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## Tuesday, March 10, 2015

## Chair

**Mr. Royal Galipeau**

# Standing Committee on Veterans Affairs

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● (0845)

[*Translation*]

**The Chair (Mr. Royal Galipeau (Ottawa—Orléans, CPC)):** Welcome, folks.

I call the 39th meeting of the Standing Committee on Veterans Affairs to order.

[*English*]

This morning we have two distinguished guests: Colonel Hugh MacKay, deputy surgeon general of the Canadian Forces;

[*Translation*]

and Col. Marc Bilodeau, Director of Medical Policy at the Canadian Forces Health Services Centre.

[*English*]

This morning, Colonel MacKay will have an opening statement of less than 10 minutes. After that, we will have rounds of questions.

I rather like the approach I took last week, with fewer constraints, and I propose to follow the same approach this week, except not quite so much. I would appreciate MPs, as they question the witnesses, keeping an eye on the chair and his twitchings, because I don't like to bring down the gavel. I appreciate the collegiality of the meeting and I'll do what I can to maintain it that way. But if you don't look at the chair, you might hear unpleasant sounds.

Thank you very much.

Colonel MacKay, the floor is yours.

[*Translation*]

**Colonel Hugh MacKay (Deputy Surgeon General, Canadian Forces, Department of National Defence):** Thank you very much, Mr. Chair and distinguished members of the House of Commons Standing Committee on Veterans Affairs.

I'm very pleased to have the opportunity to talk to you about the medical care offered to our Canadian Armed Forces, or CAF, members, the treatments and services offered to our members in the operational trauma stress support centres, known as OTSSCs, and the support they receive from the case management program when they are transitioning out of the CAF as the result of a medical condition that makes them unfit for military service.

Joining me today is Col. Marc Bilodeau, Director of Medical Policy.

[*English*]

The Canadian Forces Health Services Group's main objective is the provision of care to Canadian armed forces members both within Canada and abroad. In consideration of the fact that regular force members are excluded from the Canada Health Act, Canadian Forces Health Services Group is responsible for their care, as all provinces and territories are for that of their citizens.

In-garrison ambulatory care is provided through a network of more than 40 military clinics from coast to coast and overseas. Our interdisciplinary approach, consisting of a mix of military and civilian physicians, nurses, nurse practitioners, physician assistants, medical technicians, and a varying range of other health care providers, depending on the location, enables high-quality health care and is considered the way forward in the civilian sector. It is similar to the College of Family Physicians of Canada's “Patient’s Medical Home”. Should a service not be available in a military clinic, the patient is referred to the most appropriate civilian health care provider in order to ensure that they receive the care they need.

● (0850)

[*Translation*]

As long as a CAF member is serving, they will receive the care they require in accordance with the CAF Spectrum of Care document. The Spectrum of Care provides CAF members access to the types of care that are similar to those available to Canadians; however, when a member needs a very specific type of treatment that is not included in the Spectrum of Care, a process exists to provide for these exceptions where necessary.

The inclusions and exclusions are based on medical evidence and are reviewed as technology, medications and knowledge advance in the medical world.

[*English*]

To address the sometimes complex physical injuries that Canadian Armed Forces personnel face, Canadian Forces health services has undertaken the integration of additional physiotherapy personnel into our affiliated civilian rehabilitation centres of excellence, through the creation of the Canadian Forces rehabilitation program, to bolster the services normally provided by these centres. The acquisition of two CAREN, computer-assisted rehabilitation environments, located in Edmonton and Ottawa, has also added to the complement of standard therapies available to Canadian Armed Forces members. These measures aim to ensure that injured and ill Canadian Armed Forces members who wish to remain in uniform are provided with optimal conditions and opportunity to achieve that goal whenever possible.

The provision of care regarding mental health treatment is a priority. Canadian Forces health services has a comprehensive mental health system that provides evidence-based clinical care in most of our military clinics across Canada and in Europe. We continue to enhance our efforts to combat mental health stigma and prevention through our road to mental readiness program. Mental health care often starts in our primary care clinics. Where necessary, they are referred to our multidisciplinary mental health teams consisting of psychiatrists, psychologists, social workers, mental health nurses, addictions counsellors, and pastoral counsellors. These teams specialize in the diagnosis and treatment of all mental health conditions, which includes operational stress injuries, but also depression, anxiety, and addictions problems.

We also have seven specialized operational trauma stress support centres, centres of excellence specialized in the delivery of care of such operational stress injuries as post-traumatic stress disorder. Our OTSSCs are located on the larger military bases, but also serve as regional referral centres for military personnel from other bases. Additionally, the seven OTSSCs are part of a joint network of operational stress injuries, which also includes the Veterans Affairs Canada OSI clinics. Through a tripartite MOU, this network allows for care of military members, veterans, and members or former members of the RCMP in either military or Veterans Affairs Canada facilities when it is deemed appropriate for a given patient.

In an effort to enhance our mental health program, we're in the process of piloting CROMIS, the client-reported outcome management information system. It will allow for rapid treatment outcome assessment and will guide the optimization of individualized care. We are also in the process of implementing enhancements to the Canadian Forces health information system, which will add direct-entry capability for mental health notes. This will enable the improved timely communication between primary care clinicians and mental health professionals, further strengthening the collaborative care they provide.

Within the mental health program there's a strong research element. Currently the main research efforts are focused on the analysis of the 2013 Canadian Forces mental health survey and through the recently announced Canadian Military and Veterans Mental Health Centre of Excellence, where research is conducted on unique aspects of military and veterans mental health.

Canadian Armed Forces members with more complex medical needs also benefit from the case management program. This program was established more than ten years ago. It offers services in all Canadian Armed Forces clinics located in Canada. Case managers are specialized nurses who are integral to the care delivery team and facilitate ongoing care for patients through a complex period of medical care. The goal of the case management program is to assist the Canadian Armed Forces member to navigate the medical and administrative system. The primary goal, where possible, is to achieve a return to duty after a complex disease or injury. However, for those members who have chronic medical conditions that have led to permanent employment limitations and do not meet universality of service, they work closely with VAC to assist with transition to civilian life in the safest way possible.

There are presently 66 case managers working with and for Canadian Armed Forces members. They carry a heavy caseload, which requires prioritization of patients based on the complexity of their case and care requirements. Our case management program works very closely with their counterparts in VAC. Analysis and work are presently being done to optimize the transition of the releasing member from the DND program to the VAC program.

