HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Veterans Affairs

ACVA • NUMBER 038 • 2nd SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, February 26, 2015

Chair

Mr. Royal Galipeau

Standing Committee on Veterans Affairs

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● (0845)

[*Translation*]

The Chair (Mr. Royal Galipeau (Ottawa—Orléans, CPC)): Dear colleagues, welcome to the 38th meeting of the Standing Committee on Veterans Affairs.

[*English*]

Today we're going to be enlightened by representatives from the Department of Veterans Affairs. I'm sure we will all have erudite questions for them.

I welcome, first of all, Michel Doiron, assistant deputy minister of service delivery, who is accompanied by a case manager, Mélanie Witty.

We're going to go through the usual process of six-minute time slots, but I'm sure we'll all be as collegial as we were last Tuesday.

[*Translation*]

Mr. Doiron, you have the floor.

Mr. Michel D. Doiron (Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs): Thank you, Mr. Chair.

[*English*]

Mélanie Witty is one of our case managers. I don't really have opening remarks this morning. I think we'll get right into the presentation.

Mélanie will provide us with a second career assistance network; we call it SCAN. You have a deck. I think everybody has received a presentation on it.

This is what a transitioning veteran would receive prior to leaving, and this is the medical SCAN. This is a multi-day component.

If I understand correctly, Mélanie will provide the SCAN, and then you can ask some questions. Then we'll take whatever questions you may have on transition, if that's okay with the chair.

The Chair: I don't know if you're ready for this, Mr. Stoffer, but you're first up.

An hon. member: She's doing a presentation on SCAN first.

[*Translation*]

The Chair: You have the floor.

[*English*]

Ms. Mélanie Witty (Case Manager, Service Delivery, Ottawa Office, Department of Veterans Affairs): Merci.

First of all I'd like to say that these SCANs are not mandatory. Some members are releasing without attending. However, throughout their transition we always recommend that they sign up and take part. Some members might attend these SCANs without even having a release date, but they're concerned about what's going to happen after release and they want to hear about us and our partners.

Again, the presence of members is not mandatory, but we strongly, strongly recommend it.

All right, what is a SCAN? It's to help prepare for transition, first and foremost, and to be there for the members to answer their questions. We always have a booth. Presentations trigger lots of questions, and then we schedule one-to-one meetings afterward. They are more personalized and a better environment to discuss members' concerns, the injuries they have, and the challenges they will have after release. Again, the objective of any SCAN is to prepare for the transition and set the tone that we're there for them today, before release, but, more importantly, after release.

What is a veteran? A lot of members think they are mostly the traditional ones, but veterans can be like my clients, 22-year-old privates, who unfortunately were injured and have to release after two years of service. A veteran is someone who could be relatively young with a shorter time in the CF, or someone who has had a very lengthy career with many deployments. They may have decided it is time to leave on their own, so they will voluntarily release, or they are being medically released because they no longer meet the universality of service criteria to be deployed.

That part of the presentation is about demystifying who a veteran is and making them understand that soon it will be them. We need to talk about that during meetings.

Our mandate—I never spend much time during the SCANs on those slides because they are self-explanatory—is to be there to provide care and treatment of the members, who are veterans at that point, and their families. During the SCANs, the family component is huge. Spouses are always invited to take part. We tell members that the injuries they have and the challenges they face have significant impacts on spouses, children, and loved ones, so those SCANs are always open to the family. It is not uncommon to see couples in the crowd, which is wonderful. So, it is to provide the care and treatment, and, most importantly, the re-establishment into civilian life of anyone who has served in the CF, again keeping alive the achievement and sacrifice of those who have served.

We're not talking about the Remembrance portion during the SCAN; it's not the intended purpose. However, we're more than capable of orienting whomever is interested into that portion of the mandate of Veterans Affairs Canada.

As I was saying on the re-establishment, we're looking at it in terms of three different phases: at work, in the community, at home. It is not uncommon that someone releasing is having a bit of a challenge at work in light of their injuries, and when they get home things are really difficult. We break it down into the barriers in the community, in their workplaces, and at home, and whether there are challenges in any of those three areas. Those are what we consider barriers to re-establishment.

With regard to our mandate, transition support, I work out of the IPSC of the JPSU, which is the unit in charge of releasing members. Transition service is why we are there. I do not work out of the district office. I am posted with the unit so that any members who are looking into releasing can have access to us. Transition is huge in terms of services and benefits. Keep in mind that someone serving has had the organization, the employer, providing for their support throughout their career, whether it was a dental checkup or a need to see a doctor because a knee was hurting.

However, what is going to happen when they release? They want to know, in light of a disability award or disability pension for which they might have applied, whether Veterans Affairs Canada will be able to pay for that after release. That's a huge concern: Will their injuries be recognized and will the benefits and treatment be received after release? That's the number one question that I get when I meet with my clients.

● (0850)

Again, there's commemoration; and we're not going to go through it today but it's nonetheless a very important component of what Veterans Affairs does.

It saddens me when a member comes to me and has never talked to us before. One thing the SCAN does, and I always tell the crowd, is the presentation plants little seeds. Hopefully, seeds of interest trigger some questions some members might have about their concerns. After the presentation—and this always happens—we have some who make themselves known to us. They listen and say, “You know what? I should have met with you guys a long time ago because of so-and-so.“ We set up a time to meet with them.

Transition starts now; whether you have a release date, whether your mission has been cut and you've leaving in six months, you have to meet with Veterans Affairs. “Have to” is a big term, you're strongly encouraged to meet with Veterans Affairs.

We screen for unmet needs. We assess the risk of the member, and again of their family, so planning now means attending a SCAN. When there are members in the crowd, I tell them that's the first thing. You are showing you're interested, in terms of your release and what's going to happen afterward.

Our website is getting better every year, getting more and more user-friendly. We strongly encourage our members to open their VAC account. Open your account, browse, click, look at what's going on there. During the SCAN, I often bring it back in terms of how the newest application can be done online a little bit faster than the paper way we've been doing it. Throughout the SCAN I tell them to stay informed, click, and look on the website. Open your account so you can have better access to us online.

The career transition is not a really big component of the SCAN. The reason is that since the new Veterans Charter in 2006, the rehab program was created for better or for worse. We don't often hear about it in the news—it's mostly the disability award component— but the rehab program is automatically offered. A releasing member who's releasing as a 3(b) for diabetes, which might not be linked to service, is automatically eligible. That's the huge lightbulb that goes on when we talk about this. Transition service is not something we tap into because the rehab program has a vocational component, which is much more interesting than the $1,000 that Veterans Affairs can put in place, let's say, to update your resumé, for example. That's not a huge part of my presentation. I do touch on it, but within all my time at VAC I've had little interest about this.

Hire a Veteran, Hire a Vet, often triggers lots of questions after a SCAN. Many companies throughout the country were asked to raise their hand if they want to give a veteran a priority for hiring. At the SCAN and at our booth, we always have the slides and the presentations of companies in Canada that would give a priority to a vet. The veteran has to mention in their cover letter that they have served in the CF. All of the companies that are listed have told us, guaranteed, that they will strongly recommend and consider someone who did mention it in their cover letter. Hire a Vet is new. It's something I have talked about at length after a SCAN, connecting veterans with the private sector, because it's not uncommon that someone releasing wants a second career. Not everyone releases after 35 years with a superannuation because they've contributed to it. The bulk of my clients are in their twenties or thirties, so they still have many years ahead of them. They want to know, who's going to hire me afterward? Do I have any skills that can be transferable to civilian life?

On the rehabilitation program, I think that for everyone who meets with me we will talk about it at length. For anyone starting at Veterans Affairs, it can take two weeks just to try to understand this program when you're front line. For me to give a little bit of a resumé in a few minutes is not possible. This program has three components: the medical, anything musculoskeletal; psychological; and vocational. Again, someone who releases who has barriers to re-establishment, who contemplates a career, might not have disability awards in place with us as of yet.

● (0855)

There is automatic eligibility in this program for someone who's a 3(b) release, who's medically releasing. It's nice to know—and we'll have a scenario afterwards—that for someone who is really afraid about who is going to take care of their medical needs and take care of their psychological condition in terms of treatment and guaranteeing that they can go back to school, this program gives a sense of relief. When you meet with someone who hears about this, it is wonderful. That's why I love my job and that's why I go to work every day: this rehabilitation program is tailored to someone's needs.

The earnings loss benefit is 75% of the pre-releasing salary. We do have to mention that superannuation has to be deducted, and any other type of income. The earnings loss benefit allows the member to have at least 75% of their pre-releasing salary while they're at school and while they're seeking treatment to address all of those conditions. It's nice to know that there's some type of financial support while you're on this program.

If in light of the injuries—and this is the part where I have to be careful when I present the slides and after when I discuss this with the members. We don't want to talk about the what-ifs, but sometimes we have to talk about the what-ifs. This is our safety net. If the injuries are so severe that a return to work, gainful employment, is not possible, then there are allowances we can tap into to provide for extra financial support: the permanent impairment allowance, PIA, and the supplement. I always mention those, but I felt that the members were not there. If you are in the process of releasing, we need to assess you in terms of how you will be able, as a civilian, to return to meaningful and gainful employment. If you're not there and we know you will not be there within the next few years, let's look at the allowances that we can tap into.

This is the point in the slides where I'll plant little seeds but I will not go into details. Lots of hands go up with this slide. That usually slows my SCAN presentation, but that's fine. It's a nice segue, because it leads to the other part about the disability award application. With the rehabilitation program, and the front line, we will swim in this day in, day out. We need to understand it. We need to verbalize it clearly to our members so that they understand what they're signing up for and that they're eligible the day after their release when they officially become veterans.

On health support, on the front line we have to screen for mental health. We have to ask those delicate questions. We have to talk about suicidal ideation. We have to screen for risks. This is why we're hired. We screen for risks for our members and we screen for risks for the family. The mental health part is big. We are blessed to have the OSI clinic in our city. They are our main partners. Thank God we have them. They're a single point of contact for someone who has an operational stress injury, or if we think there is one in light of the symptoms the member is reporting, that could lead us to believe that maybe something is not quite right here and we want to get an assessment. We refer members there who have not been diagnosed but who are reporting symptoms we're worried about. The OSI clinic is big. It's our partner. Prior to that we have to screen for unmet needs and assess their risk level.

On OSISS peer support, I work out of the IPSC with the coordinator. It's wonderful to have a peer assigned to you when you're not well. You know that they have an OSI also, but they're at a different point in their recovery. With operational stress injuries, it can take years before the symptoms are controlled and before you accept and grieve over the loss of your career or your quality of life. A peer helping a peer is someone who is at a different stage in their recovery and they're in a position to help and give that support. We are very lucky to have the OSISS peer support down the hall. They are very important partners for us.

