HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

VETERANS AFFAIRS

Tuesday, March 21, 2017

Legislative Committees Office

Nova Scotia Operational Stress Injury Clinic

Printed and Published by Nova Scotia Hansard Reporting Services

VETERANS AFFAIRS COMMITTEE

Derek Mombourquette (Chair)
David Wilton (Vice-Chair)
Keith Irving
Patricia Arab
Ben Jessome
Hon. Alfie MacLeod
Eddie Orrell
Hon. David Wilson
Hon. Denise Peterson-Rafuse

[Patricia Arab was replaced by Stephen Gough.]
[Hon. Alfie MacLeod was replaced by Hon. Christopher d'Entremont.]

In Attendance:

Darlene Henry
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

WITNESSES

Nova Scotia Health Authority

Derek Leduc
Health Services Manager, Nova Scotia Operational Stress Injury Clinic

Dalhousie University

Dr. P. Scott Theriault
Associate Professor, Department of Psychiatry

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, MARCH 21, 2017

STANDING COMMITTEE ON VETERANS AFFAIRS

2:00 P.M.

CHAIR
Derek Mombourquette

VICE-CHAIR
David Wilton

THE CHAIR: Good afternoon everyone. I'd like to call the meeting to order. This is the Standing Committee on Veterans Affairs. My name is Derek Mombourquette, the MLA for Sydney-Whitney Pier, and I'm the chairman of this committee.

Today we'll be receiving a presentation regarding the Operational Stress Injury Clinic from Mr. Derek Leduc, Health Services Manager with the Nova Scotia Operational Stress Injury Clinic; and Dr. Scott Theriault, Clinical Director, Mental Health and Addictions Program for the Central Zone.

At this point we're going to go around and let the committee members introduce themselves, beginning with Mr. Wilton.

[The committee members introduced themselves.]

THE CHAIR: I also want to remind everybody in attendance to please turn your phones off or onto vibrate. After the presentation and we move into questions, I ask the presenters before speaking and answering questions, I will recognize you for our wonderful folks in the back who are recording our meeting.

In addition to today's presentation, we have some business to deal with as well. At this point I'd like to welcome the witnesses and ask them to introduce themselves and begin your presentation. Thank you both.

DEREK LEDUC: As you mentioned, I am the Health Services Manager for the Nova Scotia Operational Stress Injury Clinic. Here with me is Dr. Scott Theriault, who is our Clinical Director.

I'd like to start by thanking the committee for the opportunity to speak today on behalf of the Nova Scotia Health Authority about the Operational Stress Injury Clinic. The clinic represents a strong commitment to improving the lives of individuals living with operational stress injuries. It is an honour to be able to support those who have served and those who continue to serve, as well as their families.

For today's presentation, I'll provide a background and context about our program and how we became established. I'll clearly define what is meant by an operational stress injury, which I will refer to as an OSI throughout the presentation. I'll discuss how we fit into the larger operational stress injury national network and then discuss our specific clinical program and services, the population we serve, our approach to treatment involving an interdisciplinary team, reviewing our client flow and clinic utilization to date, our location, and how to access services, before providing some concluding remarks.

In January 2015, the former Capital District Health Authority held an initial meeting with Veterans Affairs Canada to discuss the possibility of establishing an operational stress injury clinic. In May 2015, what is now the Nova Scotia Health Authority signed a Memorandum of Understanding with Veterans Affairs Canada to establish a clinic.

NSHA opened a temporary site in October 2015, located at 45 Alderney Drive, at Queen's Square in downtown Dartmouth. We moved to our permanent location at 100 Eileen Stubbs Avenue in Burnside. This move represented a significant increase in space and allowed us to increase the number of personnel that we have.

It is important to note that Veterans Affairs Canada actually completely funds the OSI Clinic and the operating budget for 2016-17 was just over $2.8 million. This budget allows us to support 14.85 full-time equivalent positions, which includes various clinical positions as well as some administrative positions.

I want to define an operational stress injury, as it is not a specific condition or disorder. The term is used to define any persistent psychological difficulty resulting from military and/or police services and includes diagnoses such as depressive disorders, anxiety disorders, post-traumatic stress disorder, substance use disorders, as well as other conditions that may be less severe but still interfere with daily functioning, such as sleep disturbances. It is important to note that we treat a range of conditions and disorders related to operational service and not only post-traumatic stress disorder.

The Nova Scotia Operational Stress Injury Clinic is part of a national network of OSI clinics of which there are 10 in the country: in Montreal, Quebec City, Calgary,

Fredericton, London, Winnipeg, Edmonton, Ottawa, Vancouver, and here in Halifax. As part of this network, there's also a residential treatment program which is located in Ste. Anne's Hospital in Montreal, and the OSI national network provides guidance and support to all the OSI clinics.

The OSI national network provides us with access to expertise, training, education, and research opportunities. It also holds us accountable in terms of performance, outcomes, and finances. We're required to report regularly to Veterans Affairs Canada as part of that national network, and there are annual audits conducted for performance and finance as well.

Moving on specifically to what an OSI clinic is, an OSI clinic is a specialized outpatient mental health program designed to address the unique needs of clients living with OSIs. We provide eligible clients with comprehensive assessments and treatment services as well as recommendations to referral sources. These referral sources are often engaged in case management for clients and are focused on addressing various areas of needs within the clients' lives. Treatment within OSI clinics can include individual therapy, group therapy, couples therapy, and pharmacotherapy, the latter of which refers to medications. The OSI clinics do not provide crisis services.

There are four key pillars for OSI clinics, the first of which is assessment, as I've mentioned. We provide assessments for disability awards, and those are submitted to Veterans Affairs Canada and used as part of the adjudication process for disability awards. We also provide recommendations and assessments for treatment services, which are provided to the client, as well as a referral source. They're able to make the determination of where to receive those services.

