: Well that's a good point. Should be we then agree that we add to the agenda for the December 13th meeting, consideration of the Highway of Heroes question based on the response we get from the CAV? Is that agreed?

SOME HON. MEMBERS: Agreed.

THE CHAIR: Okay. Are there any other matters for this meeting. Are we agreed to adjourn. Agreed. Thank you very much.

[The committee adjourned at 10:39 a.m.]