VAC assistance service is a 1-800, 24-7 service if you're not well. I work for the government, and we close at 4:30. If you're not well, we have a VAC assistance line. There will be a mental health specialist who will help de-escalate the situation and take care of the crisis until we come back. We're not a crisis organization, but we work with clients in crisis all the time. It is what it is. It's the nature of the job.

● (0900)

We do have our VAC assistance lines for members if they need immediate assistance and they do not want to go to the hospital. Those numbers are always given out during the transition period. The CF has the same system. It's not uncommon for a member who is struggling with barriers. We're all pretty much into iPhones and smartphones and so on and so forth. Applications, of course, have been brought forward by Veterans Affairs. For someone who has an operational stress injury, they're in a crowd, they're not well, they have no one, and they need to ground themselves. The OSI clinic has brought forward an application that, in opening it, the member has cues in terms of how to try to control the symptoms until they get to a safe place.

For those younger crowds who are very much in tune with technology, I've heard wonderful feedback about some of the applications out there. Again, today is not about promoting which app is better than another, but members are interested in knowing, well, if I'm not in my comfort zone and I need support, I have my smartphone with me and I have an application that can cue me to get to a safe place and service providers.

I worked for years in a community that was funded by United Way. I work at VAC, and I realize that we can pay psychologists a very, very, very decent price per hour. We are so lucky in Ottawa to have service providers, from psychologists to physiotherapists to kinesiologists. In Ottawa, unlike for some of my members working in other places of the country, we have a provider for a member who has a particular injury, whether it be substance abuse or a gambling addiction. The providers out there know us. They know how we work. They know that we need full due diligence but also that we want to make sure that for the services we pay we're seeing gains, we're seeing markers that are moved.

Providers in the cities raise their hands to work with us. It's wonderful for a member to know that in light of seeking psychological support while they were serving for two years, that psychologist is also recognized with us at VAC, and the day after release they don't have to start new with someone else. We will continue with the same provider because they're registered with Veterans Affairs' Blue Cross. It's a huge reassurance when we meet. Nobody wants to keep repeating why they have an OSI. At the SCAN I tell them, “When you meet with us, let us know who you are seeing in the civilian...who is maybe paid by DND, and let's make it happen when you become one.”

During the introduction I talked a little bit about the family. I would reiterate that the family is what keeps the member together. It's not uncommon, when I meet with a member somewhere in their release, that by the time their release happens the member has left their home or the spouse has left them. We want to try to bring family reunification by providing support and a sounding board for the spouse and for the kids who've just had enough. At the IPSC we have the MFRC working with us, with our liaison officer. We have social workers who will link strictly with the kids, with the students, with the teenagers, with the young adults, and with the spouse who has pretty much had enough. It's huge for us to know what's going on at home and how we can also provide support for the family. The last thing a member needs, by the time he releases, is to go through a separation process.

With regard to the public service health care plan, Veterans Affairs will give it to the medically releasing member if they don't have 10 years of service. It's wonderful for the young, or younger, member who doesn't have 10 years but who needs the public service health care plan for their kids, for their wife, because they also have special needs; all of that because of the rehab program.

We talked about the special allowances if in light of the injury a return to work is not possible. In the rehab program, if we deem that the member, now a veteran, cannot return to gainful employment, we will give the chance to the spouse to go back to school. When members have served and been posted at many places, we know that the spouse was most likely the caregiver for the kids, because every time she tried to get a job, it was, “Guess what? We're moving.”

● (0905)

It's not uncommon for a member to say, my wife stayed home with the kids, and now they're older but I don't see myself returning to work, it's too difficult. It's great to know that the spouse has a chance for school at that point. It's also a big reassurance for the family that another income can be secured with the rehab program and with us training the spouse.

In the OSISS peer support we do have a coordinator who takes care specifically of the spouse. The releasing member has a spouse. She's tired, she's at her wits' end, and she also needs a sounding board, a peer helping a peer. A spouse of a veteran whose husband also has an OSI can be put in contact with that new client of ours so that she also can have a peer to talk to.

We have retreats that we organize just with them, and they're chances for them to be together and to say, I didn't sign up for this, and this is really not what I was thinking my life would be like at this point.

When this slide goes up, I get giggles in the room. I would say that it is not uncommon that I meet with someone who says, VAC, I don't like you guys. It's not you, Mélanie, I don't like VAC. I'm being released for my back, and VAC said it's not linked to service. I applied for a disability award and you guys said there's not sufficient information. I know that I'm not starting my intervention with my new client on an easy note, but I'm trying to reassure them that we have means and processes so that in light of a non-favourable decision we have recourse and we will see that it follows through.

When I hear the giggle it's about the crowd being full of members who had a non-favourable decision. Our statistics will say that there's a 79% initial approval rate for disability awards. I'm leaving it at that. They're statistics, and that's not what I do throughout the day.

On applying for the disability benefit, as you know, when a still-serving member is working with the CF, their employer's responsible for their care and treatment from the moment they enrol to the time they release. If a favourable decision comes on the table while the member's in service, what they will get from us is the money, the lump sum that we often hear about in the news, and the guarantee that from the day after release that treatment will be paid by VAC. They also have the guarantee that every two years that condition can be reassessed if they feel that it's more severe or that we didn't give them the percentage or the impairment that they feel they should have.

The initial application has to start now. We do have a turnaround time, and it's a few months. I tell the members, please don't wait. The worst that can happen is we meet when there's a release date the next month and there are no applications in the system. The member has never raised their hand to say, these are the parts of my body that are injured. SCANs often trigger a disability award application.

Okay, Mélanie, I heard you. I'm ready. I want to put in a claim for my knee, I want to put in a claim for my neck. As we start talking, six claims are put on the table. In the initial application we will pull out their medical records with their consent to know what has happened, who they spoke to, and what kind of treatment they had. In light of that a decision will be rendered.

Again, I tell members, please don't wait, come and meet us and let's start the process. It's stressful enough as it is to release. To know that VAC will cover that benefit or provide that treatment after release is a huge relief for someone.

If something happens, say the decision comes back and it's favourable but not what the member thought it should be, he can appeal. If it's not favourable, he can appeal. A lot of members, in light of receiving a non-favourable decision, get a little bit upset at us. We're so lucky, again, to have the Legion here in Ottawa, which will provide counselling.

● (0910)

They will provide guidance and also some advocacy. If a member wants to have his rights and he wants to have an appeal for a decision, he will seek support from the Legion, because for a lot of the members the Legion has always been viewed as very neutral and *non partisan*.

[*Translation*]

The English word won't come to me.

It's *impartial*.

[*English*]

The Chair: You mean impartial, non-partisan.

Ms. Mélanie Witty: Yes. Therefore, we refer them to either the bureau of pensions advocates or the Legion, and they will get the support they need.

We will talk about a scenario. I won't take too much time, but I'll give you an idea of the kinds of clients we see day in, day out, such as Sergeant John, a real case, with nine years of service, which is not enough to get the public service health care plan. He is not a pensioner and has nothing with us. Also, he did not have enough years to have superannuation from DND. He doesn't have a pension plan.

For the salary per month, we show it here on this slide. He released as a sergeant. He released voluntarily due to too many things going on at home and too many stressors. He doesn't want to wait for that 3(b) release. It's long, it's stressful, and he wants out. Again, that's very frequent. He's concerned because the daughter has special needs. He has a service-related injury that occurred, but he never applied, and now, in light of it, he asks, “What am I going to do with my life?” He says the injury stops him. He's trying to apply for jobs, but his knees keep hurting and his back is hurting. This is a very typical scenario for a releasing member.

How relieved was this member when we told him that he was eligible for the rehab program?

There are two gateways for this program. A releasing member who has a 3(b) release is automatically eligible.

A voluntarily releasing member has to answer these three questions. Is there an injury? Is it linked to service? Is it a barrier to your re-establishment into civilian life—as I talked about in the beginning—at home, at work, or in the community? In his case, it was.

He was put on the program. He received the earnings loss: 75% of his pre-releasing salary. The public service health care plan was given to him because the rehab program gives it to our members.

The spouse was able to get support for school, and he also got it later on when things were better. We're hoping that it's going to be a support for him and his family in the next phase of his life.

This doesn't speak much to when I do a SCAN for the executive level. When the crowd of members I present to you are officers and above, they have a 35-year career, and they're at a very high rank, this doesn't have a connotation for them.

● (0915)

At the general SCAN and at a medical SCAN, usually I get questions about this, because I know this hits home. When I talked about planting little seeds at SCAN and when the member tells me afterward that this is their story, I say, “Okay, let's start.”

What can we do for someone who's still serving? It's case management.

We're trying to demystify this. Some members say they have a CF case manager assigned because “I'm posted at your unit” or “I'm medically releasing”. Veterans Affairs can offer case management up to six months before release, and that's where I come in. The case management service before releasing is the single point of contact for VAC for someone in the process who is scared about the future and who just needs to have the message repeated because the memory is no longer there and they can no longer concentrate on an intervention. Sometimes I meet with them five, six, or seven times and repeat what the rehab program is about because the member has a hard time retaining information in light of the injury.

Those three components of the rehab program—the income replacement, the public service health care plan, the disability award and financial advice—are why I'm posted at the IPSC. I have over 180 members who are releasing. It's very busy, but it's an inspiring group. Every story is different. When you're able to provide this to someone and see the sense of release for anyone who's struggling, it's your paycheque at the end of the day.

I talked a bit about our website before, but this slide shows you just an idea of what the browser for encouraging members looks like: click, stay informed, and look at what's out there. We often get calls because they hear what the members of Parliament have said before we hear about it. It's not uncommon for me to get a call first thing in the morning from people who are saying, “Mélanie, what's this about?” or “I heard...”. Our website keeps them informed and our clients are well connected, but it also allows information to be shared with everyone.

I won't spend too much time on MY VAC booklet. It's a way to tailor all of their conditions in one booklet. The members knows that in light of releasing, VAC has their backs, and then VAC will pay for the ramp to go into their houses, the stair glides, the home modifications, and so on and so forth. It's one way for the member who has conditions with us to know what that will translate to when they're released. VAC can pay for oxygen therapy, they can pay for a private room, and so on. My VAC booklet is new, and I get really good feedback about it.

Reiterating the sign up for My VAC account and their responsibility is how I always complete my SCAN seminar: “Set up your time to meet with us. We will not go to you.”

For every member we're releasing, the release section will send us a fax. They will say to call this member. If they are really unwell and their case is managed by DND because they are 3(b) releasing, Montfort will call us, but there are members we try to reach and they are not meeting us halfway. “Have the members make themselves known to us. Raise your hand.” Say, “I need to meet with VAC. I need my transition interview.” That is the exit interview for anyone who has served, and allows us to know what's going on, what has happened, how it is affecting them now, and how it can affect them down the road.