In terms of treatment, which is our second pillar, we provide evidence-based treatments including cognitive processing therapy, cognitive behavioural therapy, prolonged exposure, and eye-movement desensitization and reprocessing. I highlight these therapies as they are well established within the literature and have been shown to be effective. We also engage in outcome monitoring, which I'll speak more about on the next slide.

Our third pillar is outreach. We network with stakeholders and agencies that also work with veterans, military members, and police. We've had the opportunity, for instance, to build relationships with the Military Family Resource Centre; the OSISS Peer Support Network; and areas within the Canadian Forces, such as the operational trauma and stress support cell, the integrated personnel support unit, and the joint support unit. We've also had a chance to meet and work with the RCMP health services. We certainly continue in our efforts to build relationships within a community and with other key stakeholders. Under outreach as well, we collaborate with providers in the community that are also working with the clients that we serve.

Our fourth pillar is research. We're committed to enhancing the understanding of operational stress injuries, and we have the opportunity to participate in projects across our network as well as projects specific to our own site.

One of the things that separates us from a lot of providers in the community is our commitment to outcome monitoring. All of our clients who come in to access services receive a series of measures that are completed each time we see them. Those are used to identify system trends in terms of their progress and alerts clinicians to changes in individual functioning. It also provides an opportunity for feedback to clients as well as for clinicians and clients to review that feedback. It tracks the progress over the course of treatment so that clients are able to see how they're progressing throughout their treatment episode with us.

In terms of the population we serve, we provide services for eligible military veterans as well as RCMP veterans - Canadian Armed Forces members and Royal Canadian Mounted Police members, as well as family members of clients at the OSI clinic. They're supported to provide the best environment for persons living with OSIs. It's important to note that eligibility for services is determined by the referral agency and not by the Nova Scotia Health Authority - so Veterans Affairs Canada, the Canadian Armed Forces, and the Royal Canadian Mounted Police. Referrals are not able to be accepted from other agencies, providers, or individuals. If we are contacted by individuals interested in our services, we do provide them with information about the process and support them as appropriate to get those services.

Something else that is unique to our clinic when comparing to some of the services and supports that are available in the community is that we operate from an interdisciplinary team approach. Our clinical team includes psychiatrists, psychologists, nurses, social workers, and an occupational therapist. I'm pleased to announce that we also received funding to support a family physician as part of our interdisciplinary team. That recruitment process is ongoing and expected to be complete next month.

Within our centre, clients may have more than one professional involved in their care as the treatment they're receiving is individualized to meet their needs. So it is possible for them to be working with, let's say, a psychologist on individual therapy and also seeing a psychiatrist for medications. Clients may also receive more than one type of treatment at a time. It wouldn't be uncommon for a client to be receiving individual therapy and also participating in group therapy that is available at that time. We make every effort to match clients with clinicians based on the clients' needs and goals, as well as clinicians' training and expertise.

I'm going to review the client flow within our clinic. The referrals, as I've mentioned, are received from our three referral agencies. Once they are received by our clinic, they're input into our system and we attempt to contact that client within 48 hours. That initial contact at triage is completed which provides an opportunity for clinicians to

assess risk and concerns and also answer any questions that clients may have. From there, that information is brought to an intake team that determines the best clinician to provide that assessment for that individual.

From there, it depends on the assessment. If it's a disability assessment, that information will be submitted back to back or to the referral source. For a treatment assessment, that information would be sent back to that referral source and the client is provided with an opportunity to select where they would want to receive services. That could be with us or it could be in community or it could be a combination thereof - as I mentioned, we do collaborate with providers in the community. With that said, we are not able to duplicate services. It's important to note that veterans do have the right to choose where they receive care.

In terms of clinic utilization since the beginning of this fiscal year, as of today we have 109 active clients and we've seen referral rates since last February ranging from five to 27 per month. with the average being between 13 and 14. The graph here shows a percentage of Veterans Affairs clients and the percentage of Canadian Armed Forces members that are currently receiving care; the RCMP numbers were unfortunately too low to be included in the graph at this time.

In terms of selecting a location for the clinic, we certainly gave it some careful consideration of the clients' needs and had discussions with other OSI clinics. We had an opportunity to talk about the client population specifically and what's working well at the various sites located across the country and to receive feedback from those sites as well.

We included many things in our detailed RFP process for our space and we wanted to ensure what is an appropriate therapeutic environment. For instance, we wanted to be away from military police establishment and also away from areas that might generate large noise related to construction or other things. We wanted to be accessible to major transportation routes, but also to avoid congestion at all possible, and we wanted to ensure that we had free and accessible parking and accommodations close by as many clients join us from outside of the area.

While most of our clinical services are provided at the OSI clinic, clinicians do travel to other Nova Scotia Health Authority facilities to provide care for clients. An example I'll give is Sydney. Almost every week we have a psychologist who is working in Sydney, Cape Breton. Services are also available via Telehealth in many communities in Nova Scotia. With that said, the clinical team determines if it is necessary and appropriate to see a client in or close to their home community or via Telehealth.

How to access our services within Nova Scotia - if somebody is interested in receiving a referral, we would direct them to Veterans Affairs Canada. Canadian Armed Forces members would be directed to the Canadian Armed Forces Health Services, and for

our RCMP members they would be directed to the RCMP Health Services. Again, as I mentioned, those are the three referral sources that we're able to accept referrals from.

In conclusion, the OSI clinic provides assessment and treatment services for veterans, Canadian Armed Forces members, RCMP members and their families of those residing in Nova Scotia. Eligibility for services is determined by Veterans Affairs Canada, Canadian Armed Forces, and the RCMP. Veterans Affairs Canada funds the OSI clinic, which is operated under a memorandum of understanding with the Nova Scotia Health Authority.

