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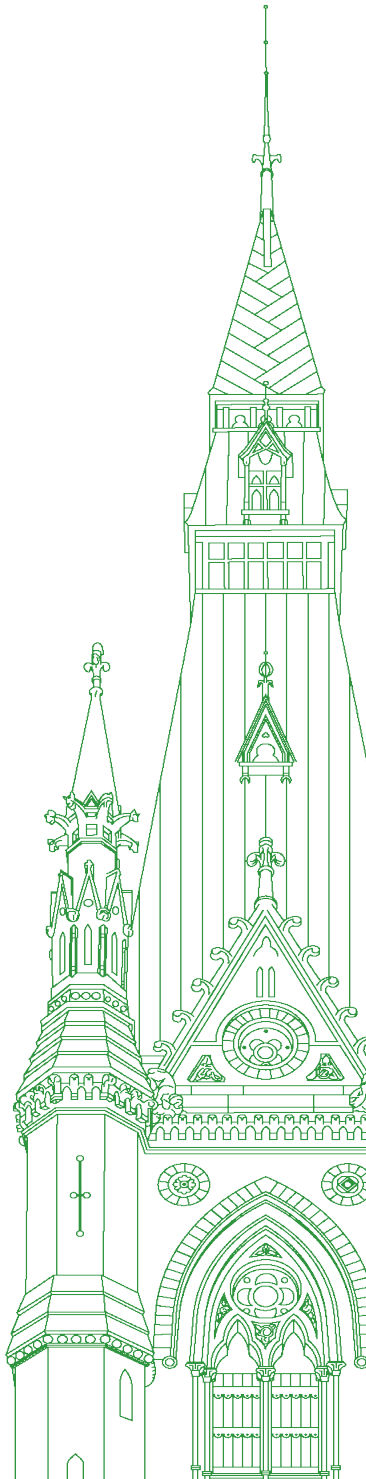

Chair: Marie-France Lalonde

Standing Committee on Veterans Affairs

Thursday, October 30, 2025

● (0815)

[*Translation*]

The Chair (Marie-France Lalonde (Orléans, Lib.)): I call this meeting to order.

Good morning, everyone. Welcome to meeting number ten of the House of Commons Standing Committee on Veterans Affairs.

The committee is meeting for its study on suicide prevention among veterans.

[*English*]

Before we welcome our witnesses, for people who are watching, I would like to provide a trigger warning. We will be discussing experiences related to suicide and grief. This may be triggering to viewers with similar experiences.

If you feel distress or need help, please advise our clerk.

For all witnesses and for members of Parliament, it is important to recognize that these are difficult discussions.

Also for our witnesses, if you do not feel comfortable at any point, please let us know. We can pause our committee for you.

[*Translation*]

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

Before we continue, I would like to ask all in-person participants to consult the guidelines written on the cards on the table in front of them. These measures are in place to help prevent audio and feedback incidents and to protect the health and safety of all participants, including the interpreters.

To ensure an orderly meeting, I would like to outline a few rules for witnesses and members to follow. Before speaking, please wait for me to recognize you by name. For those participating by video conference, click on the microphone icon to turn on your microphone, and please mute yourself when you are not speaking.

[*English*]

For those on Zoom, at the bottom of your screen, you can select the appropriate channel for interpretation: floor, English or French. For those in the room, you can use the earpiece and select the desired channel.

All comments should be addressed through the chair.

[*Translation*]

For members in the room, if you wish to speak, please raise your hand. For members on Zoom, please use the "raise hand" function. The committee clerk and I will manage the speaking order as best we can. We thank the participants for their patience and understanding.

I would now like to welcome our witnesses.

By video conference, as individuals, we have Marc-André Bernard, a psychologist at Institut Alpha, and Samara Symonds, formerly a civilian employee of the Royal Canadian Mounted Police, now retired.

Ms. Symonds, thank you for your service.

[*English*]

We will start by giving each witness five minutes to present their opening remarks. After that, we will proceed to a series of questions with the members of the committee.

[*Translation*]

Mr. Bernard, you have the floor for five minutes.

Marc-André Bernard (Psychologist, Institut Alpha, As an Individual): Good morning, everyone.

Today I will be talking about suicide prevention, which is obviously a very complex topic.

For military personnel and veterans, the risk factors for suicide are, for the most part, the same as those for the general population. They include mental illness, drug or alcohol use, isolation, grief, loss of relationships and chronic pain. However, we all know that the suicide rate is higher in this population, and it seems that some factors pose a greater risk for members of the Canadian Armed Forces.

I don't have enough time to talk about all the factors today, so I want to focus primarily on the unique processes of enlisting in and being released from the armed forces as well as notions of identity. I will base my remarks on the clinical observations I've been making for over a decade with this clientele.

