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RESETTING THE BAR FOR VETERANS HEALTH CARE: VETERANS INDEPENDENCE PROGRAM AND VETERANS HEALTH CARE REVIEW

Report of the Standing Committee on Veterans Affairs

Rob Anders, MP
Chair

May 2008

39th PARLIAMENT, 2nd SESSION

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has the honour to present its

FIRST REPORT

Pursuant to its mandate under Standing Order 108(2), the Committee has studied Veterans Independence Program and Veterans Health Care Review and has agreed to report the following:

TABLE OF CONTENTS

RESETTING THE BAR FOR VETERANS HEALTH CARE: THE VETERANS INDEPENDENCE PROGRAM AND THE VETERANS HEALTH CARE REVIEW

INTRODUCTION

The time has come to reset the bar for veterans health care even higher. This can be done by redesigning the health care programs and services provided by the Department of Veterans Affairs to surviving war service veterans and by making more of these veterans eligible to receive such care. In the process, the redesign can pave the way for better health care for young veterans of peacekeeping and other Canadian Forces operations, especially those dealing with psychological injuries. Various parliamentary reports have contributed to improvements in the health care provided to veterans. A major 1999 report by a Senate sub-committee, Raising the Bar, guided the Department of Veterans Affairs in its efforts to set a new standard in veterans health care.[1] A 2003 report by the House of Commons Standing Committee on National Defence and Veterans Affairs examined the progress made and the issues still to be resolved.[2] There is now an opportunity to reset the bar even higher because the department has undertaken the Veterans Health Care Review.

The goal of the departmental review is to modernize the programs and services it provides for the long term care of Canada's war service veterans who served during the Second World War and the Korean War. While the department is focussing more and more on the needs of younger Canadian Forces veterans who served in peacekeeping and other operations since the 1950s, providing care and services to the now elderly war service veterans is still one of its major commitments. As the Committee noted in its June 2007 report on operational stress injuries, "Canada's pledge in the original Veterans Charter of 1944 to meet the health services needs of its war service veterans remains in place, but those needs have evolved with the advancing age of these veterans and the health services have to be updated to provide the most effective and timely services possible."[3]

With this in mind, the Standing Committee on Veterans Affairs continued during the second session of the 39th Parliament its Veterans Independence Program and the Veterans Health Care Review study undertaken during the previous session. The

1 Canada, Standing Senate Committee on Social Affairs, Science and Technology, Subcommittee on Veterans Affairs, Raising the Bar: Creating a New Standard In Veterans Health Care, February 1999.

2 Canada, House of Commons, Standing Committee on National Defence and Veterans Affairs, Honouring the Pledge: Ensuring Quality Long-term Care For Veterans, June 2003.

3 Canada, House of Commons, Standing Committee on Veterans Affairs, Support for Veterans and Other Victims of Post Traumatic Stress Disorder and Other Operational Stress Injuries, June 2007, p. 1.

department's Veterans Independence Program (VIP) is inevitably a major element in any updating of the health care services provided to the war service veterans. As a result, the Committee examined the value of the VIP and its place within the spectrum of programs and services offered by the department as well as the implications of the Veterans Health Care Review. The VIP is also a major component of the changes proposed by the Gerontological Advisory Council, which advises the Department of Veterans Affairs on health issues, to update the existing system. The goal of this report is to recommend to the department that it should proceed with the proposed changes to the VIP so that the department can better serve veterans and their families.

VETERANS INDEPENDENCE PROGRAM

A. A Model for Home Care

To understand the need to proceed with the updating, it is necessary to examine the evolution of the VIP and how it can contribute to improvements in veterans health care. The VIP, called the Aging Veterans Program in its early days, was established in 1981 and as its name suggests, its main goal is to help ensure the independence of aging veterans so that they can live as long as they wish in their own homes and delay, if not avoid, becoming residents of long term care centres. Avoiding the costs associated with residential care as offered in long term care centres is a consideration. However, ensuring the independence of aging veterans is even more important because the longer they can avoid moving into such a centre, the longer they can stay at home and avoid the disruptions in family life and the often difficult adjustment to life in a health institution such a move implies. This is especially true for veterans living in small communities and rural areas outside major cities, where most of the veterans long term care centres are located, and who therefore may have to move away from their families and their communities. The move also has implications for family members who must travel sometimes long distances to visit veterans in long term care centres. In short, delaying a move to a veteran health care centre is advantageous for both the veteran and his or her family.

The grounds maintenance services such as grass cutting and snow removal are probably the best known elements of the VIP. For elderly persons, having access to grounds maintenance services can help ensure their ability to take care of their homes despite their frailty while avoiding the strains and risks associated with carrying out such tasks. However, the VIP is much more than that since the program has evolved a great deal over the years. In addition to grounds maintenance, the program offers personal care services, homemaking, access to nutrition services, health and diagnostic services, home adaptation (such as the construction of ramps for wheelchairs), nursing home care, and transportation and access to a broad range of treatment benefits. While the department can assist veterans or eligible caregivers in selecting the providers of the services they need, VIP clients can choose their own provider of services in certain categories, and thus play a role in maintaining their independence by managing their affairs.

An important development during the evolution of the VIP program into what it is today was the Overseas Veterans (OSV) At Home Pilot Project of 1999, which provided VIP home care services such as personal care and housekeeping as well as treatment benefits to veterans waiting for a bed to become available at the veterans long term care centres in Halifax, Nova Scotia, Ottawa, Ontario, and Victoria, British Columbia. There was concern in 1999 about the long period of time veterans in some communities across Canada had to wait before a space in a veterans long term care centre became available. By the time veterans requested access to a centre, the need for a transfer to such a facility was often pressing and any delay was troubling for veterans and their families. The pilot project provided care at home pending the availability of a place at a centre, thereby easing the concerns of veterans and families alike. In some cases, the veterans were so satisfied with the care they received at home, they expressed a preference to stay there, with the assistance provided by the VIP, even when the place requested at the care facility became available. In the process, the pilot project helped to demonstrate the costs savings of providing home care compared to the costs of care in a long term care facility and the popularity of such a service among veterans.

As officials from the Department of Veterans Affairs and health care experts knowledgeable about the VIP pointed out to the Committee, most of the home care services provided are supportive in nature and can be offered in many cases by persons other than nurses or other health care specialists.[4] In other words, much of the home care provided does not add another burden on the health care system. Health specialists might be required to provide some treatment at home, but other services can be provided by other specialists. The success of the pilot project led to the expansion of the home care component of the VIP across Canada in 2001. The Continuing Care Research Project currently being carried out by the department is trying to determine the right mix of home care services.

However, despite the success of the project and subsequent research, home care for veterans cannot completely replace the care provided in the long term care facilities. At some point, many war service veterans with worsening health problems may require care which is more suitably provided in a long term care facility than at home. Furthermore, some veterans with a cognitive impairment such as dementia need care in specialized facilities such as the ones now available in major veterans health care centres. Home care has advantages both for the veterans and for the reduction in veterans health care costs, but this does not mean that it can completely replace the veterans health care centres and veterans contract beds in community care facilities. The key is to ensure flexibility in the system so that veterans can obtain care at home and maintain their independence for as long as possible and be able to gain access to a more costly long term care facility only when absolutely necessary.