This last slide contains contact information for the clinic. At this time, Dr. Theriault and I would be happy to answer any questions that the committee may have. Thank you.

THE CHAIR: Thank you very much. We're going to start with questions from committee members, starting with Mr. Wilson.

HON. DAVID WILSON: Thank you both for coming in and shedding some light on what is provided at the clinic. I think it's an excellent opportunity for Nova Scotians to gain some access to treatment and care.

You indicated about $2.8 million for the 2016-17 budget - is that renewed yearly, or do you have a long-term agreement with the federal government? Or, is it every year you wait until the budget comes out - sometimes it's just before - to find out if funding has been renewed? Is it a yearly budget that you have to continue to make sure that the federal government recognizes the importance of it or is there a long-term funding arrangement?

DEREK LEDUC: We do submit budgets annually for approval to Veterans Affairs Canada each year, but they do approve standard base amounts year over year. I could get you the specifics on the MOU, but there are multiple years involved. Just to give you some perspectives, the first OSI clinic in Canada opened in 2001 and that is still open. Since that time of course, we've expanded to 10 OSI clinics as part of that national network. I think it's evident there is a strong commitment from the federal government to the need and the importance of the OSI clinics, and year over year we've seen an increase in the level of support at all the clinics.

HON. DAVID WILSON: Excellent. I know just looking at your graph from April of last year, it looks like the number of clients you have has almost tripled. If I can find it in the deck here, I think there were about 30 maybe last April to well over 100 now, so is the budget a concern? What do you project into the future that those numbers will look like? I know you said roughly five to 25 a month, average 13 or so. Are the resources there for you to continue to support Nova Scotians who reach out to get support from the clinic? Or is there a need to have the federal government look at the budget? I mean tripling the number of clients would be concerning if the money is not there to support your efforts.

DEREK LEDUC: That's a very good question. In our experience to date, any time we have provided evidence where we would need increased supports - as part of our regular reporting process, we report quarterly to Veterans Affairs Canada - we do include the number of clients that we're seeing and referrals, as well as our efficiencies. So if we're able to demonstrate a need and we provide that forward to Veterans Affairs Canada, thus far we've certainly received the funding that we've requested at this time and we've been able to address the increasing needs.

An example I'll draw your attention to was us being able to bring on a family physician and we also, as part of our model of care, introduced an occupational therapist, which is the first occupational therapist as part of our national network. We've been really fortunate here in Nova Scotia in terms of the level of support we've received federally for this program.

HON. DAVID WILSON: I'm just wondering if you're aware that the Public Safety and National Security Committee recently provided a paper to the House of Commons. I think it was about 16, maybe 18 recommendations. I think one that's important for across the country is a national strategy around operational stress injuries and everything that falls under that.

I know recently there has been some work on an Opposition member's piece of legislation that has garnished some support across the aisle. Are you aware of that? I would think that that would help an organization like yours to maybe have sustainable funding for long periods of time if there's a national strategy on exactly what you support Canadian veterans with, and that's occupational stress injuries.

DEREK LEDUC: I haven't actually up to this time been directly involved in the discussions related to that national strategy on PTSD. I can say that any increased efforts and attention and resources in that area, of course, is a great thing for individuals living with operational stress injuries.

THE CHAIR: Next we have Mr. Wilton.

DAVID WILTON: I'm just wondering about the $2.8 million. Is that for Atlantic Canada or is that just Nova Scotia?

DEREK LEDUC: The funding we receive is to provide services within Nova Scotia.

DAVID. WILTON: Do you feel that is adequate, the $2.8 million for the current base that you have?

DEREK LEDUC: We do spend a lot of time looking at our specific needs as part of our budgeting process and we're able to identify what sort of resources and supports we

would need. At this time, I think that we're certainly very happy and feel fortunate for the level of financial support that we receive from the federal government.

DAVID WILTON: Can you fill me in a little bit on the relationship that you have between the district health authority - how the funding model works - and the organization a little?

DEREK LEDUC: In terms of the relationship, the funding for the program comes to the Nova Scotia Health Authority and we're based here in the Central Zone, so all the employees that work at the Health Authority or work within the OSI clinic are all part of the Health Authority. We follow the same policies and procedures within the Health Authority. We're involved as part of that team and we're certainly well connected.

I guess one of the differences is that individuals would need to be eligible to receive services from our clinic, and if they're not, there are a number of services and supports that are available outside within other areas of the health system.

THE CHAIR: Next we have Mr. Orrell.

EDDIE ORRELL: Thank you for your presentation. I noticed in your presentation you're looking at recruiting a family physician. Given the history of the last little while of the number of tragedies and the impacts that PTSD has on some of the veterans that we hear have had tragic endings to their lives - and the RCMP and first responders - most of these things if they go to an outpatient department in their local hospital get triggered by noise or it could be children or it could be whatever.

Will that family physician be able to provide some primary care to these individuals if they go for the simple things that they need to see a family doctor for that they don't have? If they go to the clinic, can they receive both primary care and care from your OSI clinic?

DEREK LEDUC: Right now, with the family physician that we're bringing on board, we're still looking at developing what specifically that model of care will be. One of the reasons we created the position was that we were working with clients within our program where we're trying to improve their mental health, but oftentimes they had a lot of physical health issues that were contributing and complicating and they didn't have that family physician in the community, particularly those individuals releasing from the military were really impacted where they had a family physician up until the day that they were released.

We sought funding to be able to bring somebody in who can kind of address that gap and ensure that we can provide comprehensive services, so clients within the clinic who are going to be receiving services for their OSI would be able to receive some primary care services from the family physician that's there, largely in relation to that OSI.

Again, it's hard for me to say much beyond that because once we have the family physician in place they'll actually have to work with the clinical team and our partners to determine what that might look like specifically.