It won't come as news to you if I say that enlisting in the Canadian Armed Forces is a professional commitment unlike any other. It involves developing a new personal identity that merges with one's professional identity. Ideals such as public service, common good, defending shared values and strong camaraderie are prioritized, and military personnel give up some of their self-determination and individuality to prioritize the collective, in some cases risking their lives to do so. These career choices must involve individual sacrifice, and it is those sacrifices we ask of them that later increase the risk of suicide.

While in the military, people must endure physical discomfort and pain, set aside their negative emotions and avoid focusing on their mental state, which is considered to interfere with the achievement of the ultimate goal: to act as one. It's a very taxing lifestyle for the family, as it can involve being uprooted, moving and straining support networks.

Being wounded on the job and no longer able to perform the same function within the group can trigger distress. When a person can no longer be part of the institution like their peers, they may struggle to manage mental states that have been ignored for some time. They may experience shame and humiliation in relation to their weaknesses and difficulty defining themselves as an individual. That is a direct legacy of their years of training and service.

Of course, that's in addition to the burden of enduring pain on a daily basis, having nightmares, mentally reliving difficult events, experiencing worsening mood and coping with a whole new allergy to stress and pressure because of an operational stress injury. Added to that is the stigma still associated with mental health issues. Many people find it difficult not to equate psychological problems with weakness.

As I said at the beginning of my remarks, today I want to discuss suicide risk related to the nature of enlistment in the forces.

It won't come as news to you when I say that the moment people leave the armed forces, they enter a period of high risk for depressive episodes. I've seen this in my clinic. Suicidal thoughts may emerge. There are a lot of things we need to consider. The absence of continuity of care is experienced as a loss of stability. The repetitive, redundant assessments former members must undergo can ratchet up humiliation and shame when they have to face their shortcomings. They may become intensely angry when they find their experience has become run-of-the-mill and bureaucratized. Aggression and humiliation are two documented risk factors for suicide.

Furthermore, the expectation that former members of the military will be successful at self-determination after serving 15, 20 or 30 years in the forces may simply be unrealistic. It makes them feel terribly inadequate because they feel they have to prove themselves when they have just devoted years of their lives to serving their country. Let's not forget that we have, to some extent, trained these people to think in dichotomous terms, sometimes strictly in black and white with no shades of grey. While this served them well in the field, it is detrimental to them in times of distress.

Although they were undoubtedly designed with the intention of providing effective guidance and support to Canadian veterans, the standardized rehabilitation services currently available from Partners in Canadian Veterans Rehabilitation Services seem to me to be largely unsuited to veterans and do not allow for adjustments to be made for those who are vulnerable and whose military identity was all they had. Those people are the reason I wanted to testify today.

● (0820)

I am very aware of the complexity involved in supporting these men and women as they leave the Canadian Armed Forces, often with significant and chronic injuries. I also recognize the generosity of the programs in many respects, as well as the progress made in destigmatizing mental health in the forces. However, I believe that if we want to think about suicide prevention among veterans, we need to consider the nature of what is asked of them in the course of their service and the fact that the transition to civilian life, a very difficult process, is in fact a process of acculturation in their own society. It's a process in which they experience alienation from civilian society once they are released from service.

Good soldiers pay attention to their psychological health. A psychological diagnosis should therefore never end a military career if it is dealt with, as was unfortunately the case in the past. I'm told that times are changing and that young military personnel are less concerned with rigid and harmful conceptions of mental health. I hope that's true.

In closing, in one of this committee's reports on the release of Canadian Armed Forces personnel, I read that it was recommended that Veterans Affairs Canada be able to process all veterans' claims and that veterans be assigned a civilian family doctor before being allowed to leave. I think this is a very good example of what could really make a difference in the lives of some former military personnel and reduce their feelings of helplessness, humiliation and frustration around the profound identity loss they must grapple with. It remains our responsibility to take care of these people, who have sacrificed some of their health to public service.

● (0825)

The Chair: Thank you, Mr. Bernard.

[*English*]

Next is Mrs. Symonds for five minutes.

Samara Symonds (As an Individual): Thank you for the opportunity to speak with all of you today.

I wear many hats in relation to this issue and will attempt to speak to all of them in this short time.

I am a veteran with post-traumatic stress disorder and depression.

I was a civilian member intelligence analyst of the Royal Canadian Mounted Police and spent most of my service working on homicides and national security. My PTSD from the trauma exposure is real, but many times it was discounted in comparison to Canadian Armed Forces service members or regular members of the RCMP. This includes comments from Veterans Affairs employees stating that I am taking away resources from veterans who have lost limbs. My experience was consistent with mental health injuries not being treated or respected the same way as physical ones.