There are the inquiry numbers and so on, and that's where all the questions usually start.

That's a glimpse of what a presentation looks like to 300 releasing members. I'm hoping it gives you a sense of the information that is shared during those meetings.

Thank you.

● (0920)

[*Translation*]

The Chair: Thank you very much.

[*English*]

Thank you very much, Mélanie. It was very informative.

I have to tell you that I was expecting a little more witty, though.

I guess nobody caught it.

An hon. member: I just caught it.

Mr. Frank Valeriote (Guelph, Lib.): He's trying to be funny.

The Chair: The first questioner is Mr. Rafferty.

Mr. John Rafferty (Thunder Bay—Rainy River, NDP): Thank you very much, Chair.

Thank you both for being here.

My first question is for Mr. Doiron. I'm curious about this slide that the map is on. You will notice, being from northern Ontario, of course, that the area office is eight hours away from Thunder Bay. The operational stress injury clinics are at least eight hours away, personnel support centres are eight hours away. If you drove, the head office is about 22 hours away.

I can tell from this map that the whole of northern Ontario, from North Bay to Winnipeg, is relying on Service Canada centres: 186 centres in all of the province.

I'm curious. As the assistant deputy minister for service delivery, can you outline the training that happens in those Service Canada offices for personnel to deal with veterans when they stand in line and eventually get to the front of the line? What kind of training do the personnel have to deal with those issues?

I'll quickly tell you a recent story of a veteran—who doesn't want me to use his name—who waited and finally got to the front of the line. When he got there he was told that they don't do that and to go see the Legion.

It's a concern. If it happens in Thunder Bay, it perhaps is happening in other more rural or sparsely populated areas in the country.

I wonder if you could outline the training that takes place in each of those Service Canada delivery centres.

Mr. Michel D. Doiron: We have a training module that employees at Service Canada do receive, but it is very basic in what Service Canada employees provide to veterans, except the offices where we have Veterans Affairs employees embedded. In those offices, those employees can give the full range of services, as any of our offices—

Mr. John Rafferty: How many Service Canada offices would have embedded—

Mr. Michel D. Doiron: We have eight offices that are embedded.

In those eight offices they are actually Veterans Affairs employees. The other ones are Service Canada. We give them basic training, how to review a form, make sure the form is complete—not all forms, certain forms—and they have access to a hotline.

I'm quite disappointed that somebody...but I know that's happened before; that's not the only place it's happened. I'm disappointed when it does happen, because there are mechanisms to make sure the veteran gets that service. So if they don't have the training...and they don't, because some of our eligibility is very complex, as I'm sure you know.

● (0925)

Mr. John Rafferty: Well, we just heard Ms. Witty say that it takes at least two weeks to learn just the rehabilitation and financial benefits regime that Veterans Affairs uses, so I guess I can make an assumption that aside from those eight offices where someone's embedded, the Service Canada personnel in all those other offices across Canada wouldn't have that training.

Mr. Michel D. Doiron: They would not have that type of training, no.

As I mentioned, what they can do is review the forms for completeness, so that when the forms arrive at Veterans Affairs they are complete and the right information is provided. If the question is more complex, there is a hotline that goes directly into one of our offices, and they can speak to a Veterans Affairs employee. And we're presently working with Service Canada to have video connectivity to maximize the use of technology so that if the veteran wants to, they can actually sit and talk to and see somebody.

Mr. John Rafferty: Now, Ms. Witty, you indicated at one point in your presentation that people are referred to legions on occasion.

Can you, or perhaps Mr. Doiron, tell me how much money goes to legions from Veterans Affairs to help them deal with issues like this?

Mr. Michel D. Doiron: We pay the legions for a couple of different items. Some is for visitation rights, but we do not give them money for that side of the service.

Mr. John Rafferty: Okay.

Let me ask you a question about reserve members. Across the northern part of Ontario and in other small rural areas where there are armouries.... We have a lot of reserve soldiers, for example, in Thunder Bay. What is different in terms of how reserve soldiers are treated, as opposed to regular service members, when they are released for medical reasons?

That's for either of you.

Mr. Michel D. Doiron: There are many differences, and it depends. A reservist is allowed to go to a SCAN, and we strongly encourage working with our partners at the Canadian Armed Forces and that all reservists have an exit interview or a transition interview.

The reservist cohort is much different. They don't have to give the same notice before they leave. For example, if on a Thursday night they decide they're no longer a reservist, they can bring back their kit and leave. We're working very closely with the Canadian Armed Forces to ensure that medically released reservists get their transition interview. I think last year our numbers showed that about 96% of medically released reservists got the transition interview, which is much better than it used to be, and we're working very hard on that.

I'm also working very closely with Lieutenant-General Millar to ensure that reservists do get the transition interview and do attend the SCANs. But it is more challenging, because many of them work during the day. We do go and give sessions at some reserve units, but they are a harder crowd to connect with. I don't want to say it's because of the transient way of the reservists, because often they are strong members of the community, but they may be part of a reserve unit, then no longer part of the reserve unit; they come in and out.

But they are entitled to services from Veterans Affairs. It's a misconception that they are not.

Mr. John Rafferty: Let me ask you about medical files. One of the recommendations from this committee has been that all CF members and reserve members are given their complete files sometime before they leave—six months or four months—so they can be reviewed to make sure that nothing is missing, that the files are there and they have a copy of their medical files. Is that recommendation in process now? Is that happening, is that procedure now part of what Veterans Affairs does?

Mr. Michel D. Doiron: It's not Veterans—

[*Translation*]

The Chair: If I may.

[*English*]

We're having a two-hour meeting here. So far I've stretched out Mr. Rafferty's six minutes to eight minutes, so we should wind down.

We'll show the same leniency for other members, but we'd like to constrain it to some degree.

● (0930)

[*Translation*]

Thank you.

[*English*]

I'm just trying to make sure it doesn't get up to 12 minutes.

Mr. Michel D. Doiron: I do not want to talk for my friends at CAF because it was aimed at them, but at Veterans Affairs we firmly believe it's a good thing when they have their medical file and that people like Mélanie can review the file with the member while they're still receiving a salary from CAF.

Mr. John Rafferty: Thank you for your indulgence.

[*Translation*]

The Chair: Mr. Lemieux, you have the floor.

[*English*]

Mr. Pierre Lemieux (Glengarry—Prescott—Russell, CPC): Thank you very much.

Thank you for the presentation.

Mélanie, you're quite right. It's a stressful event to leave the military. I served for 20 years.

I think particularly the longer you're in, the more comfort you find in the environment you know so well. You understand the military back to front, up and down. It's a very specialized calling to be in the military. Your skill set, you think, is quite narrow. As you're leaving you're wondering if you'll make it, if you'll get a job, if your skill sets are transferable, what's the impact on your family. As you said, you're also leaving this network. I call it a finely tuned network that's provided for almost your every need medically, as well as your training, your pay, everything. And now you're going to be stepping out on your own. It is quite stressful.

First I'd like to know if this is available to all members of DND. Whether they have one year of service, six months, three years, ten years, they are all entitled to go to a SCAN seminar.

Ms. Mélanie Witty: If you've served?

Mr. Pierre Lemieux: Yes.

Ms. Mélanie Witty: And you're released. You've completed basic training?

Mr. Pierre Lemieux: Yes.

Ms. Mélanie Witty: It's yours.

Mr. Pierre Lemieux: Okay. Thank you.

I'm trying to recollect. When I left I attended the SCAN seminars. I thought DND was running it at the time. Has there been a transfer of responsibility from DND to Veterans Affairs or has it always been with Veterans Affairs?

Ms. Mélanie Witty: DND is the one running it. We're a guest. We're one of the speakers. We don't run the SCAN.

Mr. Pierre Lemieux: Okay.

Ms. Mélanie Witty: DND is the one making sure that all our partners are there, whether it's Manulife, Helmets to Hardhats, us, the Legion. They will decide in light of the need of the clientele, who the partners presenting at the panel should be.

Mr. Pierre Lemieux: Okay. So the SCAN seminar run by DND is a much larger, more comprehensive affair. You're an element of it and you've briefed us on the Veterans Affairs component of the SCAN seminar.

Ms. Mélanie Witty: That's right. A volunteering SCAN takes place over two days at the Archives. Many people talk. The member knows which presentation he wants to attend or not. A medically releasing SCAN is condensed into one day, and we are back-to-back, so by 3 o'clock nobody pays attention anymore.

Mr. Pierre Lemieux: Can spouses attend SCAN seminars?

Ms. Mélanie Witty: They're always invited.

Mr. Pierre Lemieux: That's good. It's open to spouses so they also get to hear what's going on.

Ms. Mélanie Witty: Memory and concentration are among the biggest challenges for someone medically releasing for psychological conditions. By having the spouse there, the information sometimes is retained a bit more.

Mr. Pierre Lemieux: I think that's excellent. I think it's as you said. The family has been part of the soldier's life throughout his career and they very much need to be part of his or her life as they are transitioning out. It just makes perfect sense.

Do you keep records on what percentage of DND...? I guess you wouldn't. You're just an invited guest. You're saying it's voluntary. Is there a high percentage or low percentage, 50-50 percentage of people leaving who attend the SCAN seminars or portions of it?

Ms. Mélanie Witty: It's not uncommon that a member is on a temporary category or a permanent category, and I tell them I'm going to talk at a SCAN next month at the Archives. Take part in the French SCAN because I'll be presenting. They're francophone. They're asking what a SCAN is.

I think there's a bit of a lack in disseminating the information about SCAN. Being front line, we are often the ones informing the members. There'll be a lot coming up. We know them a year in advance. Sign up, raise your hand. We connect them to the members.

I can't tell you who doesn't and who does, but I can tell you that for someone with post-traumatic stress to be in a room full of people, that doesn't work and they will tell me they won't last.

Mr. Pierre Lemieux: I see. That's interesting.

Ms. Mélanie Witty: Sometimes it's the injury that makes it so that you just cannot take part.

Mr. Pierre Lemieux: Right. You mentioned a few times that we're fortunate here in Ottawa to have A or to have B or to have C. But there are bases and military people serving across the country. Just from the experience of VAC and how SCANs are organized, do SCANs...? I imagine they're at big bases like Petawawa and Edmonton. But there are lots of smaller bases too. Are there SCAN seminars there and does VAC plug into these smaller locations?

● (0935)

Mr. Michel D. Doiron: We are plugged into every location that has a SCAN. We have either a case manager or a CSTM who will provide our part of the session.

Mr. Pierre Lemieux: Okay. So it's not that it's not accessible to members, SCAN seminars are offered at bases across the country.