4 See Canada, House of Commons, Standing Committee on Veterans Affairs, *Evidence*, December 4, 2007.

B. VIP Benefits for Widows and Caregivers

Another important development in the evolution of the VIP was the extension from one year to a lifetime of the period during which surviving spouses or main caregivers of veterans who were receiving VIP benefits at the time of their death can continue to have access to similar benefits. The first major announcement concerning this issue was made on May 12, 2003 when the Minister of Veterans Affairs announced a number of new measures concerning veterans. At that time, the surviving spouse (or primary caregiver) of a veteran receiving VIP benefits was given lifetime VIP benefits, if the veteran died after May 2003. The required regulatory changes were made by an Order in Council in June 2003 amending the *Veterans Health Care Regulations* which outline the VIP eligibility criteria and related details.

The May 2003 announcement was welcomed by all veterans groups and others who had been calling for such action for many years, but they demanded the extension of lifetime benefits to a greater number of widows or caregivers of veterans. On October 10, 2003, the Standing Committee on National Defence and Veterans Affairs tabled a report in the House of Commons which noted its adoption of a motion calling for lifetime VIP benefits for all qualified surviving spouses, not just those of veterans who died after May 2003. The House of Commons adopted a motion for concurrence with the report on October 29, 2003. Given the public's interest in the issue, the government decided to make more spouses or caregivers of veterans eligible for lifetime benefits. On November 6, 2003, the Minister of Veterans Affairs announced that spouses or caregivers of veterans who died after September 1, 1990 would now be eligible for lifetime benefits.

While welcoming this announcement, veterans groups and others questioned why such benefits were not available to widows and caregivers of veterans who died before September 1, 1990. On December 7, 2004, the Minister of Veterans Affairs announced that the spouses or primary caregivers of veterans who died after April 7, 1981 (and who were receiving VIP benefits at the time of their death or when they entered a long-term care facility) will now receive the VIP benefits for their lifetime. With this announcement and the additional amendments made to the *Veterans Health Care Regulations* in February 2005, another 4,000 spouses and caregivers became eligible for the lifetime benefits at that time. The first announcement made some 10,000 spouses and caregivers eligible, while the second made an additional 20,000 persons eligible.[5]

The April 1981 date is now used to determine eligibility because that is when the VIP program and its benefits were first established. Until recently, only the spouses and caregivers of veterans who 1) died after April 1981 and 2) were receiving VIP benefits before their death (or before their admission to a long-term care facility) were eligible to receive lifetime VIP benefits. On February 26, 2008, the Minister of Finance announced in

5 Department of Veterans Affairs, "More Veterans' Survivors to Receive Help at Home," News Release, November 6, 2003.

the Federal Budget for 2008 that the VIP benefits are now extended to the surviving spouses or caregivers of veterans who were eligible to receive the VIP benefits but who were not in receipt of them at the time of their death. The survivors must, among other things, receive the Guaranteed Income Supplement under the *Old Age Security Act* or be approved for the Disability Tax Credit in order to qualify for the VIP benefits. With this extension, up to 12,000 more surviving spouses and caregivers may be eligible to receive VIP benefits. However, while the extension of the VIP benefits to more surviving spouses or caregivers is welcomed, the fact remains that the lifetime VIP benefits are limited to those concerning housekeeping and grounds maintenance services.[6] Furthermore, to obtain the benefits, the spouse or primary caregiver must need the VIP housekeeping and/or grounds maintenance services for health reasons and to remain independent at home.

C. The Complexity of Eligibility to VIP

In general, if veterans received or are receiving disability benefits from the Department of Veterans Affairs, they were or are eligible for VIP benefits and their spouses or primary caregivers can receive the VIP benefits for life.[7] However, only about 92,000 or 40% of the total number of Canada's war service veterans, who numbered approximately 234,000 in 2006, received disability or other benefits from the Department of Veterans Affairs. In 2005-2006, 97,568 veterans and survivors received VIP benefits, an increase of over twenty thousand compared to 2003-2004. Among the 69,786 veterans receiving VIP benefits in 2004-2005, 61,977 were war service Veterans.[8] Many veterans are receiving services from more than one Veterans Affairs program so many of those receiving VIP also have access to treatment benefits. In total, 101,267 Canadian Veterans and primary caregivers were receiving various services under the VIP at the end of March 2007, but this included Canadian Forces and other veterans as well as caregivers and war service veterans.[9] It also represents only a portion of the total number of clients of the department.

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6 If the veteran had access to only one of these two VIP services, the surviving spouse or caregiver has access only to that service for a lifetime. See the Department of Veterans Affairs booklet Veterans Independence Program.

7 There are exceptions. For example, an overseas service veteran who is not getting a disability pension, but is staying at home while on the waitlist for a veterans priority access bed at a long-term care facility, can receive VIP benefits. For the eligibility of veterans for VIP benefits, see Department of Veterans Affairs, Veterans Independence Program (http://www.vac-acc.gc.ca/clients/sub.cfm?source=services/vip).

8 Information on the number of veterans and survivors or caregivers receiving VIP between 2003-2004 and 2007-2008 was provided by the Department of Veterans Affairs. According to the Part III-Report on Plans and Priorities of the 2008-2009 Estimates for the Department of Veterans Affairs (page 20), the number of individuals who will receive VIP benefits in 2008-2009 is expected to be 105,000. About 55% of these individuals will be war service veterans while 16% will be survivors or caregivers.

9 See the information concerning the VIP in Canada, Estimates, Performance Report for the Period Ending March 31, 2007, Veterans Affairs Canada.

One reason for the relatively low number of persons having access to the VIP is the complexity of determining eligibility. To be eligible for VIP, the veterans must fit into at least one of a half dozen categories.[10] As a result, there can be a whole series of reasons why a spouse or primary caregiver of a veteran who has passed away is not eligible to receive VIP benefits. For example, it could be because the veteran in question never received the VIP benefits, was not eligible to receive them, did not receive a disability pension and was not otherwise eligible for VIP, or died before the VIP program was established or before actually starting to receive benefits after the application was approved. This large number of possibilities reflects the complexity of the eligibility criteria, and the application process for VIP services is just as complicated. Concerns have been raised about the eligibility for VIP benefits based on income levels and the detailed forms that have to be filled in for VIP benefits as well as for other veterans benefits. For elderly War service veterans, it can be quite a burden to complete such application forms. Even more disturbing for the Committee is the fact that, as stated by officials from the department and veterans groups, eligibility for VIP is such a complex process that even departmental officials sometimes have difficulty determining if a veteran or the spouse or caregiver of a veteran can have access to VIP.[11] Furthermore, since eligibility to VIP depends on eligibility to disability benefits, many elderly veterans who need home care cannot have access to VIP because they do not get disability benefits.

REPORT OF THE GERONTOLOGICAL ADVISORY COUNCIL

The complexity of eligibility to veterans disability benefits in general, and to VIP benefits in particular, was a major reason why the department has undertaken the Veterans Health Care Review. The review has benefited from the advice provided by the Gerontological Advisory Council (GAC), which is a group composed of fifteen eminent experts on health care, aging, veterans, and related issues. It has provided advice and guidance to the Department of Veterans Affairs on developing trends in health care for many years. The Council also includes representatives of some veterans organizations. The focus of the GAC's report, as is the case for the departmental health care review, is mainly on the health care needs of the elderly war service veterans who served during the Second World War and the Korean War.

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10 For example, one of the categories includes "Disability benefit recipients who have multiple health conditions, which, when combined with their VAC entitled condition places them at risk." See Canada, Department of Veterans Affairs, *A Guide to Access VAC Health Benefits and the Veterans Independence Program*, April 2006.