I can echo much of the testimony you've heard about processes being difficult to navigate and taking too much time. My initial decision took about a year, which is actually very good, and I needed the assistance of the bureau of pensions advocates, which is a fantastic service, to receive a fair decision a couple of years later.

Once I began having children, I realized that PTSD in either parent makes for added challenges during childbirth. At the recommendation of my psychologist and midwife, I applied to Veterans Affairs to cover a doula to help manage my PTSD during childbirth. This is a readily provided support [*Technical difficulty—Editor*]. After a five-minute conversation, they could all understand how little I was asking for and how much benefit it would provide.

However, processes reign. I applied in fall 2024. I provided my rationale. I provided medical documentation, and I provided research papers attesting to the benefit for PTSD. I looked into any possible health care professional who could assess me and verify my claim, but I lived in the north, so my options were limited.

I'm awaiting the result of my final level of appeal, and my daughter was born over six months ago. I walked in to meet with a Veterans Affairs representative just days before I went into labour. They suggested that the local Legion pay. This is charity I was not comfortable taking. I sought assistance from the bureau of pensions advocates, and they provided helpful advice for my appeals but said they can't help with treatment benefits. I believe this to be a major gap.

This one story is exactly the type of battle and wait that veterans and families face when seeking support from Veterans Affairs for service injuries or death. To sum it up, it's onerous, isolating, adversarial and damaging.

I am also the spouse of a veteran. To respect his privacy, I won't be sharing much about my personal experience in this regard. However, almost every day I grieve for my husband before his injury and I fight to support him and maintain my own health while doing so. I am unique in that I have VAC treatment benefits for my own service injury. These end up covering my mental health needs as a spouse. I have the treatment that many other family members need and deserve. Regular sessions with a psychologist experienced with PTSD and policing have gotten me though unbelievable circumstances. I've accessed counsellors through the VAC assistance service who describe my family as in crisis and don't know how to help us when we're just surviving.

I am also a mother. I see the impact of our service already on my very young children. I worry about their ability to access mental health care in their own right one day. I also think it's important to note that you're hearing from survivors and spouses, but the experience of children is lacking to date.

I am the co-administrator of an informal support group for spouses of RCMP members and veterans with PTSD. Our group has approximately 700 members. I invited others to testify before you, but the stigma is still significant, so you'll hear from me and from Jessica Ruth only, despite a strong following and support for this issue from the group. Until spouses find the group, many feel isolated and are in complete disbelief about what their life has become.

● (0830)

Divorce is an all-too-common outcome. Other women have lived with decades of abuse as they attempt to honour “in sickness and in health”.

The point I would like to make is that almost every unbelievable story is accompanied by multiple responses saying, “I completely understand and have been through similar” and then recommending counselling.

Not only do we have the role of caregiver to our veteran, but we often have the absence of a caregiver as the veteran may struggle with the capacity to provide the typical support of a spouse. It is not sufficient to fund mental health care for spouses as a caregiver. Most of the spouses I've met struggled with their member's PTSD before the member accepted their condition. Most have struggled when their member or veteran refused further treatment. Many still struggle after a divorce. Mental health care in its own right could be a lifeline for the veteran's well-being and can help their family to be healthy and continue to contribute to their communities in their own way—as nurses, teachers, social workers and in other important roles.

Finally, I am the organizer of petition e-6654 and co-organizer of the group “Improving Mental Health Care for Families and Survivors of CAF/RCMP Veterans”. The petition was inspired by Jessica Ruth, whom you heard from. What we're asking for is something the veterans ombudsman has been recommending for nearly a decade: service-related mental health treatment for families in their own right. It's unconscionable that families are still waiting to be offered more than short-term counselling and lip service when they contribute so significantly to veteran well-being and often provide support to the veteran well beyond their years of service.

The veteran community is watching. We are encouraged to see senators asking the minister about progress on this recommendation, yet we experience more sanctuary trauma when the question is answered repeatedly with a simple “There's more for us to do.” I've received more informed answers from MPs on and off this committee. It's easy to say that the minister is new, but we all know there is a team of professionals behind her that is meant to prepare her for these questions. The bureaucracy continues to fail veterans and their families.

True prevention would start with a similar study focusing on RCMP and CAF individually. For the purposes of Veterans Affairs, though, I want to leave you with the simple answer to suicide prevention and answer two questions that have been asked by members of this committee already.

MP Auguste, you've been asking for innovative approaches to preventing suicide. Sadly, VAC hasn't even figured out the basics yet. It's so fundamental that the experts don't mention it: Fund mental health treatment, independent of the veteran, for families before death, so they have the skills and capacity to support the veteran.