EDDIE ORRELL: Your referrals come from Veterans Affairs, military, and RCMP - so they get referred. I don't know how to ask the question - a gentleman is having some operational stress problems and he goes to his family doctor and it's determined he does have some problems. The family doctor has to refer him to Veterans Affairs and Veterans Affairs refers him to your operational stress clinic.

Can a family physician, who has someone come in with a known problem, refer directly to your operational stress clinic? Why the distance all the way around - especially for someone who may not have a family doctor when they come through? Who would they talk to first before they would get to VAC and then to your clinic, if they had a family doctor they could go to?

The other side of that is if someone who doesn't have a family doctor gets into your OSI clinic and needs something from a family doctor - reports sent to a family doctor and they don't have them - will your family physician that you take on board become that person's family physician or will they just be left out in space again like they were with no doctor before? It's complicated, I'm sorry.

DEREK LEDUC: There are a few questions in there.

EDDIE ORRELL: I didn't mean for it to come out that way.

DEREK LEDUC: That's okay. It's a really challenging and complex issue.

Right now, if somebody was to go to their family doctor and they wanted a referral to our clinic, they wouldn't be able to do that. They have to be entitled to receive services because all of our services are funded federally. That being said, when that does occur we would contact that family physician to review and explain that process and work with that client. They don't have to be referred by a family physician in order to access our services - they just need to be referred from one of those three sources.

Most commonly the majority of our referrals come from case managers at Veterans Affairs Canada. Veterans are able - if they don't have a case manager - to call one of the numbers to be able to be connected. I am aware that sometimes that can be a challenging process but the specifics around those internal workings, Veterans Affairs Canada would be in the best position to answer that.

With respect to receiving some of those primary care services in the clinic, the intent would be for individuals to be able to receive some primary care services if they are

being treated at an OSI clinic and need a family physician. The example you gave - if they had some test performed, where would that information go - the family physician at the clinic would be the one who would receive those and review those.

EDDIE ORRELL: So they could act as the family physician, basically.

DEREK LEDUC: I'll just add that the intent was to address that gap that we were seeing for clients who weren't able to be connected. It is a transitional model so they will act in that capacity and support them. What we would want to be able to do is to help them transition to a provider in the community. But again, they need to be provided with those services so we'd be in a position to provide those services.

EDDIE ORRELL: You talked about having 109 clients now receiving treatment, with an average of 13 to 14 a month. How many clients could the clinic handle presently, the way it sits right now? Has the research you've been doing been able to come up with a plan that if numbers increase - as in more veterans are becoming younger with more mental issues than physical issues, because of the type of service that they provide in this day and age. Has your research team come up with any statistics or any research that will help alleviate that or improve the care they get or maybe in expanding, if need be, with the numbers going up?

DEREK LEDUC: It would be very challenging for me to try to predict in terms of what the total number of clients that we could handle would be because the clients come in with a variety of issues. Some of them are in for just one assessment and they don't return for services. Others, we might have on our books for a really long time and be working with them for a long period of time. It's tough to say. It also depends on what clinicians are involved in their care.

What I can say and what I highlighted earlier was that to date any time that we've identified an issue or we've required additional resources, we provided that information to our colleagues at the OSI national network and to Veterans Affairs Canada, they've been quite supportive in ensuring those resources are there so we can do the important work that we need to do. I think they've been really responsive to date and I think that's something that is really important to be recognized.

In terms of the research - because we're such a new clinic, we are just starting to go down that road of research so there's nothing that we'd have to present or really be able to discuss at this point. But again, we are going to be actively involved over the next number of years in some projects.

THE CHAIR: Thanks, Mr. Orrell. Next we have Mr. Irving.

KEITH IRVING: Thank you. I think you were just going down the line of questioning that I was going to ask. Maybe I'll start with the outcome monitoring that

you've done. Presumably that has given you some insights into how your services are working. Did you want to expand a bit on outcome monitoring and perhaps on what you've learned through that, on the effectiveness of your clinic?

DEREK LEDUC: The one thing I'll note about outcome monitoring - the client-reported outcomes which our clinic uses and are used across all the OSI clinics - is that it's one piece of information that's able to be used by the clinicians in terms of making a determination and assessing how the clients are doing.

I'm not able to sort of broadly look at that and assess how effective the services are, in a sense, because the reality is it depends on the complexity of those conditions and how they've been impacted and what also is going on for that individual. It's really one of many tools that can be used to assess the services and also how the clients are doing. I can't provide a clear answer in terms of using that as a way to assess the quality of services.

We do participate within the Nova Scotia Health Authority in client satisfaction surveys. We have opportunities in the clinics as well for clients to give us feedback on those services.

MR. IRVING: So there hasn't been a lot of research. Has there been an evaluation done one year in, for instance, that has shed light on any gaps within the services that you can provide?

DEREK LEDUC: That's a great question. Very recently, we had the national network manager and the national clinic coordinator on site reviewing our programs and services and looking at some of our reporting. They are going to be providing us with some recommendations. I actually expect to receive those any time in the next week or two. We will be able to use those recommendations and some of the feedback that they have provided to continue to improve the services that we provide.

MR. IRVING: It seems you've done some evaluation I guess with respect to identifying a gap, i.e. not having a family physician on your team. Is that something that came out of this analysis as a gap, and then you went to the feds, and they were able to provide that? I think you've been fairly clear that the feds have been very responsive to what you've learned through this first year.

DEREK LEDUC: Identifying the need for a family physician as a gap within our model of care really came from our clinicians having conversations with clients and then being challenged about finding some of those primary care services, particularly within psychiatry as well when they need to collaborate and liaise and work with those family physicians to ensure comprehensive care. That was a challenge. That's how we became aware about that, not through the evaluation itself. That process to bring in funding and move that forward has been in the works for several months, actually.

