VETERANS AFFAIRS CANADA

SPECIAL NEEDS ADVISORY GROUP (SNAG)

On the implementation of

The Canadian Forces Members and Veterans Re-establishment and Compensation Act – Bill C-45
"The New Veterans Charter"

REPORT # 3

14 DECEMBER 2007

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1. INTRODUCTION

a. The Canadian Forces Members and Veterans Re-establishment and Compensation (CFMVRC) Act, Bill C-45 was passed into legislation on May 13, 2005. This Act is also known as the New Veterans Charter (NVC). The terms Bill C-45 and the NVC are used interchangeably throughout this report and in all instances imply the Act itself.

b. The Veterans Affairs Canada (VAC) Ad Hoc Advisory Group on Special Needs was established to serve as an appropriate portal that will allow access for "Special Needs Veterans" to be heard. In addition, it will provide comprehensive, balanced and ongoing recommendations to the Department. This Group has become better known as the Special Needs Advisory Group or SNAG for short.

c. At the November 2007 meeting, Darragh Mogan, Executive Director, Modernization Task Force announced that the Special Needs Advisory Group was no longer "ad hoc" and the term "ad hoc" has been dropped from the title of the Special Needs Advisory Group.

d. There are two principle objectives of the SNAG. First, in the short term, obtain input on the development of regulations from those persons (Special Needs Veterans) who may have the greatest apparent re-establishment challenge with a view to determining if the "client's needs" are being met and provide recommendations to VAC on improvements, as required. Secondly, over the long-term, post April 1, 2006 implementation, the SNAG will provide ongoing advice to VAC on the responsiveness of its policies, programs and services in fully meeting the needs of Special Needs (SN) Veterans, identifying enhancements that would better respond to those clients' needs as well as determining if there are any significant gaps or omissions in benefit and service delivery.

e. This is the third report in a series of ongoing reports. It is a snapshot in time and the information presented and commented upon is based upon the information that was provided to the SNAG since 16 November 2006. The NVC is dynamic in its policies and regulations, and consequently there are changes that have taken place since this report was put together which may render certain sections and recommendations out-dated.

2. DISCLAIMER

a. The information presented in this report represents the SNAG's analysis of the material that has been provided to the advisory group by VAC. Consequently, the

SNAG acknowledges that the material contained in this report may not be complete or based upon all facts that may be available.

b. The SNAG reported in its first report that they were aware of the efforts by other independent veterans groups that are concurrently examining the NVC, and that VAC has yet to provide the SNAG with a synopsis of those efforts.

c. The members of SNAG are not experts in NVC regulations, as they pertain to programs, benefits and services, consequently many of the observations and recommendations presented are from a layman's perspective.

3. ASSUMPTIONS

a. It is assumed by the efforts of the SNAG team that programs, benefits and services of the NVC will continue to evolve so as to better meet the ongoing and changing needs of SN veterans.

b. SNAG was assembled to examine how the Charter meets the needs of SN veterans, however in the course of this Group's efforts it has become apparent that this review could not be done in isolation of the entire Charter or the previous Pension Act (PA) provisions. Therefore all aspects of the Charter continue to be considered, if not in this report, subsequent reports and compared when applicable to the PA.

c. In conversations with VAC it is assumed that the main effort of SNAG commenced with the implementation of the NVC on 1 April 2006 and that SNAG will monitor the effectiveness of VAC's ability to implement the Charter and provide observations and recommendations for improvement.

d. It is assumed that while SNAG may provide observations and recommendations, VAC does not have to implement them. It is assumed that VAC will provide feedback to SNAG as to the status of the observations and recommendations that were provided, specifically those recommendations that were adopted and for those that were not – why not.

e. It is assumed that the activities of SNAG will become a matter for public record, accordingly this report, and all SNAG submissions are written with that assumption.

f. It is also assumed that SNAG is not required to render an endorsement or rejection of the New Veterans Charter; rather SNAG is to provide unbiased assessment of success or lack thereof of the NVC and its implementation.

4. SNAG COMPOSITION

a. SNAG is national in scope and all members are willing to participate and collectively represent their particular area of expertise and/or experience. Membership in SNAG consists of Canadian Forces (CF) veterans (all of whom are SN veterans of VAC), CF representation, members of the health, medical and family services professions, and Consultants to SNAG from VAC.

b. The current and former members of the SNAG along with VAC Departmental advisors are listed at Annex A.

c. Members of SNAG, not representing or contracted by the federal government, are reimbursed for services at the prescribed VAC rates. All members of SNAG are reimbursed for travel, meals and lodging expenses to attend scheduled meetings.

d. All members of SNAG have agreed to and have signed the Terms of Reference, including Conflict of Interest, Ethics and Confidentiality agreements, as presented by VAC. A copy of each is held with VAC.

e. SNAG is a collaborative advisory group; each member brings their own individual experiences and expertise.

f. SNAG is supported administratively by the Secretariat, Consultation Directorate of VAC, which is responsible for all administrative support and for maintaining the records management function for SNAG and its operations.

g. Shortfalls/vacancies have not been filled; this is having an impact on the balance of discussions and their outcomes without the professional inputs from a physiatrist and a family doctor. It would also be beneficial to increase the numbers of veterans on SNAG as per Paragraph 4 of Annex A.

5. SNAG TERMS OF REFERENCE

a. VAC has provided Terms of Reference for SNAG generally concerning the objective of the advisory group, membership criteria, operations of SNAG and conflict of interest, ethics and confidentiality guidelines. A copy of SNAG's Terms of Reference is held by VAC.

b. It is felt however that a reiteration of the Terms of Reference Objectives for SNAG would be useful in establishing the basis for this and subsequent reports.

Objective

The immediate objective of the ***VAC Advisory Group on Special Needs*** is to obtain input on the development of regulations from those persons who may have the greatest

apparent re-establishment challenge. In examining the proposed regulatory content with actual clients, the goals would be to determine if proposals meet clients' needs; if there are variations on the proposals that would better respond to those needs; and, to determine there are any significant gaps in the proposed Government response from a benefits and services perspective. Attention to family needs will be a consideration of the Advisor Groups as well.

The Department recognizes that this regulatory process may not be able to fully address all the challenges facing its Special Needs clients. The longer-term objective of the ***VAC Advisory Group on Special Needs*** is to provide ongoing advice to the Department on the responsiveness of its policies, programs and services in fully meeting the needs of clients with special needs, identifying enhancements that would better respond to these clients' needs as well as determining if there are any significant gaps or omissions in benefit and service delivery. In this way, benefits and service will continue to evolve so as to meet the ongoing and changing needs of Special Needs Veterans.