MP Wagantall, you asked if there is anything you should be doing immediately to help. Provide mental health treatment to families before suicide, so they can help their veteran. Fund mental health care after the veteran's death, so that the suicide effects don't ripple through families as we know they do.

Thank you.

The Chair: Thank you very much, Mrs. Symonds. Thank you for your courage today. I think I heard well that you just became a mother again, so I wanted to congratulate you on the birth of your child.

We will be starting a round of questions. Each member will have six minutes.

We'll start with Mr. Tolmie for six minutes.

Fraser Tolmie (Moose Jaw—Lake Centre—Lanigan, CPC): Thank you, Chair.

I appreciate our witnesses coming this morning.

Ms. Symonds, I'm sorry to hear about what you had to experience and what you had to go through with VAC. VAC should be there to help all members. It should not be there to pick and choose and prioritize. I offer my apologies that you had to experience that.

You touched on your petition, e-6654. I'm wondering if you could please expand on that for those who may be watching this committee and share a little bit more about that.

Samara Symonds: Sure.

Currently, VAC allows for some counselling for family members, provided that the veteran is alive and engaging in treatment. What happened to start the petition is that a family member was receiving funded treatment from VAC, had an established relationship with a psychologist and was getting much-needed support. Unfortunately, their veteran committed suicide, and she was immediately cut off from her mental health treatment at a very vulnerable time. She had the bravery to walk into a town hall with the veteran ombud and confront her with the situation that she couldn't believe was happening to her. The ombud provided the answer that this was contained in a report from 2021—family members needed to have mental health treatment, funded by VAC, in their own right, not as a caregiver to the veteran.

Despite being recommended in 2021 and being agreed to by VAC in the media and in spotlight reports following up on the initial report, we haven't seen any movement to allow this. Often, what we hear is pointing to the VAC assistance service, which is equivalent to an employee assistance program. You're not guaranteed to get a psychologist or anyone who is particularly specified in the area that you're seeking assistance with.

The petition was really a simple call to pay attention to this report from 2021, which asked for this simple thing.

Furthermore, in our research since we started this, we realized that really the veteran ombud was talking about it back in 2016. This is why I say it's been a decade since we understood that families have service-related impacts and very badly need access to their own mental health treatment for those impacts.

● (0835)

Fraser Tolmie: Thank you very much for that answer.

Can I ask you where people can find that petition so they can sign it?

Samara Symonds: Unfortunately, the petition closed, with just short of 5,500 signatures. It was presented to Parliament just yesterday afternoon.

Fraser Tolmie: Thank you very much.

In your testimony, you shared a bit of what we've heard from other witnesses about sanctuary trauma, where the organization is supposed to be there to help you, whether you're an RCMP officer or a military veteran.

Could you please expand on what your experience has been with that?

Samara Symonds: Whether you're Canadian Armed Forces or RCMP, you take an oath, and it's a very deep thing. It's life-changing. You commit yourself on a level that no other employee is expected to commit themselves, and you do so with the understanding that it is service that is taken very seriously by this country. You're going to do unbelievable things for your country, and the result is that you're going to be supported when you inevitably have unbelievable damage from that commitment for the good of your country. With that comes an expectation that we accept that we have these injuries, and we turn to something like Veterans Affairs to try to make us healthy once we leave.

To have your service judged, to have your injury judged or questioned, and to not have any support in your options feels very much like you receive a cheque once a month to compensate for the damage caused to you, and that is all you're going to get for the rest of your life, when all we really want is support to try to get us to a healthy place where we can be a new form of employee, where we can be a healthy parent, where we can be a healthy spouse.

Fraser Tolmie: Thank you. That was an amazing answer. I really do appreciate it.

I want to circle back. You mentioned in your testimony how you were judged, and you mentioned in this last answer how you feel you're being judged on your injuries or your condition.

Do you feel like you're being judged...? I want to see if there's a difference between veterans in the RCMP and veterans in the military. Is there a difference? Do you feel you're being treated differently because of your service in a different organization?

The Chair: Mrs. Symonds, unfortunately, I can allow just 15 seconds.

Samara Symonds: Yes, I do feel that we are treated differently. Furthermore, we are eligible for less in benefits, which complicates things.

The Chair: Thank you, Mrs. Symonds.

I would like to now go to Mrs. Hirtle for six minutes.

● (0840)

Alana Hirtle (Cumberland—Colchester, Lib.): Thank you, Madam Chair.

Dr. Bernard, thank you for being here today and for all the work that you do in serving the Canadian veteran community.