MR. IRVING: In terms of the knowledge of your services out there amongst veterans and retired RCMP officers, do you have any sense of whether those who need your services know that you are there? Is there sufficient education or debriefing as someone is leaving the Forces or the RCMP that you're there to provide supports? Is there sufficient energy going into advertising your services?

DEREK LEDUC: You have certainly identified an area that is a priority for us. We are a new clinic, and as we continue to provide and expand our services, that's something that we're really committed to doing.

For instance, for individuals leaving the military, we now participate in the SCAN seminars which members who are leaving the Forces receive. We're also looking at other ways to increase the knowledge and understanding of our clinics. We're working with our partners at Veterans Affairs Canada, the case managers, as well as other groups within that community. I mentioned the MFRC and the OSISS Peer Support Network earlier. There are a number of others.

That's something that's a priority for us going forward. Again, we've only been operating fully at our site for a year, so there's still a lot of work for us to do to enhance the knowledge and visibility of our services.

THE CHAIR: Ms. Peterson-Rafuse.

HON. DENISE PETERSON-RAFUSE: I would like to ask about your clinic. It is open from Monday to Friday from 8:30 a.m. to 4:30 p.m. However, we know that a mental health crisis can take place at any time, and that presently you encourage people to call the mental health mobile crisis team. I'm just wondering, do you have other plans, like a Plan C and a Plan D, in case that phone call does not help the situation? Are the clients told what steps to take?

DEREK LEDUC: Clients accessing our services will be provided with information about other supports that are available to them, including the mobile crisis team. Again, the OSI clinics across the country don't function as crisis services. They're very specific, very specialized treatments that are provided at the OSI clinic.

In terms of the mental health mobile crisis, I don't know if Dr. Theriault has anything he wants to add about that.

DR. P. SCOTT THERIAULT: Derek is right. We operate within the Central Zone 24 hours, seven days a week mental health services, so any individual in crisis if they reach out to our mobile mental health crisis team, depending on the nature of the difficulty, they may receive a home visit, they may be brought into hospital for an assessment or they may be directed to come into hospital for an assessment.

We run a psychiatric emergency service at the QEII hospital, which never closes. Those services are available, but as Derek was saying, the service itself - the OSI clinic - doesn't operate on a crisis basis. It operates on sort of a regular programmatic basis to deliver services over time to individuals with identified needs. It is a bit different than a crisis model.

HON. DENISE PETERSON-RAFUSE: Yes, I do respect and understand the fact that it is more of a long-term restorative approach to a person's mental health issues or stress issues. However, as you would know, it's all intertwined so I'm just wondering - with respect once again - if there was a particular issue that needed attention immediately, how far reaching are the mental health mobile crisis teams in the province? Are they reaching out into rural Nova Scotia? Is that service available?

DR. P. SCOTT THERIAULT: I may not have the full answer on this because that's not really my area, but I do think that the mobile crisis team has phone support throughout the province. In terms of actual on-the-ground support - meaning where our team goes to - it is largely the urban area here in the Halifax area. It doesn't extend out past somewhere in Dartmouth or Cole Harbour, I think. I'm not sure of the exact parameters of that.

Just as a quick aside, and this is a more general comment and less about the OSI clinic per se - I think increasingly within mental health services, and this is true throughout the province, we need to be able to take a more trauma-informed approach. We need to understand what trauma-related activities do to people and how that presents in a mental health crisis so that wherever you present for mental health services throughout the province, if you're taking a trauma-informed approach then you're more sensitized so the sorts of needs that an individual who has experienced some sort of trauma may have. That's an ongoing piece of work that we're continuing to develop over time, which I think has become more highlighted in recent years.

HON. DENISE PETERSON-RAFUSE: Just quickly, I just want to have it straight in my mind, did you just mention that your services support those who live in a more central part of like the urban area of Nova Scotia - Halifax, Dartmouth - or do you have clients that are from Yarmouth and from other parts of the province?

DEREK LEDUC: Are you referring in terms of the OSI clinic specifically?

HON. DENISE PETERSON-RAFUSE: Yes.

DEREK LEDUC: The OSI clinic, we have clients located all across the province.

HON. DENISE PETERSON-RAFUSE: Okay, thank you.

THE CHAIR: Mr. Jessome.

BEN JESSOME: I actually had my questions answered.

THE CHAIR: Next we have Mr. d'Entremont.

HON. CHRISTOPHER D'ENTREMONT: I just want to follow up on that issue, being a representative from rural Nova Scotia. Yarmouth has been complaining about lack of psychiatrists, lack of psychologists - local Legions putting on a local seminar on PTSD. I'm just wondering how, through Telehealth or through other activities, you're going to be able to support those individuals who are at a distance from the Central Zone.

DEREK LEDUC: As I mentioned earlier, the clinical team would make a determination working with the client in terms of, is it reasonable for them to come in and receive services in our clinic. I will be honest - a lot of clients are very happy and comfortable to come to our site, but there are certainly circumstances and it's fairly frequent where our clinical staff will go to facilities within the Nova Scotia Health Authority to provide those services. Again, that determination is based on the clinical need. We have at times as well utilized those Telehealth services, which are available in numerous communities within Nova Scotia.

So I guess really the answer is, we look at that on a case-by-case basis for that individual when they're referred and we provide the best supports that we can, given the need or any issues they are presenting with.

HON. CHRISTOPHER D'ENTREMONT: A quick follow-up on that because we see it in other parts of the health system, especially people travelling from different places in this province where they'd rather not travel and the added cost that goes with that. They actually go without the services, whether they be cancer services, whether they be cardiac services and mental health services. I just hope there's more of an appreciation that people make decisions based on their distance from Halifax. A three-hour drive from Yarmouth or a five-hour drive from Cape Breton sometimes is just far too far for them to be able to deal with that.

THE CHAIR: A comment, Mr. Leduc?