6. SYNOPSIS OF SNAG ACTIVITIES

a. **Formation.** The SNAG was formed in August 2005 with an invitation from VAC to voluntarily participate. Packages of read-in material are provided by VAC to SNAG members on an on-going basis.

b. **Conduct of Meetings**

i. All meeting administrative arrangements are coordinated by the Secretariat, Consultation Directorate of VAC;

ii. The Chair of SNAG in consultation with VAC establishes the Agenda for upcoming meetings and these are then distributed to members of SNAG via e-mail or by courier;

iii. At each meeting the Agenda is reviewed and approved by the participants; and

iv. A Record of Discussion (ROD) is kept by the Secretariat, Consultation Directorate of VAC. The ROD is distributed to all members of SNAG for comments and approval of the ROD is confirmed at the subsequent meeting.

c. **SNAG Meetings**

i. The SNAG has met formally four times since Report #2 was submitted on 16 November 2006, as follows:

1) 5-7 December 2006 in Ottawa ON;

2) 20-21 March 2007, in Ottawa ON;

3) 27-28 June 2007, in Ottawa ON; and

4) 6-8 November 2007, in Halifax NS.

ii. One special SNAG meeting was convened on 6-7 December 2007 in Vancouver BC to work on elements of this SNAG Report #3;

iii. Interviews of Veterans and their families were facilitated on two occasions, once in Ottawa on 5 December 2006 and in Halifax on 8 November 2007. Interviews of Veterans during the March and June 2007 meetings unfortunately could not be facilitated in time by VAC; and

iv. SNAG Meetings, originally 4 times annually, were scaled back to 3 times in 2007 and moving forward will occur only twice a year. It is envisaged that VAC will continue to coordinate interviews with SN Veterans and their families at each meeting.

d. **Mental Health Steering Committee Report**. The Chair of SNAG made a presentation to the Mental Health Steering Committee (MHSC) on 1 April 2007 on the activities of SNAG, with a particular focus on mental health issues. A copy of the presentation given to MHSC is attached at Annex D.

e. **New Veterans Charter Advisory Group Report**. The Chair of SNAG sits as a member of the New Veterans Charter Advisory Group (NVCAG). The NVCAG held its initial meeting on 31 May - 1 June 2007 and a subsequent meeting on 27-28 November 2007, both in Ottawa ON. Information presented to NVCAG may be requested from the Chair of NVCAG through VAC.

f. **Gerontological Advisory Council Report**. The Chair of SNAG attended the Gerontological Advisory Group (GAC) on 1 April 2007 in Charlottetown PE and in Calgary on 4 November 2007. The GAC document, *Keeping the Promise* was forwarded to all members of SNAG in May 2007. Information presented to GAC may be requested from the Chair of GAC through VAC.

g. **Conference Calls**. In addition to formal meetings, there have been several Conference Calls either with the entire SNAG or portions thereof depending upon availability or calls between VAC Departmental Advisors and the Chair of SNAG as required.

h. **Veteran Interviews**

i. A series of interviews were conducted by SNAG members with veterans and families, in order for members of the SNAG to have a broader insight and understanding of the needs of SN Veterans and their families;

ii. Interviews were conducted in Ottawa and Halifax, in December 2006 and November 2007 respectively;

iii. It must be noted that part of the mandate of SNAG is to seek input from Veterans and their families. SNAG requested the opportunity to speak with veterans at both the March and June 2007 meetings but this could not be arranged by VAC. SNAG feels that these are lost opportunities and with the reduction of meetings to just twice a year it is imperative that VAC arrange for Veteran interviews at all subsequent meetings;

iv. In order to gain honest and impartial insights from the SN Veterans during the interviews all discussions were confidential in nature, no record of discussions were kept and VAC staff were not present for the interviews. However, areas of concerns identified during the interviews have been used by SNAG as part of the observation/recommendation portion of this report;

v. Many of the veterans interviewed to date that fall within the mandate of the NVC are still serving and have not entered the transition phase. SNAG will be looking at conducting supplementary interviews on selected veterans at a later date (post release) to ascertain the effectiveness of VAC Client Service Team and the NVC programs, benefits and services; and

vi. A more substantial review of the NVC and how well it is serving its clients is needed. This would be a follow on to the Corporate Research Associates survey conducted in 2005. Ideally this second survey should be conducted no later than 2009 with SN veterans and their families as the focus, and it should include service providers.

i. **Presentations**

i. At each meeting there have been formal presentations made to the SNAG by specific individuals related to the issues in the NVC; and

ii. A list of presentations made to the SNAG is attached at Annex B.

j. **Documents**. A list of documents pertaining to Presentations made to the SNAG or provided by VAC to the SNAG since the last report is attached at Annex B.

k. **Agendas and Records of Discussions**. A copy of all Agendas and Records of Discussions since the last report are attached at Annex C.

l. **Work Implementation Packages**

i. The following three Work Implementation Packages (WIP) were introduced at the September 2006 meeting:

1) NVC Gaps in Client Program Benefits and Services for Special Needs' Veterans (SNAG-2006/07-1);

2) NVC Family Needs – Special Needs Veterans (SNAG-2006/07-2); and

3) NVC Special Needs' Female Veterans (SNAG-2006/07-3).

ii. The WIP proved to be a distraction for the ongoing activities of SNAG. In addition, SNAG did not have the depth of committee members to properly address the issues identified in the WIP. Actually, the three WIP were being addressed separately by SNAG. The requirement for the WIP was dismissed at the March 2007 meeting.

7. OBSERVATIONS AND RECOMMENDATIONS

a. **General**

i. It is not the intention of SNAG to repeat previously reported observations and recommendations unless new information particularly suggestions or recommendations have come to light. The observations and recommendations continue to reflect a special need's focus while examining potential gaps in the provision of programs, benefits and services;

ii. SNAG remains concerned that there are subtle changes within VAC that may actually be reducing or limiting SN Veterans access to the provision of programs, benefits and services. At this point these concerns are anecdotal in nature but will be pursued vigoursly for substantiation by SNAG;

iii. SNAG remains concerned that the focus on the Family is not as strong as it should be and that there needs to be a greater emphasis placed upon the entire family including the provision of programs, benefits and services specifically for them; and

iv. SNAG is convinced that there are issues pertaining to CF-VAC inter-relationships and inter-departmental cooperation that could be negatively impacting on the needs of all veterans, especially SN Veterans and their families, this needs to be further examined.

b. **Report #2 Review**. The second report from SNAG, submitted in November 2006, contained 20 observations and 45 recommendations. VAC Departmental advisors have reviewed this report and have provided SNAG with verbal and written responses. SNAG understands that it is in a purely advisory role and as such appreciates any feedback from VAC Departmental advisors on issues identified. It is SNAG's hope that the observations and recommendations provided will be put to good use, not merely acknowledged and then put away with no further discussion or action.