A working group under the VAC-CAF steering committee has been established and has the mandate to broaden the definitions of case management in order to analyze the elements associated with the continuum of care for soldiers and their families. The transition period around release is a critical time to ensure long-term continuity of care for releasing members. A standardized assessment of all transitioning CF members is being done to determine the level of complexity involved in their transition from DND to civilian life. Whenever a member is identified as having complex needs regarding transition, a multidisciplinary team meeting is convened with the goal of proactively eliminating the identified barriers to allow for a proper transition from a health, financial, occupational, academic, and/or psychosocial perspective. In certain circumstances, additional transition time will be requested by the team in order to secure a safe transition. Each case is handled individually, on its own merits.

● (0855)

[*Translation*]

The multidisciplinary team will facilitate the transition of care, including referral to specialists and to a family physician in the local community where the released member has decided to reside. A case manager will also help the releasing member to obtain a provincial health card before release and to apply for all other eligible benefits such as SISIP, VAC, CPP and vocational rehabilitation.

When a member reaches the release date, although there is no longer an entitlement to care through the CAF, everything possible has been put in place to ensure the continuity of care via the provincial health care system and/or VAC.

[*English*]

In conclusion, the Canadian Armed Forces are committed to optimizing the health of our members in uniform during their years of service and to maximize their chances of returning to duty after an illness or an injury. For those Canadian Armed Forces members who are unfortunately unable to return to duty, our commitment is to provide them with access to high-quality care and assist them the best way we can to ensure continuity of care through VAC or the civilian health sector as they transition to civilian life.

Thank you, Mr. Chair, for your attention.

**The Chair:** Thank you very much, Colonel MacKay. I thank you very much for this edification. I want to thank you also because it lasted less than 11 minutes.

Our Standing Orders give the next round of questions six minutes. I'm going to stretch it out not to 11 minutes like last week, but to seven minutes. Please look at me for a signal.

Now I recognise Mr. Stoffer.

● (0900)

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

First of all, gentlemen, thank you for much for being here today. Thank you both for your service. I'm sure on behalf of the entire committee we send our condolences for the loss of one of your soldiers in arms in Iraq, Mr. Doiron. I know that this hits everyone very hard, so my sincere condolences to each and every one of you.

Sir, in your second to last paragraph you talked about how everything is in place to ensure the continuity of care via the provincial health care system or VAC. As you know, sir, almost five million Canadians don't have a regular doctor now. In our office we deal with an awful lot of people who are fearful of leaving the great health care service they receive from DND to go into the so-called public or private sector. In many communities they don't have access to that provincial care they were receiving beforehand. One of the things that has been suggested for quite some time is the ability of an individual when they release from the military to maintain those connections to CAF medical services until they find a doctor because, in many cases, as you know, sir, when they leave the military there is not a doctor or those types of services available in the public or private sector outside of DND. Has there been any consideration at your level of allowing CAF members when they release to have at least a year or two of continued access to CAF medical services while they transition to public or private services?

**Col Hugh MacKay:** Mr. Chairman, thank you for that question. I will say that at the present time as we look at the management of our patients and the complexity of their care, the way that we try to address the challenges they face with finding care in the civilian health sector is via the option of trying to extend the transition period. We try to maintain the patients within the Canadian Armed Forces for a period of time that will allow us to identify the care that may be accessed in the civilian health care sector. We have not taken into consideration engaging with the veterans once they have left the Canadian Armed Forces, but we have put in place a means to be able to extend the transition period to give us the best possibility of finding civilian health care providers.

I can tell you that I did confirm with our case managers that your point about finding primary care providers is probably their biggest challenge, and they work very hard to try to achieve that. They work in conjunction with the Veterans Affairs case managers to identify those care providers in the civilian sector.

**Mr. Peter Stoffer:** When the individuals from the Department of Veterans Affairs were here the other day, the assistant deputy minister indicated that it was up to the DVA to determine who is case managed. Who determines within the military who gets case managed? The reason I ask that is if you have a case manager, you're usually much better off in accessing services, benefits, treatment, etc., than you are if you're not case managed. I'm speaking in terms of home visits, and those types of things.

Within the CF, who determines which CF members get case managed?

**Col Hugh MacKay:** The case management decision is made within the Canadian Forces health services. It's primarily the clinicians who are caring for individuals who look at the complexity of the needs of the patients and identify whether or not it will be necessary for them to be referred to a case manager. Oftentimes that is related to whether or not they have been placed on medical categories, temporary or permanent. We have an assessment process that is undertaken with referrals for case management to determine whether or not they should have their cases managed within our case management program.

**Mr. Peter Stoffer:** Mr. Chairman, I'm just going to turn the rest of my time over to my colleague here, but I want to thank the CF members very much for the crew who went over to Africa to help with the ebola crisis. That was simply amazing. Our men and women who risked their lives on a daily basis to help eradicate, or at least stem, the tide of ebola deserve our great gratitude. If you could extend our congratulations to them for the tremendous work they did, that would be greatly appreciated.

● (0905)

**Col Hugh MacKay:** Thank you very much for that. I will extend those congratulations.

**The Chair:** Mr. Stoffer, Mr. Chicoine is....

**Mr. Peter Stoffer:** I'm going to give him an extra minute.

**The Chair:** Go for it.

[*Translation*]

**Mr. Sylvain Chicoine (Châteauguay—Saint-Constant, NDP):** Thank you, Mr. Chair.

I would also like to thank the witnesses for joining us this morning.

Could you explain, if you would, the process behind the decision to medically release a member who has experienced a service-related injury that leads to long-term disability? Could you also tell us whether the member has the opportunity to challenge the decision?

[*English*]

**Col Hugh MacKay:** We have in the military a process primarily run by the directorate of medical policy, whereby we assign employment limitations based on the nature of an illness or injury of a member. We in the health services do not make a decision as to whether or not somebody meets the universality of service standard. That decision is made by the chief of military personnel in the directorate of military careers administration, DMCA.

They look at the employment limitations that have been assigned based on the nature of the illness or injury, and make a determination with respect to universality of service. There certainly is a process where a member who is assigned employment limitations can question those employment limitations. The first step would be to do that with their health care provider. They can review the case, and seek specialist consultation if necessary to determine the nature of the employment limitations and the reasonableness of those employment limitations. If they're not satisfied with the decision from their primary care provider, they can also request a re-evaluation from our headquarters level in the Health Services Group, and we will then also consult further on the case and make a determination as to whether or not those employment limitations fit the illness or injury of the member.

At that point, the file will probably go over to DMCA, which will make a decision with respect to universality of service. If a member is not satisfied with the decision by the DMCA, they also have a further ability to grieve that decision, which could go all the way up to the level of the Chief of Defence Staff for a final determination.