11 For example, during the 8 May 2007 meeting, Darragh Mogan, Executive Director, Service and Program Modernization Task Force, Department of Veterans Affairs, stated: "We have a very complex eligibility system. After 60 years of adding patchwoks, it's very difficult for people to navigate through it, even our own staff." Canada, House of Commons, Standing Committee on Veterans Affairs, Evidence, May 8, 2007, p. 6 (pdf version).

The November 2006 report of the GAC, Keeping the Promise: The Future of Health Benefits for Canada's War Veterans, identifies the strengths and weaknesses of the department's health care programs and recommends new measures. The report identifies as strengths the recognition of the need to help war service veterans maintain their independence (the Veterans Independence Program (VIP) being the best example); the ability of the department to adapt its programs to meet the changing needs and preferences of the veterans; and the personal relationship developed between the veterans and departmental area counsellors. The weaknesses include the complex eligibility criteria for access to departmental health programs; the reactive rather than proactive nature of the programs (they are available after veterans suffer some loss in functional ability); limited housing needs (some veterans have to go to a long term care facility when another type of facility would be more suitable); and the lack of help to promote the health of veterans, to navigate the health and social services, and obtain the services they need.

The GAC report recommends a "bold" new approach to health programs and services: the Veterans Integrated Services (VIS), a system which would combine the three existing programs (the health benefits program, the VIP, and the residential care programs). While designed to meet the needs of the war service veterans, the GAC suggests that this could provide a model to meet the needs of all aging veterans if not all aging Canadians. The new VIS approach would be more comprehensive, flexible and responsive than the department's current programs; would reach more veterans and their families; would enhance the health and well-being of the veterans; and would give them access, when they need it, to more appropriate health and social services.

All war service veterans and their families would have access to the VIS, but the services provided would be based on their health needs rather than on their veteran status. The components of the VIS include a single entry point for all departmental services; screening and assessment to determine the needs of veterans and their families; a departmental interdisciplinary team; innovative service delivery models including home support; flexibility in moving resources; and outreach to veterans through veterans groups. While the focus of the GAC's report was on the health needs of war service veterans, it also highlighted the fact that the proposed new approach provides "a model of care for all current and future Canadian Forces veterans."[12] The New Veterans Charter changed the way the younger Canadian Forces veterans can have access to rehabilitation and other programs. In the past, little could be done to help injured veterans who had recently left the military until decisions were taken concerning their disability benefits. With the New Veterans Charter, assistance can be provided even while the veteran is waiting for the processing of applications for disability benefits. A similar approach will have to be considered to meet the health care needs of Canadian Forces veterans, such as those who have served in operations in Afghanistan and have suffered injuries including operational stress injuries such as post traumatic stress disorder (PTSD).

12 See Keeping the Promise, p. 2.

However, any changes in the health care provided to Canadian Forces veterans will depend on the successful updating of the veterans health care system providing care and services to Canada's war service veterans. Furthermore, this updating will have to be done not only successfully and effectively, but also quickly. In its report, the Gerontological Advisory Council urged the department to take action quickly. It added: "Like all older Canadians, our war veterans are coping with the effects of aging. Unlike other Canadians, they are also coping with the long-term effects of military service. There is a small window of opportunity to make a real difference in the quality of their lives."[13] The Council also stated: "It is time to keep the promise." The Committee agrees entirely with the Council's call for quick action. It also believes that quick implementation of the changes proposed in the Council's November 2006 report is the best way to ensure that the Veterans Health Care Review undertaken by the Department of Veterans Affairs will develop the quality health care programs and services all war service veterans deserve.

The Committee's agreement with the course chartered by the Gerontological Advisory Council is based on the widespread support for its recommendations expressed by the health experts and representatives of veterans groups who appeared as witnesses. For example, representatives from the Canadian Centre for Activity and Aging, the Canadian National Institute for the Blind (CNIB), and the National Initiative for the Care of the Elderly (NICE) welcomed the Council's emphasis on providing services based on the actual needs of the veterans rather than on their veterans status. There was also strong support, notably from the CNIB, for the role of the high needs care manager in the interdisciplinary team, an important element of the VIS approach recommended by the Council's report. Furthermore, while recognizing the leadership role played by the VIP in providing home care to veterans, many witnesses welcomed the innovative models of service delivery proposed by the Council which include intensive home support.

Given Canada's aging population, concerns are often raised about the affordability of providing home support, whether to veterans or other elderly Canadians. However, innovative models of service delivery such as intensive home support should be viewed as preventive services. For example, Mrs. Gloria Gutman, Professor Emerita at the Department of Gerontology at Simon Fraser University, told the Committee: "I would argue that we cannot afford not to provide prevention, because if people are needing those kinds of services and they can't get them, then they will end up occupying much more expensive services at a premature time in their lives."[14] The prevention of falls is another example of measures which can help to avoid more costly care in the future while maintaining the quality of life of the elderly. The successful prevention of falls helps persons avoid long stays in hospital and the rehabilitation process, not to mention the loss of some mobility which may result from injuries such as a broken hip. The research projects on fall prevention supported by the Department of Veterans Affairs in cooperation with the Department of Health between 2000 and 2004 was beneficial to all elderly Canadians, not

13 Ibid.

14 Canada, House of Commons, Standing Committee on Veterans Affairs, *Evidence*, March 4, 2008, p. 4 (pdf version). In the rest of this report, references to testimony are indicated by the term "Evidence".

just to veterans. Among other things, they identified measures elderly and frail seniors can take to avoid falls and the help they can get, such as assistive devices, to deal with the consequences of falls if they are the victims of such accidents.[15]

The value of prevention has also been recognized by federal and provincial health officials with regard to health promotion for all elderly Canadians. Mr. Claude Rocan, Director General, Centre for Health Promotion, Public Health Agency of Canada, pointed out that up to 70% of cancers, 90% of type 2 diabetes, and 50% to 70% of strokes are preventable. Encouraging the elderly to lead active and healthy lifestyles can help them avoid many illnesses and delay if not prevent a move to a long-term health care facility. As Mr. Rocan stated, "later-life introduction of regular physical activity can extend years of life and years of independent living and can improve the quality of life of older people."[16] The emphasis on health promotion in the Council's report reflects the approach adopted by health care authorities in the face of Canada's aging population, but it also points out to the Department of Veterans Affairs that, in keeping with this trend, it must be more proactive rather than reactive in meeting the health needs of veterans. As noted by, among others, Ronald Griffis, the National President of the Canadian Association of Veterans in United Nations Peacekeeping, the department has often demonstrated the ability to react quickly and fix a problem faced by a veteran seeking access to needed care, but it does so basically when an issue has been brought to its attention.[17] However, the department must be more proactive in, as the Council stated, "promoting the health, well-being, and independence for all veterans in later life." It should also pay attention to, among other things, the specific health issues of Aboriginal veterans in its health promotion programs. In the process, it should reach out to all surviving war service veterans who need assistance, not just to those who are already its clients. It should also be remembered that the younger Canadian Forces veterans are also aging and will certainly benefit in the years to come from a more proactive departmental approach in the promotion of health, well-being, and independence.

The need for the department to reach out to all war service veterans requiring services, not just to those who are already clients of its programs, was highlighted by two recurring themes during the testimony heard by the Committee. The first theme is the lack of awareness among some veterans about all of the services and benefits available to them, despite the efforts made over the years to provide information. In his testimony, Mr. Griffis noted the case of a 71 year old veteran in declining health who was unaware of the benefits available to him. Another case was highlighted by Mrs. Clara Fitzgerald, Program Director of the Canadian Centre for Activity and Aging, who mentioned the case of one veteran she helped who was not aware of funding available through the VIP for health promotion services. She also noted the experiences of three veterans who, as she described it, "didn't know what they didn't know" about the veterans programs and benefits

15 For more information on the Falls Prevention Initiative see the website of the Department of Veterans Affairs at http://www.vac-acc.gc.ca/clients/sub.cfm?source=health.