c. **SNAG Membership Composition.** In discussions with SNAG members it has become apparent that there is too much to consider regarding the implementation of the NVC to be handled by just 11 members (with 3 vacancies). This small number does not lend itself well to establishing working groups to address specific areas of interest. It is recommended that SNAG be increased from the present 11 members to 17 members as follows:

i. 9 Veterans;

ii. 1 Spouse/significant other;

v. 1 Legal advisor;

vi. 1 Social Worker specializing in family needs;

vii. 1 Family Physician;

viii. 1 Physiatrist/Rehabilitative Medicine Specialist;

ix. 2 Psychiatrists; and

x. 1 CF advisor.

d. **Format of Observations and Recommendations**. The format for this portion of the report will follow the format used in previous SNAG reports, using the Observation and Recommendation format. The Observations and Recommendations are grouped into the following categories for the purpose of this report:

i. Rehabilitation and Case Management;

ii. Families and Care Givers;

iii. CF/VAC Collaboration;

iv. Programs, Benefits and Services; and

v. General Issues.

e. **Rehabilitation and Case Management**

i. **Treatment Benefits**. From SN veteran interviews there appears to be a gap in the provision of massage, physiotherapy and chiropractic services when it comes to the extension of services beyond first approval. There is then a pause in treatment until extension of benefits are granted (if indeed they are granted), this pause reduces the overall effectiveness of the treatment plan and causes undue stress on the veteran.

Recommendations. It is recommended that for SN veterans the process for extension of massage, physiotherapy and chiropractic services be streamlined to eliminate delays in the continuation of provision of services allowing for a greater success in treatment outcomes. For SN veterans three options could be considered:

1) Request a treatment plan from the service provider and approve the recommended plan and not limit it to simply 10 sessions forcing a reapplication or cessation or services;

2) Increase the basic limits from 10 sessions to 25 sessions to eliminate the constant need to reapply or concern that treatments maybe interrupted; or

3) Implement a process in which the service provider can request an extension of service simply by calling the Treatment Authorization Centres (TAC).

ii. **Complex Case Management**. It has been noted in a number of veteran interviews that some of the clients presented as demonstrating some significant mental health issues that resulted in challenges to their social interaction and social skills. Behaviours such as these could be construed as belonging to a “difficult client” or a “violent client” or a “client that is a constant annoyance”. In one case, the Veteran was constantly being assigned new Area Counsellors (AC) presumably because he was labelled

a difficult client. These cases should be considered complex and that VAC requires some form of complex case management. In such cases VAC should not abandon the member; rather VAC should institute specialized case management with specially trained ACs with skills in anger management, the ability to identify chronic depression or other mental health issues and have the skills to deal with violent or aggressive veterans. To simply keep reassigning ACs will not solve the problem, perhaps it will make the problem worse that could lead to deterioration in the veteran's health or the health of the caregiver/family.

Recommendations

1) When Veterans are labelled as difficult, VAC needs to implement a critical or complex case management plan/tool that utilizes highly specialized, properly trained area counsellors to work on a case plan to lead to as best an outcome as possible; and

2) If required, critical care management of difficult cases should be contracted out to a third party to remove the VAC/Veteran interfaces with a view to achieving a more successful outcome/rehabilitation.

iii. **Physical Injury Peer Support Network**. SNAG has witnessed first hand some of the difficulties that SN veterans encounter when trying to navigate the myriad of programs, benefits and services offered by VAC. For those with Occupational Stress Injuries (OSI) related injuries VAC provides support through OSI clinics and OSI peer support networks. These clinics and support networks assist those veterans and their families suffering from OSI related injuries in receiving treatment, information and support from other veterans who have experienced similar injuries. However, and it has been mentioned in Report #2, those SN veterans suffering serious physical injuries do not have the same level of support and SNAG recommended the navigator concept as proposed by Dr. M. Westmoreland. SNAG has learned from veteran interviews that there is an overall lack of information about VAC programs, benefits and services despite VAC's best attempts and that an organization similar to OSI peer support networks is required for those SN veterans with physical injuries.

Recommendation. VAC develops, similar to OSI peer support network, a physical injury peer support network. This physical injury peer support network initially would be for SN complex case veterans and their families. This network would be complimentary to whatever information is being provided by VAC, but just like the OSI peer support network it would be peer to peer.

iv. **Holistic Definition**. VAC implies that the NVC and its programs, benefits and services are holistic in nature through the use of terms like client-centred approach and case management. Holistic, as defined in the Webster's Dictionary is "relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts". SNAG firmly believes that if VAC examines the definition of holistic it will see areas for improvement in the delivery of programs, benefits and services.

Recommendation. VAC develops a definition for the term holistic and follow that definition in its holistic approach when dealing with complex needs clients particularly SN clients where the whole person/family is treated, not dissected into parts each being dealt with independently.

v. **Case Planning**. From veteran interviews it is apparent that Case Management plans are being developed for the veteran only and do not necessarily take into account the spouse (usually the principal caregiver) and family.

Recommendation. Case management plans must include the spouse and family. If the case management plan requires treatment for family members, VAC must consider providing that within the overall case plan. If the spouse is not the principal caregiver, then that caregiver must also be involved in any case management plan development.

vi. **Approved Local Service Provider Lists**. SNAG was informed that Area Counsellors/Case Managers (AC/CM), as part of their visits with clients and in the development of case plans often recommend local service providers. More specifically, local service providers for which direct billing to VAC is approved are preferred as this eliminates invoicing of the veteran. However, from veteran interviews it appears that these sorts of lists are hit and miss and are not consistent between District Offices. More often than not, the veteran is asked to get two quotes and provide these to VAC; this seems rather bureaucratic if VAC already has a list of authorized service providers. In addition, SN veterans may not be able to successfully get quotes and may opt not to ask for the service as getting the requisite quotes could be seen as too difficult to do.

Recommendations:

1) District Offices develop approved lists of local service providers, preferably ones that do direct billing to VAC, so that the AC/CM

can use or recommend and provide this list to the veteran, spouse and/or caregiver; or

2) Instead of clients being asked to get two quotes especially when there are approved lists that VAC contract these services directly on behalf of the SN client.

f. **Families and Caregivers**

i. **Definition of Family**. VAC, under the NVC, promotes "the Family", however there is no apparent clear definition of the word "Family" and how the NVC clearly promotes and supports the Family. The VAC website, various pamphlets and the programs, benefits and services state "Family", but what does this really mean, and how are programs, benefits and services delivered to the Family? In contrast, the CF has the Military Family Resources Centres (MFRC) for families, including resources for wives, girlfriends, partners and loved ones that these individuals can access for information and support. Unfortunately, when the CF member transitions to being a veteran, the family loses those fundamental support and information systems that were offered by the CF at the MFRC.