Committee members, at our first meeting we ensured that we received trauma-informed practices training before any study was undertaken, knowing that witnesses would be bringing forward both powerful and challenging stories and issues. The committee has heard from witnesses in our study about the benefits of ensuring that trauma-informed practices training is made available to those who are working with and ultimately serving the needs of veterans.

We've also heard from family members of veterans that there are difficulties, and you've indicated what they sometimes characterize as insurmountable challenges in navigating services or communicating with veterans who are struggling with PTSD, which is where I'd like to begin today.

I understand that you encourage a range of therapy techniques in your practice. Can you tell us what are some of the most commonly effective types of treatments in your experience with veterans suffering from PTSD and how you view emerging therapies in contrast to more traditionally relied-upon approaches?

Marc-André Bernard: That's an excellent question.

Yes, I was trained initially in CBT. There is prolonged exposure therapy that's used, trauma-related exposure.

What I was talking about is that I don't like the cookie-cutter rehab that's going on, because it's about trying to fit everybody into the same kind of process. I do feel that with vets or with the RCMP the journey is so different that new approaches might be necessary.

I have some vets who really benefit from therapy with horses. I don't know what you call it in English, but it's a new kind of therapy that helps vets. One of the main problems with PTSD is the digestion of emotional baggage, which a lot of people have trouble with. Whatever helps the person connect with their emotions and learn to manage their emotions will prevent the PTSD from getting bigger. All those approaches that help the veterans connect with their emotions in a non-threatening way—therapy with horses is one of them—can be very beneficial.

I know that EMDR is something that's used. This is one of the approaches I've never used before. It's not part of my arsenal, so I cannot comment on this.

There's another type of therapy that's used more than that. It's called “narrative therapy”, where there is the idea of making a story about the whole journey the person goes through—in this case, in their professional life—to make milestones. Trauma is something that changes you forever, but it doesn't mean that it has to change you only negatively. Post-traumatic growth and resilience have been studied, and a lot of people journey out of that. There is a possibility for growth through it, but there is a very tough moment when people need to be helped. What narrative therapy does is connect or integrate all the parts of your life together and make sense of them, which is what resilience is about. It's about integrating every part of your life together and being comfortable with it, with better emotional management, which is not something that is thought of in the armed forces. We can understand that in a certain way, but I think the way people are trained to do difficult work like police work or military work sometimes requires putting aside the emotional world. That doesn't mean it goes away. It just gets accumulated and complicated.

All the approaches to trauma are about making it simpler to digest those things and making it okay to address those things. That's what I was saying about humiliation and shame, because I feel that those are things that can lead to suicide. People would rather disappear than have to face those emotions. They don't know how to deal with them, and they are not in an environment where it's okay to deal with them.

I don't know if this answers your question.

● (0845)

Alana Hirtle: That was wonderful. Thank you.

I think I have just under a minute left, so I'm going to ask a quick question. The answer might be yes or no.

Do you find that a combination of talk therapies and monitored acute or long-term pharmacological solutions is effective?

Marc-André Bernard: Yes, I do, although there was a period when people used medication way too much, which brought a lot of problems.

In some cases, the combination of the two might be the best way to pass through the hardest part. If there is talk therapy or strategies to help the person cope, in combination with medication, that could be indicated in many cases.

Alana Hirtle: Thank you so much.

[*Translation*]

The Chair: Thank you.

Ms. Gaudreau, you have the floor for six minutes.

Marie-Hélène Gaudreau (Laurentides—Labelle, BQ): Thank you, Madam Chair.

I thank the witnesses.

Mr. Bernard, thank you for taking the time to take care of our veterans. I also want to thank you for summarizing the situation for us and cluing us in to that very important critical mass. You said you see between 15 and 20 veterans a week, on average. I believe you're well qualified to make recommendations.

First of all, did you hear Ms. Symonds' testimony? If so, is that a unique case, or is it the case for many people?

Marc-André Bernard: It's definitely not a unique case. What Ms. Symonds talked about is something I see every day in my practice. I often have to invite my patient's partner to individual therapy to provide information, answer questions or get their information, because they don't have access to support elsewhere. I also see a lot of RCMP officers because they don't get the same services and it really is harder to access services.

Families are heavily impacted by military service and the ensuing psychological problems. Indeed, as Ms. Symonds said, families are the primary supports for veterans. It's often at the spouse's suggestion that a veteran seeks help and receives support. The story Ms. Symonds shared today really isn't unique at all.

Marie-Hélène Gaudreau: I heard you say that when people leave the forces, it's extremely important to maintain that connection, not only because there's a kind of brotherhood, but because people have a deep need to stay in touch. I imagine people tell you they feel they don't matter after they leave the forces. Did I understand that correctly?

Marc-André Bernard: Absolutely, yes.