DEREK LEDUC: I was just going to say that I certainly agree and appreciate the challenges, given the size of the province and those travel distances. I know, like everybody in the room, we certainly spent a lot of time on the road and that can be very difficult, particularly when you look at our clients who are struggling.

One point I do want to make, though, is that generally if clients are coming into our services, a lot of those costs that they incur are recovered through Veterans Affairs Canada, so that is one thing that is a benefit where they do have some support. But I fully appreciate the challenges in trying to provide that level of service to rural and remote communities

and that is something that, as we continue to build and expand, we're looking to make sure that we do it and do it well.

THE CHAIR: Thank you, Mr. d'Entremont. Next we have Mr. Gough. (Interruption) Oh, I'm sorry, I didn't see you. Dr. Theriault, you can go ahead, if you wish.

DR. P. SCOTT THERIAULT: Just a brief comment and this is more related to general mental health services rather than specifically the OSI service. As a psychiatrist, I only have to see the person, I don't ever have to touch them, if you know what I mean. Telehealth is an important vehicle we could use and I think we could advance those services - both direct Telehealth services and potentially other electronic health services - that would allow us to access patients at a distance so that they could have the same quality and level of services as required now by having to come into the city. That's an area for development I think that's long overdue and, with today's technology, is really quite feasible.

THE CHAIR: Next we have Mr. Gough.

STEPHEN GOUGH: Thank you for your presentation. I'm just wondering, with your OSI clinics, what criteria were used to choose a site location?

DEREK LEDUC: As I mentioned during the presentation portion, I provide a little bit of that criteria. With determining that specific site, we had an opportunity to connect and speak with a number of other clinics across the country. We actually reviewed and received their floor plans as well and had an opportunity to visit a couple of those clinics as well.

Really what we wanted to do was seek their feedback in terms of what was really working well in the areas where they are located, what their major challenges were, and how we ensure that we avoid making some of those similar mistakes that they had made.

A lot of that was feedback they had received from the veterans and we also worked with our national network, hearing about their experience with a long history of working with this population - what some of those criteria are that we should consider when selecting the location.

We built into the RFP process a number of those criteria. I know I mentioned earlier we wanted to ensure that we were away from where we would see visible military police, we wanted to be away from areas that would generate a lot of noise. We also wanted to be away from areas that would generate crime or sort of alcohol and that sort of stuff. That was a lot of the criteria that went into it.

Really the transportation was a key issue. We know that often clients can be triggered by particular situations and one is in relation to traffic congestion. That can be

quite triggering and upsetting for them. We wanted to ensure that we were in a place that felt therapeutic for them.

In terms of the facility itself, we also, in the site that we are in, we actually designed the entire space and it was built to our specifications, as per the Health Authority - everything from the colour of the walls to the insulation in the walls, to the flow of traffic. Everything was considered and based on the feedback we received from the clients who we were going to be working with. Quite a bit of thought went into ensuring we had the best facility we could.

MR. GOUGH: Has Veterans Affairs Canada been co-operative in the interactions you've had thus far? What is the relationship like? Is it a good relationship?

DEREK LEDUC: Yes, thus far I'm happy to say that we have a really positive relationship with the OSI national network, which we report to under the directorate of mental health. We have certainly felt very supported not just financially but also when we were looking for support in terms of training, education, or expertise. Even dealing with some different situations, they've been able to provide some guidance. A lot of these clinics have been doing this work for a really long time, so we're in a good position. We're able to leverage that amount of expertise to support the work that we're doing here in Nova Scotia and, of course, also to give back and provide some expertise in different areas to that network as well.

We also have a strong relationship with the case managers in the province. When we first opened, we had a number of the case managers over to tour the clinic and provide them with information. We continue to meet with them fairly regularly so that they're aware of the clinic and changes. If I had to sum it up, I would say currently we have a really positive relationship with Veterans Affairs Canada.

THE CHAIR: Back to Mr. Orrell.

EDDIE ORRELL: I guess something I wonder about is that you have an MOU with the federal government to provide the funding. I think it's a little over $2.8 million, and it's to treat veterans and retired RCMP members, both federal responsibilities as far as payments and so on and so forth. Is there anything in that MOU that would allow or would consider allowing us to start extending those programs to firefighters, paramedics, or regular police officers?

I know that the provincial government is carrying out the program. I hope there's something in that MOU that would allow us to start expanding that into some provincial and municipal responsibilities for people who provide the same type of service and receive the same type of stressors that may cause an operational stress injury.

DEREK LEDUC: I think you've identified a real issue that we can all see. It has been a challenge, and so we look across the OSI national networks. None of the clinics in the country currently provide services to anybody other than those individuals I have identified who are eligible to receive those services. I'm not able to speak to the specifics in the MOU, but I can say that that's not happening across the country.

I'm not aware of what that plan might be going forward, but what I can say is we are able to leverage some of the expertise within our clinic for other areas of our programs. For example, our clinic hosted some specific training on prolonged exposure, and we opened up quite a few seats to clinicians who were working in various areas of our province as part of our community mental health teams and actually provided them with the opportunity to train side by side with us to build that capacity and give them that experience.

It's really fortunate for us to be in that position. That's one way that we are able to translate that knowledge and experience into building capacity, through training and development. As I mentioned, currently, we can't provide services beyond those who are identified as being eligible through the MOU.

EDDIE ORRELL: You get funding from the provincial government, but you use provincial experts. Dr. Theriault is a psychiatrist here. He works for the Nova Scotia Health Authority, but he treats these federal patients. You translate that back to provincial use, yes, and it's great to teach and that.

How would people know that? Is the clinic in Sydney advertised, that it has a clinic there? Or is it just if someone needs it, they go down there? Is this a regular thing, and they'll go to Sydney on a regular basis, or Yarmouth, or Amherst, or something? If they are, is it advertised so that people who need that service can get it in those areas? Or do they have to travel here?