Recommendations:

1) VAC clearly states the definition of "Family" to include spouse, common-law and significant other partners, parents, in-laws, siblings and children;

2) VAC develop a suite of programs and support within the NVC for the "Family" similar in nature to the CF's MFRC; and

3) VAC investigate partnering with the CF for the co-use of MFRCs, thus providing a bridge for the Family during the member's transition from serving member to veteran.

ii. **Family Needs Analysis**. The term "Family" and support from the NVC appears to be overused and as previously observed without a clear definition and resulting programs, benefits and services.

Recommendation. VAC engage a 3rd party to produce a Family Needs Analysis for SN veterans and their families, or update the current Family Needs Analysis that was produced a number of years ago.

iii. **Care of the Caregiver**. Care of the caregiver is a common theme from all veteran interviews. It was also mentioned in Dr. Keating's presentation to

the GAC on 4 November 2007. There is a risk that caregivers can become burnt out or even worse become OSI casualties themselves. Care of the caregiver is extremely important in managing the ongoing care of SN veterans and it is felt that VAC has overlooked this critical aspect of SN veterans' care.

Recommendations:

1) Caregivers be participative in the case management plan of their SN veteran;

2) Caregivers have their own case management plan or are included in the veterans' case management plan which would outline the Right of the caregiver for respite and formal training in the delivery of care;

3) VAC must clearly provide documentation and support to families with regards to babysitting services or child care subsidies for daycare to assist the Veterans' families, especially when the caregiver is required to provide constant care for the SN veteran;

4) Primary Caregivers/Spouses must be recognized for their unselfish work through the provision of an allowance, similar to the spousal allowance offered under the PA. This undoubtedly would be significantly less in cost than if the primary caregiver/spouse were to indicate that they were not in a position to be the primary caregiver and that service would have to be contracted out. (VAC cannot expect primary caregivers to provide a service without remuneration); and

5) The Disability Award calculation must also take into consideration the Primary Caregiver and children of a veteran. This provision would allow for further recognition that the disability of the veteran impacts the family as a whole. The calculation of the disability award must recognize the Caregivers and families own pain and suffering in providing 24/7 care to their SN veteran.

iv. **Caregiver Support**. It has become clear that there are consequential impacts to spouses and/or caregivers when dealing with a seriously injured veteran. The health of the family/caregiver must be given priority consideration by VAC. Caregivers need support, respite, training, acknowledgement, consideration and compensation. Caregivers need to be healthy. It also must be noted that caring for a SN veteran coupled with raising children can accelerate burnout. VAC needs to take into

consideration children, particularly their age and provide additional support as required.

Recommendations:

1) Caregiver or attendance allowance needs to be reinstated under the NVC or support for respite costs need to be contained in the programs, benefits and services. Furthermore, the family dynamic has changed since the Traditional Veteran era, many spouses have careers of their own and may not be willing or able to (financially) leave those careers to provide caregiver services to their SN veteran – remuneration needs to be strongly considered;

2) VAC needs to provide the families and caregivers with psychological, counselling and social support, consideration of a helpline service or access to these services is required;

3) VAC needs to provide support to the caregiver who may also be the spouse who in many instances could also be raising young children at the same time looking after a disabled spouse;

4) VAC needs to provide professional training in the provision of care for spouses providing caregiver services; and

5) VAC needs to offer caregiver services in the event that the spouse and/or family chose not to or cannot provide these services themselves.

v. **Family Rights**. SN veterans' dependents need benefits such as spousal and children's allowances similar in nature as to what was provide under the PA. Dependents have rights that need to be enshrined and protected in the NVC similar to the Veteran Charter of Rights.

Recommendations:

1) VAC develop a Family Charter of Rights similar in nature to the Veterans Bill of Rights;

2) VAC recognizes, as part of a Family Charter of Rights, family compensation, either as part of the Disability Award calculation or as a separate benefit to be paid to spouses and children for the pain and suffering that impacts the family when a parent becomes disabled. By providing such benefits, VAC demonstrates a

commitment to the Veteran's family and demonstrates an understanding of the loss in overall quality of life suffered by the family as a whole;

3) VAC provide post secondary education support to families of low income SN veterans; and

4) VAC needs to develop programs, benefits and services designed specifically for the family. Keeping the family intact should be a cornerstone building block for VAC. SN veterans programs, benefits and services will become very costly if there is no spousal or family support (implying that all services would have to be contracted out). By providing family programs, benefits and services VAC would reduce the dissolution of some of the families as a result of a seriously injured veteran returning home.

vi. **Medical Treatment Escorts**. The regulations pertaining to escorts for medical treatments outside of the veterans' community seem out dated when it comes to who can be the escort. In the majority of the cases, the spouse is the principal caregiver, yet VAC does not acknowledge that role for something as simple as accompanying the veteran for treatment. Finding a non-family member to escort a veteran could be stressful, in some cases non-achievable and in all cases more expensive. VAC must either start providing escorts or change to the policy to allow the principal caregiver to attend as an escort. It is also suggested that professional escort services are very expensive (billed by the hour) when compared to what ever allowance would be provided to the principal caregiver.

Recommendation. VAC allows the principal caregiver/spouse to be the escort when one is required, and change the regulations and policy accordingly.

vii. **Definition of Common Terms**. It has been noted that there are many references to "family" and other undefined terms in the NVC. While these may be fully understood by VAC staff there is room for misinterpretation by SN veterans, their families and service providers. In addition, by not having clear definitions, terms of reference and references to supporting policies it may be difficult to design appropriate programs, benefits and services. These definitions need to be promulgated accordingly.

Recommendation. The following, just to name a few, are samples of ill-defined terms that would also require referencing to supporting policies:

1) Family;

2) Holistic;

3) Caregiver (including terms of references and VAC expectations);

4) Escort for medical treatment;

5) Respite; and

6) Case Management.

viii. **Family access to services**. A common theme that arose during the Veteran interviews were the difficulties encountered by spouses/primary caregivers and children to access counselling services and other programs. It has been noted that the paperwork is too complex (SNAG is unsure why so much complexity is required) and if approved it takes too much time to put in place. Moreover, there also appears to be a gap in VAC's ability to communicate directly with spouses/caregivers (SNAG is unsure why VAC does not communicate directly with spouses/caregivers in the event of SN veterans).