16 *Evidence*, January 31, 2008.

17 *Evidence*, December 13, 2007.

available to them.[18] The department has made many efforts over the years to inform veterans about the programs and services available to them, but much more obviously has to be done. These efforts should not be focused only on veterans because the physicians, psychologists, occupational therapists, and other professionals who provide care to veterans need to know about available programs and services so that they can help their patients as much as possible. Indeed, the families of veterans, especially the elderly ones, also need to be more aware of the programs and services that are available. In reaching out to all veterans and their families in remote areas, the department should also notably pay attention to the needs of Canadian Aboriginal veterans.

In fact, the second recurring theme concerns access to programs and services for all veterans in small communities and rural areas far from major cities. Dr. Norah Keating, a member of the Advisory Council who is a specialist in long-term care and mental health, told the Committee: "Supporting people in later life is not just about addressing physical frailty or providing a pension; it's about helping them to age well in the place where they live."[19] Helping people to age well is one thing, but giving them access as much as possible to the programs and services they need where they live is a challenge when the veterans live far from major cities. According to Dr. Keating, it is recognized that in the general population, frail older adults living in rural areas of Canada end up in nursing homes sooner than those in major cities.[20] Moving to a nursing home sooner has implications in terms of health care costs, but it can also have a major impact on the quality of life of the individuals. Many veterans prefer to delay a move to a long-term care centre because such a transition can be a depressing process. For someone from a rural area, the problems associated with making such an adjustment are exacerbated by the move to the unfamiliar environment of a major city, where most veterans long-term care centres are located, which can be very far from the rural community they have known for most of their lives and from their families and friends. During the study, the Committee heard about situations where veterans from rural areas moved with great reluctance to health facilities in major cities or refused to make such a move despite the consequences for their health.

There will hopefully be more research into ways of improving access to health care for people living in areas far from major urban centres, including young as well as elderly veterans. Professor Emerita Gloria Gutman noted the many possibilities offered by new technologies to provide health care information to individuals in remote areas, but indicated that much work remains to be done to provide systems at a price affordable to most people. In the meantime, more effort will have to be made through more traditional means to reach out to veterans in small communities and isolated areas to assist them in finding the care and support they need. Regional branches of the Royal Canadian Legion and other veterans groups can be contact points where veterans outside major cities can obtain information on local resources available in their regions. The Legion branches and other

18 *Evidence*, January 29, 2008, p. 4.

19 *Evidence*, May 10, 2007, p. 1.

20 Ibid., p. 3.

veterans groups already play a role in promoting the independence and dignity of older adults including veterans. However, their resources are limited and their presence in small communities and rural areas may vary from one region of the country to another. In reaching out to veterans, especially those living outside of the major cities, the Department of Veterans Affairs could explore new ways to cooperate with the Legion and other veterans groups which will help it attain its goals.

Increased awareness about veterans programs and services and access to these and health programs and services in small communities and rural areas are issues of concern not only to war service veterans and their families, but also to younger Canadian Forces veterans and their families. Many veterans of peacekeeping and other operations have or will soon become senior citizens and the improvements in programs and services advocated by the report of the Gerontological Advisory Council will be of great value to them as well as to the war service veterans. Promoting the health and well-being of all Canadian Forces veterans has all the same benefits as those identified by the Council with regard to war service veterans. Indeed, the Department of Veterans Affairs should be more proactive in its approach to the health care needs of all veterans, young and old, and their families.

FUTURE VETERANS, NEW VETERANS, AND THEIR FAMILIES

While examining health care issues of direct interest to veterans, young and old, the Committee also paid attention to matters pertaining to Canada's future veterans, individuals currently serving with the Canadian Forces who will become veterans upon leaving the military. Many of these individuals will be seeking access to the benefits and services provided by the Department of Veterans Affairs in the near future either because of injury or a decision to return to civilian life. Thus, it is important to anticipate what will be the demands put upon the disability benefits and health care programs and services provided by Veterans Affairs to Canada's future veterans at a time when those programs and services will still be trying to meet the demands of an aging population of Canadian Forces and surviving war service veterans. As a result, within the context of its study of the Veterans Health Care Review, the Committee also examined issues which are more within the purview of the Canadian Forces and the Department of National Defence than that of the Department of Veterans Affairs. However, there are situations, notably during the transition period when personnel are in the process of leaving the Forces to become veterans, where individuals are dealing with the two departments. Besides, the Committee has already examined issues of concern to both departments in its report on operational stress injuries including post-traumatic stress disorder (PTSD) tabled in June 2007 and wanted to continue to monitor some of the problems identified in the earlier report.

Thus, in the first half of 2008, the Committee visited a number of Canadian Forces bases to gain an insight into the support programs available to members of the military and their families. Visits were made to air force bases (Comox, British Columbia; Cold Lake, Alberta; Shearwater, Nova Scotia; and, Goose Bay, Newfoundland and Labrador) in February 2008 and to army bases in Petawawa, Ontario, and Valcartier in the province of

Quebec in April. The Committee greatly appreciates the briefings provided by military personnel and representatives from the Military Family Resource Centres (MFRCs), the Operational Stress Injury Social Support (OSISS) network, the Department of National Defence, and the Department of Veterans Affairs as well as by all other individuals who participated. While units from Petawawa and Valcartier have contributed large numbers of personnel to the recent rotations of troops deployed to Afghanistan, some personnel from the other bases have also been involved in operations in Afghanistan and elsewhere. The experiences of these various bases and the lessons they learned helped to provide the Committee with a better picture of how the Canadian Forces support its personnel and their families, and of how the Department of Veterans Affairs assists individuals when they leave the Forces and become veterans. The support provided by the Department of Veterans Affairs includes the network of five Operational Stress Injury Clinics across Canada to which five new clinics are being added in keeping with the announcement made in the 2007 Federal Budget. The first of the five new clinics opened in Fredericton on May 23, 2008. The Minister of Veterans Affairs announced in April and May 2008 that agreements have been concluded with provincial health authorities to establish new clinics in Vancouver, Edmonton, and Ottawa. These three new clinics are expected to open by December 2008. An announcement concerning the site of the fifth new clinic was expected in the near future. On May 6, 2008, the Minister of Veterans Affairs also announced the hiring of an additional eight family peer-support coordinators for the OSISS network.

The information gathered during these base visits have underlined the importance of the support programs helping military families deal with the pressures associated with the increased tempo of Canadian Forces operations in recent years. Life in the military can be difficult for families because of frequent moves and the resulting changes in schools for the children and in health care services. When one of the parents is deployed overseas for six months, the family faces an even more stressful situation. Thus, the support provided during deployments by the base's administration, the units, the padre, and the local MFRC is crucial in helping a military family cope with the long absence of one of its members and in some circumstances, with the death or injury of that member. A key element of this support is the network of MFRCs across Canada and in some locations overseas. Each military base has a MFRC, a non-profit corporation administered by a board of directors which includes an important representation of spouses of military personnel. The MFRC offers a wide selection of services ranging from help for spouses trying to find employment to day care programs for the children thanks to the efforts of employees and volunteers. On some bases, the MFRCs have started their own clinics because some military families, like many other Canadians, are having considerable difficulty finding a family physician. Since the 1990s, there have been many efforts to increase the support provided through the MFRCs to military families, a measure strongly supported by the 1998 report of the Standing Committee on National Defence and Veterans Affairs (SCONDVA) on Quality of Life in the Forces. However, there is still room for improvement in the support provided to families by the MFRC, the military in general, and the Department of Veterans Affairs.