Ms. Mélanie Witty: It's not uncommon that I meet with a member who is from the U.S. and made his way down. DND pays for it. They come to attend the SCAN. Or they're overseas. Wherever you are in the world you are invited to take part.

Mr. Pierre Lemieux: That's a good point actually because we do have a lot of members who serve in liaison positions or exchange positions in other countries, particularly, for example, the U.S. That's just close enough, but they have to make a trip to come to the SCAN seminar.

Ms. Mélanie Witty: We go to Colorado once a year.

Mr. Pierre Lemieux: Yes. I'll ask this question to DND when they come. I'm going to ask why it's not mandatory. When we check out of the military we actually have a release spreadsheet. You must go see pay and benefits, you must go see your release adviser, you must do this, you must do that, and everything must be checked off before actually you're considered to be released. I'll ask them why it is that SCAN seminars, while perhaps they might be highly recommended, are not actually a check box on a release format so that you actually have to attend at least part of it to know if you want to go to the rest of it. You probably can't answer that so I'll ask them that.

One of the things I'm going to find interesting about this study is you've got a member in DND who is receiving programs and services from DND because he is a serving soldier or she is a serving soldier and then there is SISIP. They transition through SISIP. The SCAN seminar I think is information based. So it's here's what's happening to you, here are the resources that are available to you. As you're leaving DND, SISIP might be providing some services. VAC provides services as well. I'm going to be interested in understanding what is it, for example, that SISIP might do that you might also do and are they cancelling?

For example, take vocational training. When I went through my SCAN seminar and interfaced with SISIP I was told I believe about vocational training and what was available to me in terms of vocational training. But I believe you have vocational training at least in your slide package.

So, for example, is that the same vocational training? In other words, there is a $70,000 limit in vocation training—you can confirm that number for me—and SISIP would offer something else. Are these two different types of vocational training? Or are they considered one program with two entry points? Can you tell us a bit about that?

Ms. Mélanie Witty: When a medically releasing member signed up for the CF, he had to contribute to Manulife. You have to pay your dues in case there is long-term disability. SISIP owes it to you. They owe you two years of income replacement post-release. They owe you a chance of school no longer than two years post-release up to $25,000, approximately, of tuition.

The rehab program knew about that when it was brought on the table in 2006. Our vocational portion of the program will kick in in two years, when SISIP runs out. So if a member released tomorrow, for example, Veterans Affairs will pay for the medical and the psychosocial needs with the rehab program. SISIP will do the vocational chance for school, income replacement. We don't talk about it. We can discuss it, but we don't touch it. It's SISIP's responsibility. Two years goes by. Then the chance for school is paid by us because of the rehab program. So there's a bit of an interface here.

Mr. Pierre Lemieux: So on the one hand one could say it's a little bit confusing because you have different organizations offering services. But on the other hand you could say the veteran actually has access to services at many different points. It's not one entry point, that's it, you missed the window, that's too bad. There are services offered by SISIP for example in vocation training. And there are other services also in vocational training offered by VAC if he transitions through SISIP into VAC.

Ms. Mélanie Witty: One is an insurance company. We're a department. That's what I tell the members.

Mr. Pierre Lemieux: Right, but from the veterans' point of view they're just interested in vocational training. They don't care whether it's insurance or whether it's Veterans Affairs. They're just saying, listen, I need a skill set because I was infantry for eight years or nine years or twelve years and I need a skill set so I can transition into a job. I don't care where it comes from. I don't care if it's insurance or VAC. I would like some vocational training. What I'm hearing from you is that there are actually two vocational options, one through SISIP early, one through VAC later. But he has options.

● (0940)

Ms. Mélanie Witty: But I must tell you, sir, that it is not uncommon for someone medically releasing, whose limitations are so severe that a return to school is not even on the table. We tell them they have the chance to hop out of school with SISIP. They will still get the earnings loss. But for SISIP to set them up in school can at times be setting them up for failure.

Two years down the road, when they'll be in a better place, their symptoms are better controlled, and their providers are in place, the treatment will show and the psychologist will confirm that they're ready for vocational assistance. It's reassuring for the member to know that he or she doesn't have to sign up for school the day after release. It's offered to him or her two years down the road.

[*Translation*]

The Chair: Mr. Valeriote, you have the floor.

[*English*]

Mr. Frank Valeriote: Thank you, Mr. Doiron and Ms. Witty, for attending before this committee. I had the pleasure of meeting Mr. Doiron yesterday and I appreciate that you have a huge task that you took on a year ago. I appreciate the efforts you are making and your candour yesterday.

Ms. Witty, you mentioned the rehab program. From my reading of the Auditor General's report, I understand the rehab program is quite different and only available to a limited number of people. The Auditor General identified about 15,300 people who applied over the last number of years for health benefits.

Is it accurate to say that the rehab program is a very small particular program and only affects about 1,000 veterans, as the Auditor General identified in his report yesterday at committee? Maybe Mr. Doiron would like to answer.

Mr. Michel D. Doiron: The rehab program affects more than 1,000 veterans. As Mélanie mentioned, the VAC rehab has three components. There's the vocational rehab which is the educational program. There's a psychosocial, and that's where we have to work to get somebody ready to get into a vocational rehab. Then there's the medical rehab. We do some and the military has a tendency to do medical rehab.

There are a lot more than 1,000 people in the entire rehab. Yesterday, the Auditor General was talking about mental health and rehab. I don't have the total number of people in rehab just off the top of my head. I can get it to you, though.

Mr. Frank Valeriote: Could you?

Mr. Michel D. Doiron: Yes.

Mr. Frank Valeriote: Mélanie, is a case manager the same as a case worker?

Ms. Mélanie Witty: Yes.

Mr. Frank Valeriote: What's your workload?

Ms. Mélanie Witty: Right now, I have 180 members who are medically releasing, so we know they're in some type of category, a temporary, a permanent, or a message has been cut.

Mr. Frank Valeriote: Are there case managers with more than 180 somewhere in Canada?

Mr. Michel D. Doiron: I want to clarify. Mélanie does the transition interview. She and two other case managers handle all the CF members—not veterans yet—in the greater Ottawa area. It's more than Ottawa and this area, right? Once they have transitioned out of the forces, they are transferred to a case manager wherever they are going to be retiring.

They handle a big caseload. They also do some case management. They do work with the military case managers, do the interviews, and help them with the medically releasing. There are case managers, but she's assigned to the IPSC. All the soldiers assigned to the IPSC work with Mélanie and her peers.

Once you have left the IPSC, or JPSU, if you're military, you go into....That's what we were talking about yesterday, the ratios. The average across Canada is 1 in 34. The target is 1 in 40.

We are concerned about that, I'll be honest, because our members....As I mentioned yesterday, and Mélanie touched on it earlier, the intensity and complexity of the work, because of mental issues, is much higher than it used to be.

Mr. Frank Valeriote: Is there a plan to hire more case managers, then, to improve that ratio?

Mr. Michel D. Doiron: I did a review in the summer months. Presently, with the number of veterans we have, we have approximately the right number. The issue is that they're not at the right places.

● (0945)

Mr. Frank Valeriote: Locations?

Mr. Michel D. Doiron: Locations. However, I'll be very honest. I did go out and put out a selection process. Some of you are very well aware. We posted for case managers and CSAs. The big issue is that if the forecast continues, we expect from now to 2020 an increase of about 30% in case-managed veterans. If that does occur, I do not have sufficient case managers. But a forecast is a forecast, right? So we're following it very closely.

Mr. Frank Valeriote: Let's talk about locations, Mr. Doiron, and that's an important point.

I was in Brandon and I met with veterans. I met with service officers who said they're not qualified—and I know you mentioned the Legion's help. They feel they're not that qualified to help people on these appeals. They can render some assistance, but they're not all that qualified. Similarly, in Sydney, service officers have themselves declared that they are not all that qualified. I know you'd like to rely on them, but I'm concerned about that. I'm also concerned about the fact that Brandon veterans have to drive to Winnipeg, or people from Sydney have to drive to Halifax. You talk about location, and that's been one of the biggest complaints in the last year, has it not? How are you going to remedy that?

Mr. Michel D. Doiron: We are. The thing is that case-managed veterans do not have to drive. The case manager or the nurse will go to the veteran. A lot of people say they have to drive to Halifax—

Mr. Frank Valeriote: How often?

Mr. Michel D. Doiron: As often as is needed.

In the case of Sydney, in the case of all those areas, I'm presently looking at the workload in those areas: how many people? At some offices—and it's a misconception—we've had zero traffic at the Service Canada office, where we have embedded employees, since the closures of the offices. We have to be careful. At some offices we've had traffic. We are looking at making sure there is an even better presence, let's say case manager presence, in some of these locations to ensure that there is no wait for that veteran in that location. I have to say no veteran who is case-managed, or needs nursing services from us, is having to travel to one of the other locations.

Mr. Frank Valeriote: Okay. When you say “no traffic” could that mean that they're not prepared to drive the three hours, say from Sydney to Halifax, to Service Canada to be serviced?

Mr. Michel D. Doiron: I didn't mention Sydney in my—

Mr. Frank Valeriote: No, but I'm just giving an example. When you say “no traffic” could it mean that people are giving up and not bothering to come because they feel either the people at Service Canada are not qualified or it's too far away?

Mr. Michel D. Doiron: I doubt that, to be honest, because we also.... What's not on the map—somebody asked a question about the map earlier—is that we work with data, big data, to see where an office is, where an OSI clinic is, and how many veterans are in the catchment basin. In some of these offices we had very few case-managed veterans.

Mr. Frank Valeriote: How many case workers are there again?

Mr. Michel D. Doiron: There are 226.

Mr. Frank Valeriote: I don't want to know names or anything, but could you provide to the committee, in numbers only, the 226, and opposite that their workload, the cases they're managing? Not the names, just the numbers of their files.

Mr. Michel D. Doiron: We have that. I'm not sure effective what date because I have asked for that a couple of times, but I can provide the last one I have.

Mr. Frank Valeriote: Okay. We read recently you've cancelled the survey. I asked you about this yesterday, the one that was done in 2010, and there's a declining satisfaction with Veterans Canada. I know you're trying to change that. I'm not diminishing your efforts in any way, but in the absence of a survey I want to ask you this final question. Can you tell me your understanding of all of the complaints that veterans have been voicing—a lot of veterans, not all of them, but a lot of veterans. Goodness knows you've heard them and I've heard them. What is your response to those complaints?

Mr. Michel D. Doiron: I'm going to be over eight minutes answering that. Sorry.

The Chair: You're already at nine.

● (0950)

Mr. Michel D. Doiron: Thank you, sir.

We hear the same complaints members of this committee would hear.

Mr. Frank Valeriote: Like....