One thing I've noticed that is problematic and specific to the military at the moment is that continuity of care during the transition from service to release is lacking. In many cases, Veterans Affairs lacks access to files. When military personnel leave the forces, they lose their doctor and other providers. I am in a privileged position because, as a psychologist outside the military, I can treat military personnel while they're on duty, when they leave and after they leave. In many cases, I am the only care provider present throughout this process.

There are many things that make the veterans I am currently working with vulnerable. One of the biggest ones is having to repeat the same things ad nauseam in the context of repeated assessments. These veterans were properly assessed while in the service. They are completely reassessed when they leave the forces, as if the forces' assessments didn't count. Many of them have to fight with the officials to get me to do the assessment, because the officials want someone else to do it. Continuity is not a priority. I know that it's extremely humiliating for veterans to have to tell their story over and over again. It's extremely frustrating to come up against a bureaucracy that, by all appearances, has no continuity. I think that greatly increases the distress upon release.

● (0850)

Marie-Hélène Gaudreau: Excellent. I still have a little time.

So, that connection needs to be maintained, and support must be available, including to relatives, children and spouses, who are the first line of support. What I'm also hearing is that becoming a specialist does not mean that you've worked in the armed forces. It's more about better understanding individuals. It has been suggested that people receive specific training, which would enable other doctors like you to take over and maintain a connection to provide psychological support to these people. What are your thoughts on that?

Marc-André Bernard: Yes. Specific training would be necessary, as Ms. Symonds explained. This kind of involvement in this kind of work is not very common. It is important to understand what this kind of investment in one's career entails and the effects it can have. I can't really speak to the RCMP, but the military is a culture within a culture. It's a very different culture. I find that men and women in the military have a hard time opening up to someone who's unfamiliar with the culture. It's much easier for me to offer therapy now, 10 or 12 years later, because I know all the codes and the culture and I know how people operate. It is easier to create a protective bond with them, in my opinion.

Marie-Hélène Gaudreau: Thank you, Mr. Bernard.

The Chair: Thank you, Ms. Gaudreau.

[*English*]

Next, we have Mrs. Wagantall for five minutes.

Cathay Wagantall (Yorkton—Melville, CPC): Thank you, Chair.

Ms. Symonds, thank you so much for what you shared today, and how it relates to what the ombudsman shared with me at this committee.

I want to clarify.... You realize that at the moment VAC is limited in its ability to do what we're requesting. The government agreed that family members deserve to have mental health care in their own right. However, the legislation needs to be changed to give VAC that window to provide that service.

To clarify, you are asking the government to make the legislative change to include family members in their own right to receive that treatment. Would you agree?

Samara Symonds: That is my understanding from the ombudsman, whom I trust as a very reputable source, of what's required. I have heard different potential ideas that are very much in their infancy.

I appreciate any effort that MPs are making to try to improve services. However, we still like the long-term objective of it being properly legislated to protect that right.

Cathay Wagantall: Thank you so much.

Mr. Bernard, in your work with veterans, are there ever times when they share their thoughts of committing suicide as the answer to their circumstances?

Marc-André Bernard: Yes, there are.

Cathay Wagantall: Can you tell me at what point of your engagement with veterans do you learn of this concern in their hearts and minds?

Marc-André Bernard: Once the therapeutic relationship is installed, it's something I have to probe for and something I have to bring forth. It usually doesn't come from them.

Cathay Wagantall: As you work through that with the them, have they ever shared circumstances where they have considered MAID, or have been encouraged to consider that, as an option in light of their circumstances?

Marc-André Bernard: I've never seen a case where people were encouraged to consider it, but I've seen vets being shaken by the suicide of combat brothers and this opening a door of consideration for it in their minds.

Cathay Wagantall: If I'm interpreting that correctly, having seen comrades and friends commit suicide, perhaps seeing how that impacts family, are they then looking at MAID as an alternative?

● (0855)

Marc-André Bernard: Maybe we misunderstood each other. What I meant to say is that when one of their combat brothers commits suicide, it sometimes shakes them to the point of also considering it.

Cathay Wagantall: Okay, I understand. That's very disheartening.

You talked about veterans having a choice in the type of treatment they choose and that there are many different kinds of opportunities for them. I know they speak to each other and hear where things have gone well with the type of treatment they've received. Can you speak a little bit to the need to give veterans far more choice in what type of treatment they choose? I know we have this whole new program with PCVRS that is supposed to assist them with finding providers.

What's your perspective on the role of the veteran in their own treatment?

Marc-André Bernard: As I said in my presentation, I think it's a difficult position, because we need them to have more self-determination, but it is very hard for them to do that because they've learned not to for many years. I think they are sometimes at a loss with the choices they have to make.