One of the issues raised during the Committee's visit to the bases is the fact that an MFRC is often faced with a situation where it is more reactive than proactive since the onus is on the family to seek help when the need arises. The MFRC is not always aware of which Forces member on a base has been deployed and thus cannot always reach out to these families to alert them about the resources available should they need assistance. When large numbers of personnel on a base are deployed, the MFRC is naturally aware that many families might call upon its resources. However, in other cases, only a few Forces members from a base might be deployed, and the centre might not be aware of their departure and the need to assist their families until an emergency occurs. The challenge facing the MFRC in reaching out to the families of deployed personnel is a significant one because many of the families live in the community outside of the base. Even if the families are more aware of the services offered, they might not be able to participate in, for example, information sessions because they live some distance from the base. While there is still work to be done to make families better aware of the resources available to them from the MFRC during deployments overseas, there is also a need to better coordinate the efforts of the centre's staff and the base's leadership (base commander and other senior officers). For example, the availability of support services is especially important for families of personnel who are injured or killed during a deployment. The MFRCs have resources to help families cope with the stress of the situation or can refer them to the appropriate military or civilian services, but it was noted that the assisting officer, the officer on a base assigned to assist families when deployed personnel are injured or killed, does not necessarily know about all of these resources. There should be better coordination between all the sources of support available on a base to ensure that families can obtain all the help available to them quickly and without duplication of efforts when they are dealing with a traumatic event.

Support for the family, especially during and after overseas deployments, is also an important element in helping Regular Force and Reserve Force members of the Forces deal with operational stress injuries. As pointed out by Ms. Colleen Calvert, the Executive Director of the Halifax and region MFRC, a member of the Forces on a deployment cannot concentrate on the job at hand while worrying about the family back home and whether or not it is getting the support it needs.[21] The mere existence of the MFRC can reassure members of the Forces. However, the MFRC is only one of the elements of the process put into place by the Canadian Forces to help personnel better cope if they are dealing with stress-related injuries. As indicated in the Committee's June 2007 report, the military has developed programs to prepare personnel for the rigours and dangers of an overseas deployment, although there is room for improvement especially in making personnel more aware of operational stress injuries and how to deal with them. The Committee was very interested in the program developed by the 5th Canadian Mechanized Brigade Group (5 CMBG) at Valcartier to prepare its personnel for the deployment in Afghanistan which began in the summer of 2007 and ended between February and May 2008. The Committee hopes that the lessons learned with the program to increase resiliency in stressful situations (*programme d'entraînement à la resilience militaire* (PERM)) will assist

21 *Evidence*, March 11, 2007, p. 2.

other Forces units preparing for deployments. As discussed in the 2007 report, the Canadian Forces have also developed a gradual process to help its personnel adjust to life back home in Canada after months in an overseas theatre of operations. The process includes a third location decompression period of about five days usually spent in Cyprus as well as a gradual reintegration into life back at the base, which consists of a few half days of work on the base before a long period of post-deployment leave. The purpose of this gradual process is to ensure, among other things, a smoother reintegration of the Forces member with his or her family. This gradual reintegration process, the information briefings on stress-related injuries provided by the military to its deployed personnel, the briefings provided by the MFRC and others to the families, and the monitoring done by mental health professionals do not guarantee that such injuries will be avoided. However, the process can place Forces members and their families in a better position to identify the symptoms of operational stress injuries and to deal with their implications.

Indeed, the fact that a member of the Forces is dealing with an operational stress injury can have a significant impact on the well-being of his or her family. This impact can be minimized if the family is well prepared to identify the signs indicating that the spouse and parent who just returned from overseas is dealing with such an injury. A well-prepared family will have a better chance of providing the individual with the support required to overcome the misunderstandings and substance abuse which often accompany such an injury. However, whether or not an individual returning from overseas is dealing with a stress-related injury, the reintegration with the family after a long absence can be a difficult process, and some other members of the family may need access to mental health services to deal with the situation. The long absence of a parent can be especially difficult for children and a troubled reintegration of the parent with the family after a deployment may create more challenges. This is why the Committee has been particularly concerned with the support available to help children of military personnel during and after a deployment.

The well-being of military families is important because if a member of the Forces suffers a physical or psychological injury, the support provided by the family members is crucial to the ability of that individual to recover from the injury. The continued support of the family is also crucial when an injured member of the Forces leaves the military and becomes a veteran. However, the fact remains that an injury can have a significant impact on the well-being of the family, especially when the injured individuals are left with a high level of disability and must leave their careers in the Forces many years earlier than they anticipated. A recent research report by Dr. Norah Keating, a member of the Gerontological Advisory Council, and by other researchers at the University of Alberta, *Wounded Veterans, Wounded Families*, underlined this fact. The survey of a number of veterans between the ages of 25 and 65 with high levels of disability found that, among other things, the “Families of these younger, high-needs Veterans are at substantially higher risk of poor financial, social and health outcomes than any other group of caregivers

examined to date."[22] Given the young age of some of these veterans, the families will have to cope for 20 or more years with the financial and emotional stresses of caring for individuals with high levels of disabilities. Some of these veterans may also be dealing with psychological conditions as well as with physical disabilities. Even if individuals leave the Forces because of less severe injuries or for other reasons, the transition from the military to life as a veteran can be difficult for the individuals and their families. This transition should be as smooth as possible so that persons leaving the Forces have no difficulty getting access to the disability benefits and services provided by the New Veterans Charter when they need them.

Based on the information the Committee obtained from some witnesses and during briefings held on the bases and elsewhere, it is clear that the transition from the military to civilian life has not been that smooth for a number of veterans. To obtain benefits for disabilities due to injuries associated with military service, veterans have to make applications and, if necessary, go through the appeal procedures. Medical records are a key element of the application and appeal process, but there are often delays in obtaining them and disputes on their interpretation. This issue straddles two departments, National Defence and Veterans Affairs. The medical records kept by military health professionals when an individual serves in the Canadian Forces document, in most cases, the injuries suffered during service. When the individual leaves the military and becomes a veteran, they become the evidence on which the Department of Veterans Affairs and, for appeals, the Veterans Review and Appeal Board (VRAB), base their decisions. As was noted in the October 2007 report of the Auditor General on military health care, there were problems associated with the military health services in the late 1990s, including deficiencies in the management of health records. Measures have been taken since then to improve the military's health records system while other steps were taken in light of the Quality of Life initiative to improve the transition process when someone leaves the Forces, especially if the person has suffered a physical or psychological injury. One of these steps was the establishment in 1999 of the Department of National Defence and Veterans Affairs Canada Centre for the Support of Injured Members, Veterans, and their Families, known simply as The Centre.