**The Chair:** Mr. Hawn.

**Hon. Laurie Hawn (Edmonton Centre, CPC):** Thank you very much, Mr. Chairman.

And thank you both for being here and for your service, as Mr. Stoffer had said.

Just following up on that, we're seeing that it's quite a long process before somebody is determined not to fit the universality of service and that there are many methods for the member to seek redress if he disagrees with that.

Thank you very much.

Can you tell me the average time a member is spending before they're medically released? What's the average time from the determination a member might be medically released to the time the member is actually released?

**Col Hugh MacKay:** I think that for complex cases right now the average time we're looking at is about three years. For non-complex cases, we may not see a three-year transition period. It may be more like two years.

**Hon. Laurie Hawn:** For the more seriously injured, there's quite a long time of transition, where some of the things you described are in play to condition the member to transition as smoothly as possible to civilian life. Is that a fair statement?

**Col Hugh MacKay:** That's right, sir.

**Hon. Laurie Hawn:** Okay.

Maybe this is an unfortunately timely example, but there are the three fellows who were injured in Iraq. One is in Landstuhl, so I would assume he's the more seriously injured. Can you step through the process that happens from the time of injury in the field, in deployment—because that's where we're talking about a lot of bad things happening, obviously—to coming back to Canada for those three individuals, starting with the fellow in Landstuhl? For the other two, I don't know their conditions, obviously.

**Col Hugh MacKay:** Perhaps we can focus on the individual in Landstuhl, because that's the more complex case. The others may actually be able to return to their mission, depending on the nature of their injuries.

From the point of wounding, they will have buddy first aid applied. Then a medical technician will provide some advanced trauma care on the scene. They'll be picked up for medical evacuation and brought to a higher level of care, usually at a role 2 or role 3 facility within the area of operations. Once they receive some stabilization care in the role 2 or 3 facilities, a determination will be made as to their suitability for air evacuation back to Canada.

At the present time, we have access to the Landstuhl facility in Germany, which helps us step those casualties back in a safer manner. We step them into Landstuhl, where the patient may again receive further stabilization care, some more definitive care for their injuries. While they're in Landstuhl, we make arrangements for hospitals in what we call role 4 or back-in-Canada care, to be able to receive and manage the needs of patients who are in Landstuhl. I'm aware that we're right now arranging an intensive care unit to intensive care unit transfer from Landstuhl to Canada for this particular casualty.

● (0910)

**Hon. Laurie Hawn:** Landstuhl played a major role during Afghanistan. Do we still have CF medical staff in Landstuhl routinely?

**Col Hugh MacKay:** Due to the nature of our operations at the present time, sir, we do not have a detachment in Landstuhl, but our medical personnel in Geilenkirchen are tasked to go to Landstuhl when we have casualties there, in order to help them manage and coordinate that care and the transfer back to Canada.

**Hon. Laurie Hawn:** To switch gears, you mentioned a system called CROMIS. Could you talk a bit more about that and if it's able to speed up the assessment and so on. How does that work and how much is it speeding up the assessment?

**Col Hugh MacKay:** CROMIS is a mental health outcome measurement system. It's actually a system that Veterans Affairs Canada has been using in their OSI clinics. We recognize it as a valuable tool for us to be able to track the care of mental health patients.

As for what this does, patients present, and for each of their care appointments they fill in a questionnaire. We can map the results of that questionnaire on a graph and track the progress of symptomatology, because what the questionnaire measures is their symptomatology, and we know that there's a standard path that we expect patients to take with the improvement of their symptoms.

Should they not be seen to be following the path that we would like to see them follow, then we need to take a second look at what's going on with their care. It allows us the information to be able to tailor the care being provided and to more quickly adjust care if we're not achieving the effect we're looking for.

**Hon. Laurie Hawn:** The patient, the member, has access to that. He gets a question with some regularity about his condition improving or worsening and if the treatment is effective and so on. The patient is involved in that?

**Col Hugh MacKay:** When they come for their appointment, sir, they have an iPad and they answer the questionnaire. When they go in with their clinician, the clinician reviews the results with them and looks at their position on the plot.

**Hon. Laurie Hawn:** To go to the CAREN system for a minute, I was fairly involved with that in Edmonton, as you may know, and I've seen it in operation many times. It's a great piece of gear.

Last night I talked to the folks who were here at another meeting. They said they're mainly using it for research right now in Ottawa. In Edmonton, I think they're using it for some clinical work as well. How is that system developing in terms of it being used not just for research but for actual clinical work in difficult areas like PTSD? How is that coming?

**Col Hugh MacKay:** We are still in the research phases with respect to using the CAREN system for PTSD. We have another virtual reality system that we're using for PTSD that's more portable and office-based. We are working with our allies. The Israeli defence force in particular has some skills with respect to CAREN and its use for mental health treatment. We're working with them and looking at creating a study to better utilize that CAREN system with post-traumatic stress disorder patients.

**Hon. Laurie Hawn:** The first time I saw it, we were hooked up between Edmonton, Israel, and the Netherlands, and the technology was quite startling.

**Col Hugh MacKay:** It's quite incredible, isn't it?

**Hon. Laurie Hawn:** As for the capacity of members to remain attached to the Canadian Forces' medical system after they release, the point Mr. Stoffer and Mr. Chicoine were making, there's limited capacity within the CF in terms of the numbers of doctors. Is it as tight within the CF as it is within the civilian world, in terms of the numbers of doctors to numbers of patients who want them?

● (0915)

**Col Hugh MacKay:** I would say that we do not have any members of the Canadian Forces who don't have a family physician. We're able to provide for everybody in that regard. For us to undertake additional care, we're only staffed to manage our current cadre of military members and those reservists for whom we do provide care.

**Hon. Laurie Hawn:** Even if you wanted to hire them, do you think those doctors exist on civilian streets to be hired into uniform to provide the kind of after-service care that was mentioned?

**Col Hugh MacKay:** We do know we have challenges both recruiting uniformed physicians and hiring civilian physicians to work within our clinics. I suspect we would have difficulty filling additional physician positions.

