ANNEX A TO SEAN BRUYEA'S TESTIMONY

ACVA April 14, 2021

STUDY ON VETERANS AFFAIRS CANADA MENTAL HEALTH CARE PROGRAMS

SHATTERING THE STIGMA:

Making a Better Department of Veterans Affairs

Submitted by Sean Bruyea

PART I: SUMMARY OF RECOMMENDATIONS

VAC Frontline Staff

1. **VAC to hire more Case Managers (CM) and Veteran Service Agents (VSA).**

2. **CM's and VSA's work closely together with case managed clients. This micro team to be provided with dedicated administrative support to assist with the administrative burden.**

3. **An external independent audit be commissioned to thoroughly evaluate administrative burdens upon VAC frontline workers with the goal of reducing that burden.**

4. **Case Managers to be considered medical professionals by VAC as most are either certified Nurses, Occupational Therapists, Social Workers or certified Case Managers.**

5. **Case Managers to receive similar training stipends as other VAC and Public Service healthcare professionals.**

6. **Case Managers to be included in all healthcare team meetings at district, regional, and national level when their Veteran clients are being discussed.**

7. **VAC to restore greater autonomy to Case Managers to independently authorize treatment, devices, and programs recommended by the Case Manager or by a treating medical practitioner.**

8. **Recognize that Veteran Service Agents have neither the time or training to provide "guided support". In order to provide guided support VSA's would require:**
    a. **Specialized training in how to provide this "case management lite" to Veterans.**
    b. **Autonomy and authority to authorize treatment and services for Veterans and their families under their "guided support".**

9. **Family members to be included in all Case Management plans without exception.**

10. **Enforcement of the POC 12 policy that all Veterans with psychological injuries and/or complex needs be case managed.**

11. **VAC fund lifetime case management of those Veterans with psychological injuries and their complex needs.**

12. **Recognize that "maintenance therapy" also requires active case management.**

13. **All Veterans, especially those with complex needs and/or a psychological injury, be provided with a frontline employee who will assist in writing and submitting applications, as well as exploring unaddressed or unidentified needs. The focus and intent would be to assist Veterans to provide information sufficient to meet VAC program standards, recognizing that disabilities, especially psychological injuries, affect cognitive functioning and diminish resilience to deal with complex bureaucratic processes.**

14. **First Call Resolution to be scrapped in favor of a first point of contact program that best addresses the needs and limits of Veterans and their families while also respecting the limits of frontline workers.**

15. **In scrapping the First Call Resolution, VSA's be allowed to spend the time on the phone necessary to address the needs and concerns of the Veteran and family member without interruption from VAC managers.**

16. **Independent and ongoing reviews be commissioned to determine the true caseload carried by CMs and VSAs.**

Short Term Recommendations: Under the Current VAC Case Management Model

17. **Interdisciplinary Teams (IDT's) and their associated meetings to undergo a rethink. The needs of the Veteran and family members must be put above all else including prioritized over goals to reduce case management ratios, the reflex reaction by VAC to deny or limit care or save money, etc. The question before any opinions or recommendations are put forward by IDT members should be "how can we provide the care and treatment Veterans and their families need".**

18. **Veteran Service agents to be included in all Interdisciplinary Team meetings.**

19. **CM's and VSA's to take the lead during IDT meetings while all other IDT members defer to these individuals.**

20. **It be recognized that senior District Medical Officers, District Nurses, STEO's, Rehabilitation and Mental health specialists do not know what is best for the Veteran. As such, Case Managers and Veteran Service agents to work closely on case managed files since they best know the Veteran and the family members**

21. **IDTs to include the Veteran and family member when decisions are made affecting them. IDT team members including the CM, VSA, DMO, DNO, and "specialists" must meet with the Veteran before coming to any conclusions let alone rendering a decision.**

22. **Primary Care practitioner of the Veteran such as a family doctor, psychologist, psychiatrist and/or occupational therapist must be present during IDTs**

23. **Former CF medical doctors acting as Senior District Medical Officers (SDMO's) receive sensitivity training from one of the more recognized international trauma societies such as the International Study for Traumatic Stress Studies (ISTSS) to eradicate the longstanding CF bias towards labelling PTSD falsely as Personality Disorder.**

24. **Standards, Training, and Evaluation Officers (STEO's) no longer be permitted to play an active role in any Veteran's file or VAC decision. STEO's to be relegated as a passive resource to provide a librarian-like function in understanding VAC's complex policies.**

25. **STEO's be required to carry out sensitivity training to understand CF culture, Veterans living with disabilities, and mental health issues.**

26. **All advice and/or opinions contributed by IDT members or other VAC officials such as STEO's, Mental Health and Rehabilitation specialists, be accurately recorded on the Veteran's file such as CSDN with the names and details of that input clearly recorded.**

Long Term Recommendations: Building a True Collaborative Care Model for Veterans and Their Families.

27. **VAC fund a nationwide community of ***clinical*** case managers (social workers, occupational therapists, and registered nurses) to work independently from VAC's processes. Veterans would be allowed to select which clinical CMs is the best fit. Current CMs will continue with their administrative roles processing treatment and benefits.**

28. **VAC fund a nationwide network of independent Primary Care medical doctors or provide funding directly to Veterans' existing primary care practitioners such as family General Practitioners to work on a Veteran's Primary Care Team (PCT).**

29. **VAC fund a nationwide community of experienced occupational therapists to also work on PCTs.**

30. **Veterans would select the PCT (Medical Doctor, Clinical Case Manager, and Occupational Therapist) best suited to their needs. PCTs would then collaborate with the Veteran and family members to develop an ongoing rehabilitation plan.**

31. **Existing CMs and VSAs, in addition to continuing their current administrative roles with much reduced administrative burdens, would coordinate with the various PCTs to secure community resources selected by the PCT for the Veteran and the family. This coordination would minimize delays to accessing treatment as well as other resources necessary for the PCT established rehabilitation plan.**

32. **IDTs would no longer be necessary in their current form. Instead, the various positions would help CMs and VSAs expedite PCT designated treatment and benefits. DMOs, RNOs, Rehabilitation and Mental Health policy experts would instead advocate and coordinate the necessary policy changes to accommodate PCT, practitioners with a Collaborative Care Model, as well as Veteran and family needs.**

33. **STEOs as policy experts would no longer be required. Instead, the positions would be converted to mental health and disability experts who**

would train and educate the entire department on issues affecting Veterans with disabilities and their families.

34. **These new mental health and disability experts would scrutinize Departmental policies and programs to identify and revise obstacles to care, inherently discriminatory (gender, disability, race) policy and program details, as well as work with communication experts to revise all communications so as to respect the limits, conditions, and sensitivities of psychologically injured Veterans and those with complex needs.**

35. **All communications concerning a Veteran and his/her family must include the full name and file number of the Veteran in the subject line so as to facilitate *Access to Information and Privacy* requests. All consultation, communication, recommendations, and references affecting a Veteran and the family be clearly entered into the official record (CSDN) with the identity of the source clearly identified. Any breaches of this requirement be met with automatic sanctions such as fines proportional to an employee's salary or leave without pay.**

36. **Case Management policy immediately reverse its narrow interpretation of eligible conditions in favour of the intent of the *Veterans Well-Being Act* which is to be "holistic" and "flexible" in recognizing that all health conditions suffered by the Veteran and all mental health conditions suffered by the family be included in any Case Management plan.**

Remaking the Department of Veterans Affairs

37. **VAC employees, especially those in policy, STEO positions, appeal, adjudication, and senior management to undergo regular sensitivity training to better understand psychological injuries, the impacts upon the Veteran and the family, as well as the negative impacts that impersonal decisions making processes have had upon Veterans and their families over time.**

38. **Comprehensive and regular independent studies be carried out as to the negative impact VAC communications, decision processes, and actions have had upon Veterans and their families. The studies would identify that which needs to improve so VAC can remove these negative impacts of its processes and policies in favour of positive impact upon the lives of Veterans and their families.**

39. **All senior and middle managers who have never worked as a frontline worker to be obligated to carry out one week per year working as a frontline worker, answering phones, filling out applications, speaking with treatment providers, etc.**

40. **All VAC employees be required to record, on the Veteran's file, the details of any inquiry made about that file from the Office of the Veterans' Ombudsman.**

41. **Advisory Groups be established similar to the model of the General Advisory Council and accompanying subcommittees created during World War II. The group members would be independently chosen, composed entirely of non-government personnel, and have the authority to create, edit and publish their own reports.**

42. **Office of the Veterans Ombudsman to be a legislated position reporting to Parliament.**

43. **Office of the Veterans Ombudsman be empowered to file with the Federal Court with the broad and flexible mandate of making lives better for Veterans and their families.**

44. **Privacy, Information Commissioner and a legislated Ombudsman reporting to Parliament be given enhanced powers of investigation, compelling testimony, and sanction.**

45. **Data storage is relatively cheap. Beginning with Veterans Affairs and in conjunction with Library and Archives Canada, the Government of Canada establish an easily searchable 20-year database for all computer based records and communications, especially email files.**

46. **Accurate minutes and attendees be maintained of all meetings held within VAC to make decisions on policy affecting the care and benefits of Veterans and their families.**

47. **An independently appointed Board of Directors consisting of a widespread swath of Canadians be established to oversee senior management of the Department.**

48. **VAC to move its head office from Charlottetown to Ottawa.**

49. **A hiring freeze for middle and senior managers be put in place for positions currently in Charlottetown. As personnel leave those positions, the same positions are to be created and staffed in the Ottawa region.**

50. **Call centres, Treatment Authorization Centers, IT Services, etc. can be placed in Charlottetown to minimize any potential economic impact of moving Head Office back to Ottawa.**

51. **Appoint a Judicial Commission with a mandate to thoroughly investigate the toxic culture at VAC and make recommendations to comprehensively change it.**

52. **Appoint a Royal Commission with a broad mandate to investigate, hold public hearings and report upon the care, treatment and re-establishment of Canadian Forces Veterans and their families.**

53. **ACVA hold a year-long study of nationwide public hearings with a similar broad mandate as the Royal Commission recommended above. Interim reports and recommendations would be prepared and acted upon expeditiously with legislation as required.**

PART II: INTRODUCTION

Note: This report and accompanying recommendations are to be considered a complementary submission to Sean Bruyea's report and 19 recommendations presented to the Veterans Affairs Committee as part of Sean Bruyea's testimony on March 22, 2010.