The Centre is an inter-departmental initiative designed to provide a one stop source of information and support for military personnel (Regular Force and Reserves) who are injured and for individuals who are medically released from the Forces. The Centre also provides support to the families of persons who are injured and those who leave the Forces. The headquarters of the Centre are located in Ottawa and over the last decade, services have been provided throughout Canada from this location. However, in recent months, the Centre has opened detachments on the bases to better respond to the needs of injured personnel and their families. These detachments of the Centre have developed a strong partnership with the various elements involved in supporting the injured. On the

22 Janet Fast, Norah Keating, Alison Yacyshyn, *Wounded Veterans, Wounded Families*, Hidden Costs-Invisible Contributions research program, Department of Human Ecology, University of Alberta, February 2008, p. 1. The report is available from the research program website: http://www.ales2.ualberta.ca/hecol/hcic/.

military side, this includes cooperation with the chain of command, the Canadian Forces Health Services, the MFRC, and the Chaplains while in the community the partners include the regional Veterans Affairs Canada office, the Royal Canadian Legion, and the OSISS peer support network. In the detachments, military personnel, veterans, and their families will find representatives from the various sections of the Canadian Forces involved in personnel issues as well as from the Department of Veterans Affairs. The Committee welcomes this initiative to establish detachments of the Centre on the bases and the close cooperation between the two departments in efforts to ensure a seamless transition for releasing personnel.

However, despite these efforts, a number of veterans have not experienced a smooth transition. Briefings during the Committee's visit to Petawawa and Valcartier highlighted a number of issues. There still appears to be a number of problems with regard to the sharing of information between the two departments and while measures have been taken by the Department of National Defence to provide medical reports electronically and quickly, it will still take a few years to fix these problems. Meanwhile, it may still take months and even years to complete the full transfer of medical documentation from National Defence to Veterans Affairs, a situation which is unacceptable. Questions have also been raised concerning the need to fill in applications for benefits from Veterans Affairs when individuals have been serving in the military for years and their injuries have been documented.

It has been suggested that Veterans Affairs Canada should consider using the same identification number in its files as the one used by the military. The transition period from military life to veteran status might be smoother if the two departments standardized the system to identify serving individuals so that file transfers could be done in a seamless fashion. Individuals joining the Canadian Forces, if they consent, could be automatically registered upon enlistment in the records of both departments. If a member of the Forces is seriously injured, Veterans Affairs could be quickly notified and use information in its databanks to prepare for the release of the individual from the military. Injured individuals may require services including those provided by the VIP in short order, but face delays while waiting for the approval process to be completed. Despite the efforts made over the last decade, there are still occasions where there is a gap between the period where individuals leave the Forces and the time those individuals, now veterans, and their families receive all the veterans benefits and support programs they need. Dealing with a disabling injury and an earlier than anticipated departure from the Forces is a very stressful situation for young veterans, especially if they have a young family. More needs to be done to assist these individuals with a more seamless and speedy transition from military life. This could include giving a copy of the medical records to an individual leaving the Forces so that the veteran would have the information required upon leaving the military to obtain veterans benefits and services. The Centre for the Support of Injured Members, Veterans, and their Families already encourages individuals to request a copy of their medical records when they leave the military. However, the onus should perhaps be more on the Department of National Defence than on the individual leaving the military to ensure that copies of the documents will be in the veteran's possession.

The role of doctors inevitably comes into play in discussions of the transition from the military to veteran status. Military doctors provide care to military personnel and document the injuries they suffered during service. When individuals leave the Forces and apply for veterans disability benefits, civilian doctors may be called upon to examine the veterans and to provide evidence of injuries. However, civilian doctors are not always familiar with the complexities of the applications and the documentation required by the Department of Veterans Affairs. During the visit to Shearwater, Lieutenant-Commander (Retired) Heather Mackinnon, a medical doctor, provided the Committee with some insight on the issue based on her experience in providing care and assistance to injured veterans. Her military experience helped her understand some of the issues raised by her patients seeking help in dealing with the application and appeal process within Veterans Affairs. She suggested that the department should provide civilian doctors with more information on its requirements so that they can assist veterans.

However, the veterans may also have difficulty simply finding a doctor in their area just like the military families mentioned above who have trouble finding a family physician. This was an issue raised at CFB Petawawa. For someone being released from the military, finding a doctor can be difficult in any region of the country, but it can be even more difficult in areas outside large cities. The situation may vary from one base to another since some bases like Valcartier and Shearwater are close to large cities where there are many doctors while others are in more isolated areas with few health professionals. Many injured and other veterans may choose to live in the area around the base where they spent much of their career in the military, but the lack of physicians in that area can be a problem when they seek care for their injuries and assistance in providing the documentation required by Veterans Affairs. Furthermore, while the veterans who were members of the Regular Force received care from military doctors during their entire career in the Forces, once they become civilians, and veterans, they are basically on their own to find a doctor. The situation is even more difficult for Reservists who serve with units deployed to Afghanistan, but then leave the unit and their base upon their return to Canada. While the health of Reservists, like other personnel who were deployed overseas, can be monitored in the months immediately following a deployment overseas, psychological and other injuries may become evident only many months and years later. After a deployment, Reservists, compared to Regular Force members, may have limited access to the military's health care system and to the network of support such as OSISS provided for operational stress injuries because they live far from the base of the units with which they deployed overseas. The problems faced by Reservists and veterans of the Reserve Force has been a concern for many, including the members of this Committee. Actions will hopefully be taken quickly to address the problems with the treatment of injured Reservists identified by the April 2008 special report of the Ombudsman for the Department of National Defence and the Canadian Forces, especially with regard to the recommendation for quick action to enable prompt medical releases for Reserve Force personnel.[23]

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23 Canada, Ombudsman for the Department of National Defence and the Canadian Forces, *Reserved Care. An Investigation into the Treatment of Injured Reservists*, Special Report to the Minister of National Defence, April 2008, p. 56. See http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/rc-str/index-eng.asp.

Some of the problems faced by veterans who served in the Regular Force or the Reserves could be addressed if military personnel could still have access to military doctors after leaving the military. In a written submission, Dr. Mackinnon suggested the establishment of a Medical Transition Service to assist injured members of the Regular Force and of the Reserves in making the transition to the civilian medical system. Such a service could also assist individuals who leave the Forces for reasons other than injuries, but who may have illnesses related to military service which might be recognized only years after they have become veterans. Given the long period of time it has taken in some cases to recognize that some veterans had indeed suffered operational stress injuries, a Medical Transition Service would be a very worthwhile initiative. Mrs. Helen Gough, an occupational therapist who has worked with elderly veterans and who is a member of a military family, noted the lack of understanding of military culture among civilian health care professionals. She suggested that the military could have its own military occupational therapists who could assist military families during the transition from military life to veteran status by, for example, finding a civilian occupational therapist in the community. She also recommended that Veterans Affairs should recognize the diverse skills of occupational therapists in assisting veterans dealing with mental and physical limitations. Another measure which would help veterans and their families make the transition from the military to civilian life would be the creation of a handbook to give health care professionals a consistent message on the programs and services provided by the Department of Veterans Affairs. This would help health professionals to avoid losing time trying to determine what programs are available for veterans, especially if they have had little previous experience assisting veterans and their families.

The fact that civilian health care professionals are often not very familiar with the Canadian Forces culture and the types of situations veterans have experienced was frequently noted during the Committee's examination of the support provided to veterans dealing with operational stress injuries. Some of the psychologists who made presentations to the Committee such as Doctor Pascale Brillon have had considerable experience assisting veterans dealing with PTSD and other operational stress injuries. However, many psychologists and other health professionals have a more limited experience dealing with veterans and this may cause delays in making correct diagnoses and providing treatment. There is growing awareness of the impact of psychological injuries on military personnel and veterans, but there is still a need for more effort to give health professionals a better understanding of what military personnel and veterans have experienced, as noted in Recommendation 12 of the Committee's June 2007 report.