**Hon. Laurie Hawn:** Is it even more acute on the mental health side?

**The Chair:** That's it. Hold it.

**Hon. Laurie Hawn:** Can he answer that question?

**The Chair:** Yes.

**Hon. Laurie Hawn:** Is it even more acute on the mental health side?

**Col Hugh MacKay:** It is more acute on the mental health side. We have a shortage of mental health providers, yes.

**The Chair:** Go ahead, Mr. Valeriote.

**Mr. Frank Valeriote (Guelph, Lib.):** Thank you for appearing before us today, Colonel MacKay. It was curious that you... [*Technical difficulty—Editor*]...presentation. On my iPad I was looking up the Israeli efforts into the study of PTSD, so I'm pleased that you mentioned it. I'm very curious about this. Can you elaborate a bit on the degree to which our Canadian Forces are looking at best or better practices in other countries? I know that Israel is studying the use right now of certain medications with the active forces before they are identified as having any kind of PTSD, so that, while in combat, there's an effort to train our forces to perhaps better or more stably respond to circumstances that might otherwise trigger PTSD. Can you elaborate a bit on that?

**Col Hugh MacKay:** As you can well imagine, trying to keep up with what's going on in the world of mental health care is not an easy challenge today. There are a lot of people spending a lot of time and energy researching mental health care and we're learning tremendously. We recognize these advances. We work very hard to keep up with what is going on, and to achieve that we participate in the NATO Human Factors and Medicine Research Panel, where all of the NATO countries and other invited countries are able to discuss what's going on in research in mental health, as well as other aspects of health care and medical care and protection. We also participate in a quadripartite group, the TTCP. I'm sorry, but I can't remember what that stands for right now, but it consists of Australia, Canada, the U.S., and the U.K, and it's where we share what's going on within health care. We've just stood up the centre of excellence in mental health, with Dr. Rakesh Jetley as the chair of mental health research at that centre. His role and that of the other members of that centre of excellence is to track what's going on with advances in mental health care treatment and to try to make sure that the knowledge is translated across our organization and within Veterans Affairs so that we can best apply those new practices.

**Mr. Frank Valeriote:** Are you aware of any breakthroughs on the horizon in treatment? Are we still stuck in the same old treatment or are there some new treatments forthcoming?

**Col Hugh MacKay:** I think that the greatest advances and greatest potential we have right now is where we're looking at more personalized health care. In the past, mental health care has been a little bit a case of, well, “We'll try this medication with the patient and see if it works, and if it doesn't then we'll try another medication.” We're starting to see through some forms of neurofeedback and genetics that some medications may be better for some patients than others, which is going to allow us to better target those things. We're also looking at neurofeedback to guide the actual treatment the individual is undertaking. Those are the kinds of things that I think are going to help us better care for our mental health patients.

**Mr. Frank Valeriote:** You mentioned an acronym, CAREN, a computer-assisted rehabilitation environment in Edmonton and Ottawa. If I were a member being moved to Edmonton or Ottawa and it wasn't my normal place of residence and I was suffering from PTSD, I would have a certain amount of anxiety and trepidation just in that move. To what degree are families accommodated in the treatment of CAF members when they are asked to go to these rehabilitation centres, if I'm getting it right? Do they spend long periods of time there? Is it days, weeks, months, and are their families accommodated so that they're not just phoning home from time to time?

● (0920)

**Col Hugh MacKay:** As I explained, we're really not at the point of using the CAREN system too much for the treatment of mental health casualties. It's mostly people who have physical injuries that we're using the CAREN system for right now. When we're treating patients with mental health concerns, we do bring in the family as much as possible, in discussion with the patient, in order to help the family member assist that patient. For the physical injuries, when we move a patient to Ottawa or Edmonton to use the CAREN system, at present we would not necessarily move a family member to do that.

**Mr. Frank Valeriote:** While still in uniform, can a CAF member who will be medically released meet with VAC representatives to prepare for the transition to civilian life? In other words, we've perceived a kind of Death Valley between active service and Veterans Affairs—this is what we've all heard about—and there is no doubt an effort to close the gap. Can you tell us about that transition from active service to becoming a veteran? While you're telling us that, can you talk about the family members who may be involved in the transition process?

**Col Hugh MacKay:** At the present time, our case managers usually pick up the case early on and start to manage it. Prior to release, we do engage with the Veterans Affairs case managers to make sure that things start to link up. Within our joint personnel support units and our affiliated IPSCs, there are Veterans Affairs case managers present. Most of the patients who are going to transition into civilian life are within JPSUs or IPSCs, where they are able to have contact with Veterans Affairs case management personnel.

As I said in my opening remarks, we are working, through a working group right now, to look at how we can make sure that there isn't that gap between the Canadian armed forces case manager and the Veterans Affairs case manager, trying to integrate them more fully into the planning of the transition for the member and the family.

[*Translation*]

**The Chair:** Mr. Lemieux, over to you.

[*English*]

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

Thank you very much for being here.

When I was in the military, there was a process with a temporary medical category leading perhaps to a permanent medical category. I'm wondering if you might be able to explain that process to the committee. I ask because sometimes there is a perception that, "Oh, we have an injured soldier; he's out." I don't think that's quite the case.

You had mentioned before that the process can take two to three years, depending on the condition. I'm wondering if you could perhaps walk us through the temporary category process, the permanent category process—with an injury that is either self-disclosed by a soldier or noticed by the system, let's say, when it's known that the soldier has an injury—and perhaps the timeframes involved. When you talk about the temporary category, phase one, can you explain some of the time periods that are involved in that?

**Col Hugh MacKay:** When members have been injured or become ill, whether they've come and reported it or somebody in the system has noticed it and asked them to have an assessment, their caregivers will usually take some time to evaluate their condition and try to see whether or not there is going to be much of a shift in those members' condition. The individual who has been wounded in Iraq, unfortunately, is not in a temporary medical category yet. He won't be in a medical category for some time, because we're going to need time to be able to assess and evaluate him. I think it's probably two, three, or sometimes six months before even the first temporary medical category may be assigned to an individual as the individual goes through the care workup and assessment.

A temporary category is usually six months. After an initial period of six months on a temporary category, very rarely would we put somebody in a permanent category. Almost always that person will have a second temporary category of six months. Usually after that second temporary category of six months, we are now well over a year into the process of this individual's illness or injury, so we are starting to get a good idea of what the prognosis is going to be. After that second temporary category, if we have good visibility of that prognosis, we may assign a permanent medical category.

There are conditions, however, where depending on the complexity of the case, it may take up to two years before a permanent medical category is assigned. After a permanent medical category is assigned, there is then the administrative process that has to be undertaken, and that can take six months to a year before a decision is made with respect to universality of service compliance. It's only at that time that a decision is made as to whether or not the individual will be released or be able to be retained within the Canadian Forces. Once that decision is made, I believe there is typically another six-month period of finalizing the transition. If we are starting to see that a member is going to have to leave the forces as we assign a permanent medical category, we'll really start the planning for what will be undertaken in that transition.