Many references are omitted as the sources of information wish to remain anonymous at this time. The author can vouch for the credibility of this information as most of it has been corroborated. The author apologizes for any errors in the report as time constraints prevented more thorough editing.

At no other time in Canada's history have we witnessed such an enduring litany of failures in our government's care, treatment and re-establishment of our military Veterans and their families. Only the post-World War I interwar period could compare. This was a time when Veterans took to the streets in nationwide protests at government's failure to fulfill its obligation to our Veterans.

The never-ending stories on Canada's failures may have ebbed and flowed over the many decades but such stories have become all too familiar and tragically predictable. Whereas 40 years or even 20 ago if Canadians were asked about Veterans, most would explain that a Veteran served in the World Wars and were all well cared for by Canada. Today, most Canadians would be able to explain a more accurate reality: Canada has consistently failed to care for our post-World War Veterans and their families, especially those with psychological injuries.

However, this is not as government bureaucrats and politicians would claim to be: a failure to communicate the hard work and dedication of Veterans Affairs employees. All the media spin and hard work on programs that are not properly designed and far from compassionately administered cannot change reality. Veterans with complex needs and psychological injuries and the families who care for them are being repeatedly failed by our government.

This reality has been public since 1997 with the release of the Stow and later the McLellan Reports as well as the 1998 SCONDVA hearings and reports. Although all three focussed upon the well-being of serving members and their families, scandalous neglect of those CF members once Veterans were all too commonplace. That reality has changed little for our psychologically injured Veterans and their families.

Certainly piecemeal programs have been developed attempting to address the needs of the psychologically injured. But why are these programs failing our Veterans and their families with the greatest needs? The answer is simple. Programs are designed by bureaucrats who are not disabled Veterans, do not suffer mental health illnesses, are

not frontline workers, and/or are not medical professionals nor do they have any expertise in rehabilitation, case management, and long term treatment of chronic conditions. VAC is designing programs from an administrative and budgetary point of view as policy experts, not from a Veteran, disability, or medical expertise. That the programs sometimes partially address the well-being and the needs of Veterans and their families appears to be either a secondary priority or a haphazard coincidence.

Prioritizing Treasury Board requirements in the hopes of addressing the needs of Veterans and their families has been a failing recipe. Furthermore, the policy designers and administrative managers have very little idea what it is like to walk in the shoes of someone with a psychological injury or share in the burdens of the families caring for them. It is akin to expecting someone who only walks everywhere to design a car. Even worse, it is these same bureaucrats that interpret the administration of the very programs they design with a focus on cost control and success measurements typically disconnected from the well-being of the Veteran and his/her family.

VAC is a department established with the mandate for the care, treatment, and re-establishment of Veterans, with many programs ostensibly focussed on assisting Veterans with chronic injuries. It is therefore somewhat ironic and thoroughly tragic that VAC senior management should be so inept at communicating with and administering programs to assist these Veterans. There is also a longstanding belief within Veterans Affairs that Canadian Forces Veterans are undeservedly more demanding, overly entitled, and unappreciative of the hard work VAC employees devote to administering programs.

VAC culture seems to forget its own history.

VAC senior managers instead have cultivated a toxic culture that cannot withstand constructive criticism from within and from without. VAC has long been on a path of self-reinforcing isolation from the reality of the lives of Veterans and their families, disconnected from the views of frontline workers, and incompetently arrogant about dismissing not only the Veterans' pleas for help but the medical and treatment specialists representing Veterans. Employees or Veterans who speak up are sidelined, ignored, attacked, or manipulated into advisory group positions where they are prevented from speaking out.

This toxic culture has had reprehensible and devastating consequences for Veterans suffering psychological injuries and their families. For many decades, Veterans and families have been coming forward pointing to hard medical evidence that VAC's neglect and dismissal of their concerns is directly harming Veterans and their families. When VAC fails and the Veteran raises the issue with middle or senior managers, the Veteran is quickly dismissed as unbalanced, unworthy, and/or an irritating nuisance.

Since the senior culture is so insecure, believing that it is always right, then no complaint brought against it can be justified. It is the Veteran who is at fault. In extreme cases with prominent advocates, the bureaucracy rallies not only all levels of the bureaucracy but also the Minister's office to attack the advocate's character and qualifications.

For Veterans suffering a psychological injury, these attacks on their character, the accompanying contempt of their concerns, and condescendingly referring Veterans with legitimate complaints to seek medical or case management help is grievously devastating.

Perhaps the best measure as to how little concern Veterans Affairs genuinely has for Veterans and their families suffering psychological injuries is the Department's extreme resistance to keep track of Veteran suicides. Louise Richard and Luc Levesque began asking for such statistics to be maintained since the late 1990's. VAC has still not acted on the call, despite several claims that it will.

Governments have repeatedly claimed that Veterans Affairs is doing its best. Perhaps this is true. That is why we must rethink and completely renovate this department so that its "best" actually addresses the needs and well-being of our most vulnerable Veterans and their families. Hard work for a wrong end is still wrong.

Let's look at it this way; if Veterans while in uniform were willing to put everything on the table to protect, defend, and/or act in Canadians' interests up to and including the loss of their lives, then we must be willing to put everything on the table in designing a department that can truly care for, work with, and guide our Veterans and their families into better lives. Perhaps in this context, these recommendations are not ambitious enough. Nevertheless, we as a nation and as individuals will all benefit when we assist our Veterans and their families to reach their optimum potential. Veterans suffering psychological injuries need our care and compassion more than most. This is the endless debt of gratitude that we actually can repay as a nation.

In more tangible terms, as government's deaf and blind awareness of the needs of Veterans and their families continues, Canadians awareness of how government treats Veterans and their families manifests clearly: CF enrollment and retention is directly impacted.

PART III: EMPOWERING FRONTLINE WORKERS: CASE MANAGERS (CM's) AND VETERAN SERVICE AGENTS (VSA's)

Previous testimony to this committee and Veterans Affairs Canada own internal audits reveal that Case Managers (CMs) are burdened with paperwork to the extent that for most CMs they spend 50% or more of their work time on completing this paperwork. Promised reductions in caseloads have either not materialized or the increased paperwork requirements have nullified the goal of lowering Veterans to case manager ratios.

The goal of lowering this ratio is ostensibly to allow for Veterans and their families to have more fruitful contact with their CMs. With increased contact, the assumption is that Veterans and their families will receive better, more comprehensive, more attentive, and/or more targeted case management resulting in better health and well-being outcomes.

There are a number of problematic factors in the assumptions around VAC's approach to case management.

- Anecdotal reports directly from case managers reveal that actual numbers of Veterans receiving case management may be as high as 60:1 vice the 2018 VAC audit of 32:1. This may be a result of how a Veteran is categorized as receiving case management services. Although Veterans may not be placed in this case management category, the CM may be responsible for coordinating and managing ongoing services to Veterans not officially categorized as case managed.
- Case managed Veterans are widely reporting that they are being dropped from case management in order to meet internal VAC quotas before the Veteran has obtained the objective goal of optimizing their recovery and potential.
- Many Veterans that require ongoing case management but have been dropped are being transferred to the responsibility of Veteran Service Agents (VSA's) under a "guided support" model.
- VSA's are forced to take on this responsibility when many are already burdened with having the responsibility of upwards of 1000 to 1500 Veterans and family members in their portfolio.
- Besides not having the time to provide in-depth care "guided support" Veterans require, VSA's do not have the training to provide this role nor do they have the same autonomy to independently authorise benefits and programs to the extent that CM's do.
- VSA's are widely treated as the second class cadre of workers at VAC with Senior District Medical Officers, District Nurses, and even CM's showing them little respect for the immensely valuable role they have. VSA's are often the only

Veterans Affairs employee who has personal contact with Veterans, coming to know them better than any other VAC employee.

- The focus upon statistics ignores the most important role of Veterans Affairs: ensuring that Veterans and their families are treated holistically receiving the most comprehensive and high quality care *for as long as they require such care*.
- Veterans being dumped surreptitiously or expeditiously from case management is a sign that Veterans Affairs should both hire more case managers and Veteran service agents, while simultaneously reducing the administrative burden shouldered by frontline workers.
- CM's are now required to be registered nurses, occupational therapists, social workers and/or have a case management certificate provided by a post-secondary educational institution. Yet, CM's are not considered "health professionals" by either VAC or the Public Service. As such, VAC fails to provide them with annual training stipends to maintain or advance their skills and training.
- CM's by virtue of not being considered "health professionals" are excluded from district, regional, and national meetings for health professionals. Often, client files are discussed in district health professional meetings yet the VAC professionals, CM's and VSA's, that best understand the Veteran and his/her family are not present. VAC health policy likewise could be decided or influenced during national health professional meetings while those workers that best understand Veterans are excluded.
- "First Call Resolution" (FCR) initiative was apparently initiated by VAC official, Graham Williams. The goal of FCR was intended to "reduce paperwork, cut wait times and delivery modern options for Veterans to interact with the Department"[i] FCR has become mutated to principally focus upon reducing wait time for callers. Software tools allow management to monitor calls in progress in terms of time on telephone calls.
- As with CM ratios, FCR statistics have overshadowed the role of providing quality service to Veterans. Unfortunately, bizarre management behaviour has emerged. VSA's who often work the phones are already overburdened with their client loads. Meanwhile, frequent anecdotal reports have emerged of managers interrupting VSA's to instruct them to monitor the time and even end calls whether or not Veterans had their issues addressed.
- Veterans Affairs senior managers have initiated frequent legislative proposals and policy changes since the tabling of the "New Veterans Charter" now the *Veterans Well-Being Act* in 2005. One consistent feature of these changes is that senior managers more frequently than not have failed to consult with frontline workers as to whether they can handle the additional workload let alone understand the changes. When rarely consulted, input from frontline workers essentially is ignored in any policy change.