I do agree with what you're saying, that more choices have to be offered, because some approaches are not for some people. For example, exposure to trauma is a very efficient way to treat trauma, but it is a very difficult one. Some people are not made for it, and we have to respect that. I think they should have more choices.

Maybe we're out of time, but I do have problems with the way PCVRS does rehab at the moment.

Cathay Wagantall: Thank you very much.

The Chair: You have 20 seconds.

Cathay Wagantall: You treat PTSD. Are you able to discern when an injury is PTSD and when it might be due to TBI, a brain injury?

Marc-André Bernard: I don't have the expertise for that, but we always screen for it, because if there was TBI, there needs to be an investigation on that side to make sure those are not overlapping. They can sometimes seem the same, but they won't give the same results in talk therapy.

[*Translation*]

The Chair: Thank you, Mr. Bernard.

Ms. Auguste, you have the floor for five minutes.

Tatiana Auguste (Terrebonne, Lib.): Thank you, Madam Chair.

I would like to thank Ms. Symonds for being here this morning and for sharing her story.

Mr. Bernard, you said that, as your interactions with the veterans you see unfold, suicide sometimes comes up. In your practice, what barriers do you encounter to preventing suicide among veterans?

Marc-André Bernard: The obstacles I encounter are often related to getting veterans to talk openly about this solution. This is often a difficult subject to bring up, and they will keep quiet about it in an attempt to protect their families. The other obstacle I see is the same as for treatment in general, namely, that veterans have been trained not to disclose anything that could be perceived as a weakness. I always try to communicate the psychological concept that suicidal thoughts or post-traumatic symptoms have nothing to do with weakness of character, but rather reflect suffering.

These thoughts must be brought to the forefront if we want them to subside, if we want to understand what they're talking about. The main obstacle is getting the veteran to be able to open up completely about this subject and talk about it. Veterans are often afraid that I will have them hospitalized or take severe action if they mention suicidal thoughts. However, in reality, if suicidal thoughts are detected early on, there is plenty of time to talk about them at length so that they dissipate. Therefore, there is no need to take action. When quick action is needed, it's often because the thoughts have been present for a very long time.

Tatiana Auguste: Thank you very much.

In the context of science, you mentioned earlier some approaches that you haven't adopted, but that have been adopted elsewhere. Ms. Symonds mentioned that she receives support from her peers. In your practice and based on your expertise, what role does peer support play for our veterans?

● (0900)

Marc-André Bernard: That's a very good question.

Veterans are a little different on this subject. Some will feel that they need to be supported by people who can fully understand their situation. They will therefore benefit greatly from peer support, from people to whom they don't need to explain a lot of things. It's a protective network. However, other veterans, upon leaving the armed forces, feel the need to distance themselves from the military and their comrades in arms. In their case, the support would be very different and would instead involve helping them create a network in the civilian world that would provide them with support.

I've seen both, but peers can certainly play an important role. The problem, at least among the generation of military members I've treated, is that these people don't talk about these things much among themselves, or don't dare to talk about them, when they could sometimes offer each other valuable support if they were at least able to talk about them.

Tatiana Auguste: Thank you very much.

You say that you are dealing with a certain generation of military members. What generation is it exactly?

Marc-André Bernard: In the past 10 years, I've mainly seen soldiers who went to Bosnia or Afghanistan, men between the ages of 35 and 60. I've seen fewer young soldiers between the ages of 20 and 30. If things have changed for this younger generation, since the military has evolved a bit, I'm less well placed to comment on that.

Tatiana Auguste: Thank you very much.

My other question is about therapeutic approaches. Are you using any new approaches that you would like to share with us?

Marc-André Bernard: The approach I use the most is exposure to traumatic memories, narrative therapy, which is becoming increasingly popular. That's the approach I've adopted most recently. Eye movement desensitization and reprocessing, or EMDR therapy, is the main approach used in western Canada. It may be used a little less in Quebec to treat trauma, but it is still used. Many of the veterans I've treated have benefited from it, while others haven't liked it, but it's been around for a long time. From what I've seen, the approach that produces the best results in terms of emotional management is the one that involves animals.

Tatiana Auguste: Thank you.

The Chair: Thank you very much.

Ms. Gaudreau, you have the floor for two and a half minutes.

Marie-Hélène Gaudreau: Thank you, Madam Chair.

Mr. Bernard, animal therapy is very interesting.

However, I would like to understand something. What is an institution's defence mechanism when it's faced with something big, heavy, touching and restrictive, and it doesn't know, perhaps due to a lack of expertise, the specifics of each case? What can happen in an organization?

Marc-André Bernard: I'm not sure I understand the question.