Recommendations:

1) Streamline application forms for spouses and children access to counselling services;

2) Consider providing spouses, caregivers and significant others including parents (in the case of single solders) with their own unique VAC number – perhaps an "F" number reflecting family values in the NVC. This way VAC can establish treatment plans, case management plans, conduct follow-up concerning family matters; and

3) Consider establishing a type of employee assistance plan (EAP) for the use by spouses, children and families. This would reduce the burden on AC/CM in dealing with issues not necessarily related to the veteran and it would provide very timely, if not immediate service to the family. This type of EAP contract service is very common in large successful organizations. VAC would do well by considering this.

g. **CF/VAC Collaboration**

i. **Application Preparation**:

1) Upon initial application for a disability it was noted (Ken Miller's Disability Award Chart slide #4 presented at the 6 November 2007 meeting) that RCMP applicants appear to be well represented resulting in a higher favourable first decision than their CF counterparts. Perhaps the RCMP rank and file are better at filling out forms by virtue of their job requirements. There appears to be a gap in that Privates/Corporals may not be represented at all, resulting in lower favourable first decision results;

2) The VAC rationale of abrogating the responsibility of preparing applications to the Royal Canadian Legion (RCL) Service Officers is an outdated concept. RCL Service Officers are aging, and while they may be knowledgeable about the PA there is a significant knowledge gap when it comes to the NVC. In addition, many younger veterans are not associated with the RCL so the service provided is not necessarily meeting the needs of the younger CF veteran;

3) Increased early stage availability of VAC support would assist members who are the least capable of preparing VAC program, benefits and services applications; and

4) CF Case Managers need to be advised as to where to direct medically releasing members along with their spouses/caregivers to get assistance in preparing VAC applications.

Recommendations:

1) VAC provide a peer support coordinator to assist all applicants in their preparation of their application;

2) VAC hire more Pension Officers trained and located within the Director of Casualty Support and Administration (DCSA) detachments on all CF bases; and

3) VACS considers increasing the number of Service Officers in various veterans' organizations, not just the RCL, and provide them training with regards to the NVC.

ii. **Medical Forms**. It has been noted that releasing CF members are not being supported by their "family" physician at the CF Health Services Clinics in the preparation of requisite VAC forms. In all cases, releasing CF members' "family" physician is actually their unit medical officer.

Medical Officers have been directed not to fill out medical release forms due to the potential conflict of interest in assigning a disability versus medical category.

Recommendations:

1) VAC negotiate better support from the CF in supporting releasing members in their successful transition with the completion of requisite medical forms; and

2) VAC, in partnership with the CF's Health Services and DCSA, develop a medical releasing unit that has designated VAC and CF medical officers, Pension Officers, CF Case Managers, DCSA staff and VAC Transition Area Counsellors working as a multi disciplinary- interdepartmental proactive cell to ensure that medical releasing members are properly prepared for release.

iii. **Family Doctors**. SNAG has consistently indicated at meetings and in its reports that there is a need for increased intervention by VAC in the provision of family doctors after release from the military. There is a gap that can compromise SN veterans from having successful outcomes from therapy and rehabilitation they may receive while in the CF, if it is compromised by not having a dedicated family physician to ensure referrals are made after being medically released from the CF.

Recommendations:

1) This is not short-term solution; rather it is as long term as the NVC is intended to be. This recommendation is very similar in nature to the program that the CF have had in place for years – the Medical Officer Training Plan where the CF pays for the cost of educating doctors in exchange for a period of service in the CF. This recommendation would be for VAC to initiate a similar program and for VAC to become more proactive in the provision of post military service family physicians for SN veterans until they can re-establish themselves; and

2) Consider VAC/CF Collaboration in the provision of health services. In locations where the CF Health Services have clinics provisions need to be made for VAC clients and their families to have access to those health services. Provision of this health care would be covered under Blue Cross.

iv. **Remote Location Services**. SNAG has heard some of the difficulties of accessing VAC programs, benefits and services because of remoteness from VAC District Offices. This is compounded when dealing with SN veterans who may not be able to easily travel (further compounded by the provision of escort issues as previously mentioned). It also means that VAC probably has the same level of difficulty reaching these same SN clients due to distance, travel, timings etc that could impact on successful outcomes. It has also been observed that the CF has mobile recruiting teams that go to communities beyond established recruiting centres.

Recommendation. VAC establishes mobile clinics specifically designed to reaching out to SN clients on a regular scheduled basis and providing support at the clients' residence as part of active case management.

v. **Operational and Trauma Stress Support Centres and OSI Hand-Off**. The Operational and Trauma Stress Support Centres (OTSSC) and OSI clinics handle the same clients; OTSSC while the member is still serving in the CF and OSI clinics after release. For SN veterans suffering from OSI related injuries the impact of having to re-establish case files and new persons of trust could be overwhelming, traumatic and in some cases cause for an unsuccessful outcome.

Recommendation. VAC and the CF jointly manage the OTSSC and OSI clinics to enable a successful hand-off from the serving member at the OTSSC to the veteran at the OSI clinic particularly when it comes to case plan management for both the veteran and their family.

vi. **OSI Clinic Hours**. OSI clinics are usually open Monday through Friday during normal working hours (0900 to 1800), however for some veterans who are undergoing vocational training, rehabilitation training or have been successful in securing employment they may not be in a position to attend appointments during normal working hours. In addition, spouses/caregivers and their families may not be able to attend due to work and school priorities.

Recommendation. OSI clinics, based upon demand, are accessible in the evenings and on weekends for those that cannot make it during normal hours.

vii. **Duty Travel Claims**. It was noted that Class A Reservists are considered to be on duty while traveling to and from work yet from speaking with regular force veterans there are instances when traveling to and from work was not considered to be "on duty". There appears to be a gap in defining when a member is on duty. Case in point, during the CF presence in

Europe throughout the Cold War alerts and recalls were practiced on a regular basis. Soldiers regardless of the hour or whether they were on leave or not were required to report to duty within a specified timeframe. It was the soldier's duty to report as soon as possible, yet VAC considers this travel as not being "on duty" in determining eligibility for pension applications. This travel, in response to alerts and recalls, should be considered duty travel.

Recommendations:

1) Claims by veterans who may have been injured reporting to duty during an alert or recall should be considered to be on duty for pension purposes; and

2) CF and VAC to jointly define "on duty".

h. **Programs, Benefits and Services**

i. **Disability Award Shortcomings**:

1) The Disability Award (DA), which SNAG has reported on in its previous reports, still requires adjustments. The lump sum award recognizes in a single act the life long pain and suffering that the veteran will experience;

2) The single payment scheme while planned, modeled and properly budgeted for forgets the simple tenet that pain and suffering are forever and experienced every single day. Years after the award has been granted the veteran will still be experiencing pain and suffering;

3) That same veteran will observe how the DA increases over time, keeping pace with cost of living/consumer price index (CPI), but the pain and suffering are constant and cannot be measured like cost of living or CPI. All veterans in receipt of the DA should be recognized by VAC by being awarded annually the cost of living/CPI adjustment acknowledging that Canada and VAC realize that pain and suffering is not simply a one time event that can be compensated just once;

4) SNAG is still very concerned that veterans in receipt of the DA are not fully aware of its value. In speaking with veterans it is apparent that the DA is being spent like a lottery win usually on

high-end consumables. Injured veterans need guidance as to how best utilize the DA to ensure it remains a lasting benefit;

5) Furthermore, the DA must keep abreast of awards for very serious injuries within the Courts and adjust the DA amounts accordingly.