- Veterans and their families are effectively seven degrees removed from having any say in designing programs that profoundly affect them and their futures. Frontline workers best understand the needs, plights, struggles, hopes, fears, and limits. Changes that affect Veterans and their families as well as frontline workers must include meaningful representation from the most important components of providing for the well-being of Veterans and their families: the Veterans and families themselves and the VAC workers who cultivate trust and advocate for their needs.
- Family members as countless mental health professional organisations and studies have pointed out are integral and fundamental to as well as inseparable from a patient's management of and recovery from a mental illness including traumatic brain injury[ii]. In spite of VAC's written commitment to include family members in developing Case Management plans, it is the exception that family members are actually contacted and included.
- Veterans with psychological injuries by definition have complex needs. As Program of Choice (POC) 12 principles stipulate, "clients presenting with complex needs shall be case-managed"[iii] Psychological injuries are chronic illnesses often requiring lifelong support. Even maintenance therapies for Veterans presenting with psychological injuries require case management. The complex needs resulting from somatic manifestations of the mental illness in the Veteran's physical health are dynamic, unpredictable, and require collaboration and coordination to manage these needs throughout a Veteran's life.
- Previously, before CM positions were created, these officials were known as Area Counsellors. A Veteran with complex needs would have access to an Area Counsellor for as long as the Veteran needed. These needs have not diminished merely because VAC has changed the title of the job, the essential criteria of the position, or the need to reduce case management ratios to present a rather thin façade of VAC effectiveness in addressing Veterans' well-being.
- The demands upon frontline workers are immense in terms of client loads but also absurdly complex paperwork which has been in a constant state of flux since 2006. Policy manuals for not just case management but all VAC programs available span multiple volumes with one volume alone containing 1500 pages. So-called policy experts, many who have never met a Veteran who is a client of Veterans Affairs let alone spending meaningful time with a frontline worker, inundate frontline workers with endless revisions of and requirements for paperwork to be completed by frontline staff.
- The legislation creating underpinning the current suite of benefits and services for Veterans originated in the 2005 legislation colloquially named "The New Veterans Charter", now *The Veterans Well-Being Act*. A cornerstone of this legislation was the commitment to comprehensive clinical case management.

However, even three years later, VAC's research department was studying the definition of Case Management. That definition and what VAC provides under its auspices has been a moving target for 15 years. The 2019 VAC internal of case management as well as VAC client surveys have repeatedly shown that these failings to develop a clinical practice of Case Management results in poor outcomes, unhappy Veterans and ignored family members.

PART III: Recommendations

1. **VAC to hire more Case Managers (CMs) and Veteran Service Agents (VSAs).**

2. **CM's and VSA's work closely together with case managed clients. This micro team to be provided with dedicated administrative support to assist with the administrative/paperwork burden.**

3. **An external independent audit be commissioned to thoroughly evaluate administrative burdens upon VAC frontline workers with the goal of reducing that burden.**

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15. **In scrapping the First Call Resolution, VSA's be allowed to spend the time on the phone necessary to address the needs and concerns of the Veteran and family member without interruption from VAC managers.**

16. **Independent and ongoing reviews be commissioned to determine the true caseload carried by CMs and VSAs.**

PART IV: INTERDISCIPLINARY TEAMS AND THEIR PARTICIPANTS-*STRIPPING DOWN THE VENEER*

The Interdisciplinary Teams (IDT). Following the implementation of the New Veterans Charter in 2006, Interdisciplinary Teams (IDTs) were created at both the regional and national level. They apparently also exist at the district level. As VAC internal audits note, there were (and apparently are) no clear terms of reference in "policy nor business process"[iv]. IDTs included the newly created positions of Rehabilitation Officer (regional and national for both vocational and medical rehabilitation) as well as Mental Health Officer (regional and national). The intention of IDTs is to provide direction to frontline staff and play a "*key role in the delivery of intense and complex case management services*" [v]

Healthcare Teams (HCT) predated IDT's and included district medical staff but HCTs became integrated into IDTs. The result was that IDTs are typically staffed by District Medical Officers (DMOs), District Nursing Officers (DNOs), contract Occupational Therapists (OTs), Regional Rehabilitation Officers (RROs), Regional Mental Health Officers (RMHOs) and Standards Training and Evaluation Officers (STEOs) as well as the Veteran Service Team Manager (VSTM). Veteran Service Agents (VSAs) are typically not invited to attend IDTs. The only representation of the Veteran's interests and the only person who may have met the Veteran in attendance at IDTs is the Case Manager (CM).

What a True Interdisciplinary Team Should Look Like: It must be emphasized that *true* collaborative care teams are interdisciplinary teams whose members are typically all personally familiar with the patient because they provide care directly to the patient. They are all medical professionals. Thus, true interdisciplinary teams in this context are speaking from personal knowledge of the patient's status, needs, and well-being as well as the having the medical and treatment background to offer relevant input into decisions affecting the patient. For the best results in terms of health outcomes or achieving rehabilitation goals, these collaborative interdisciplinary teams also include the patient and the family members at various points in the care and rehabilitation.

VAC IDT's Pervert Reality Thus Shortchanging The Veteran: The Veterans Affairs Canada IDT is an *administrative body,* not a healthcare team in any meaningful sense. The members do not administer healthcare or treatment to the Veteran patient nor do they know the Veteran or the family and thus have very little understanding of their needs and lives.

VAC IDT members may be able to offer best practices advice or policy interpretations but a true interdisciplinary team must first and foremost include the patient and the family members. Sadly, in many decisions affecting initial applications to the VAC

rehabilitation plan, IDT members including the case manager make decisions without having ever spoken with or meeting the Veteran.

Most problematic in the IDT model that the only representative of the Veteran's interests, CMs are heavily *outranked* by all members of the team and are often condescended to since they are not considered true healthcare professionals by the other members. Since most case management plans do not involve communicating with family members, the most important support for Veterans suffering a psychological injury, the families, are completely excluded.

It is true that on paper that Case Managers are typically the decision makers for any treatment or benefits. However, the rapid hiring of many CMs by VAC has resulted in younger and/or inexperienced CMs being unable to stand up against the authority of the other members and their opinions. CMs, even if experienced, risk career limiting or career ending actions should they repeatedly attempt to overrule such an overwhelming body of so-called experts.

Anecdotal evidence points to an IDT culture that never begins with "how can we provide what this Veteran and his/her family need" but instead begins with an overly bureaucratic scrutiny of the "case file" with the goal of limiting VAC's case management and financial commitment to the care and treatment of Veterans and their families.

Saving money and meeting VAC bureaucratic benchmarks become the primary focus of VAC IDT's not the care and well-being of the Veteran and his/her family.

Some of these so-called experts who sit on VAC IDTs must have their credentials re-evaluated in the context of whether they have the best interests of Veterans and their families at heart. Or are they following an inflexible and biased policy interpretation as well as financial restraint as the guiding paradigm?

The absolute lack of familiarity of most IDT members with Veterans and their families has further devastating consequences for the Veteran with psychological injuries. IDTs often carry out "rehab rounds" which are a constant vetting of "files" to bump Veterans from case management to meet district as well as regional and national goals of seeking to reduce the ratio of Veterans to case managers. Once again, bumping the Veteran from case management is performed by IDT members without having ever met or treated the Veteran or his/her family.

If the VAC Case Management and IDT model is so flawed, how can this benefit Veterans and their families? The importance of continuing with even inadequate care for Veterans suffering mental illness cannot be overemphasized. Accessing and/or approving care and treatment through VAC can often be an arduous process. Having a Case Manager, even in this flawed model, does accelerate the approval process in

most cases. Having an assigned Case Manager even in this context, offers security and reassurance to a Veteran with complex needs. In this context, Case Managers provide some form of continued support in seeking treatment for a Veteran under case management. For a psychological ill Veteran, this treatment and the reassurance knowing a Case Manager has been assigned may be the only thing preventing the breakup of the Veteran's family or the only lifeline preventing suicide.

District Medical Officers (DMOs) are General Practitioners (lacking in medical specialty training) and frequently have worked in the CF environment. Unfortunately, this background can be to the detriment of the Veterans' interests, especially Veterans that suffer psychological injuries. Furthermore, these GP's often have limited knowledge/experience in treating not just psychological disorders but also gerontological medical issues that affect Veterans as they age.

The CF medical model for serving members with mental illness is to provide just enough care to have them return to their positions or sufficient levels of health to reclassify to another trade. Those that cannot meet either standard are medically released. These released Veterans often have chronic disabilities that will never resolve or be "cured".

CF medical doctors do not typically have experience with the needs and well-being of chronically ill Veterans. They often are influenced by the stigma of mental illness pervasive in the military such as viewing a psychological injury as a moral or character weakness. Worse, the stigma often sees those suffering psychological injuries as faking in order to receive an incorrectly perceived gravy train of VAC benefits.

Some in the CF medical community have unfortunately been misled about or misunderstand PTSD and Major Depressive Disorder (MDD). There has been a tendency to misdiagnose PTSD and MDD as personality disorder, a condition requiring far different treatment protocols.