DEREK LEDUC: Just to reiterate the referral process, that would come usually from Veterans Affairs Canada. When veterans are working with those case managers, they're aware of the services and supports that are available. It is on a case-by-case basis, depending on whether or not we would be sending clinicians to or close to those home communities. The example I used in Sydney - almost every week we have at least one psychologist who is seeing a number of patients at one of our sites up in Sydney, one of our community health sites. We're fortunate that we have the ability to utilize a lot of those spaces, particularly on short notice as well, if needed.

THE CHAIR: Mr. Wilson.

HON. DAVID WILSON: I want to thank my colleague for asking that question. It's kind of along the same lines of what I was going to ask around the other men and women who wear a uniform, and that's our first responders.

Of course, I'm glad to see the federal government stepping up to the plate across the country to provide support for veterans and RCMP, and the reason why none of the clinics are providing care provincially or on another level is because now we need the provinces to step up to the plate. That's something I think all provinces and jurisdictions across the country need to recognize. Our first responders provide an immense service, and they see the same traumas as veterans and RCMP. I would hope that the provincial government here recognizes that.

I've been a strong advocate for presumptive coverage, for example, for PTSD for WCB benefits so that you can take something off the plate of someone who might be suffering from PTSD and allow them to get more access or faster access to care and hopefully get back to living a life that is enjoyable for them.

So would you see a benefit for those first responders and others in our province in this type of program? I would think it would be an easy next step for the province. It does take funding. Everybody understands that. Would it not be beneficial? Do you have the data? I know you've only been open for a year, but I think you said the clinics originally opened in 2001. There should be enough data showing that this type of clinic is having positive results. Is that true? I know it's not your role, but would be it be beneficial if this type of program could be provided to a different sector other than veterans, military, and RCMP?

DEREK LEDUC: I'm not able to speak to the potential in terms of what would be the solution to the need. What I'm hearing clearly is that there are a number of first responders and individuals in our communities who are providing these services, who are being exposed to traumas, and they don't have access to the same facilities. So I absolutely can appreciate that and recognize that challenge.

What I can say is that the operational stress injury clinics and the model that we follow - and that has been developed in the evidence-based therapies that we provide - we do know that those are effective therapies, and we have seen positive outcomes in a number of those areas. So I would draw your attention back to that national network and liaising and communicating with them in terms of how they built the infrastructure that exists now, what it took to get there, and how we provide those services.

HON. DAVID WILSON: As I said, you're providing care on a monthly basis to about 109 clients. Coming from the Department of Health and Wellness at one point in time, $2.8 million is a great investment to be able to address that many people when you look at the overall budget of $4-plus billion.

I know there has been a lot of research and funding going towards research around operational stress injuries and everything that kind of falls off of that - PTSD and others. I know here in Nova Scotia, we're doing some research. Are you guys plugged into that? I

know you said the model is evidence-based, and hopefully that research can support not only your clinic now but also the idea of maybe providing a similar type of clinic to the general population of the province.

DR. P. SCOTT THERIAULT: To answer your question and reflecting back on what you were saying a minute ago, Derek is right: there are models out there that inform care for individuals with trauma related and operational stress-type injuries. You're correct again that those are not wholly subsumed by individuals in the RCMP, the military, or the ex-military. You're right: first responders and any number of other people in the community have similar kinds of difficulties.

In the configuration that we have now with the Nova Scotia Health Authority, those individuals receive services from their local mental health service providers. I think there is a great need - and Derek would know this as well - to develop capacity to deal with those difficulties within the context of general mental health services. That means training staff who are informed in the different modalities that are out there that have been shown to be effective, making sure those staff are available throughout the province and having systems in place that quickly identify individuals who may need that sort of care and allow them to access the services.

As you have also mentioned, that probably comes with a cost in terms of developing that kind of capacity and sustaining it over the longer term.

THE CHAIR: Next we'll go to Mr. Jessome.

MR. JESSOME: Just seeking further clarification on a question raised earlier by Mr. Irving around outcome monitoring. It sounded like there was kind of a constriction to use the outcome-monitoring system to decide whether the services that are being provided were beneficial. Can you speak a little bit more about how the clients are monitored beyond your walls and how that has an impact on how you decide what's working and what's not?

DEREK LEDUC: I touched briefly on outcome monitoring and so to give you some perspective, when clients come to our clinic for an appointment, they are actually handed a tablet and there's a number of measures that come up that they're going to respond to. That information is then available to the clinicians. That individual who is providing the therapy can review that and it will give them a trajectory - are they progressing as they had anticipated or are there any alerts or areas for concern? They have an opportunity to review that when they see the client as well. That is one of many tools that are used by the clinicians to do their work.

In terms of using it solely as a way to evaluate those services, there are many other factors and complexities that would need to be taken into consideration, so its real role is to be able to monitor how clients are progressing, to support the work the clinicians are doing.

In terms of knowing if the services are effective, we know that we are providing evidence-based therapies that have been well established in the literature. They've been approved by Veterans Affairs Canada and they are being implemented at all of the sites across the country, so we're confident in the quality of services we're providing and the treatments we provide.

MR. JESSOME: So it sounds like it has more to do with the individual's personal situation, just in terms of deciding whether that individual has progressed or whether the overall services I guess are meeting their outcomes. It's more important to focus on what that individual's progress has been, versus the overall.

DEREK LEDUC: That's correct, yes. We've been using that individual interaction with the client and their clinician.

MR. JESSOME: Thank you for that.

THE CHAIR: The final member on the list is Ms. Peterson-Rafuse.

HON. DENISE PETERSON-RAFUSE: You mentioned in the presentation that sometimes you also include couples within the therapy. I'm wondering, does that extend into a wider base, the family, with regard to specifically children? As we know in recovery of this nature, bringing the family together and maybe some other identified people in that person's life would be a key support in their recovery or their ability to manage in the program with your clinic.