Recommendations:

1) The DA is one of the largest issues that SNAG has determined needs adjustment within the NVC. VAC must recognize that veterans will permanently experience pain and suffering and that compensation in the form of an annual adjustment on par with the cost of living/CPI adjustments must be provided. The pain and suffering experienced by the veteran cannot be simply overlooked or forgotten by VAC and Canada. By providing an annual adjustment is simply the continual acknowledgement of the sacrifice that those veterans have made for their country;

2) VAC needs to improve controls on how the DA is used by the veteran. This could mean imposed limitations or assignment to the courts to administer. To simply provide large amounts of cash to injured veterans without any moral obligation to ensure it is used correctly is irresponsible on the part of VAC. Controls must be put in place to ensure the veteran does not misuse the DA; and

3) VAC needs to develop a detailed comparison of what VAC is currently offering as a DA for very serious injuries. The DA for injuries such as single and double amputations, spinal cord injuries and burns need to be compared with the current standard of monetary awards being awarded through Canada's Courts and if necessary the DA amounts need to be adjusted.

ii. **Permanent Incapacity Allowance.** The Permanent Incapacity Allowance (PIA) is the cornerstone to the NVC's meeting the needs of SN veterans. It has been noted that since the inception of the NVC in April 2006 very few, if any, (two estimated for 2006/2007) are in receipt of PIA. Several reasons can be attributed to this: veterans unfortunately qualifying for PIA are few (this is good), the qualifying criteria is too restrictive or the injured member is still serving and must be released before being eligible to apply.

Recommendations:

1) VAC review the criteria for awarding PIA, if it is too restrictive it is not meeting the needs of the SN veterans and their families that should qualify for it; and

2) VAC considers making this award available to injured serving members whose release, for the very reasons PIA is awarded, is inevitable.

iii. **Catastrophic Injury Benefit**. Some SN veterans may never be successfully rehabilitated to their pre-injury level due to massive or catastrophic injuries. While the DA recognizes pain and suffering and the financial benefits programs offset earnings loss those programs will never fully replace what was lost and what will never be realized. Earnings loss benefits will forever limit a SN veteran to just 75% of his/her pre-injury income. Even PIA at its maximum only provides a taxable benefit amounting to $18,000 annually. In special circumstances (multiple limb loss, para and quadriplegia, significant head injuries or horrific burns) a "Catastrophic Injury" benefit should be considered. This allowance could be used to provide respite, provide post secondary education for children, the hiring of professional caregivers and a very tangible acknowledgement of what has been forever lost and recognition of what will never be achieved.

Recommendations:

1) Implement a Catastrophic Injury benefit; or

2) Adjust the PIA to allow for an exceptional grade.

iv. **Dental Health**. Through studies and reports prepared for the GAC there is a direct correlation between good oral health and overall general health. SNAG recommended in its Report #1 that in addition to the provision of a medical health care plan (the Public Service Health Care Plan (PSHCP)) for the overall well being of veterans and their families that VAC consider the Pensioners' Dental Services Plan (PDSP) for the overall dental well being.

Recommendation. VAC provide dental health care for veterans and their families through subscription to the Pensioners' Dental Services Plan, similar to how health care services are provided by PSHCP.

v. **Treatment Benefits**. SN veterans suffering from high level PTSD or other related injuries need to have ongoing medication and socio/psycho therapy, including the involvement as necessary of psychiatrists,

psychologists and social workers in the case of the family. The services in many cases may exceed the normal VAC benefit limits. There is a requirement to better identify treatment benefits for SN PTSD veterans in order to better access programs services and benefits on a continuing basis without the rigour of constant renewal.

Recommendation. It is recommended that an additional Program of Choice (POC) category be added to the Veteran Card, "Box 15" entitled Socio/Psycho Services. This POC should have expanded limits of treatments for the majority of services that PTSD veterans require, including not only increased limits for the veteran but also for the caregiver and family members, if needed and referred by a physician. In addition, Box 15 would include the ability to prescribe medications that may be in excess of the Pharmacy TAC and treatments such as massage therapy in excess of the Massage Therapy TAC.

vi. **Veterans Independence Program Benefits**. It appears as if VAC's policy has changed with regards to Veteran Independence Program (VIP) Housekeeping benefit and that some applications are being denied because there is an able spouse in the house. It was noted during veteran interviews that some spouses, who also double as the principal caregiver, are working up to 16 hours a day at two jobs just to make ends meet because the veteran is unable to work. Requests for housekeeping services in these instances were denied. Similarly, in the same instances groundskeeping services were approved. Approval of one VIP benefit and denial of another appears to be skewed, inconsistent and perhaps even sexist.

Recommendation. Housekeeping services, if warranted, should be automatically approved for SN veterans in recognition and acknowledgement that the spouses of SN veterans are in most cases also the principal caregivers and housekeeping services provide a small modicum of respite.

vii. **VIP Benefit Reductions**. It was noted that VIP Benefits were reduced for a member when the medical treatment was deemed successful. In this case the condition was being successfully managed but the client was not cured (i.e. diabetes can be managed but not cured). In this instance the veteran had their VIP benefits for housekeeping and grounds maintenance reduced on the premise that they were less disabled, although still suffering from mental health and physical issues. Since the veteran was young, the family was told that VAC expected that the spouse assist with the housekeeping and grounds maintenance, due to the VIP benefits being primarily for "older traditional veterans". This, in SNAG's opinion, is not

in the spirit of the NVC, certainly not family focused or holistic in nature and could be considered discriminatory if one set of clients gets the benefit yet the other set does not by virtue of age.

Recommendations:

1) VIP benefits should only be reduced upon recommendation from an appropriate medical authority indicating the medical condition of the client is such that VIP benefits are no longer required;

2) VAC must ensure that there is national consistency for VIP benefits being allocated; and

3) VAC Area Counsellors must not base decisions for the approval or denial of VIP benefits based upon the age or marital disposition of a veteran, but on the nature of the disabilities.

viii. **Medical insurance plan coverage**. During several veteran interviews it was noted that the veterans did not have medical insurance plan coverage (PSHCP). Upon further questioning it was revealed that in one case the veteran could not afford the additional expense of monthly premiums and in another case misunderstood what the plan was and how it would benefit his family.

Recommendations:

1) SN veterans in the lower income brackets should be offered PSHCP without the monthly premium burden and have 100% coverage not the current 80%. If necessary, this could be a means tested benefit; and

2) AC/CM need to better explain the benefits of PSHCP to veterans and their spouses.

ix. **PSHCP Costs**. It has been noted that the PSHCP premiums offered to Veterans are charged out at a higher monthly rate than those in the public sector.