Once employed by VAC, the military experience of these GPs sometimes has further negative repercussions. They often, without authorization, dig into the military medical file of a Veteran, opining with a perceived authority to dismiss medical specialist reports or minimize concerns of the other members of the IDT when the infrequent concerns of these IDT members coincide with the needs of the Veteran.

In some cases, these DMOs have treated the Veteran while the Veteran served. That a Veteran did not reveal his/her psychological injuries while serving is used against the Veteran. That virtually all military members who suffer a psychological injury will hide that injury at some point appears lost on some DMOs. This presumptuous dismissal of a Veteran's needs is exacerbated when Veterans so often cannot find a civilian GP or specialist to advocate for their treatment needs.

Regional and National Rehabilitation Officers sometimes have a medical background but it is unclear if that background includes case management or rehabilitation. Anecdotal reports from frontline workers regarding regional level officers are favourable. However, Rehabilitation Officers are often bound by administrative interpretations of policies as opposed to compassionate and personal understanding of the Veteran and the family.

The national level officers are unfortunately far removed from the interests and knowledge of Veterans and their families. Revelations in regards to their interpretation of policy, particularly dependant care, demonstrate a callous, insensitive, and pecuniary approach to authorizing rehabilitation-related programs. There appears to be a near complete absence of viewing Veterans' needs compassionately and humanely.

Mental Health Officers (MHOs), in the past have, like many rehabilitation specialists at head office, had little background in providing mental healthcare. They were merely program management (PM) category public servants who were appointed to the position. At the regional and apparently at the national level, a background in mental healthcare is now required. However, like all IDT members, in opining upon the needs of any particular Veteran and his/her family, these officers have never met or treated the Veteran and therefore cannot represent the best interests of Veterans and their families.

Standards Training and Evaluation Officers (STEOs) are the most problematic of all IDT participants. STEOs were originally established after the implementation of the New Veterans Charter to provide a repository of policy expertise, interpretation, training, and guidance to VAC employees. There is apparently no requirement for individuals occupying these positions to have any medical or rehabilitation-related background.

Around 2015, Veterans Affairs Canada established a national learning unit. In the subsequent years, approximately 800 employees received training for the "National Orientation and Training Program". [vi] Anecdotal feedback has been generally good indicating skilled and/or experienced mentors provided valuable training to frontline workers. Presently, it is unclear whether the national learning unit has received sufficient funding as there has been very little formal training being offered frontline workers since 2019.

When the national learning unit was established, and under Deputy Minister Walter Natynczyk tenure, VAC has taken on the more unattractive aspects of an ***insurance company model*** while failing to take on the more favourable aspects of the insurance industry such as greater transparency, need to set aside funding for future liabilities, and adherence to clearly published service standards. Nor can VAC be held to legal account as Canadians have held insurance companies: VAC has, at this point, no legally recognized duty of care.

As part of this insurance company model, the role of STEOs transformed from a passive role to a highly disturbing active role. STEO participation in IDTs has transformed the way IDTs function. STEOs often take the lead role in heavily scrutinizing rehabilitation applications and micromanaging details about “eligible conditions”. Of note, if an eligible condition is not included in the plan, no treatment can be authorized by VAC under the plan. Such scrutiny fundamentally contradicts the commitment and intent of the *Veterans Well-Being Act* and its policies to treat Veterans and their families holistically and compassionately.

It must be reemphasized that STEOs are not medical practitioners nor do they have any medical background. They never meet Veterans or their families in a meaningful capacity. Their training is solely focussed upon policy interpretation as well as cost-cutting and program limiting decisions. There is no doubt that STEOs are *not in the business of caring for Veterans.*

Secrecy of the IDT Process. Up until very recently, members of the IDTs would opine, influence, and make decisions on a Veteran’s rehabilitation, treatment, and other aspects of their well-being without ever recording a single word of their input. Anyone accessing the computer system recording decisions made about Veterans, the CSDN (Client Service Delivery Network) would not be able to find any of these recommendations or input let alone the names of those on the IDT who influenced the decisions.

Case Managers report having been ordered to protect the identity of those on the IDT including maintaining secrecy around any input made by the members of the IDT. This is completely contrary to government wide policy that all information pertaining to making decisions be maintained. Such decision-relevant information must be maintained and, by ATIP standards, is not “transitory” in nature. This violates the current (and previous) government commitments to transparency and accountability

We must ask the most obvious of questions: if VAC is truly proud of the work it carries out, why does the most important body affecting the outcome of VAC decisions for Veterans and their families operate in near complete secrecy? The answer is simple: VAC senior officials know very well that these decisions are not being made in the best interests of the Veteran but in the best interests of fiscal management, statistical reporting, and therefore adhering to narrow interpretations of Treasury Board policy while emphasizing cost-cutting above the care and well-being of Veterans and their families.

PART IV Recommendations

Short Term Recommendations: Under the Current VAC Case Management Model

17. **Interdisciplinary Teams (IDT's) and their associated meetings to undergo a rethink. The needs of the Veteran and family members must be put above all else including prioritized over goals to reduce case management ratios, the reflex reaction by VAC to deny or limit care or save money, etc. The question before any opinions or recommendations are put forward by IDT members should be "how can we provide the care and treatment Veterans and their families need".**

18. **Veteran Service agents to be included in all Interdisciplinary Team meetings.**

19. **CM's and VSA's to take the lead during IDT meetings while all other IDT members defer to these individuals.**

20. **It be recognized that senior District Medical Officers, District Nurses, STEO's, Rehabilitation and Mental health specialists do not know what is best for the Veteran. As such, Case Managers and Veteran Service agents to work closely on case managed files since they best know the Veteran and the family members**

21. **IDTs to include the Veteran and family member when decisions are made affecting them. IDT team members including the CM, VSA, DMO, DNO, and "specialists" must meet with the Veteran before coming to any conclusions let alone rendering a decision.**

22. **Primary Care practitioner of the Veteran such as a family doctor, psychologist, psychiatrist and/or occupational therapist must be present during IDTs.**

23. **Former CF medical doctors acting as Senior District Medical Officers (SDMO's) receive sensitivity training from one of the more recognized international trauma societies such as the International Society for Traumatic Stress Studies (ISTSS) to eradicate the longstanding CF bias towards labelling PTSD falsely as Personality Disorder.**

24. **Standards, Training, and Evaluation Officers (STEO's) no longer be permitted to play an active role in any Veterans' file or VAC decision.**

STEO's to be relegated as a passive resource to provide a librarian-like function in understanding VAC's complex policies.

25. **STEO's be required to carry out sensitivity training to understand CF culture, Veterans living with disabilities, and mental health issues.**

26. **All advice and/or opinions contributed by IDT members or other VAC officials such as STEO's, Mental Health and Rehabilitation specialists, be accurately recorded on the clients' file such as CSDN with the names and details of that input clearly recorded.**

PART V: A NEW CASE MANAGEMENT APPROACH FOR VETERANS WITH PSYCHOLOGICAL INURIES AND COMPLEX NEEDS

Canada was at the forefront of rehabilitation and re-establishment of Veterans returning from World War II. A comprehensive program for all Veterans including those with chronic illness and disability was initiated in the fall of 1939. The programs were in place when Veterans began returning in 1943 and finalized to assist over 1,000,000 serving personnel at war's end.

Back then, frontline Department of Veterans Affairs employees personally interacted to assist, guide, and teach Veterans and their families on the many skills needed for re-establishment. Senior leaders in the department had spent a year or more prior to the end of the war communicating directly with the Veterans and the civil society that would help them re-integrate into civilian life.

Fifty years later in the late 1990's, revelations as to Canada's neglect and abandonment of our transitioning military members fell on deaf ears at Veterans Affairs. We are now Twenty five years after the SCONDVA, McLellan and Stow reports shocked DND into addressing quality of life issues, including for those Veterans with psychological and complex injuries. Canada still does not have any equivalent public airing of the often tragic struggles of Veterans and their families to have Veterans Affairs Canada provide a comprehensive healthcare approach to caring for our Veterans suffering psychological injuries.

Such neglect and unceasing rhetorical obfuscation to avoid getting this right underscores a system-wide cultural failure at VAC. This is not the time for Band-Aid half measures. Much we need to know and do is being done elsewhere and/or done before. Our history of success with returning World War II military members is an excellent start.

In spite of failings in the American and Australian models, they offer much from which we can learn, including their mistakes. Both nations offer "presumptive"[vii] recognition of diseases related to service such as Veterans exposed to Agent Orange during the Vietnam War. A direct cause-effect link is not required to prove that a Veteran who suffer from one or more of numerous cancers or other diseases had those diseases caused by military service. Private initiatives in both Canada and other nations offer insights as to community based projects to care for homeless veterans or to help veterans find work in a graduated, supportive manner.

Assertive Community Treatment (ACT) has been so successful over the past 20 years that it has become foundational to how civilian populations help those with serious mental health issues integrate with the community. ACT teams "provide intensive treatment, rehabilitation and support services" which not only support recovery but help

those being treated to join their communities in productive ways.[viii] These models have been in place for American Veterans for over 20 years. [ix]

Collaborative interdisciplinary care, especially in the ACT framework, works well. A primary care team of a doctor, case manager, the patient and the family members works with other treatment providers as necessary to work on rehabilitation and recovery goals. These are not the administrative IDTs that we find at VAC, but hands-on practitioners working in the field, working with the patient, and working with each other in the patient's best interests on the patient defined goals.