● (0925)

**Mr. Pierre Lemieux:** Generally speaking, because I know it's dependent on each specific case, if I heard you correctly, you said it can take roughly six months or up to six months to determine whether or not you can even start with a temporary category process. If he's assigned a temporary category, that can last six months. There's usually a second temporary category window of another six months. At the end of that, the decision to move to a permanent category will take time on top of that. You mentioned perhaps up to two years depending on the nature of the injury. Then there's the administrative process of determining whether or not he can stay in the forces with his permanent category, and that can take six to twelve months. Then there's the actual administrative release process. When a decision is made that you don't meet the universality of service, you start the release process, and that can take up to six months. That's how you're coming up with a window of anywhere from, let's say, two years. You had mentioned three years and it looks as though it could take as long as four years.

**Col Hugh MacKay:** It can.

**Mr. Pierre Lemieux:** It depends on the nature.

Perhaps you could shed some light on the difference between someone who has a permanent medical category and who does not meet the universality of service and therefore must be medically released and the person who has a permanent medical category and yet can be retained.

Are you able to give a generic example of each of those situations?

**Col Hugh MacKay:** Somebody with a permanent medical category who doesn't meet universality of service may be one of our patients who has had a heart attack and has a left ventricular ejection fraction of 25%, if you will, and is just not able to undertake the demands of military service and so would end up being released.

Somebody with perhaps a knee injury who has a permanent medical category and can only undertake restricted physical activity but who is still able to meet the universality of service may be retained. I'll also say, though, that there are people who have permanent medical categories, who do not meet universality of service, but who can be accommodated for a period of time within the organization.

Can that be up to three years?

**Colonel Marc Bilodeau (Director Medical Policy, Canadian Forces Health Services Centre, Department of National Defence):** It can be up to three years.

**Col Hugh MacKay:** So there are various categories and options. DMCA decides whether or not somebody will be accommodated, and that depends on where we are with respect to the trade the individual is in.

● (0930)

**Mr. Pierre Lemieux:** This might dovetail with what you said earlier about making sure that there's a continuation of care. In other words, they could be retained for a longer period of time if DMCA says so and if that can be coordinated within the trade to allow them perhaps a smoother transition back into civilian life or into civilian medical care?

**Col Hugh MacKay:** That may permit that transition, but oftentimes it's not the accommodation that's undertaken in order to enable the smoother transition. It's not called an accommodation. We just extend the transition period. They are going to be released, and we try to extend that as much as possible to allow the transition to occur.

**Mr. Pierre Lemieux:** Okay.

Thank you.

[*Translation*]

**The Chair:** In accordance with routine motions, the remainder of the questions and answers cannot exceed five minutes. I have a bit of flexibility, but not much.

It is now Mr. Chicoine's turn.

**Mr. Sylvain Chicoine:** Thank you Mr. Chair.

Gentleman, could you tell me when Veterans Affairs comes into the picture once a decision has been made to medically release a member? Is the department notified immediately? What's the process for the transfer of medical information?

[*English*]

**Col Hugh MacKay:** Are you familiar with that?

**Col Marc Bilodeau:** There are basically two different ways that Veterans Affairs is informed. One is through a member application for VAC benefits. As soon as a member decides to apply for these benefits, then the VAC is informed and will do their review process.

That's separate from the medical administration of the specific case.

In a complex case where we know that VAC involvement will be required after release, we are trying to have them involved as early as six months before the release. Our case manager and the VAC case manager will get together with the member and try to support them and transfer the support from one organization to another during that transition period, six months before the release. This process is separate from the other process by which a member can apply for VAC benefits.

We have some issues now because some members are applying late for their VAC benefits and are not considered eligible for these benefits within the six months before release. We are trying to work on that and reduce that timeline by having our case managers be more proactive in inviting the members to apply. We cannot do it for them, as they have to do it themselves, but we are encouraging them to apply for benefits when it's a service-rated condition and they can opt in for some support from VAC.

[*Translation*]

**Mr. Sylvain Chicoine:** Thank you.

Often, Veterans Affairs doesn't have access to the member's medical records. How does the department get that information? Does the member have to consent? Sometimes, the member's medical records are transferred to Veterans Affairs, but other times, they aren't. What steps have to happen to make the transfer of medical records possible?

[*English*]

**Col Hugh MacKay:** The transfer of medical records is usually done on a request from Veterans Affairs, based on the request by the member to Veterans Affairs Canada.

We are not able to transfer files directly from the Canadian Armed Forces to Veterans Affairs Canada because of their regulations and the Privacy Act. When we receive a request from Veterans Affairs Canada, we need to take the medical record and sever any third-party information from those medical records.

For example, sometimes when you are encountering a patient, a physician may write in a clinical note that the member's spouse is having problems with mental health issues. It's not appropriate for us to give information about the spouse to Veterans Affairs Canada. We need to make sure that that kind of information is removed from all of the files. That creates a bit of a delay in our being able to process and transfer those files. I will say that we have increased the staff that are doing that severing right now. We've reduced the backlog of files from about 1,600 to 800. We are now able to process requests from Veterans Affairs Canada within 31 days, which is far better than we did about 6 or 8 months ago.

We cannot release those files without the member's authorization and a request to Veterans Affairs Canada.

● (0935)

[*Translation*]

**Mr. Sylvain Chicoine:** So the CAF member has to request it, not Veterans Affairs. Medical records aren't transferred automatically. The member has to give consent.

**Col Hugh MacKay:** That's correct.

**Mr. Sylvain Chicoine:** Very good.

Can the CAF member gain access to their medical file easily? I would think they absolutely have to ask for it. Are they told that they can request it upon their release?

[*English*]

**Col Hugh MacKay:** A member can request a sit-down meeting with the caregiver to go through the medical file at any time. The member would be able to sit down with the primary care provider to go through that file.

We don't usually make a copy of it and hand it over until it is time for the release. At that time we prepare a severed medical file, namely one that is severed of third-party information. Sometimes if we have a vaccination parade, we may vaccinate 100 people, and that list ends up on the medical file. So there are 100 names that shouldn't be there, and we need to make sure that that information is removed. When a member is to be released, the member will receive a copy of the medical file, unless they make a special request to receive a copy of it before that time.

**The Chair:** Mr. Hayes.

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

I want to focus a little bit on mental health services to get an understanding of the synergies between Veterans Affairs and DND.

You referred to a Canadian Forces rehabilitation program, and obviously there's a rehabilitation services and vocational assistance program through Veterans Affairs.