Mr. Michel D. Doiron: Those would include delays in receiving certain services. Receiving “no” as an answer is a big complaint. I want to be clear, “no” is often the right answer. We have to remember that. If there's a committee that knows it well, it's this ACVA committee, after the review and everything you've done for Veterans Affairs. I do thank you for that, because it has helped me. It has to be linked to service. When Mélanie was talking about disability benefits and people not being happy with us, it's true. However, our act is linked to services. So when I get a lot of complaints of “You said no”, well, you know....

I get complaints about timeliness; we talked about that yesterday. The OAG highlighted it in their report that we can be more timely. We've agreed with that at the department. We're working to improve that.

The wait time to see a case manager is a problem in some locations of the country. I mentioned that yesterday also. The average across the country is 1 to 34. Some case managers are managing 50 to 55 veterans.

Now, let's understand that the complexity and the intensity of that work is different. For some veterans it's one phone call a month: “How are you doing on your vocational rehab? Is everything okay?” That's an easy call. However, for a veteran who is struggling with mental illness, or an addiction, or maybe homelessness, it's not quite the same effort. That is a high-intensity effort.

We do try to balance the workload. That said, 50 is too high. We're trying to work at that.

Then there's the one that I don't hear that much about but I'm sure you hear a lot, and that's the pension issue. I hear it because I read all the clippings and everything else, but they don't come to me about that. The ones I get, because I'm the service guy, is more that it takes too long to see a case manager or that I gave a “no” decision.

Those are the two major ones I would get, to be very honest.

Mr. Frank Valeriote: Thank you, Chair, for your indulgence.

The Chair: There you go—all 11 minutes of it.

Mr. Hawn.

Hon. Laurie Hawn (Edmonton Centre, CPC): Thank you, Mr. Chair.

Thanks to both of you for being here.

First of all, I have to say, on behalf of my infanteer friends down here, that the insinuation that infanteers have no skills—

Voices: Oh, oh!

Mr. Ted Opitz (Etobicoke Centre, CPC): It's these gunners; it's the gunners.

An hon. member: Politics was the only career left...

Hon. Laurie Hawn: At any rate, I took my SCAN 21 years ago. It was a theatre full of people in Cold Lake for a couple of days. I can tell you that I don't remember all that much of it, because I didn't have any issues, per se. But this, what you're laying out here, is far more comprehensive and so on than my experience that long ago.

I want to go back a little bit to Mr. Valeriote's point. I have advocated for many, many years for a culture of “yes” versus a culture of “no”. You're right that sometimes “no” is the answer, but what happens a lot is that when somebody gets “no” for an answer, even if it's the right answer they immediately go public. Of course, everyone wants to sympathize with the veteran. That's right and proper. But then, as you said earlier, veterans listen to what happens here in this place. When somebody goes public, and everybody sides with the veteran, as is understandable, then politics enters into it—I'm not casting aspersions, because that's just politics and it's whichever side you're on—and it gets ramped up. Then everybody gets excited about this poor veteran, which is a normal human reaction and totally understandable.

You don't have to answer it, although I'm sure you feel a little bit of that frustration when you guys get pointed at and are told “You bad people, you said no”, and you can't stand up and say, “Well, yes, but no is the right answer”. I sense your frustration.

Really I'm speaking to all of us here in saying, look, sometimes they do give the right answer. Sometimes the right answer is “no”, and maybe we should be a little bit careful about rushing off with a lot of political rhetoric.

I want to ask a couple of specific questions. We talked about the training module for Service Canada folks. Especially in remote locations and so on it is difficult, and it appears to be less than ideal. Now, is VAC looking at ways to ramp up the training for those Service Canada folks in...anywhere, but particularly in the more remote locations?

Mr. Michel D. Doiron: Yes. I'm in just about constant dialogue with my colleagues over at Service Canada, ESDC, about how we can improve how we offer those services, to make them more accessible, to make them more appropriate, to make sure that when somebody walks in, they actually know that they are allowed to go there. That has happened. We are working very closely with our colleagues over at Service Canada to improve that, and to make sure that the tools are at the various sites, especially in the remote sites, and the veteran can get services.

● (0955)

Hon. Laurie Hawn: Have you, with Service Canada, established any milestones, goals, or concrete objectives to say you're going to get to this level by this time with this many people?

Mr. Michel D. Doiron: We have not as you're mentioning it, sir.

Hon. Laurie Hawn: Is it safe to say that's the general direction you're moving in?

Mr. Michel D. Doiron: Yes.

Hon. Laurie Hawn: There's the whole point about forms, and that is an issue.

One of the things Service Canada folks do is to make sure the form is complete. With respect to providing services, how common is it that a screwed-up form delays things and you have to go back and get them to redo it, and sometimes they're remote and it's hard to get hold of them, and so on? Is that a pretty common occurrence?

Mr. Michel D. Doiron: It is a common occurrence. I wouldn't say it's a common occurrence when they come from Service Canada; I think they do that part very well. But it is a common occurrence that we receive forms not fully completed or properly completed.

Hon. Laurie Hawn: My point is that as perhaps limited as the Service Canada training is, that's a pretty important part of it that they do fulfill.

We talked about there being no traffic in the offices. Just to be clear, I think what you said was that, for instance, in Sydney, the office now—I think it's one of the ones in exactly the same building —there is no traffic. People don't have to drive somewhere to get traffic. They can walk or take the bus to the same place they always did. It's just now an embedded Veterans Affairs person in that Service Canada office.

Mr. Michel D. Doiron: When I say “traffic”, I mean clients coming to see them.

Hon. Laurie Hawn: I understand.

Mr. Michel D. Doiron: In Sydney, they are actually embedded in the eight offices. The embedded Veterans Affairs officer is in the Service Canada office.

Hon. Laurie Hawn: And in some of those places, the traffic has been limited to—

Mr. Michel D. Doiron: Yes, but that's not the case in Sydney. Sydney does see—

Hon. Laurie Hawn: Maybe Sydney is a bad example.

Mr. Frank Valeriote: Sydney does what?

Mr. Michel D. Doiron: It does see some clients.

Hon. Laurie Hawn: Mélanie, you talked about numbers. You're at the front end of the transition screening and so on, and you have 180 clients. Do you personally have 180, or how many Mélanies are dealing with these 180?

Ms. Mélanie Witty: Over the last year I've seen 180. They were all medically releasing.

The IPSC is saying that if you have boots and you've worn them and you're coming down the hall, you're a client, whether you're a reservist class A, B, or C; whether you're a regular force member; or whether you twisted your ankle during basic training. That's it.

I know exactly how many members will release for the next year.

Hon. Laurie Hawn: Is there more than you at IPSC?

Ms. Mélanie Witty: We have three case managers, and we have three client service agents. We need more in terms of the volume, but we make it work. We disseminate the work at our district office, which is down the road.

Hon. Laurie Hawn: You mentioned that it can take up to two weeks to understand the rehabilitation services, and so on. Is that mostly because they're so complex, or is it mostly because some of the people you're dealing with have, for various injury reasons, difficulty taking it all in?

Ms. Mélanie Witty: It takes that long to understand the program, the policies, and the business process. It's quite lengthy. Coming from the outside, we get the proper training. We have standard officers who will give us guidance. We will be sent off on training. As an employee of Veterans Affairs, as a case manager, when you've done that training, you do understand it.

Hon. Laurie Hawn: The question I was left with was that it takes two weeks for the veteran to understand—

Ms. Mélanie Witty: No. I'm saying it's hard to recap the rehabilitation program in a deck of slides. When you yourself are a new employee, the training is offered to you so that you can understand it and deliver it appropriately.

Hon. Laurie Hawn: I understand. It's a lot more simple for the veteran to get the message.

Ms. Mélanie Witty: Yes.

Hon. Laurie Hawn: That's a good thing.

With regard to the MFRC, there have recently been some changes. The MFRC was for military members and their families, and so on. I think that in eight MFRCs we're starting a pilot program to make it available to vets and families. I'm not sure that's actually in place yet. Have you any comment on how that will help the veteran community?

Ms. Mélanie Witty: All I can tell you is that the MFRC has employees working with us at the IPSC, and they're looking to hire more. A posting went out for another officer to help with the families. That's my only experience in terms of that.

Hon. Laurie Hawn: On the vocational training, and so on—and Mr. Lemieux covered that—if someone were in a frame of mind to accept training, he could actually take $25,000 worth of training through SISIP and then two years later start $75,800 training through VAC.

● (1000)

Ms. Mélanie Witty: Yes.

Hon. Laurie Hawn: In an ideal situation, the person or spouse would have access to over $100,000 worth of vocational training.

Ms. Mélanie Witty: Yes.

Hon. Laurie Hawn: You talked about being eligible for benefits, financial and so on, the day after release. That's a good thing. Do we have any tracking on when they actually get their first cheque after release?

Mr. Michel D. Doiron: It depends on which cheques you're talking about. Yesterday I was informed at the committee that the pension cheque can take many months, which I was a little bit surprised to hear. That's not my responsibility, by the way. I just want to be clear.

There can be delays. When they come into our programs, if they've done the SCAN and they've had the transition interview, and they've done all the work with the Mélanies, I won't say it's always seamless, but the delays are minimized. If they have not, and they come to us and give the 30-day notice and they're gone—and people do that—then there is a delay.

Every case is different, depending on when they come to us.

Hon. Laurie Hawn: I just want to touch on the Legion for a moment, because they are an important component of service to veterans.

Mr. Michel D. Doiron: Absolutely.

Hon. Laurie Hawn: There are 1,400 or so Legions across the country, and they all have, or have the facility to have, a Legion service officer. I'm not sure if all do or not. I looked at Brad to nod his head. They do.

We recently doubled the amount of financial support to the Legion for visits and so on. Are you looking at anything with the Legion from VAC for additional training for those Legion officers, or in the areas where Legions are more accessible, to have Veterans Affairs people work together with the Legions to say here's some extra training we can give?

Are you hearing from the Legion that they are interested in doing that?

Mr. Michel D. Doiron: I don't think we're doing additional training, but we do training on a yearly basis with the service officers with the Legion. Actually, I've attended the training myself—not the full training, but I went to speak. They are a cherished partner to us. They're in the locations; they know the services. So they're a close partner.

Hon. Laurie Hawn: The Legion would be a pretty important partner in this from a pure numbers point of view.

Mr. Michel D. Doiron: They're very important partners in this.

Hon. Laurie Hawn: You said folks are available 24-7 to talk, but you also talked about the PTSD app on a device. Obviously, that's 24-7 because it's electronic. Is there somebody on the other end of that app, or is it electronic queuing—

Ms. Mélanie Witty: It's queueing and prompting: “What happens if?” So if the member, wherever they're at, feels their symptoms are not well controlled, if they don't feel safe, the queuing and prompting from the application will ground them and bring them to a safe place. There's nobody on the receiving end.