The most common collaborative, interdisciplinary approach known as Collaborative Care Model (CCM) was developed 20 years ago and has been highly successful with those suffering mental illness. It is based upon the ACT team model. CCM,

> *can improve mental and physical outcomes for individuals with mental disorders across a wide variety of care settings, and they provide a robust clinical and policy framework for care integration.*[x]

CCM works better both in short and long term outcomes than standard care in treating those with mental illness including "*standard care*" models.[xi] The US Department of Veterans Affairs has implemented the CCM model for those Veterans suffering psychological injuries through its "*VA Behavioral Health Interdisciplinary Program*".[xii]

CCM in this case is similar to other collaborative interdisciplinary models and includes a number of key elements such as anticipatory, continuous care; self-management support; and coordination with community resources.[xiii] To be effective, CCM must be truly collaborative. The patient, not the administrative hierarchy, defines the health obstacles to be addressed. These are confirmed by the physician. The team which includes the patient sets the goals and establishes the plan. Most importantly, a continuum of self-management is supported by comprehensive care and treatment to teach skills, guide changes, and provide emotional support. Follow-up is active and sustained.[xiv] CCM does not "drop" or "transition" patients out of collaborative care in order to meet administrative targets unlike VAC's case management practices.

Collaborative care inherently is an interdisciplinary care team. The list of participants in the care team can be extensive, dynamic, and is always tailored to the needs of the patient. As noted above, Veterans suffering psychological injuries will also have those injuries manifest themselves physically. These are not imagined symptoms but the consequence of stresses on the mind consequently imposing stresses upon the body. Driving a car continuously at excessive speeds will not only risk a catastrophic engine failure, it will stress all parts of the car. The human body is far more complex than a car. The potential breakdown of other systems of the body is ever-present and changing. In

addition to consequential illnesses to a psychological injury, there are often co-morbid conditions that must be addressed.

As such, collaborative care will not only have a Primary Care Team (PCT) of the case manager, a treating doctor, and perhaps a psychiatric nurse or occupational therapist. The PCT in close collaboration with the patient and the family will have access to any number of mental and physical treatments providers depending on the state of health and stage of rehabilitation in which the patients find themselves. The practitioners potentially accessed could include any of the following or more:

- Mental health clinical specialists including psychiatrist, psychologist, and neurologist
- MD Specialists for physical conditions (gastroenterologist, genitourinary tract specialist, sleep medicine specialist, rheumatologist, respirologist, cardiologists, allergists, psychiatrists, etc.
- Occupational therapist
- Specialized therapists, counsellors, and coaches (speech therapist, equine therapist, trauma therapist, art therapist, couples/marriage therapist/counsellor, family counsellor, psychotherapist, sleep therapist, job coach, addiction therapist/coach, spiritual/religious counsellor, eating disorder therapist, somatic therapist)
- Nurse (psychiatric or community nurse)
- Social Worker
- Kinesiologist
- Dietician
- Physiotherapist
- Chiropractor
- Massage Therapist
- Acupuncturist
- Podiatrists,
- Audiologists

Furthermore, peer support, volunteer, and other community groups could be included in the ongoing goal setting for the Veteran. Any number of courses could also be accessed which provide both community involvement and education to the Veteran such as community learning, mindfulness, trade and skill building, as well as other courses. Post-secondary schooling and certification could be pursued with no particular goal other than the empowerment and cultivation of self-esteem in the Veteran. Such programs are essential to ensure that the Veteran maintains normal social contacts and feels like a contributing member of the group.

Those with psychological injuries not only benefit from the direct care provided by each practitioner, but the security provided by the ever-present availability and accessibility of care, support, and growth establishes a strong foundation to expand a Veteran's goals knowing that people and resources will be readily accessible.

Current Obstacles Preventing CCM

VAC presently offers services from many practitioners and programs listed above. However, the ***accessibility to programs is not the same as availability of programs***. Case Managers do not have the time, support, and often the skill to provide true case management. There exists no "Primary Care Team" which is essential to ensure proper validation of the goals faced by the Veteran and the family members. Absent a PCT, the Veteran and an overworked CM must muddle through a case plan and haphazardly coordinate care. Meanwhile, Veterans will face an uphill and lengthy battle to receive necessary treatment.

First, Veterans must understand what they need. They must become their own case manager, understanding their own limits, goals, and appropriate treatment protocols. This is frankly unfair to place this burden upon a disabled Veteran suffering a psychological injury. Even if the Veteran succeeds in identifying treatment needs, he/she must convince an already overworked and overbooked family doctor to refer for the treatment, if the Veteran has a family doctor. It is particularly unfair for single and homeless Veterans, who lack family support.

Then a Case Manager may authorise the treatment but will often have to bring the decision to the Interdisciplinary Team whose members know nothing of the Veteran. Once a decision is made and if positive, the Veteran or the family doctor must arrange the booking and wait in line for an appointment.

The new treatment provider will have to use the initial visits to get to know the Veteran. The new treatment provider will know nothing of the views of other treatment providers. And this process must be repeated for each and every treatment provider who becomes part of the plan.

This *ad hoc self-case management* is clearly not a model for success.

VAC suffers from a host of further structural and cultural problems that prevent collaborative care. In addition to the narrow and bureaucracy-centric care model at VAC, the following needs to be soundly addressed.

- Permanently disabled Veterans (Diminished Earnings Capacity/Totally and Permanently Incapacitated) are not given to access vocational-related post-secondary education. It is lost upon VAC that such education will provide

immense self-esteem, community support and a sense of belonging, especially for the psychologically injured.

- Family members are excluded from development of most rehabilitation plans and are almost never contacted during follow-up.
- As noted in Sean Bruyea's March 22, 2021 submission to Committee, other family members often suffer more than the family member diagnosed with the chronic illness, especially if that chronic illness is a psychological diagnosis Yet, family members are not allowed to receive mental health or any other care in their own right, let alone of their own accord.
- VAC practices do not recognize that family members are fundamentally important to any collaborative care model.
- VACs case management program is set up for Treasury Board short-term success, not long-term Veteran self-esteem and well-being. In short, VAC case management of chronic mental illness is set up for failure.
- When VAC's case management system inevitably fails, Veterans will notice. Veterans will therefore rightly complain. However, VAC views complaints from Veterans as the whinging of an overly entitled modern Veteran.
- If the Veteran persists in pointing out VAC systemic or policy failings, VAC forces the Veteran back into the very case managed context which failed the Veteran. In essence, VAC portrays the complaints of the psychologically injured as merely delusional manifestations of the Veterans' mental illness. This is called **"gaslighting"** and is particularly damaging for mental health sufferers and is more prevalent for females.[xv] VAC, like most bureaucracies resistant to any outside criticism, has raised **gaslighting** to a disturbingly callous level.

PART V Recommendations

Long Term Recommendations: Building a True Collaborative Care Model for Veterans and their families.

27. **VAC fund a nationwide community of *clinical* case managers (social workers, occupational therapists, and registered nurses) to work independently from VAC's processes. Veterans would be allowed to select which clinical CMs is the best fit. Current CMs will continue with their administrative roles processing treatment and benefits.**

28. **VAC fund a nationwide network of independent Primary Care medical doctors or provide funding directly to Veterans' existing primary care practitioners such as family General Practitioners to work on a Veteran's Primary Care Team (PCT).**

29. **VAC fund a nationwide community of experienced occupational therapists to also work on PCTs.**

30. **Veterans would select the PCT (Medical Doctor, Clinical Case Manager, and Occupational Therapist) best suited to their needs. PCTs would then collaborate with the Veteran and family members to develop an ongoing rehabilitation plan.**

31. **Existing CMs and VSAs, in addition to continuing their current administrative roles with much reduced administrative burdens, would coordinate with the various PCTs to secure community resources selected by the PCT for the Veteran and the family. This coordination would minimize delays to accessing treatment as well as other resources necessary for the PCT established rehabilitation plan.**

32. **IDTs would no longer be necessary in their current form. Instead, the various positions would help CMs and VSAs expedite PCT designated treatment and benefits. DMOs, RNOs, Rehabilitation and Mental Health policy experts would instead advocate and coordinate the necessary policy changes to accommodate PCT, practitioners with a Collaborative Care Model, as well as Veteran and family needs.**

33. **STEOs as policy experts would no longer be required. Instead, the positions would be converted to mental health and disability experts who would train and educate the entire department on issues affecting Veterans with disabilities and their families.**

34. **These new mental health and disability experts would scrutinize Departmental policies and programs to identify and revise obstacles to care, inherently discriminatory (gender, disability, race) policy and program details, as well as work with communication experts to revise all communications so as to respect the limits, conditions, and sensitivities of psychologically injured Veterans and those with complex needs.**

35. **All communications concerning a Veteran and his/her family must include the full name and file number of the Veteran in the subject line so as to facilitate *Access to Information and Privacy* requests. All consultation, communication, recommendations, and references affecting a Veteran and**

the family be clearly entered into the official record (CSDN) with the identity of the source clearly identified. Any breaches of this requirement be met with automatic sanctions such as fines proportional to an employee's salary or leave without pay.

36. **Case Management policy immediately reverse its narrow interpretation of eligible conditions in favour of the intent of the *Veterans Well-Being Act* which is to be "holistic" and "flexible" in recognizing that all health conditions suffered by the Veteran and all mental health conditions suffered by the family be included in any Case Management plan.**

PART VI: REMAKING HEAD OFFICE AND ERADICATING TOXIC CULTURE

VAC senior managers and Head Office located in Charlottetown have long operated in a closed, self-reinforcing world unto itself. This world resists outside input and recoils at any criticism from within and without. Although VAC professes a myriad of rhetorical slogans about caring for Veterans and their families, the actions of the department show something far different.

Programs are developed in isolation, by policy bureaucrats without any direct input from Veterans, family members, medical, treatment, or medically trained rehabilitation specialists. Not only are Veterans shut out from creating policies that will affect the rest of their lives, VAC has never consulted with Canadians and the communities that care for Veterans and their families. Frontline workers who implement the programs and are the VAC employees who best know the Veterans have no say in the development of the programs. Instead they are inundated with a tsunami of constantly changing administrative burdens. It cannot be emphasized enough that Veterans Affairs designs programs first to meet the needs of Veterans Affairs and Treasury Board, not the needs of the Veterans and their families.