We just studied mental health. In the Auditor General's report, and specific to the Veterans Affairs rehab services, the Auditor General is really happy that the eligibility decision is made within two weeks, 84% of the time.

I want to understand the eligibility component. How is it determined that a member would need mental health services? What is the wait time to determine that?

Here I want to understand the synergies between the mental health services that are provided through Veterans Affairs versus Canadian Forces. If there are two complete distinct separate components, that leads me to think there's a duplication of services, and I can't imagine that's the case.

So, talk a little bit about shared efficiencies, and talk about the eligibility decision behind the receipt of mental health services.

**Col Hugh MacKay:** Our mental health program is primarily designed to deliver care to Canadian Forces members or reservists who are entitled.

That said, we do also have an agreement with the RCMP and Veterans Affairs Canada to be able to look after some veterans or RCMP members within our mental health program. We are also able to access the OSI clinics of Veterans Affairs Canada for some of our members if there is a need, and usually that would surface with a reservist because we may not have a base nearby where the reservist lives.

To be eligible for mental health care in the Canadian armed forces, you present to our clinic. Usually you present to a primary care clinic first to discuss whatever medical problem you have, and you are taken into our program.

Usually the management of a patient would start at primary care. If the primary care providers feel there a need for further specialist care, then the patient would be referred either to our mental health clinic or to the OTSSC depending on the nature....

Sometimes we undertake screening. We do screening with our periodic health assessments for mental health problems. We also do an enhanced post deployment screening about six months after people return from deployments. If we pick up somebody in that screening process, we'll call them in to have a discussion with them about what's going on with them, and determine whether or not it's time for them, or if they do have a mental illness we need to help them with.

● (0940)

**Mr. Bryan Hayes:** The Canadian Psychiatric Association has said that almost a third of Canadians who seek mental health care report that their needs are unmet or only partially met. That speaks to the evaluation component with respect to mental health care.

I want you to talk a bit about the quality of what's provided, and how you evaluate whether the members are receiving what they need, or is there an evaluation methodology?

**Col Hugh MacKay:** CROMIS is going to be our main evaluation methodology. That is really going to be how we're going to look at outcomes.

However, we have looked at the patient satisfaction with the care they are being provided through two venues.

Our directorate of force health protection does a health and lifestyle information study every four years. In it there are questions about accessing mental health care, and whether or not the person felt they got the help they needed when they did access care. Also within the recent survey that we had done by Statistics Canada, which was a follow-up to our 2002 study looking at mental health in the Canadian armed forces, we also had questions about satisfaction with care.

That would be the latest data we've collected. Unfortunately, I don't have that analysis available to me just yet, and I'm not sure that analysis has been completed from that 2013 survey just yet, but we did look at it.

**Mr. Bryan Hayes:** Good.

Thank you.

[*Translation*]

**The Chair:** Mr. Lizon, you may go ahead.

[*English*]

**Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC):** Thank you, Mr. Chair.

Thank you, gentlemen, for coming here and thank you for your service.

I will go to mental health again and I will read a portion of your presentation here:

> Within the mental health program there's a strong research element. Currently the main research efforts are focused on the analysis of the 2013 Canadian Forces mental health survey and through the recently announced Canadian Military and Veterans Mental Health Centre of Excellence, where research is conducted on unique aspects of military and veterans mental health.

Can you expand on that and maybe tell us what exactly that research is focusing on?

**Col Hugh MacKay:** The mental health survey from 2013 is really trying to help us understand the extent of mental illness in the Canadian Armed Forces and look at the change between 2002, when we initially did this survey, and 2013. We designed that study in a way that also used questions that were very similar to the civilian survey that was done by Statistics Canada, so it gives us the ability to compare numbers in the Canadian Armed Forces with those in the civilian health sector as well, which is useful for us to be able to understand mental illness in the Canadian Armed Forces.

We have also looked at things like how military personnel access care. Who do they go to if they feel that they have concerns with mental illness? What is it that would stop them from going for care if they feel they have mental illness? We try to evaluate access to care, barriers to care, and those kinds of things so that we can try to put in place measures to ensure that people are able to come forward for care when they need it.

Our centre of excellence is going to be looking at things from a more clinical perspective than we're able to do in a survey. The centre of excellence really wants to try to keep track of what's going on cutting edge with respect to care. This is where we're going to try to undertake some of the studies that are looking at personal life mental health care, looking at neurofeedback, looking at neuro-imaging, what we're learning with respect to how the brain responds to post-traumatic stress disorder, and whether or not there are changes that we can track and see when people are being treated.

We're also trying some new medications and are looking particularly at control of nightmares and sleep disturbance in post-traumatic stress disorder. I think that those are probably the main differences between the Centre of Excellence and what we're doing with the survey.

● (0945)

**Mr. Wladyslaw Lizon:** You were talking about treatment, but it would be a great success if we could prevent to a great degree mental illness. Therefore, is there anything being done on that side, and then the findings incorporated into a training program of Canadian Armed Forces members so they will not actually get mental illness? That would be a great success.

**Col Hugh MacKay:** That's a very good point. Absolutely.

We have our education program called the road to mental readiness. We do have a study to look at the road to mental readiness and the effectiveness of the road to mental readiness program.

One of the things that we've identified is that you can't use a cookie cutter education program within the Canadian Armed Forces. We have different populations within the Canadian Armed Forces and we've started to tailor some of the road to mental readiness program to those different communities that we have.

There are, for example, the special forces community, the group of people who do intelligence work and fly remotely piloted vehicles. Those types of communities may have different needs, so we're starting to try to tailor that education and prevention program through the road to mental readiness to those particular populations and to try to do an evaluation of the effectiveness of those programs.

**Mr. Wladyslaw Lizon:** Just quickly—I don't have much time left—you mentioned 66 case managers and that they have very heavy workloads. Can you maybe expand on this? What is a heavy workload? How many people would they have to look after?

**Col Hugh MacKay:** We have 66 case managers, who are carrying on average 70 cases per person. It is a difficult workload for them, so we need to examine how we can make sure that they are able to provide, from a case management perspective, for the care that our personnel need. We are able to prioritize the people who have the most complex care needs to the top of the list; they're able to see a case manager within seven days of a referral from their primary care provider.

We're also looking at things such as how to redo their work. For example, instead of doing individual sessions with some people, they're able to do group sessions for people who require case management education.

We're also looking at the integration of case management between our case managers and Veterans Affairs', to try to share the load as we look at transitioning patients.