Hon. Laurie Hawn: I would assume that one of the prompts from that would be, “Here's a number. Call and talk to somebody.”

Ms. Mélanie Witty: That's correct.

Hon. Laurie Hawn: Thank you.

The Chair: The next speaker is Monsieur Chicoine.

[*Translation*]

Mr. Chicoine, I'll be lenient, but we should try to keep the speaking time short because it is important that everyone have a chance to speak.

Mr. Sylvain Chicoine (Châteauguay—Saint-Constant, NDP): Thank you, Mr. Chair. I will try to be brief.

I have a few questions.

I would like to thank the witnesses for being here to explain the transition services to us.

What happens to someone who is released from military service for non-medical reasons and realizes a few years later that he does have a service-related injury? I'm thinking of someone with post-traumatic stress disorder.

Is it difficult for him to obtain all the services when he gets in touch with you? What happens to someone like that?

Mr. Michel D. Doiron: We assess his condition and a psychiatrist, psychologist or health care professional determines whether he has a mental health problem, such as post-traumatic stress disorder, or another illness. In 72% of cases, people who come to see us are suffering from PTSD.

We have accelerated processes to ensure that they have access to the appropriate services. If they take part in the rehabilitation program, they are provided with mental health services. If they have never applied for a veterans' disability award, they need to do so, because that opens up a whole other set of doors.

In October, we introduced an accelerated process for PTSD. In the case of mental health problems, it is well known that the faster care is provided, the better the chances are of success. We therefore accelerated access to service. This is known as evidence-based accelerated service. We want to make sure that people have access to service.

● (1005)

Even if we cannot make the connection, it is important to remember that many services are available within communities. If they are not, case managers or service agents can help the veteran find help locally, even though we do not cover the cost.

Mélanie did not talk about this, but when she conducts the transition interview, one of the main questions has to do with where the person will live and whether appropriate care will be available there. In some parts of the country there are no psychologists or psychiatrists. I come from northern New Brunswick and I know it is not always easy.

In short, our people help these individuals find someone, even though we do not cover that cost. We help them or we put them in touch with mental health communities or psychologists. We try to include them in our process. If they served in a special duty area, the decision is much easier.

Mr. Sylvain Chicoine: If I understand correctly, they are entitled to all the same services, in a timely manner, even for non-medical reasons.

Mr. Michel D. Doiron: The big difference is that they can go to our operational stress injury clinics. They can use the 1-800 number and they can also have 20 sessions that we will pay for. Whether the person was diagnosed or is suffering from a service-related problem, we will pay for him and his family. Veterans Affairs Canada pays for up to 20 sessions per incident. We put the person in touch with a psychologist or psychiatrist, usually within 48 hours, all across the country. The family is also covered in that case.

Mr. Sylvain Chicoine: If I understood correctly, the number of consultations is limited.

Mr. Michel D. Doiron: We are talking about 20 sessions. The person can call the 1-800 number. We work in partnership with Health Canada.

Mr. Sylvain Chicoine: Suppose an individual is entitled to medical care on the military base and is released for medical reasons related to his service. I imagine that in that case, the individual no longer has any access to the resources provided by your department.

Is there some kind of follow-up involving the professionals treating that person?

Ms. Mélanie Witty: The Montfort Hospital has a centre where active members of the Canadian Forces are treated. There are six case managers and six nurses. When a member's case is assigned to them, they get in touch with us directly. When a member whose case is considered complex by National Defence is releasing and the release date is not known, we are invited to take part in a case conference with the psychiatrist, the psychologist and everyone in the department who is involved. We supplement the care team.

We take part until the individual is released. There are excellent hand-offs and the Canadian Forces team at the Montfort is our main partner. We are in touch with the people on that team on a daily basis because we share the same clients. They see that the release is coming and they are concerned. They need Veterans Affairs Canada to take over managing the case.

Mr. Michel D. Doiron: If an individual with special needs lives in Ottawa, Quebec City, Montreal, Halifax or Fredericton, it is much easier to find appropriate care for him than if he lives in, say, Edmundston, New Brunswick, which is not my hometown, but the city where I grew up.

The Canadian Forces hand off cases to us, but in some instances, our partners in the Canadian Forces have supported us, even though the person was no longer a member of the forces. In the case of Fredericton, for example, the province could not provide a psychologist, so the psychologist at the base in Fredericton looks after veterans. Our partners in the Canadian Forces help even in the case of people who have been released.

In short, people have the right to live in the regions, but it is more problematic.

● (1010)

Mr. Sylvain Chicoine: I imagine that a soldier's medical file is automatically transferred to you when the soldier becomes a veteran.

Mr. Michel D. Doiron: It is not automatic.

Mr. Sylvain Chicoine: I know that in several cases, people said they had been medically released. The Canadian Forces doctors had readily recognized the injury, which was then denied by Veterans Affairs. I have heard of several similar cases. In fact, if you don't have the medical file, I imagine that it becomes impossible, because you don't have the Canadian Armed Forces doctor's diagnoses. I'm very concerned about that.

I'd like you to comment on that. I think it is sad that a veteran should have to fight to have an injury recognized when the Armed Forces doctors recognize that injury and the fact that it is service-related.

Mr. Michel D. Doiron: In my opinion, the most common problem is not recognizing that there is an injury, but the relationship with the individual's service. If the doctor tells us that Michel tore the ligaments in his knee, we'll accept that. If we really have doubts, we'll refer the file to the doctors who work for us to find out what the X-ray shows.

That is generally not the problem. The problem is determining whether the injury can be considered service-related. Often that is the biggest problem. Sometimes, even if someone says they have a certain illness, we have three different opinions. That can happen. I'm not saying it never happens. Often, it is the service relationship.

We try to say “yes” as much as possible. People think we have a negative philosophy, but that's not true. People really try to get to “yes”, but the law is very clear: the injury must be service-related. Unfortunately, some soldiers of a certain generation don't document their files. You can ask the Canadian Forces. Often when we study a case, it seems reasonable, but when we delve a little deeper, we realize there is no documentation. Then there are serious problems.

The Chair: Mr. Hayes, you have the floor.

[*English*]

Mr. Bryan Hayes (Sault Ste. Marie, CPC): Thank you, Mr. Chair.

You have my permission, sir, to please stop me at my six-minute point. I will respect that. Thank you kindly.

Madam Witty, you obviously have a lot of experience. Given your experience, can you answer whether you think SCAN should be mandatory?

Ms. Mélanie Witty: I know for a fact that if they are mandatory, a great deal of the clients I help can still not attend.

Mr. Bryan Hayes: That being said, do you think, given your experience, that they should be mandatory? I am not asking whether it is possible for them to be mandatory, because in certain circumstances I understand that this is probably not possible. Given your experience, would it be beneficial, in your opinion, that this be mandatory?

Ms. Mélanie Witty: This is a good-to-know.

Mr. Bryan Hayes: Okay. Thank you.

Ms. Mélanie Witty: If DND wants to make it mandatory, it's up to it.

Mr. Bryan Hayes: You wouldn't be disappointed.

Ms. Mélanie Witty: You know what? I presented on Friday, and we had 300 participants. I am presenting next week, and we'll have just as big a crowd.

Mr. Bryan Hayes: I want to get an understanding, Mr. Doiron, of the transition exit interview. I have never experienced it, and I'm sure probably my sister, her husband, and my father did. I really don't know. What happens at an exit interview? What do you discover through an exit interview? Are there signals that would...? I think you know where I'm going with this.

Mr. Michel D. Doiron: Absolutely.

During what we call "the tran", the transition interview, that's when a client service agent will sit with the CF member—they're still in CAF—and go through a questionnaire with them and ask them certain things, and try to establish their risk. We'll ask if they've been injured. We like it when they bring their health files, but they have to request them. We can't. We can go through the process with them.

It's outside the SCAN. There are 300 people at the SCAN. Mélanie talks to a crowd. That transition interview is a one-on-one interview with the individual. Hopefully you bring your family. We encourage strongly, but some do, some don't. So you go through it.

If the client service agent realizes...Medically releasing, it's a case manager; for all the other regular forces, it's a client service agent. So the case manager will go into much more depth with the medical releasing, because we already know you're releasing because you can't meet universality of service. There's already a premise for your leaving. In the other cases, we don't know, so we're going to look at it, and as Mélanie discussed in the SCAN, we're going to ask what do they want to do once they're released.

If you have 35 years of service and you're 50, 52, 53 years old, you may be very happy to take your pension. However, in the case that Mélanie was showing, which is someone with nine years of service, you do have to live and support your family, so employment becomes very important. We ask those important questions: around the family, as Mélanie highlighted, around health, around their career —what they want to do. We encourage them to apply for rehab. Everybody should apply for rehab within that 120 days. It keeps their rights open long term, so we encourage them to apply for rehab. They have that discussion.

If it's not medically releasing and they realize this person's at risk based on what they're saying—stress injuries or mental health injuries—there are signals, and I'm not a health care professional, but the health care professionals can recognize them—they will refer that individual, even if they're not medically releasing, to a case manager to go more in depth and to ensure they have a case manager.

We are working...and you made recommendations on the ACVA report on transition. There's also a joint steering committee on ACVA that I co-chair with General Millar, where we are really trying to eliminate that seam, because there is still a seam, and I know our two ombudsmen are also looking at transition currently: how can we facilitate that for the member, from a member's perspective, not from VAC's perspective. At the end of the day it's not VAC, it's for the retiring veteran. For regular forces that is mandatory.

● (1015)

Mr. Bryan Hayes: Much is focused on a medically releasing veteran, especially when you talk about rehab, or vocational rehab. That to me is to find a new vocation. So if you're not medically releasing, are you entitled to voc rehab and tuition training and education?

Ms. Mélanie Witty: The rehabilitation program has two gateways. The first one, the straightforward one, you're 3(b) releasing, whether it's for diabetes or gout.

Mr. Bryan Hayes: What's 3(b)?

Ms. Mélanie Witty: Medically releasing. You're automatically eligible for this program, whether it's for diabetes or gout or high blood pressure.

Mr. Bryan Hayes: If you're not medically releasing?

Ms. Mélanie Witty: If you're voluntarily releasing, we call it the rehab-need gateway, and we have to answer three questions. Is there an injury, is it linked to service, and is that injury a barrier to re-establishment in civilian life?

Mr. Bryan Hayes: So this again is always focused on an injury.

What if you're not injured and you want to get re-educated? You're not injured, there's nothing wrong with you, you're releasing voluntarily after 12 years, for life circumstances or whatever, and you don't know where the hell you're going to go, or what you're going do, what services are available? Can you get re-educated?

Ms. Mélanie Witty: With my authority as a case manager, I cannot deem the member eligible if he doesn't meet that gateway for this program.