Sadly, any criticism of VAC and its practices whether it comes from Veterans, advisory groups, or the media is usually met with two, often combined, denial of any shortcomings in the department. When pushed repeatedly, VAC will provide commitments without substance or follow through. The two-part denial first lauds the hard work carried out by VAC employees. Second, usually statistics or rhetoric of some sort is provided which points to 'most' veterans being happy and VAC cares deeply about Veterans and their families.

VAC's use of statistics has become decidedly problematic since the inception of the New Veterans Charter. When VAC contracted client surveys carried out every 2 years began showing a significant portion of the CF (vs. World War II and Korean War) Veteran dissatisfaction with VAC services, VAC stopped client surveys for seven years between 2010 and 2017.

When the surveys were restarted, CF client dissatisfaction worsened in many areas. However, the dissatisfied population's opinions were diluted by including them with the larger VAC client population which showed the majority of Veterans were content with VAC's services. Headings in the surveys included "Most feel staff are competent", "Many clients say VAC staff treated them exceptionally" and "Majority satisfied with the quality of service delivery"[xvi]

One must dig deeper to understand which Veterans disagreed with these conclusions. In many cases, the younger CF Veterans and especially the case managed Veterans have far more negative outcomes and perceptions of VAC services than the general

VAC client population. It must be remembered that the majority of VAC Veteran clients suffer more minor injuries and disabilities. “Most” of the Department’s budget is spent on a ‘minority’ of the disabled Veteran population. The severely disabled need VAC benefits and services the most. Case Managed veterans are in greater need of support and services, yet they are the most dissatisfied than any other demographic with VAC benefits and services.

The most telling demonstration of VAC’s failures that endless rhetoric and statistics has not been able to dispute: the ongoing backlog of disability applications. In reality, this backlog has been a constant feature of VAC’s maladministration. There have been peaks and troughs but when backlogs reach a number representing 50,000 claims, it must be remembered that VAC services are provided to just over 100,000 Veterans.

Veterans’ Legislation for fifteen years has been ramrodded through Parliament, or hidden in omnibus bills. Consultation on regulations is farcical at best if it is offered at all. In the passage of the entire New Veterans Charter regulations were open for comment only over the Christmas holiday season and during an election. The end product was not surprising: only one word was apparently changed”[xvii]. A similar pattern emerged for all major amendments to the so-called “living” New Veterans Charter. When *Pension For Life* was passed, not one word of debate was allowed in Parliament, the legislation was hidden in an omnibus bill and Treasury Board rules were ignored preventing any consultation on the Gazetted regulations of a program VAC has repeatedly said represented an investment of billions.

Advisory Groups members are often forced to sign non-disclosure agreements. Once signed, some members report that they are not offered copies but have the agreements quickly whisked away. The groups are stacked with government friendly bureaucrats, co-chaired by bureaucrats. Meetings typically have the agendas set by the bureaucracy and a host of them hover in and out of the meetings, often distracting and intimidating the members. The reports are often written by the bureaucracy and/or edited by the bureaucracy. Recommendations are full of “weasel words”, i.e., are so vague as to allow the government to do very little or something very different and still claim it acted on the recommendation.

The goodwill and good faith of the participants seeking real change is disrespected. More importantly, the opportunity to prevent tragedy and suffering for Veterans is tragically wasted in bureaucratic self-interest, parochialism and lack of meaningful contact with Veterans and their families.

Stakeholder Consultations are likewise exercises in a grandiose display of the wholly controlled bureaucratic agenda. These meetings are structured to bully and intimidate any dissent, filling rooms and breakout groups stacked with government friendly

members. No reports or recommendations result from the input of more than a hundred stakeholders. In rooms filled with sufferers of PTSD, Walter Natynczyk ignored the request of Veterans to use a microphone. Instead he preferred to trigger the psychologically injured by barking in a ‘parade square voice’ how well Veterans Affairs was treating Veterans. This is a relatively minor episode that is highly indicative to the overall insensitivity and intimidation employed by VAC senior leadership to suppress open debate and discussion in a “consultation” meeting.

More disturbingly, how can psychologically injured Veterans confront Canada’s top soldier in a crowded room of many who still believe one cannot question government? The irony seemed lost on Canada’s once most senior soldier.

Deputy Minister Walter Natynczyk. Many of these actions, including the tightly controlled Advisory Groups and Stakeholder Consultations have occurred under the leadership of Deputy Minister Walter Natynczyk. During his tenure, the elected Ministers have increasingly become marionettes for a bureaucratic agenda. Previously, when a Veteran had suffered an injustice or unfairness, Ministers would mobilize the bureaucracy to react quickly to rectify the obvious injustice. During the past five years, the bureaucracy has instead hardened itself against any claims of unfairness. Legalistic processes are now the norm. The internal review and appeal process is opaque, confusing, and overwhelming at best.

Head Office under Deputy Minister Natynczyk has empowered non-medical Standards Training and Evaluation Officers (STEOs) to manipulate, intimidate, inundate, and overrule not just VAC medical personnel and case managers on the IDTs but also medical specialists representing Veterans and their families. The Interdisciplinary Teams are now vehicles to deny care and rehabilitation while micromanaging Case Managers through overly narrow interpretations of policy and legislation.

Walter Natynczyk has overstepped his bounds to defend the department. He personally pressured media editors to stop publishing negative news coverage of Veterans Affairs in a move that attempts to trample our Charter Freedom of Expression rights.[xviii]

Equally troubling, his track record on defending Veterans from unfairness at the hands of his own department is questionable at best. Craig Dalton, the Veterans Ombudsman, sent four files to the department as part of an innovative triage system to expedite addressing unfairness endured by Veterans. Under Walter Natynczyk’s tenure, the department fulsomely ignored all four investigations and offered no recourse to the Veterans whatsoever.[xix] Such bureaucratic obstinacy reflects arrogance at the most senior levels of VAC.

Ombudsman. VAC controls the funding and many other administrative aspects of the office having oversight over VAC, the Office of the Veterans Ombudsman. The Veterans

Ombudsman reports to the Minister, not to Parliament. Repeated individuals occupying the office have called for the Office to be legislated and have it report to Parliament. This would allow the office to control its own funding, administrative, and other support. More importantly, the office could investigate what it sees fit without interference or obfuscation from the Minister or the Department.

The recent submission of four files to the Minister points to the fundamental flaws of having the office report to the Minister. The Department fulsomely ignored the investigation, findings and recommendations of four individual Veteran files. The files were then sent to the Minister. Three of the four files received a similar response to that of the bureaucracy. This is no surprise as it has been longstanding practice that the Minister's office receives its marching orders from the Deputy Minister.

A strong and entrenched Deputy Minister like Walter Natynczyk is likely highly resistant to any influence from the Minister's office. On the contrary, the Minister's office is beholden to the Department. How can half a dozen political staffers with far less experience in VAC matters and a Minister who takes little interest in his portfolio confront and succeed against such entrenched leadership? This entrenched leadership is reinforced by four decades of an insular culture in Charlottetown far removed from Ottawa. Likewise, an Ombudsman's office split between Ottawa and Charlottetown and with no powers of investigation or sanction has had very limited success in making systemic changes in VAC.

Secrecy and Access to Information and Privacy. Up until approximately four years ago, frontline workers when communicating about a Veteran were required to include the full name and VAC file number in the subject line of communications. Since that time, employees have reported that they were vehemently instructed to not include any Veteran identifiers in subject lines. Code words and initials were employed. These directions apparently were given to avoid having communications about Veterans being captured by *Access to Information and Privacy* requests.

Sean Bruyea's massive privacy breach and associated documents revealed that such practices were in place in Charlottetown as far back as 2006. Mr. Bruyea's requests since that time confirm that the practice has intensified. The 2010 privacy breaches came to light *not* because of a longstanding VAC practice of senior managers voluntarily disclosing minimal or no documents in response to ATIP requests. Previously, VAC ATIP managers understood this and authorized searches of computer backup tapes/servers. In one case, a Director General at the centre of the 2010 privacy scandal had voluntarily disclosed one harmless email. The computer backup server search revealed 50 of some of the most incriminating documents providing a trace of who, what, when and why Briefing Notes were created.

A computer server search of 232 VAC officials who were connected with monitoring Sean Bruyea's media activities resulted in producing 2.1 million documents as a result of a six year investigation by the Information Commissioner. This has never been reported publicly.

Since that time, Veterans Affairs has refused requests to access records on computer backup tapes/servers. Furthermore, VAC has stopped producing Briefing Notes, Dockets and/or maintaining files of Veterans who advocate for change in the media. Communications requesting decisions or actions of senior managers in dealing with sensitive matters such as reconsidering rehabilitation program benefits do not have a record trail.

Employees have reported that senior managers have instructed that no records or minutes be kept of meetings especially when decisions affecting programs, policies and Veterans are involved. This is completely contrary to Government of Canada requirements that requires records be maintained related to any meaningful decision.

Are decisions that affect the lives of Veterans and their families not meaningful?

A disturbing pattern emerges when these unofficial policies of secrecy are added to the strict instructions to not record the identity, input, or recommendations regarding decisions associated with Interdisciplinary Teams decisions.

No Consequences for Breaking the Law. The Privacy and Information Commissioners have long reported the toothless nature of their offices. They cannot or *choose not* to enforce the law with sanctions. In spite of the hundreds of Veterans Affairs officials who freely shared distorted accounts of Sean Bruyea's finances, medical condition and benefits, not one VAC employee was officially punished as a result of the Privacy Commissioner's findings. There were 54 employees sanctioned for peering into Mr. Bruyea's Client Service Delivery Network (CSDN). However, CSDN breaches were never part of the Privacy Commissioner's investigation or Sean Bruyea's legal claim.