**The Chair:** Mr. Rafferty.

**Mr. John Rafferty (Thunder Bay—Rainy River, NDP):** Thank you, Chair, and thank you both for being here today.

I'm a little confused about something you said earlier regarding medical files. One of the recommendations from this committee was to ensure that all regular force members had their files before they were released. If I heard you correctly, you said that is being done.

**Col Hugh MacKay:** That is being done.

**Mr. John Rafferty:** It is being done?

So there is a disconnect for me. Why would Veterans Affairs even have to get back in touch with you again, if all the members who are now accessing Veterans Affairs already had their medical files. Could you clear that up for me?

**Col Hugh MacKay:** Usually our members make application to Veterans Affairs before they leave. We're giving them a copy of their medical file around the time of their release, but Veterans Affairs certainly wants to become engaged and to be able to evaluate what entitlements they may have before it is time for their release. Members at any time, even if they are not going to be potentially released, can make application to Veterans Affairs for benefits. Particularly, if they have suffered some illness or injury that isn't causing them a great deal of medical problem within a special duty area, they may make application to Veterans Affairs.

**Mr. John Rafferty:** The member who doesn't access Veterans Affairs immediately but may do so, say, five or ten years down the road, will have their medical files with them. So there won't be any need for Veterans Affairs to get back in touch with you to get their files, because they will already have them from their service.

● (0950)

**Col Hugh MacKay:** Giving the members those files as they depart is relatively new for us. Traditionally, the files have gone to Archives Canada, and Veterans Affairs has not had to come back to us. If it's five years out that a member applies to Veterans Affairs, they would get the file from Archives Canada, typically.

**Mr. John Rafferty:** Then let me ask you what changes you would make to ensure the continuity of care between Canadian Forces and Veterans Affairs. Is there something in your daily work about which you would say, we could make this better? Are there any changes you would make to improve that continuity of care?

**Col Hugh MacKay:** I think the work we're undertaking right now, trying to better link up our case management systems, is the key for us with respect to ensuring that we don't have a gap or potential break in the continuity of care as they transition from us to Veterans Affairs Canada. That's where I think we need to focus our efforts.

**Mr. John Rafferty:** Colonel Bilodeau, did you want to make a comment on this?

**Col Marc Bilodeau:** I took a few notes while you were speaking, but early case management involvement is, from a VAC perspective, really key, and we're working on this. The other piece we're working on is to try to establish similar competencies between the two groups of case managers. Our case managers are nurses; VAC case managers are not all clinicians. This creates an issue from the perspective of sharing the medical information. VAC is working to bring itself to a similar level of clinician case managers.

**Mr. John Rafferty:** Would it be helpful if every member, when released, automatically kept their number, for example, whatever their member number was, and automatically everything went to VAC, so that everything happens whether they access VAC services or not. Is there a way to make sure that people don't fall through the cracks as they try to access services that they might be confused about?

**Col Hugh MacKay:** I know there is work under way within our VAC CAF steering committee, including discussions around My VAC Account, which I think is a good idea. The intention is that, as members join the Canadian Armed Forces, they become aware of Veterans Affairs Canada and may start a VAC account so that they already have something in place with Veterans Affairs Canada. I think we're far less likely to have people leave the service, go off into their civilian lives, and then have some trouble reconnecting with Veterans Affairs Canada at a later date if they have something like that in place.

**Mr. John Rafferty:** Thank you.

Do I still have time for one more question, Chair?

**The Chair:** You have time for a quick question, not a Valeriote kind of question.

**Mr. John Rafferty:** When you are asked by your bosses to find efficiencies, and it happens with all governments—it's happened for decades—is there a process you go through to find those efficiencies? I'm not talking about this particular government. It happens all the time.

For example, if one of your ways to find efficiencies is to let people retire and not replace them for a period of time until new budget cycles or whatever the case may be, perhaps there's more of a reliance on provincial and territorial health care systems in that kind of instance.

When you are asked to find efficiencies in your area, what is the process you use to go about doing that?

**Col Hugh MacKay:** I think our requirement, our mandate, is to find efficiencies always. We as an organization have tried very hard to be as efficient as possible.

We have something we call our quality and patient safety advisory committee. Within that quality and patient safety mandate, we are forever trying to find greater efficiencies.

A perfect example has to do with the management of back pain, for example. Many people expect that, when they show up at a doctor's office with back pain, somebody's going to do a CT scan on their back. Well, there's no clinical indication to do a CT scan. We actually had a look at CT scanning and identified that perhaps our clinicians were doing more CT scans than they should to manage low back pain. We put together a working group and have come up with a clinical pathway to guide clinicians on how to better use the resources they have at hand.

We have processes in place to look at what we're doing, evaluate whether or not we're meeting best practices, and try to make sure we do get in line with best practices and use the resources we have as efficiently as possible.

Thank you.

● (0955)

[*Translation*]

**The Chair:** Mr. Opitz, you may go ahead.

[*English*]

**Mr. Ted Opitz (Etobicoke Centre, CPC):** Thank you, Mr. Chair.

Thank you both for being here today.

I'm hoping to ask something directed at policy, so Colonel Bilodeau gets to weigh in on some of that.

As a former infantryman, I was broken a lot.

**Col Marc Bilodeau:** And you're still broken.

**Some hon. members:** Oh, oh!

**Mr. Ted Opitz:** Yes, I am. I was even accused of being unskilled by my artillery comrade last week.

Anyhow, it was a very positive experience because anything I and my comrades needed, we got. We got put back together and we got back into service, or we were put back into a serviceable condition at least.

I have personal examples. I have a friend who's posted to the college right now. He has 38 years' service and was supposed to retire last year, but you didn't let him because you had to fix his knees and a whole bunch of other things, and he wasn't being released until he was 100%. This fall, perhaps you'll actually let him go, so that's very, very positive.

On similar lines to some of the questions we've already had, it seems to me you're not static: you're very dynamic in the way you're looking at treatments. You're looking forward. You're looking at the NATO example, in terms of the working group there. I presume you're working with CIMVHR, the Canadian Institute for Military and Veteran Health Research, and looking at some of the good papers they've come up with, and in collaboration with that.

Could you maybe describe some of that?

Last year, by the way, it pays to note that the defence committee did a study on the care of the ill and injured as well, which is a very detailed study that dealt with a lot of this, with a lot of the virtual reality treatments you're doing with people who have lost limbs and so forth, in concert with the Ottawa Hospital and so forth.

Can you describe how some of those dynamic principles are at work in what you do every day and how they help adjust and shape policy?