The importance of quick and correct diagnoses of psychological injuries and the need for psychologists to know about the Veterans Affairs operational stress injury clinics at the Ste. Anne's Centre and other locations across Canada were underlined in the testimony of Mrs. Jenifer Migneault and her spouse. She told the Committee: "When the wheel keeps going round but nobody can help you, you end up becoming completely discouraged and wondering where to turn… . Nobody seemed to understand what he was

experiencing, and what he had."[24] For individuals still in the military, it is important to have access to psychologists when the need for treatment is identified. The number of psychologists on bases has increased in recent years, but there is a need for more, especially given the number of overseas deployments some personnel participate in. When the individuals leave the Forces and become veterans, they also need access to psychologists, but they may have difficulty finding one in communities outside of major cities. Whether veterans consult psychologists in cities or in isolated areas, those psychologists must be aware of the needs of veterans and the resources available to help the veterans and their families.

Besides giving more information about the resources available through Veterans Affairs, another way of making psychologists better aware of the needs of veterans in terms of treatment for PTSD and other operational stress injuries would be to encourage new psychologists to do research on care for veterans. Mrs. Marie-Josée Lemieux, Vice-President, *Ordre des psychologues du Québec*, the regulatory body of psychologists in the Province of Quebec, suggested to the Committee that scholarships could be offered to encourage interns training to become psychologists to specialize in services for veterans. This would be especially useful in the Province of Quebec where some students in doctoral programs in psychology face financial difficulties, but it would also be a valuable initiative in other parts of Canada. Research grants would also serve to encourage students and new psychologists to learn more about the treatment of veterans. Even if they do not specialize in such care, the exposure to veterans issues would give them better preparation to assist the veterans who will consult them. The Department of Veterans Affairs already carries out a number of research projects on operational stress injuries and other veterans health care issues. However, the department should explore how it can stimulate the interest of psychologists in issues concerning veterans through research grants and developing existing ties with universities such as, for example, the recently announced affiliation of Ste. Anne's Hospital with McGill University in Montreal.

CONCLUSION

Different generations of veterans have served Canada well over the past decades. They and the country's future veterans should have veterans benefits and services which respond to their needs and those of their families. The process through which these benefits and services have been improved and better adjusted to the needs of veterans and their families has been a long one and more efforts are required to address the problems identified in this report and others. The work done by the Gerontological Advisory Council, notably in its November 2006 report, has contributed a great deal to the improvement of the health care provided to veterans. Although its mandate was mainly to improve the care given to Canada's war service veterans, its recommendations are also valuable to the updating of the care and benefits provided to the Canadian Forces veterans who have served their country in peacekeeping and other operations over the recent

24 *Evidence*, November 27, 2007, p. 5.

decades. Many of the Canadian Forces veterans are part of Canada's aging population and the Council's recommendations will help them lead active and healthy lives in the coming years. The promotion of healthy living and the improvements in the delivery of services to veterans advocated by the Council are as relevant to young veterans as they are to the war service Veterans. As the Council's November 2006 report states in one of the principles guiding its proposed approach, the Veterans Integrated Services (VIS), "Services provided earlier in life can make veterans more resilient as they age." The Committee hopes that its report will help the Department of Veterans Affairs improve the efforts it has deployed to improve the quality of life of Canada's veterans and its ability to meet the needs of Canada's veterans, young and old.

LIST OF RECOMMENDATIONS

Recommendation 1

The Department of Veterans Affairs should put in place a redesigned veterans health care program which promotes the health, well-being and independence:

1) **of all surviving war service veterans from the Second World War and the Korean War, not just those now receiving veterans disability benefits from the department; and,**

2) **Canadian Forces veterans, including those who were involved in peacekeeping and other overseas operations;**

while ensuring that they have access to care and support when they need it.

Recommendation 2

To accomplish this, the Department of Veterans Affairs should modify its veterans health care program as recommended by the department's Gerontological Advisory Council in its November 2006 report, Keeping the Promise, in order to put in place a new approach to veterans health programs and services called Veterans Integrated Services which will include:

1) **a single entry point to all departmental services supporting healthy aging where ideally the same departmental representative will deal with a veteran while following up on the original request or when responding to subsequent requests for assistance;**

2) **a screening and assessment process to determine the needs of the veterans and their families;**

3) **an interdisciplinary team with early intervention specialists and high needs care managers in addition to the client service agents and health specialists on current teams to promote health and to provide services for older adults; and,**

4) **innovative models of service delivery with a greater variety of residential choices and especially an intensive home support component based on the lessons learned in recent years while providing home care through the Veterans Independence Program.**

Recommendation 3

While modifying its veterans health care program, the Department of Veterans Affairs should ensure that the application process for grounds maintenance, home support and other services, while meeting basic accountability requirements, is simplified and that the assistance of a departmental official is provided to reduce the burden on veterans and their families seeking care and support and that access is based on need rather than on the basis of veterans status.

Recommendation 4

During the redesign of its veterans health care program, the Department of Veterans Affairs should pay particular attention to the availability to all veterans of services in the official language of their choice, to the needs of veterans and their families in rural and remote areas outside of the major urban centres, and to specific health issues of Aboriginal veterans.

Recommendation 5

The Department of Veterans Affairs must ensure that the redesign of its health care program:

1) **will not remove or reduce the Veterans Independence Program benefits already obtained by surviving spouses and primary caregivers of veterans;**

2) **will provide similar grounds maintenance services on a lifetime basis (after the death of the veteran) to the spouses and primary caregivers of all the war service veterans who, in addition to those who currently have or had access to the Veterans Independence Program benefits, become eligible for health care benefits as a result of the redesign; and,**

3) **gives access to services such as health promotion and home support in addition to those concerning grounds maintenance to surviving spouses and caregivers based on need.**

Recommendation 6

The Department of Veterans Affairs must increase its efforts to raise the awareness of veterans, their families, and health care professionals about the benefits and support programs available to all veterans, notably in rural and remote areas. It should explore new partnerships with branches of the Royal Canadian Legion and other veterans groups to better inform and offer services to veterans and their families living outside major urban areas.

Recommendation 7

The Department of Veterans Affairs and the Department of National Defence must continue to enhance their work together to ensure as much as possible a seamless transition process from the military to civilian life when a member of the Canadian Forces leaves the military so that the individual, now a veteran, can have access without delay to the veterans benefits and services to which they are entitled.

Recommendation 8

The Department of Veterans Affairs and the Department of National Defence must continue to enhance and explore the standardization of their system identifying individuals who have served in the Canadian Forces so that:

1) **Personnel, if they consent, can be recorded automatically in the files of both departments upon joining the Forces;**

2) **medical and other records of military personnel injured during military service can be transferred quickly from one department to another; and,**

3) **the application process for disability and other veterans benefits can be reduced to a minimum.**

Recommendation 9

The Department of Veterans Affairs and the Department of National Defence must work together to increase the awareness of civilian medical doctors and psychologists concerning the support programs available to assist military personnel in the process of releasing from the Canadian Forces and veterans dealing with operational stress injuries.

Recommendation 10

The Department of Veterans Affairs should explore with the Department of National Defence the establishment of a medical transition service so that health professionals of the Canadian Forces Health Services can continue to provide care to an injured veteran for an appropriate period to be determined following release from the Canadian Forces.

Recommendation 11

The Department of Veterans Affairs should advise the Department of National Defence on the need to increase the number of psychologists available on military bases to assist military personnel dealing with operational stress injuries after deployments overseas and to provide occupational therapists to assist injured personnel and their families during the transition period after their release from the Canadian Forces.