There is no Downside to Breaking the Law, Only an Upside. VAC employees, especially at the senior level can sleep soundly knowing they will not face any negative consequences for refusing to voluntary release emails and other records. Facile justifications are provided to the Commissioners including excuses that documents were really not that important so they were erased from the server or employees can't remember to whom or from whom private information was communicated.

In fact, VAC is merely playing the game that all federal departments play in categorizing most communications as "transitory" and then erasing them from servers. Meanwhile, where records do exist on backup server/tapes, arguments are made that it is too time consuming, not necessary, and too expensive to access the stored material.

Toxic Culture and Toxic Leadership. Veterans Affairs isolation in Charlottetown has allowed senior leaders to cultivate a toxic culture. There is no standardized measure of a toxic culture but VAC's Head Office can lay claim to the most common measures.[xx] This is not the toxic culture of the RCMP with sexual harassment and abusive swearing.[xxi] VAC suffers from other more bureaucratic forms of toxic culture including:

- an overemphasis of hierarchy,
- rigid rules and policies take precedence over compassion, experience and common sense,
- senior managers rarely interact with frontline workers with the intent of listening to and acting upon their concerns,
- employees are overworked and/or unhappy with very little to recognize their sacrifices,
- autonomy and independence of employees is minimized or constantly under attack; and,
- most importantly, "fear is palpable in the environment".[xxii]

Not surprisingly, VAC demonstrates disturbing signs of a toxic leadership[xxiii] including:

- an unwillingness to listen to let alone act on feedback,
- excessive focus upon goals that make the senior managers look good at both the frontline employees' and Veterans' expense,
- the constant rhetoric deflecting longstanding criticism, Veterans concerns and systemic failings is evasive at best, and dishonest,
- The focus upon statistical measurements and program availability while ignoring the outcry of Veterans and their families reveals a widespread lack of a moral philosophy of social justice, compassion, empathy, humanism, etc. Saying pretty ethical/moral words does not mean they are following them,
- Rewards for failures and lack of accountability has been endemic in a culture far removed from the oversight agencies of Ottawa,
- Lack of support for the increasingly unhealthy workload placed upon all employees, but especially frontline workers who are too overwhelmed to properly follow their moral philosophy to care for the Veterans and family members they know; and,
- Leadership at the departmental, division, and section cliques demonstrate the presence of intimidation and bullying to force lower ranking employees such as VSAs and CMs to tow the line. Any attempts to voice dissent are met with isolation, and other career limiting reprisals.

Stigma and Discrimination against Veterans with Psychological Injuries in VAC has been longstanding. Applications are so lengthy, complicated, and overwhelming as to be arduous at best and impossible at worst for those Veterans suffering psychological injuries. The applications are not transparent in many cases as it is unclear what Veterans let alone medical doctors or psychologists must provide to receive the needed benefits and treatment. Medical and other professionals let alone Veterans suffering psychological injuries cannot 'divine' what VAC standards require. Application criteria are often disconnected from the adjudication criteria applied to approve or deny benefits.

Case Managers and VSAs do not have the time to provide the emotional and administrative support needed to properly fill out applications. Nor do they have the time or training to comfort a psychologically injured Veteran in dealing with the indisputably intimidating process to apply for programs.

Often, Veterans who manifest symptoms of distress in dealing with VAC, are met with heavy security measures including District Office escape rooms, bullet-proof glass, a 100% intolerance to any frustration or anger caused by VAC's lack of compassion, and, in far too many situations, Veterans are threatened with police intervention. VAC has trained its employees to be overly reactive, viewing Veteran frustration and anger not as a symptom caused by VAC's overwhelmingly complex and insensitive bureaucracy, but as an imminent dangerous threat to life and person. De-escalation, compassion, understanding, and sympathy are in short supply in VAC.

Communication. In spite of two decades of open criticism of VAC's processes and communications, response letters continue to be insensitive in their tone, complex in their language and therefore devastating to a psychologically injured Veteran. Three decades of delays in applications for benefits are gut punches to Veterans who did not question being sent across the world on 48 hours' notice, leaving behind a shocked and grieving family. The brown envelopes containing VAC's often negative decisions are a haunting, triggering reminder of a Veterans' inconsequential value to the government for which the Veteran has sacrificed so much of her/his body and mind.

Veterans Reporting Shortcomings. As noted above, when VAC inevitably fails in its mandate to care for Veterans suffering psychological injuries, there are two common reactions. Veterans will either retreat into self-destructive behaviour or, less commonly, lash out at those around but not at VAC. To attack government is a betrayal of the deep indoctrination that tells serving members that they must be willing to sacrifice their lives for our nation at the orders of government. For most Veterans, the system of government and the nation are emotionally inseparable. In the CF culture and for most Veterans, to criticize government is to criticize Canada.

It is ironic that Veterans are so conflicted about exercising the very freedoms like freedom of expression that they sacrificed their minds and bodies to protect.

Fewer Veterans will find the inner strength and resilience to recognize and call out an injustice. VACs closed institutional culture over the past 40 years since the Head Office relocated to Charlottetown, has become hypersensitive to any criticism from inside and without. VAC culture cannot imagine it is failing Veterans if it is working so hard. The blame must lie elsewhere. Since the Veteran is suffering a mental illness, the Veteran's criticism is obviously merely a manifestation of the mental illness, a delusion or irrational transference of anger.

VAC culture isolated in Charlottetown far removed from the lives and of psychologically ill Veterans and their families, has long written off Veterans who complain as 'just another angry Veteran'. After decades of VAC failings, Departmental culture has not been able to shake this highly discriminatory and belittling label. VAC attacks the messenger to ignore the message.

Veterans with Psychological Injuries Compose the Largest Proportion of Veterans Requiring Case Management. There are currently almost 35,000 Veterans and RCMP members with a "psychiatric diagnosis", close to 25,000 of whom have a PTSD diagnosis. Although almost half of case managed Veterans are Veterans with a psychological injury, only 27% of Veterans with a mental health illness are "eligible" for the Rehabilitation Program.[xxiv]

Veterans with psychological injuries will inherently have "complex needs" whether they be the psychological or the associated physical wear and tear of mental illness. Physical comorbidity with PTSD[xxv] is well known and is a predictor for future poor health outcomes.[xxvi] Cardiovascular disease, sleep and eating disorders, gastrointestinal and genitourinary tract problems, chronic pain, and pulmonary issues are highly common with mental illness along with cognitive, marital, family, social, employment, and emotional problems.

VAC mental health treatment policy clearly states that "client presenting with complex needs shall be case-managed"[xxvii] Why then are only 27% of Veterans with a psychiatric disability "eligible" for the Rehabilitation Plan? There is no excuse for failing to ensure the complex needs associated with 100% of Veterans with psychological injuries are supported in a comprehensive and collaborative manner.

Disempowering Veterans with Psychological Injuries. VAC has a long track record of failures that have fundamentally jeopardized and even harmed Veterans and their families. In that context, no amount of success can excuse these failures.

The key to successful management of a mental illness whether from a recovery model, a collaborative care model, and even a traditional psychiatric model is that the patient be empowered to have control over their treatment, recovery, and future.[xxviii] [xxix] The inability of VAC senior leadership to address decades of criticism about responding to and supporting Veterans with psychological injuries and complex needs is a symptom of a toxic and dysfunctional culture that has lost its moral compass. VACs rhetoric is impressive but its actions are far out of step with the pretty words.

VACs Fundamental and Systemic Failings Disempower Veterans with Psychological Injuries and Their Families.

VAC is broken on numerous fronts. These failures directly and negatively impact the most disabled Veterans with complex needs: Veterans with psychological injuries.

- VAC has great difficulty communicating respectfully, timely, or in a meaningful manner with its most disabled Veterans.
- VAC senior leaders cannot listen to constructive criticism in any form.
- VAC aggressively retaliates against the very Veterans they are legally mandated to care for should Veterans publicly criticize the Department or even locally criticize services.
- VAC consistently manipulates advisory and stakeholder groups, minimizing or ignoring the groups' input.
- VAC consistently neglects the most important social support for the most disabled, Veterans' families.
- VAC case management is the flagship program of the *Veterans Well-Being Act* yet it is constantly understaffed and overburdened. Case Managers are bullied, manipulated and/or intimidated into denying needed care for Veterans.
- Medical specialists supporting the mentally ill Veteran are overruled by far lesser experienced VAC officials, often officials who have no medical training.
- VAC officials mislead Veterans, Parliament and the public with a tireless campaign of spin and rhetoric.
- VAC processes to address Veterans' needs don't involve the Veteran let alone the Veteran's family or the Veteran's practitioners. These are ersatz Interdisciplinary Teams that do not reflect best practices or respectful inclusion of the Veteran to decide his/her destiny.
- VAC officials have repeatedly broken Privacy Laws and snub their noses at the principles of open and transparent government.
- VAC senior leaders have encouraged a culture of secrecy and obfuscation in dealing with Veteran case files.

- Identities of those providing input on case files and interpretation of policy have been strictly guarded revealing a culture that knows it is doing wrong and wishes to hide it.
- VAC senior leadership has snubbed its nose at not just the concerns of Veterans voicing injustice, VAC senior leaders show resentment for the Ombudsman when it reports on unfair treatment of individual Veteran cases.
- VAC has repeatedly refused to accept that they have a legally binding duty of care while simultaneously promoting rhetoric about how much it cares for Veterans.
- VAC has for decades refused to track suicides of Veterans claiming it is too complicated, while ignoring the fact that Veterans with psychological injuries lead very complicated lives each and every hour of every day.
- VAC Head Office shows the hallmark signs of a toxic culture, spearheaded by a toxic leadership culture.