**Col Hugh MacKay:** I'll start out.

The medical world is very dynamic and we do our best to keep our finger on the pulse of what's going on in the medical community. We do that through our relationships with organizations like the Canadian Medical Association, the Canadian Psychological Association, and all of those kinds of groups. We absolutely are closely linked to CIMVHR and are looking at what they're coming up with.

We work closely with our allies. We have a lot that we can learn from our allies, and we have a lot that our allies can learn from us. It's very important that we maintain those relationships and look at what they're doing with respect to the care of their ill and injured, and to try to, where it makes sense, implement what they're doing within our organization.

We have a body called the Spectrum of Care Committee that sits periodically in order to evaluate what new technologies or new treatments come online. We assess those against criteria, the primary one being that of a good medical evidence base to support its use. Where it makes sense, our Spectrum of Care Committee will introduce those types of treatments within our spectrum of care so that we can stay on the cutting edge.

**Mr. Ted Opitz:** When you said that case managers are overloaded —basically with 70 cases each—why is it so hard to attract good case managers?

**Col Hugh MacKay:** We have only 68 full-time positions for case managers. At the present time we're restricted as to how many case managers we can actually hire.

Case management is a kind of specialized field of nursing in our consideration, so there aren't a whole lot of case managers out there. Within the 68 positions that we have, 16 of those are filled through our third-party contractor because we haven't been able to attract nurses to come into the public service. Some of that has to do with competitiveness for that particular profession.

● (1000)

**Mr. Ted Opitz:** What would your optimum number be for case managers?

**Col Hugh MacKay:** We've targeted 50 to 55 cases per case manager, which would suggest that I would need another 20 case managers in order to reach that particular target.

**Mr. Ted Opitz:** Okay.

In terms of doctors and mental health care professionals, why are they having such a difficult time coming up with doctors and mental health professionals on the civilian side?

Would you have any insight into that?

**Col Hugh MacKay:** Well, the universities have funding to produce a certain number of professionals in each of the professions. I believe it is the limitation of the training system to be able to produce greater numbers of these professionals at this time.

**Mr. Ted Opitz:** So it's a focus on medical schools. For example, I think I may be wrong on the number, but last year my understanding is that one of the universities in Toronto graduated only two gerontologists for an aging population.

Is that the similar kind of issue that we're dealing with there?

**Col Hugh MacKay:** Absolutely.

Psychiatry hasn't been an attractive profession sometimes as well, so not a lot of residents would necessarily look at psychiatry as a profession.

**Mr. Ted Opitz:** Now, you talked about introducing veterans correction....

**The Chair:** [*Inaudible—Editor*]

**Mr. Ted Opitz:** Say again? Am I done?

**An hon. member:** You're getting the evil eye.

**The Chair:** You're more than done.

However, with the committee's indulgence, I like your line of questioning, and if you don't mind I have some questions of my own, and they have to do with case managers.

Did you have spies here when we had the witnesses from the Department of Veterans Affairs 12 days ago?

**Col Hugh MacKay:** Sir, I didn't have a spy, but I read the transcript.

**Some voices:** Oh, oh!

**The Chair:** That's even better. You will have noticed in that transcript that we were told that the wait time for a case manager at DVA is a month. Here, with National Defence, it's seven days. The average number of cases for each case worker is 34 at Veterans Affairs. With you, it's double, 70.

The one question that I raise is how do we make the transition seamless, from being an active member of the forces to becoming a veteran? Is there a mechanism by which your case workers and those at Veterans Affairs speak with each other, so that one would know, that oh, my God, I have 70 cases actively but you only have 34, life is unfair.

**Col Hugh MacKay:** So, Mr. Chairman if I may, in fairness to my colleagues in Veterans Affairs—

**The Chair:** Who will now read your transcript.

**Col Hugh MacKay:** Probably so.

I put the caveat on the seven days to those that have complex cases. As I said in my opening comments, we have a prioritization system and we will prioritize those persons with very complex care to the top of the list. We are seeing them within seven days. We have about a one-month wait list for all other categories within our case management program. Although my case managers are carrying more cases, we do still also suffer from some wait list...but not for those with the most complex care issues. We do have a mechanism for our case managers to speak with the Veterans Affairs case managers. The case managers of Veterans Affairs are within the Canadian forces IPSCs and our case managers meet with them there.

One of the challenges has been having the Veterans Affairs case managers pick up the clients a little earlier in their transition phase as opposed to near the end of their transition phase. That's one of the big things that we're working on to try to make sure that we can have as smooth a transition as possible as the veterans leave the Canadian armed forces. So our case managers are speaking about the cases. I believe they even participate in the multi-disciplinary team meetings —

● (1005)

**Col Marc Bilodeau:** Yes.

**Col Hugh MacKay:** —at the present time as well, so that they hear about what the plan is for their care within the Canadian armed forces and what the plan is as they transition out.

**The Chair:** I thank you very much for your testimony today and thank you for sharing with us.

Mr. Hawn.

**Hon. Laurie Hawn:** I call a point of order to your attention but it's really not a point of order. It's a point of information related to one of Mr. Valeriote's—

**The Chair:** It's one of these Valeriote kind of things?

**Hon. Laurie Hawn:** It will inform the members and it's relative to one of his questions about whether families are involved in rehab when they're at distance. There's a place in Edmonton called Valour Place, which you may be aware of. It's a place that is serving as a model I think for other cities in the country where up to 12 families can be accommodated gratis while their member is undergoing physical or mental rehab at the Glen Rose Rehab Hospital or the other hospitals in Edmonton. So it's a great facility. It was started by some very good folks in Edmonton. I think other cities are looking at it because it is something worth having. Valour Place. You just google Valour Place. You'll see it and you'll be impressed.

Thank you.

**The Chair:** Thank you very much, Mr. Hawn.

[*Translation*]

I want to let the committee members know that the 40th meeting will take place on Thursday.

[*English*]

Our witnesses for the next meeting on continuum of transition services will be from Veterans of Canada, Honour House Society, the Veterans Transition Network, Monster Canada, Military Minds Incorporated, and Veteran Voice.info. Thank you very much.

Mr. Stoffer wants to share something.

**Mr. Peter Stoffer:** As you know, the main estimates are out and usually it's practice to invite the minister as soon as possible when the estimates are out to discuss them. Is there an opportunity for the minister and his officials to show up within the next few weeks?

**Mr. Pierre Lemieux:** When are the estimates due back?

**The Clerk of the Committee (Mr. Jean-François Pagé):** May 31.

**Mr. Pierre Lemieux:** Okay, so let me get back to the committee on that.

Thanks.

**The Chair:** Thank you, merci.

The meeting is adjourned.