Recommendation. VAC needs to investigate the premium costs being charged to veterans by the PSCHP and align those monthly premiums with other members of the public sector PSCHP plans. This could be viewed as discriminatory that veterans are being charged a higher rate for PSCHP than other members.

i. **General Issues**

i. **National Contact Centre Network Inquiries**. It was observed that the National Contact Centre Network (NCCN) attendants are making decisions that should be made by the AC. During a veteran interview, the veteran indicated that he called the NCCN to inquire about housekeeping services and the attendant told him "no". This type of inquiry for services especially for a SN veteran should be referred to the AC who works with the veteran and may have a case plan for that veteran; but it should not be the NCCN attendant regardless of that person's qualification.

Recommendation. When a SN veteran calls the NCCN for an inquiry, due the complex nature of many SN Veterans, the call should be forwarded to the veteran's AC to make a decision in consultation with the case plan and the veteran.

ii. **NVC Review**. SNAG has not benefited from an independent review of the NVC by a recognized authority and has had to rely upon information provided by VAC. SNAG does not doubt the information being provided, but is suggesting that maybe not all-pertinent information has been examined.

Recommendation. VAC contract for an independent assessment/review of the NVC as part of its centre of expertise or research based approach to the design of the programs, benefits and services that are being provided under the NVC.

iii. **Program, Benefits and Services evaluation**. The many new programs, benefits and services that are being provided under the NVC need to be assessed as to their success. Statistics need to be reviewed for favourable/unfavourable decisions and how the outcomes of the programs, benefits and services are being measured and reviewed for effectiveness.

Recommendation. VAC contract services to determine which programs benefits and services are providing the best services to the veteran, spouse and families.

iv. **VAC Data Collection**:

1) VAC has a plethora of application forms for various programs, benefits and services offered under the NVC. For SN veterans and/or their caregiver some of the information is redundant, other information is irrelevant and a lot of the information could be considered tombstone data (facts that do not change from form to

form such as language of use, birth date, "K" number, CF service number, date of release, etc). The value of some of the information requested is questionable;

2) Many of the forms ask for a statement as to how the injury is related to service. In some cases, particularly for OSI veterans, having to restate how the claimed condition is related to service could be very traumatic and detrimental to the individual's rehabilitation. Again, once the information is collected is should not have to be restated time and time again;

3) Most if not all of the forms appear to be manually filled out and not accessible on line. VAC claims that a high percentage of veterans have and use the Internet on a regular basis, thus for a large percentage of veterans, particularly the younger veterans, using Internet based services is very common; and

4) With the ability to electronically scan documents even medical and dental records, examinations, reports etc can be stored electronically and attached electronically to forms as necessary. It is noted that if individuals can do their banking on line utilizing secure network services with password access in 128 bit encryption then accessing their VAC files should be no different.

Recommendations:

1) VAC makes its requests for information, application forms and other documentation accessible on the Internet and available for download utilizing secure network services;

2) VAC develop e-mail correspondence protocols in order to disseminate blanket information to all veterans (example; advise clients of policy changes to VIP);

3) Tombstone data should only be collected once, held on file and auto-populate all applicable sections on VAC application forms as required;

4) Medical and dental information collected by VAC for verification and establishment of claims needs to be held electronically on file and be accessible by the veteran and VAC staff as required;

5) AC/CM when doing visits with clients should bring the client's electronic file with them (laptop/blackberry) for instant updating or accessing for validation of information;

6) Veterans have access to files retained on the NCCN to ensure information is correct; and

7) VAC AC/CM client notes should be available to the client to ensure transparency, accountability, consistency and fairness.

v. **Declaration Form**. Many of the VAC Application forms have a full page Declaration section. The size of print (font size) is very intimidating and implies an inherent level of mistrust on the part of VAC towards its clients. Some forms have a full page Declaration for just 125 words.

Recommendation. Remove intimidation and inherent level of mistrust by adjusting the font size to normal.

vi. **Access to Information**. Most, if not all, application forms that have a Declaration section indicate that a copy of the completed form may be requested through the Access to Information and Privacy Coordinator's Office. This process of asking for information about oneself, for many, is viewed as intimidating. In addition, the information pertaining to how to request Access to Information is contained within the declaration, so once it is signed and returned to VAC the veteran must recall how to access the information he has provided. OSI and SN veterans may not be capable or up to requesting such information for fear of retribution or being just "too tired" to make the application.

Recommendation. Copies of all forms, once filled out, are automatically provided to the client (either in hard or soft copy) without having to go through the Access to Information and Privacy Coordinator's Office. Furthermore, by providing this information back to the veteran, any errors or omissions can be corrected sooner rather than later.

vii. **Veteran Interviews and Surveys**. One of the mandates of SNAG is to interact with veterans, preferably SN veterans and their families, to determine the effectiveness of the NVC. It was requested in previous SNAG reports that formal research/surveys are also required in order to reach a greater number of veterans and their families all across Canada.

Recommendations:

1) VAC commit to SNAG to provide opportunities to interview SN veterans as part of all SNAG regular meetings; and

2) VAC engages Corporate Research Associates (CRA) to conduct a survey similar to the one done in 2005 sometime after April 2008, but no later than 2009. Furthermore, arrangements need to be made with CRA to conduct similar surveys at two-year intervals starting in 2010 to measure progress in the implementation and success of the NVC. Consideration should also be given to surveying service providers, as they are integral to any case plan success.

viii. **Next of Kin Form**. The CF requires that all members sign and update on a regular basis a Next of Kin (NOK) form so that contact can be made with the family on behalf of the member. VAC does not appear to have a similar process, thus contacting family members on behalf of the client does not happen, all correspondence is directed to the veteran, whether that veteran is capable or not of handling correspondence.

Recommendations:

1) VAC institutes a similar process as the CF for having a NOK form and that form includes "next best friend" or "trusted friend" categories; or

2) VAC and the CF blend the existing NOK form for use by both organizations, therefore a change in the NOK will update existing CF databases and provide VAC with the most current information provided by the serving soldier (potential veteran).

ix. **Wills**. It was noted that during AC/CM assessments veterans are asked if they have a will; obviously this information is needed for end-of-life issues or in the event that the spouse/caregiver passes away. It was also noted that while AC/CM asked about Wills there was no further support given if the veteran indicated there was no Will.