PART VI: Recommendations-Remaking the Department of Veterans Affairs

37. **VAC employees, especially those in policy, STEO positions, appeal, adjudication, and senior management to undergo regular sensitivity training to better understand psychological injuries, the impacts upon the Veteran and the family, as well as the negative impacts that impersonal decisions making processes have had upon Veterans and their families over time.**

38. **Comprehensive and regular independent studies be carried out as to the negative impact VAC communications, decision processes, and actions have had upon Veterans and their families. The studies would identify that which needs to improve so VAC can remove these negative impacts of its processes and policies in favour of positive impact upon the lives of Veterans and their families.**

39. **All senior and middle managers who have never worked as a frontline worker to be obligated to carry out one week per year working as a frontline worker, answering phones, filling out applications, speaking with treatment providers, etc.**

40. **All VAC employees be required to record on the Client's file the details of any inquiry made about that file from the Office of the Veterans' Ombudsman.**

41. **Advisory Groups be established similar to the model of the General Advisory Council and accompanying subcommittees created during World War II. The group members would be independently chosen, composed entirely of non-government personnel, and have the authority to create, edit and publish their own reports.**

42. **Office of the Veterans Ombudsman to be a legislated position reporting to Parliament.**

43. **Office of the Veterans Ombudsman be empowered to file with the Federal Court with the broad and flexible mandate of making lives better for Veterans and their families.**

44. **Privacy, Information Commissioner and a legislated Ombudsman reporting to Parliament be given enhanced powers of investigation, compelling testimony, and sanction.**

45. **Data storage is relatively cheap. Beginning with Veterans Affairs and in conjunction with Library and Archives Canada, the Government of Canada establish an easily searchable 20-year database for all computer based records and communications, especially email files.**

46. **Accurate minutes and attendees be maintained of all meetings held within VAC to make decisions on policy or the care and benefits of Veterans and their families.**

47. **An independently appointed Board of Directors consisting of a widespread swath of Canadians be established to oversee senior management of the Department.**

48. **VAC to move its head office from Charlottetown to Ottawa.**

49. **A hiring freeze for middle and senior managers be put in place for positions currently in Charlottetown. As personnel leave those positions, the same positions are to be created and staffed in the Ottawa region.**

50. **Call centres, Treatment Authorization Centers, IT Services, etc. can be placed in Charlottetown to minimize any potential economic impact of moving Head Office back to Ottawa.**

51. **Appoint a Judicial Commission with a mandate to thoroughly investigate the toxic culture at VAC and make recommendations to comprehensively change it.**

52. **Appoint a Royal Commission with a broad mandate to investigate, hold public hearings and report upon the care, treatment and re-establishment of Canadian Forces Veterans and their families.**

53. **ACVA hold a year-long study of nationwide public hearings with a similar broad mandate as the Royal Commission recommended above. Interim reports and recommendations would be prepared and acted upon expeditiously with legislation as required.**

Endnotes

[i] Veterans Affairs Canada. *Audit of VAC's Telephony Service*. June 2016. https://www.Veterans.gc.ca/pdf/deptReports/2016-audit-telephony-service.pdf

[ii] Headway. *The Rehabilitation Team*. https://www.headway.org.uk/about-brain-injury/individuals/rehabilitation-and-continuing-care/the-rehabilitation-team/

[iii] Veterans Affairs Canada. *Mental Health (POC 12).* https://www.Veterans.gc.ca/eng/about-vac/legislation-policies/policies/document/1104

[iv] Veterans Affairs Canada. *New Veterans Charter Evaluation-Phase II-August 2010-Service Delivery Framework*. https://www.Veterans.gc.ca/eng/about-vac/publications-reports/reports/departmental-audit-evaluation/2010-08-nvc-evaluation-phase-2/4-3

[v] *Ibid.*

[vi] Veterans Affairs Canada. *Minutes to Veterans Affairs Canada Service Excellence Advisory Group Meeting* Wednesday, June 5, 2019. https://www.Veterans.gc.ca/eng/about-vac/what-we-do/public-engagement/advisory-groups/service-excellence-advisory-group/06-05-2019

[vii] Veterans' Diseases Associate with Agent Orange. U.S. Department of Veterans Affairs. https://www.publichealth.va.gov/exposures/agentorange/conditions/

[viii] Assertive Community Treatment (ACT) Teams. Canadian Mental Health Association. August 21, 2012. https://toronto.cmha.ca/programs-services/assertive-community-treatment-act-teams/

[ix] McCarthy, J.F. et. al. Initiation of assertive community treatment among veterans with serious mental illness: client and program factors. Psychiatric Services 2009 February. 60(2) https://pubmed.ncbi.nlm.nih.gov/19176413/#:~:text=PMID%3A%2019176413-,DOI%3A%2010.1176/ps.2009.60.2.196,-Abstract

[x] Woltman, Emily et. al. *Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty, and Behavioral Health Care Settings: Systematic Review and Meta-Analysis*. Aug, 2012. The American Journal of Psychiatry. https://doi.org/10.1176/appi.ajp.2012.11111616

[xi] Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer-term Outcomes. *Arch Intern Med*. 2006;166(21):2314–2321. doi:10.1001/archinte.166.21.2314

[xii] U.S. Department of Veterans Affairs. *VA continues to pioneer new approaches for treating Veteran mental health conditions.* March 15, 2019. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5217

[xiii] Bauer MS, Miller CJ, Kim B, et al. Effectiveness of Implementing a Collaborative Chronic Care Model for Clinician Teams on Patient Outcomes and Health Status in Mental Health: A Randomized Clinical Trial. *JAMA Netw Open.* 2019;2(3):e190230. doi:10.1001/jamanetworkopen.2019.0230

[xiv] Von Korff, Michael, et. al. Collaborative Management of Chronic Illness. *Annals of Internal Medicine*. December 15, 1997. https://doi.org/10.7326/0003-4819-127-12-199712150-00008

[xv] Davis, Shirley. Medical and Mental Health Gaslighting and Iatrogenic Injury. CPTSD Foundation. June 8, 2020. https://cptsdfoundation.org/2020/06/08/medical-and-mental-health-gaslighting-and-iatrogenic-injury/

[xvi] Veterans Affairs Canada. 2020 Veterans Affair National Client Survey. Final Report. 2021-01-15. https://epe.lac-bac.gc.ca/100/200/301/pwgsc-tpsgc/por-ef/veterans_affairs_canada/2021/033-19-e/VAC_FullReport_Final_Apr_06_2021_EN.pdf

[xvii] Sean Bruyea pointed out the need to change the word psychotic. His subsequent audit and communications with Dan Fenety, VAC contact for the consultation, indicated that this was the only change in the entire consultation.

[xviii] VAC email trail Janice Summerby to Shirley Rochon, Morgan Bailey, DMO, Sue Foster, Jane Hicks, Lauranne Mason et. al. Draft prep note for DM meeting with Esprit de Corps Publisher. 2015/02/17 5:23PM.

[xix] Veterans Ombudsman. Response to Media Relations Request 20210202OVO. February 12, 2021.

[xx] Ryan, Liz. Ten Unmistakable Signs of a Toxic Culture. Forbes. October 19, 2016. https://www.forbes.com/sites/lizryan/2016/10/19/ten-unmistakable-signs-of-a-toxic-culture/?sh=a6e551115fea

[xxi] Global News. RCMP's 'toxic' culture is rampant through entire force, finds damning report. November 19, 2020. https://globalnews.ca/news/7472215/rcmp-toxic-culture-michel-bastarache-report/

[xxii] Ryan, Liz. Ten Unmistakable Signs of a Toxic Culture. Forbes. October 19, 2016. https://www.forbes.com/sites/lizryan/2016/10/19/ten-unmistakable-signs-of-a-toxic-culture/?sh=a6e551115fea

[xxiii] Kim, Jean. M.D. 8 Traits of Toxic Leadership to Avoid. *Psychology Today*. July 06, 2016. https://www.psychologytoday.com/ca/blog/culture-shrink/201607/8-traits-toxic-leadership-avoid

[xxiv] Veterans Affairs Canada. Facts and Figures. March 2020. https://www.Veterans.gc.ca/pdf/about-vac/news-media/facts-figures/facts-and-figures-mar2020-1.pdf

[xxv] McLeay SC, Harvey WM, Romaniuk MN, Crawford DH, Colquhoun DM, Young RM, Dwyer M, Gibson JM, O'Sullivan RA, Cooksley G, Strakosch CR, Thomson RM, Voisey J, Lawford BR. Physical comorbidities of post-traumatic stress disorder in Australian Vietnam War Veterans. *Med J Aust.* 2017 Apr 3;206(6):251-257. doi: 10.5694/mja16.00935. PMID: 28359007.

[xxvi] Seng JS, Graham-Bermann SA, Clark MK, McCarthy AM, Ronis DL. Posttraumatic stress disorder and physical comorbidity among female children and adolescents: results from service-use data. *Pediatrics*. 2005 Dec;116(6):e767-76. doi: 10.1542/peds.2005-0608. PMID: 16322133.

[xxvii] Veterans Affairs Canada. Mental Health (POC 12). https://www.Veterans.gc.ca/eng/about-vac/legislation-policies/policies/document/1104

[xxviii] Jacob K. S. (2015). Recovery model of mental illness: a complementary approach to psychiatric care. *Indian journal of psychological medicine*, 37(2), 117–119. https://doi.org/10.4103/0253-7176.155605

[xxix] Woltman, Emily et. al. Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty, and Behavioral Health Care Settings: Systematic Review and Meta-Analysis. Aug, 2012. *The American Journal of Psychiatry*. https://doi.org/10.1176/appi.ajp.2012.11111616