Recommendation 12

The Department of Veterans Affairs should develop a comprehensive recruitment strategy to recruit new psychologists and to make students in psychology more aware of the issues concerning veterans dealing with operational stress injuries by offering scholarships and research grants in cooperation with provincial health authorities and universities.

APPENDIX A
LIST OF WITNESSES

39th PARLIAMENT, 2nd SESSION

Organizations and Individuals	Date	Meeting
Department of Veterans Affairs Ken Miller, Director, Program Policy Directorate	2007/11/20	2
Department of Veterans Affairs Darragh Mogan, Director General, Program and Service Policy Division		
As an individual Jenifer Migneault,	2007/11/27	4
As an individual Claude Rainville,		
Department of Veterans Affairs David Pedlar, Director of Research, Research Information Directorate	2007/12/04	6
Gerontological Advisory Council Marcus Hollander, Member		
Fédération des aînées et aînés francophones du Canada Willie Lirette, President	2007/12/06	7
Fédération des aînées et aînés francophones du Canada Marc Ryan, First Vice-President (Ontario)		
International Federation on Ageing Greg Shaw, Director, International and Corporate Relations		
Canadian Association of Veterans in United Nations Peacekeeping Ronald Griffis, National President	2007/12/13	9
Canadian Centre for Activity and Aging Clara Fitzgerald, Program Director	2008/01/29	10
University of Western Ontario Mark Speechley, Professor, Department of Epidemiology and Biostatistics, Faculty of Medicine and Dentistry		

Organizations and Individuals	Date	Meeting
Canadian Institutes of Health Research	2008/01/31	11
Linda Mealing, Assistant Director, Partnerships, Institute of Aging		
Department of Health		
Nancy Milroy-Swainson, Director, Chronic and Continuing Care Division. Health Policy Branch		
Public Health Agency of Canada		
John Cox, Acting Director, Division of Ageing and Seniors		
Public Health Agency of Canada		
Claude Rocan, Director General, Centre for Health Promotion		
CNIB (Canadian National Institute for the Blind)	2008/02/05	12
Catherine Moore, National Director , Consumer and Government Relations		
CNIB (Canadian National Institute for the Blind)		
Bernard Nunan, Researcher, Writer, National Office, Ottawa		
National Initiative for the Care of the Elderly	2008/02/07	13
Maggie Gibson, Member, Psychologist, Veterans Care Program		
Simon Fraser University	2008/03/04	15
Gloria Gutman, Co-leader of BC Network for Aging Research , Former Director and Professor Emeritus, Gerontology Research Centre and Department of Gerontology		
Korea Veterans Association of Canada	2008/03/06	16
Les Peate, Immediate past President		
Military Family Resource Centre, Halifax and Region	2008/03/11	17
Colleen Calvert, Executive Director		
Military Family Resource Centre, Halifax and Region		
Wendy Purcell, Adult and Family Services Coordinator		
National Aboriginal Veterans Association	2008/03/13	18
Alastair MacPhee, Policy Advisor		
National Aboriginal Veterans Association		
Claude Petit, President		
As an individual	2008/04/01	19
Helen Gough, Occupational Therapist and military spouse		

Organizations and Individuals	Date	Meeting
Ordre des psychologues du Québec Stéphane Beaulieu, Secretary General **Ordre des psychologues du Québec** Marie-Josée Lemieux, Vice-President **Ordre des psychologues du Québec** Édith Lorquet, Legal Counsel and Secretary of the Discipline Committee	2008/04/03	20

APPENDIX B
LIST OF WITNESSES

39th PARLIAMENT, 1st SESSION

Organizations and Individuals	Date	Meeting
As an individual	2007/02/27	28
Pascale Brillon, Psychologist and Professor, University of Montreal		
As an individual	2007/03/01	29
Robert Belzile		
As an individual	2007/03/20	30
Col. Donald S. Ethell (retired), Chair, Joint Department of National Defence and Veterans Affairs Canada Operational Stress Injury Social Support Advisory Committee		
Department of National Defence		
Lcol. Jim Jamieson (retired), Medical Advisor, Operational Stress Injury Social Support Advisory Committee		
Major Mariane Le Beau, Project Manager, Operational Stress Injury Social Support Advisory Committee		
Veterans Affairs Canada		
Kathy Darte, Program Co-Manager, Operational Stress Injury Social Support Advisory Committee		
As an individual	2007/03/22	31
Stéphane Guay, Psychologist and Director, Centre d'étude sur le trauma		
Department of Veterans Affairs	2007/04/19	35
Bryson Guptill, Director General, Program and Service Policy Division		
Raymond Lalonde, Director, National Centre for Operational Stress Injuries, Ste. Anne's Hospital		
Department of National Defence	2007/04/24	36
Major Chantal Descôteaux, Base Surgeon Canadian Forces Base Valcartier, Acting Brigade Surgeon		
Marc-André Dufour, Psychologist, Mental Health Services, Candian Forces Base Valcartier		
Margaret Ramsay, Acting Senior Staff Officer, Canadian Forces Mental Health Initiative		
Gerontological Advisory Council	2007/04/26	37
Victor Marshall, Chair		

Organizations and Individuals	Date	Meeting
Department of Veterans Affairs	2007/05/08	40
Brian Ferguson, Assistant Deputy Minister, Veterans Services		
Darragh Mogan, Executive Director, Service and Program Modernization Task Force		
Gerontological Advisory Council	2007/05/10	41
Norah Keating, Member and long-term care and mental health specialist		
As an individual	2007/05/15	42
Hon. LGen Roméo A. Dallaire (retired)		
Gilles-A. Perron, MP		
Gerontological Advisory Council	2007/05/31	45
Dorothy Pringle, Council member		
Gerontological Advisory Council	2007/06/05	46
Pierre Allard, Royal Canadian Legion Service Bureau Director		
Canadian Peacekeeping Veterans Association	2007/06/14	48
Ray Kokkonen, National Vice-President		

APPENDIX C
LIST OF BRIEFS

39th PARLIAMENT, 2nd SESSION

Organizations and individuals
Military Family Resource Centre, Halifax and Region
National Aboriginal Veterans Association
Gough, Helen
Ordre des psychologues du Québec
Royal United Services Institute of Nova Scotia

APPENDIX D
LIST OF BRIEFS

39th PARLIAMENT, 1st SESSION

Organizations and individuals
Royal Canadian Legion
Brillon, Pascale
Department of National Defence
Department of Veterans Affairs
Gerontological Advisory Council

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant Minutes of Proceedings for the 39th Parliament, 1st session (Meetings *Nos. 28, 29, 30, 31, 35, 36, 37, 39, 40, 41, 42, 43, 44, 45, 46 and 47*) is tabled.

A copy of the relevant Minutes of Proceedings for the 39th Parliament, 2nd session (Meetings *Nos. 2, 4, 6, 7, 9, 10, 11, 12, 13, 15, 16, 17, 18 and 20*) is tabled.

Respectfully submitted,

Rob Anders, MP
Chair

MINUTES OF PROCEEDINGS

A copy of the relevant Minutes of Proceedings for the 39th Parliament, 1st Session (Meetings *Nos. 28, 29, 30, 31, 35, 36, 37, 39, 40, 41, 42, 43, 44, 45, 46 and 47*) is tabled.

A copy of the relevant Minutes of Proceedings for the 39th Parliament, 2nd Session (Meetings *Nos. 2, 4, 6, 7, 9, 10, 11, 12, 13, 15, 16, 17, 18 and 20*) is tabled.

Respectfully submitted,

Rob Anders, MP
Chair