I'm just wondering, do you do that? If not, is it because of resources? Is it because you are new or is that some area that you are looking at expanding towards?

DEREK LEDUC: I think that's a great question. Right now when we provide services to family members, it's largely in relation to supporting that veteran. An example I use is if there is an individual who was diagnosed with a particular condition we might work with that spouse to provide some psycho-education to help them understand that condition, maybe some coping skills - or within a couple, they might work on communication skills and a variety of other things. The clinic staff would determine what those needs are and what would be appropriate to help achieve the goals and the outcomes they are hoping for.

We don't provide services for children but the clinical staff would determine what would be the appropriate level to involve members of the family in that treatment. Unfortunately that's about as far as I can go, given my role. I'm not as knowledgeable about the specifics around that, but I do know that our clinicians are very skilled at making those determinations. Certainly we see lots of family members in the clinic.

HON. DENISE PETERSON-RAFUSE: Is that something you can see that is critical? Those children and other extended family members could play a key role in the recovery and understanding, too. I mean outside your clinic, they are back into the reality of real life and have to deal with those individuals who are in their family who can potentially be supportive or non-supportive, which could make a difference in the recovery. Do you see that as a future role, that there may be an important aspect to provide those services?

DEREK LEDUC: I certainly agree and think it is important that we are able to support the family members of veterans and of course our current serving members. Within the clinic at the time, we're certainly focusing on those individuals and how we can support them in their recovery. So, as I mentioned, that often involves working with some of those family members.

There are some limits, in terms of what that looks like, because of course that does take away from our availability to provide services to veterans as well. Across that network, there is some consistency in terms of that level of support.

Another thing to keep in mind, too, depending on if those individuals require support for some of the issues that they may be experiencing, there are also additional resources within the system that are available. But again, anything specific around the family is where that couples work really comes down to the clinical team making decisions about that and working within our sort of framework. It's unfortunate - that's about as much as I can say today.

HON. DENISE PETERSON-RAFUSE: Is your clients' medical information set up electronically so that it's available in the other health facilities in the province that have that system? If there is a particular situation going on and they end up at the QEII or whatever, they would are able to quickly see electronically that this individual is actually a client of yours, which may result in a different means of treatment that they would receive going into the hospital? If that is not the case, why isn't it?

DEREK LEDUC: What I can say is that for clients who are receiving services within our clinic, we are part of what is known as Horizon Patient Folder, which means that the clinical documentation is uploaded to the same system that we use within the Central Zone. So if somebody does access an emergency department, they are able to see that they are a client in the clinic and to see some of those notes that would be listed there.

In terms of the rest of the province, I will say that's a little bit beyond my level of knowledge. I don't know if Dr. Theriault has any more information about what they are able to access outside of the Central Zone.

DR. P. SCOTT THERIAULT: As I understand it, Derek is right, if you reside within Central Zone, all your medical health records are contained on Horizon Patient

Folder. So if you go to the emergency department, I can pull up your records and see all your contacts, presuming that they've actually been loaded onto Horizon Patient Folder, but that's a separate story for another day.

I don't know that that's true in the other zones around the province. There are different sorts of systems in different areas. You can get those records but they are not immediately available.

THE CHAIR: Thank you, Ms. Peterson-Rafuse. That concludes our list of questions. At this point I'd like to give both of you the opportunity to make some closing remarks. We can start with Mr. Leduc or Dr. Theriault.

DEREK LEDUC: I'm very pleased to have had the opportunity to share this level of detail regarding our clinic and services today and to answer any questions that you may have had based on the information I provided.

I just wanted to reiterate that our process starts with referrals from Veterans Affairs Canada, the Canadian Armed Forces, and the Royal Canadian Mounted Police. Our interdisciplinary team of experts is here to support veterans and their families, and we're very fortunate to be part of the larger network of OSI clinics across Canada. Once again, I want to thank you for your time today.

THE CHAIR: Dr. Theriault.

DR. P. SCOTT THERIAULT: I don't know that I've got anything much to add. I think that this program is an important asset to the province in terms of dealing with individuals with operational stress injuries. It is, at best, a partial solution to a broader issue of individuals who have similar sorts of difficulties who come from different walks of life but who, nonetheless, have similar sorts of difficulties as individuals who have served in various capacities.

An ongoing piece of work for us within the broader mental health and addictions program is to try to develop those systems that would allow individuals, from whatever walk of life, if they present with these sorts of difficulties to get the services that they need.

THE CHAIR: Thank you both, and I thank all the committee members for your questions and the discussion. We will take a five-minute recess now to allow the presenters to say good-bye and hello.

[3:06 p.m. The committee recessed.]

[3: 13 p.m. The committee reconvened.]

THE CHAIR: I would like to reconvene the meeting of the Standing Committee of Veteran Affairs. We have a few items for committee business.

Number one, you all would have received a copy of the correspondence from Mr. Allan MacMaster, MLA, to hear from the veterans of the Veterans for Healing Egypt Falls project. I've received that. If I could make a recommendation, it's that I reach out to Allan to look at having them in at a later date. If everybody is in agreement, then it would go back to caucus and bring it back for the agenda setting. You're in agreement, okay.

Number two is rescheduling the Legion Services Bureau Network. We missed them at the last meeting. I recommend that we bring them in for April. Is everybody in agreement with that? (Interruption) I'm just trying to keep on script. We're going to look to reschedule them. I think that was a great group. They were really keen on coming here, so I think it would be great to have them in in April.

Last, we're looking at doing the agreement to have the agenda setting for May or June 2017.

As always, great conversation today, everybody. Thank you all for your participation. We are adjourned.

[3:15 p.m. The committee adjourned.]