We talked about career transition services. The $1,000 maximum, that might be where we tap into it. There are lots of charities out there. The Prince Charles charity is for anyone who wants to be an entrepreneur. If you've served in CF, you go to that workshop for a few weeks in Halifax or Manitoba and you get a chance to meet with other members who have released, are gainfully employed, and self-employed. If that fits into that category, then we know how to tap into our partners: Hire a Veteran, Helmets to Hardhats, and so on.

● (1020)

Mr. Michel D. Doiron: They are not eligible for rehab at that point. We encourage them to apply anyway and put their name in, because you never know what happens 20 years down the road; something may show up after the fact; however, if they're just being honourably released and everything is fine, they're not eligible for rehab.

However, as Mélanie said, there is the MET program. We work with a lot of private sector industries that are veteran-friendly. There are many jobs, and we encourage them.... I have resources embedded within Canadian companies to find jobs and to work with veterans on getting jobs. But in that case, they would not be retrained. The $1,000 is available, but the other slew of programs is not, at that point.

Mr. Bryan Hayes: Thank you, Mr. Chair.

The Chair: After seven and a half minutes, now it is time for Mr. Opitz.

Mr. Ted Opitz: Thank you, Mr. Chair.

Thank you for being here. I appreciate it; it's very informative.

Just along the lines of what my colleague was saying, perhaps we should start the mandatory part of the SCAN a little earlier. What do you think?

If a member joins the regular force or reserve, right at the beginning of their intake some of this information should be disseminated on a mandatory basis and probably repeated every year. Both the regular force and reserve units are required to have a security briefing, a fire briefing, this briefing, and that briefing. I think a VAC briefing is something that would be useful. It could be included as well if, for example, a troop were deploying into a DAG, a Departure Assistance Group. You go through the checklist so that you can “DAG green” and deploy, but providing knowledge of what's available to them should they be injured on tour might be something we could do.

Can I get your thoughts on that?

Mr. Michel D. Doiron: Before they deploy, they go through all their insurance and they meet with us. But I agree that whether it's SCAN or something similar, it's important.

SCAN is not just about our services. It's about their pension plan, it's about their medical plan, it's about a multitude of things. As the ex-DG of the federal public service pension plan, I always encourage people to take the pre-retirement seminars early, not when you're hitting 50 and you're going to leave at age 55. My personal feeling would be the same for SCAN: the earlier you could get at least some preliminary information—perhaps not the full three days, but some of that important information—the better.

What we are doing presently is working with the Canadian Armed Forces to increase awareness of the importance of documentation. This is not SCAN; we're actually going to bases and making sure that the senior leadership—not just the officers, but senior NCOs—get the message to their members to document. It's not SCAN, but we are doing that also.

Mr. Ted Opitz: Along the lines of documentation, we know that sometimes attributing things to service is the problem. Sometimes you could be missing a CF 98 that hadn't been filled out—I probably forgot to fill out a whole bunch of them. There are many things that are attributable to service that soldiers don't even report. You jump off the skid of a helicopter, and the next thing you know, you fall into a ditch and your ankle is sprained or broken or something like this. Sometimes, if it's serviceable, a day or two later the guys just don't bother to report it, but the damage could occur later on. It's things of that type.

How do you work to reconcile the fact that some of that documentation...? It's not always the soldier, either. Sometimes the document or the file literally disappears, to reappear three or four years later.

Mr. Michel D. Doiron: Thank you, sir.

Since about July I've been working with the new evidence-based model for adjudications, which is to accelerate. What we are also doing is working with our colleagues at CAF to use the military occupational codes so that we can start identifying.... I think they use new terminology now. They keep calling it MOC, but I think it has different initials now.

If you've been an infantryman or woman and have humped however many thousands of miles, it would be reasonable to assume certain injuries. We're working with the military institute of research to ask what we could expect to see, and we want to put that information to adjudicators when they're looking at the file: is this a reasonable injury to expect?

We're not quite there yet. With PTSD we're much more advanced, because it's easier to link a little bit to some things. We're looking right now at musculoskeletal injuries in knees and shoulders—the back is more complicated, to be honest—because you have had the packsack on for.... We're working on this and working with our colleagues at CAF to see what the job description of a certain person is and what the most common injuries are that link to it.

What we have done for PTSD is run it against our system and ask how often we would approve it. If you have a 99% approval rate for a certain injury to an infantryman or woman.... There's a certain logic.

We're working on it. We're not quite there yet, but we're working on it.

● (1025)

Mr. Ted Opitz: I applaud that.

Over the past 30 years, some of the equipment we had in the beginning compared to some of the stuff they're being issued now, which is just state-of-the-art, excellent, load-bearing kit.... But back in the day when you were wearing a jump ruck on some of the older things, things were not balanced on your body...the boots and so on and so forth. These things do literally add up on the person's skeletal frame.

If you get to that it would eliminate a lot and help you get to the “yes” answer to my colleague's point a lot faster. As we understand, sometimes “no” is the thing.

When you do say no, can you give us just a broad general example of why?

Mr. Michel D. Doiron: We ask for the medical file and the service file when we review a certain condition, so when the person applies with a condition, we review the file. Hearing aids are not a good example, but if a person says, “I hurt my back”, we'll go through the file to ask if they have met with a doctor, and because of your back is there a form in there that says you had an accident, which we can look at? If the forms are there, it's quite easy. If the forms are not there, we'll look at other evidence. Did you serve somewhere that would make us believe that?

What we've implemented since July is that our adjudicators are now calling the individual before saying no. It's been a bit of a culture change, I will admit, but now they're calling the individual and saying, “Michel, I see you've applied because of a bad back. I can't find anything in your file. Can you substantiate your claim because there is nothing here. Can you get us something?”

Instead of having them go through all the levels of appeals.... And it's hurting my stats a little bit because I have to put the file aside and they have 90 days to answer, so it's not automatic. We're really trying to get to that yes.

But if at the end of the day the soldier cannot demonstrate that it was service related, that there is nothing on the service file or the health file or the psychiatric file—there are three files we work with, depending on the case—then the answer will be no.

Mr. Ted Opitz: Just following up on that, sometimes that's tough to do. As I said, sometimes the troop doesn't say that something is wrong. He just carries on. But somebody may have seen it. A guy in his platoon says, “Oh yes, I remember when this guy fell down that trench and all of a sudden his knee blew out”. Would a statutory declaration from somebody who had had seen it—a commander or a platoon commander or that sort of thing—be considered as legitimate substantiation?

Mr. Michel D. Doiron: That is considered legitimate.

The other thing that not a lot of people know is that I have two liaison officers in my office so the adjudicators use them often. Let's say they see an injury or a situation they don't understand. I have a lieutenant-colonel and I have a senior chief, and these two individuals often sit with the adjudicator.

The adjudicator will ask, is this possible? Sometimes it's not. The guy will say, no, that never happens. They've been around. These guys are 30-year serving members. Often they will say, yes, that is actually what has happened, it's easy to see: let me make a phone call or go here and I'll get some information for you.

That's with the liaison officers. I have the same thing with the RCMP in my office.

Mr. Ted Opitz: You do work with the Legion, as I know, to help you with these. I think the Legion has always had a very historic role in dealing with veterans, and of course we've now turned a corner, post-Afghanistan mission and all these other things. I think the Legion has a tremendous amount to offer here as well. Of course, I'd like to see a lot of the troops join the Legion on their way out the door, but that's something the Legion's own recruitment is going to have to work on.

I'm done, Mr. Chair. Thank you.

● (1030)

The Chair: Thank you very much.

Mr. Stoffer.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you very much, Mr. Chairman.

Thank you both very much for coming.

Sir, how many case managers do we have in the country now?

Mr. Michel D. Doiron: We have 226.

Mr. Peter Stoffer: What is the average caseload?

Mr. Michel D. Doiron: The average last month was 1 in 34.

Mr. Peter Stoffer: If I do the math very quickly.... I'm just trying to do this as quickly as I can. I'm not in school anymore.

Mr. Michel D. Doiron: We have approximately 7,300 case-managed veterans,.

Mr. Peter Stoffer: Okay, so DVA has a client base of about 200,000, give or take a few.

Mr. Michel D. Doiron: Yes, sir.

Mr. Peter Stoffer: There are roughly 680,000 veterans, RCMP, and dependent spouses in the country, so of the 200,000 who are actual clients of DVA, approximately 7,000 are case-managed.

Mr. Michel D. Doiron: Of the 200,000, it's 7,000, yes.

Mr. Peter Stoffer: You qualified your statement a couple of times by saying “case-managed clients”.

Mr. Michel D. Doiron: Yes, sir.

Mr. Peter Stoffer: The difficulty is, who determines who gets case-managed? The reason I say that is many times I get calls from people asking for a home visit on something. The DVA will say, “If you're not case-managed, you don't get a home visit.” My question to you is, who determines who's case-managed because that is a sticky point in terms of home visits after these closures?

Also, the training at Service Canada.... I visited several of these offices across the country where there's not an embedded person, and they told me they had four hours of online training, or something of that nature, for DVA. I can assure you it may happen in some cases, but it doesn't happen in a lot. A person will go in with a complex file and all his paperwork, and you say that a Service Canada person will actually help them look at the forms to see if they're done correctly? Sir, these forms are quite complicated, as you know. It takes a lot of training for someone like Mélanie to look at these forms and ensure that they're filled out, because 60% of the problems with the VRAB decision is the fact that a form wasn't done properly or there is a document that was missing, so the person was initially declined. I'm just wondering. If someone had four hours of online training or something at Service Canada, how do you quantify, then, that a person at Service Canada can accurately look at a complex form and see that it has been filled out properly to ensure that when that person makes a claim there will be no hiccups or problems down the road?

Mr. Michel D. Doiron: The training they get is to ensure that the right boxes are completed, not the information in the boxes. They don't receive eligibility training. They receive completion.... So they have the training, and they have a form that says this is what should be completed, there should be tick, tick, tick. It's the same thing they were doing for passports, the same thing they've done for other programs. So that's what they look for. Is it complete? We give them the parameters they should be looking at. That's what they look at, not if you'll get your DA/DB. Did you forget to say that you fell off the truck or something? That's not what they're looking for. It's if the boxes are well completed.

Mr. Peter Stoffer: I would make the suggestion, then, that—

Mr. Frank Valeriote: Mr. Chair, he didn't answer the first question yet. He may have overlooked it. How is it determined that somebody actually is case-managed?

Mr. Michel D. Doiron: I thought the honourable member was going to come back to me on that.

Mr. Peter Stoffer: No, no, go ahead.

Mr. Michel D. Doiron: We at Veterans Affairs determine based on risk factors. We have three tools that establish risk. If they fall between a medium and high risk, they receive a case manager.

Mr. Peter Stoffer: Thank you.