Recommendations:

1) If the response is "no" to having a Will VAC should facilitate the veteran and/or family in securing a Will, through the provision of recommending an appropriate agency to prepare a Will. This is particularly important for SN veterans who may need power of attorneys or assign an executor for the estate to prevent the estate from being contested or in probate putting the survivors at risk; or

2) VAC develop a legal will package for all veterans to fill out akin to the CF last Will/NOK identifier.

x. **Repeat Job Placement benefits**. SNAG understands from the literature provided that the Job Placement benefit is a one time only event. There is some concern about veterans who may experience a relapse at some point after a successful rehabilitation including job placement. SNAG is concerned that in some cases the relapse could be from the new line of work. A repeat of job placement benefits would be needed for veteran to seek a completely different vocation (less stressful, less physical or more accommodating and not contributing to subsequent relapses).

Recommendation. VAC considers altering the conditions for Job Placement and offer additional/repeat Job Placement opportunities if and when circumstances warrant.

xi. **Detention Benefit**. The Living Charter continues to recognize the Detention Benefit, but not to the extent that SNAG recommended in Report #1. In that report, SNAG identified that the Detention Benefit appears to be modeled on experiences from traditional wars. It remains SNAG's position that conflicts of the 21st Century are not traditional in nature, do not follow the Geneva Conventions or other recognized protocols. Rather "enemy" forces are ethereal in nature and ruthless in their actions. Detention of any length under these emergent factions needs to be recognized.

Recommendation. The Detention Benefit starts at Day One not at Day Thirty.

xii. **VAC Hours of Operation**. VAC hours of operation are standard public servant hours. VAC prides itself on being different than other public service departments, consequently in recognizing that veterans in rehabilitation or reintegration, and perhaps more important the spouse/caregiver may not be available for interviews, assessments or follow-up on case plans due to their work hours. In these instances VAC should make themselves more accessible outside of normal working hours.

Recommendation. VAC establishes after-hours (evening and weekends) hours of operation to accommodate veterans and their families' unique situations. Moreover, by offering after-hour services, this approach would tie into the "client-centre philosophy of VAC, where the focus will be on the veterans and their families rather than on VAC hours of operation.

xiii. **Benefit of Doubt**. It has been noted that when a decision on a pension condition or any other request has been negative there is always the opportunity to appeal. In many instances the appeal results in a positive decision. The implication is that the "benefit of doubt" was not applied fairly or in the spirit of the definition. In the case where a decision has been appealed and subsequently approved implies that perhaps there was no need to appeal in the first place. This places undue stress on the veteran and the family, as they "must mount an appeal". In some cases veterans may chose not to appeal, as they have no strength for a "fight". This might also be simply the case where VAC has not delegated the approving authority to the lowest possible level resulting in appeals being mounted simply due to bureaucratic restrictions.

Recommendations:

1) VAC POC TAC and AC apply the "benefit of doubt" when veterans are making applications. Reasons for denial should be clearly stated and if a medical authority has rendered the decision the name of the medical authority and their qualifications to render a decision should be clearly stated; and

2) VAC needs to delegate approving authorities to the lowest possible level resulting in fewer decisions needing to be appealed to the next higher level.

xiv. **Area Counsellor/Case Manager Portability**. During veteran interviews it was noted that when a veteran moves to a new area that s/he must re-establish contact with the new District Office and VAC staff. Veterans build up a rapport, understanding and a level of trust with their AC/CM, consequently moving can be traumatic. It was also noted that there are differences in levels of service provided between AC/CM (probably due to individual interpretation of the policies and regulations). AC/CM are also assigned based upon postal codes. Portability of AC/CM, once trust has been established, is required. In many cases the services the veteran is looking for can be conducted by phone or e-mail, thus where the veteran is located in relationship to the AC/CM is not as important. In cases where the veteran has simply moved across town there should be no reason to change AC/CM just because postal codes have changed.

Recommendations

1) Veterans who request to retain their current AC/CM when relocating should be allowed to do so; and

2) VAC should consider amending its allocation of AC by postal codes to something less rigid, especially within large urban areas.

xv. **Determination of Disability Award level**. VAC needs to clearly articulate as to when the determination of the DA is made. Is it at the veteran's worst condition or once recovery is complete? Is it when the CF member is stabilized before being medically released, and if so, what is the definition of stabilized? For serious and complex cases, recovery could take many years or not be achievable at all and there would be periods of relapse and complications. The current standard for the CF is to attempt to retain the CF member for up to 3 years. It is clear that VAC must determine a level of disability sooner rather than later to allow the veteran to move on.

Recommendations:

1) VAC clearly state when the DA percentage is determined and develop policies and business processes that ensures that VAC compliance on timings of determination of DA are made; and

2) VAC provides the DA within a three-year maximum timeframe.

j. **Synopsis of Observations and Recommendations**

i. All the aforementioned observations either singularly or combined with the observations from the two previous SNAG reports should be considered gaps or elements of a larger gap in the provision of programs, benefits and services under the NVC. While the wording of many of these observations is anecdotal and in layman's terms it is important to look beyond the wording and understand the underlying rationale for making the observations and their accompanying recommendations.

ii. Many of the observations have been brought to SNAG's attention during veteran interviews. The message has been consistent from virtually every interview conducted, therefore SNAG considers the comments made to be significant and with substantiation; therefore these observations should be viewed by VAC as being extremely valid. VAC would do well to heed these observations and recommendations as many have come from candid first person interviews.

iii. This report contains approximately 55 observations and 81 recommendations for VAC's consideration. Many of these points could be mitigated if VAC were to become proactive with its approach to veterans and their families and offer tangible support rather than being the

gatekeeper of programs, benefits and services. The first step would be to provide assistance in navigating the way through the NVC.

iv. Issues identified by SNAG in this report while grouped in five categories for the purpose of the report can actually be summarized as follows:

1) Five family related issues;

2) Six caregiver/spouse issues;

3) 12 AC/CM and case planning issues;

4) 13 benefit related issues;

5) Three issues pertaining to definition of terms used by VAC;

6) Seven treatment related issues; and

7) Eight issues related to the collection of data and usage of forms.

8. SUMMARY

a. The focus for a good many of the observations in this report can be cross-referenced to Caregiver/Family issues. This is consistent with the two previous reports. VAC needs to give greater emphasis to the family as an entity including special consideration for the spouse who in most if not all cases is the principal caregiver. The value and the role of the family and spouse in the life of a SN veteran has been completely underestimated and devalued by VAC.

b. SNAG continues to ask for an independent assessment of the NVC and if it is meeting the needs of the new veteran.

c. SNAG continues to ask the simple yet important question – is the NVC fair to the SN veteran? Has VAC compromised its position relative to the treatment of New Veterans when compared to Traditional Veterans?

d. SNAG reports need to be placed in the public domain for consideration by all interested parties. Furthermore, a formal response to SNAG reports needs to be prepared and published. In addition, while SNAG has been debriefed on the points it has raised, little or no action appears to have happened other than verbal discussions. The NVC as a Living Charter must be seen as such; adjustments need to be made in a timely fashion.