Also, when the people call the 1-866-522-2122 number, how many of those calls go to a private company?

Mr. Michel D. Doiron: I'm not sure which number that is. I don't know them by heart.

Mr. Peter Stoffer: That's the local DVA number you call if you have any concerns or questions about DVA. It's 1-866-522-2122. It's imprinted in my DNA.

But I do know that awhile back some of those services were privatized to a private company called Quantum, which handles the calls, and then they direct that call to wherever the person is looking. How much of that is now in private hands in terms of the initial call?

Mr. Michel D. Doiron: I'd have to confirm the number because I don't know them by heart. I'll take your word on that number. If it's our NCCN number, it goes to a Veterans Affairs' employee, and I apologize for not knowing the number by heart. I should, but I don't.

Mr. Peter Stoffer: Perhaps you could, then, possibly advise us, because you are the ADM of service delivery, and a lot of that is the initial phone call. How many of those phone calls go to a private company? The name of the company...well, I know the name's Quantum. Where are they located and how many employees do they have? It would be interesting to call them in to see what training they've received in order to assist a veteran who's calling for the first time and trying to go through a complex situation in this particular regard.

My last question for you is on the transition.

Mélanie, you deserve the Order of Canada because I know the patience required in dealing with some of these very complex individuals, especially when someone's releasing on a 3(b) release and they don't necessarily want to leave the military. You deserve kudos for the tremendous patience that you have. I know many case managers and case workers across the country, and just their personality gives the veteran and their family a tremendous amount of comfort by listening, so well done for you on that.

When you're doing a transition, if you don't have the medical file, how difficult is it to continue on with that transition? I would assume that the first question you would ask is, “How are you doing? Do you have your medical file?” If you don't have it, then it must be challenging, then, to assist them in whatever they have down the road.

● (1035)

Ms. Mélanie Witty: Any medically released member has a CF case manager at Montfort. It's a nurse. The nurse calls me to say, “Mélanie, meet my client. This is the ABC; this is what's going on. These are the diagnoses. Can you pick it up from there?”

Mr. Peter Stoffer: And for non-medical release?

Ms. Mélanie Witty: When I meet with my member, I ask them if they've gone to the archives at Montfort to ask for their medical file. It's very easy; it's one form. They can have it on a CD now instead of having the printed copy. It's very easy.

But I go with an evidence base.

In light of releasing, the member meets their doctor. We will get part (b) of the medical release that will say the release is for these conditions, and everything that has a diagnosis from high blood pressure to osteoarthritis of the lumbar spine will be on that paper, which will be shared with me. It is a "protected B" document. I do have those documents with me.

Mr. Peter Stoffer: My last question for you especially concerns the "no" or the missing documents and such. I would assume, and I'm not sure if this is happening, that when a person's six months away from release and they're asked if they have their medical files, once they get them someone sits with them and goes through the entire file to make sure that everything is there. Then that person would have to sign a form saying they've been peer-reviewed on their medical documents, that everything is accurate and correct. They'd sign off agreeing that the medical files they have are complete, in order, and exactly what they....

If that happened, then if a person five to seven years down the road calls and says they have a medical problem and they think it's military related, at least you'd have that information and they would have agreed, prior to release, that everything was complete.

Mr. Michel D. Doiron: I agree with you, sir.

We do look at the files, and that's part of what we're looking at, eliminating the seam, and how much more we can do there. I would even go further than that to ask if they want to apply.... Now, they have to apply, but do they want to apply for their DA now?

Because if you do that now, with the help of either a CSA or a case manager, depending on where you are.... And it depends on your injury, if you're 3(b) or another one...that somebody looks at your file. There's no more question about that injury. You may still appeal or not be happy with the level of injury. We don't talk about that often, but people are often not happy because they think their injury is much more complex than what you're saying, and that's an opinion.

But that said—

The Chair: That said, it's Mr. Lizon's turn.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much, Mr. Chair, and I would like to join my colleagues in thanking the witnesses for coming here this morning.

My first question is on SCAN. Madam Witty, you were asked whether it should be mandatory, and you did state that it would be impossible for some people to attend. Is there anything currently available for that group to deal with them on an individual basis, and if not, what would you recommend?

Ms. Mélanie Witty: Anyone who's severely injured, and we're talking about someone who could not sit a day in a room because it's crowded, because there are people, because it's closed—very linked to OSI—should be posted at the IPSC. At the IPSC we have all of the same partners at the SCANs. We have the Legion that comes. We have SISIP, the OSI clinic, the OSISS peer support, the MFRC.

So by being posted at the IPSC.... We have currently 220 medically releasing members. At the IPSC where I work, the partners at the SCANs are working with us, and if they're not there permanently, they come on a monthly basis. I would link my client—and I do it all the time—to the same partners they would hear about, just tailored to their needs, by coming to meet us at work.

There have been other ways that those members were able to seek the same kind of information, but at their own pace. Because, to be honest, in terms of my 45-minute presentation, when you're not well, you don't retain. I need to break it down in many meetings.

● (1040)

Mr. Wladyslaw Lizon: Now, would there be people who require one-on-one assistance, and if there are, is that assistance provided at the current—

Ms. Mélanie Witty: That would be me.

Mr. Wladyslaw Lizon: That would be you. What would be the percentage of people who would require one-on-one assistance instead of going to the sessions?

Ms. Mélanie Witty: Well, when you're case-managed by Montfort, because you're medically releasing, that implies you need a case manager when you release from Veterans Affairs.

Mr. Wladyslaw Lizon: No, I'm still talking about the SCAN, to replace the SCAN because they can't attend it and they can't come in the other group. You would have to provide that information on a one-on-one basis. Is that available?

Ms. Mélanie Witty: It is available for someone coming to us and saying, "I can't attend a SCAN and I have a lot of challenges". We need to break this down. That's when we start case managing them.

Mr. Wladyslaw Lizon: Michel, you mentioned that there are complaints of delays in receiving the benefits. Can you inform us what the delays are caused by, why there are delays, and how they can be fixed?

Mr. Michel D. Doiron: It depends on what program we're talking about because every program is a little different.

In the case of the adjudication process we've invested a lot of money in the past six months to a year with our colleagues at CAF, but we still have delays receiving medical health records. They're much better; they're down to about five weeks now. At one point this year it was nine weeks. If you have a 16-week process, and nine weeks to get a file, it's causing us some issues. DND are all over it. They've added resources, but on the adjudication side that's one of the areas.

Another area we get delays is with getting medical assessments. In certain parts of the country it is difficult to get a doctor, a GP. When they're in the forces the member has a doctor. When they release, in certain communities you're on the waiting list to get a general practitioner. In P.E. I., where we are, it could be eight months before you are assigned a GP. You could always go to a clinic before you get a GP. I think it's even longer than that in some locations in Quebec. If you need a medical assessment from the provincial authorities, that causes delays. All those are things that go into delays.

In certain cases we have to refer them to specialized services. We're doing a case plan with an individual and we have to refer them to a special mental health worker. In Ottawa it's not a big issue because the service is quite good. In Fredericton, New Brunswick, there is an issue. New Brunswick is a low-paying province when it comes to salaries for psychologists and psychiatrists. Therefore they go into the private sector much quicker than they stay for the province. We run into some of those that cause delays in getting the diagnosis. We take other processes to try and eliminate that, like working with our CAF and sending them to a CAF doctor, but those are some examples of delays we see.

Mr. Wladyslaw Lizon: The next question I have is about the disability award, 75% of—

Mr. Michel D. Doiron: —79% are approved at first application, yes.

Mr. Wladyslaw Lizon: You mentioned that a person receiving the disability award is able to work and make extra money. At what point would the disability award be clawed back? How much extra money would you have to make?

Mr. Michel D. Doiron: The disability award is not clawed back. The disability award is a lump sum. That's not clawed back.

Mr. Wladyslaw Lizon: No, for—

Ms. Mélanie Witty: You're talking about the earning loss when you're on your rehab program.

Mr. Wladyslaw Lizon: That's correct, earning loss replacement.

Ms. Mélanie Witty: It's not uncommon that a client who is on the rehab program is gainfully employed. He receives no earning loss because he makes too much money, but he needs the case management. He needs someone to coordinate the needs with his medical and psychological conditions.

● (1045)

Mr. Wladyslaw Lizon: What I'm asking is, if the person is receiving the income replacement, and is working part-time making money, is the full amount that he is earning deducted?

Ms. Mélanie Witty: We have to deduct it because it's considered an income. Not the full amount, but there is a calculation. It's not uncommon for someone to work part-time. He has to declare it with us. We will do the calculation because it will be considered an overpayment. He has to declare that he earns an income. We are providing income replacement. You can't earn an income on top of it without having any offset.

Mr. Wladyslaw Lizon: I understand.

The example you are giving here is a person making about $60,000 a year, so about $5,000 a month. Therefore 75% would be $45,000. Logically thinking, if a person was making $15,000 extra a year, to make it to $60,000, then in my view it shouldn't be deducted. Anything above it, maybe. Is this how it works?

Mr. Michel D. Doiron: They're allowed to make a percentage, but I don't know what it is. We can get that number to you. There is a formula. They are allowed to make a little bit of money, but at a certain point it starts clawing back. They would not be allowed to do $15,000 to get to that.

The Chair: With the committee's indulgence, I'd like to allow Mr. Valeriote one quick question. I know that we've gone beyond the two hours already.

Mr. Frank Valeriote: Thank you, Mr. Chair, and I'll be quick.

This is on the heels of the Auditor General's report, Peter's question about those who are told no, and your answer that some people don't like no for an answer. I get that, but we know that, of the 15,000 over the last number of years who applied, 24% appealed and 65% were successful. That means that 2,386 who were originally told no were later told yes. We also know that 128 of those who were told no had to wait more than three years to ultimately be told yes.

The Auditor General, in short, said Veterans Affairs should provide additional assistance with the application process. I think he means Veterans Affairs, not the Legion, but Veterans Affairs. You're the boss. What effort is being made to actually say more than, “Okay, we'll review the application and we'll call them back before....” I'd like to know why you can't be a service provider who says, “Get the heck in here. We'll help you fill out your application because we don't want you to be one of the ones who falls through the cracks.”

The Chair: Mr. Valeriote, I think that this is more than just a simple question.

With the committee's indulgence, I will ask the clerk to send Mr. Doiron a transcript of this question, and then you could submit a response to the clerk.

Mr. Frank Valeriote: Thank you, Mr. Chair.

The Chair: For the moment, as I still have quorum, I'd like to thank all members of the committee for their continued collegiality here.

I'd like to convene you to come back here on March 10 at 8:45 in the morning for our 39th meeting, when we will entertain information from the Department of National Defence, much in the same way as we did this morning.

This meeting is adjourned.

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