Marie-Hélène Gaudreau: For public servants and politicians who don't experience these realities, what is the mechanism? What can happen?

Marc-André Bernard: As psychologists, we can easily see the level of helplessness and suffering that people feel, and even we, who are well trained to deal with it, can find it difficult. Public servants and politicians have even fewer tools to deal with this suffering. So, often, in response to this level of helplessness, there is a tendency to want to act quickly and to want to regulate it. Unfortunately, this creates a lot of bureaucracy, processes and assessments, and the desire to reassure ourselves by doing this causes veterans to suffer. It's as if they have to jump through hoops over and over again to finally believe that we have what we have, in order to get the treatment we need. I don't think people do it on purpose, but I think it's a process that adds to the veteran's suffering.

● (0905)

Marie-Hélène Gaudreau: From what I understand, with all the expertise we have on program implementation, when it comes to veterans, it would be appropriate to adapt to greatly improve the situation instead of creating other programs. Is that correct?

Marc-André Bernard: That's exactly right.

Marie-Hélène Gaudreau: Thank you very much.

Thank you, Madam Chair.

The Chair: Thank you very much.

[*English*]

Mrs. Symonds, I don't want to put you on the spot, but I saw you nodding at times, and we do have a little bit of time before I have to end this panel to go, out of respect, to our second panel.

I would really like it if you could just maybe share some thoughts, because I saw you nodding. I apologize. I don't want to put you in an awkward position, but I would really like to hear from you for a few minutes on some of the perspectives that Dr. Bernard has shared, or on questions that have been asked that you would like to reflect on.

Samara Symonds: Overall, I would just say that of the many times when the doctor deferred, they may not have had the best sense of expertise or experience. Maybe they were on the younger side, which I still qualify as.

On the RCMP in particular, I find the comments he made on the experience of those groups to be factual, particularly with regard to the fact that some RCMP members have a lot of trauma from the organization specifically. This might be through the discharge process or other bureaucratic or managerial things they experienced, either beside or congruent to their trauma in service.

There are definitely some who really don't want anything to do with that specific population. It's important to consider that while peer support has worked well for me as a spouse, it doesn't necessarily translate to every veteran. It's often very informal, and while that's good, because it can show up in the way veterans want it to, there has to be a way to promote and support that as well, so that those communities exist.

Flexibility is also really important. I think that's part of what the doctor is trying to get at when he says we have to hear people individually and then promote that self-determination for them to request what they need.

I really appreciated the equine therapy talk. I've heard that it's very positive for veterans as well. This is the type of thing that veterans often find and that those of us who are skilled in bureaucratic things will seek out, but we have to provide research and a rationale and we have to get a doctor, a psychologist, an occupational therapist and every possible professional imaginable to verify what we're asking for. In contrast, if I come in with prescriptions for numerous medications, those will be covered without hesitation.

The Chair: Thank you very much for your contribution.

I want to say again, on behalf of this committee, thank you for your service. We wish you all the very best with the little one at home. I know it is a difficult time right now. Thank you for that courage.

[*Translation*]

Mr. Bernard, thank you very much for participating in our study.

[*English*]

I will suspend for a few minutes, and then we'll go to our next witnesses.

[*Translation*]

The meeting is suspended.

● (905)

(Pause)

● (915)

[*English*]

The Chair: Before we introduce our second group of witnesses, for people who are watching, I would like to provide a trigger warning. We will be discussing experiences related to suicide and grief. This may be triggering to viewers with similar experiences.

For all witnesses and members of Parliament, it is important to recognize that these are difficult discussions. Also, for our witnesses, if you do not feel comfortable at any point, please let us know. We can pause our committee for you.

I would like to make a few comments for the benefit of our new witnesses. Please wait until I recognize you by name before speaking. To activate and turn off your microphone, press the large button on the console. If you would like to use interpretation, you can use the earpiece. There are buttons on the console that will allow you to select the language and modify the volume.

With that, I would like to welcome our second panel of witnesses.

As an individual, we have Mr. Shane Nedohin. He is described as “farmer”; I would say “person”. Thank you for being here, sir.

From the Canadian Institute for Military and Veteran Health Research, we have Dr. Nicholas Held, interim scientific director.

We will start by giving you each five minutes to present your opening remarks. After that, we will proceed to a series of questions with the members of the committee.

Mr. Nedohin, the floor is yours for five minutes.

Shane Nedohin (Farmer, As an Individual): Good morning, Madam Chair, committee members and fellow veterans.

I have a lot of notes written here. I realize it is way too much for the five minutes, so I'm going to try to just hit wave-tops and talk fast.

My name is Shane Nedohin. I'm a retired JTF 2 assaulter, and I have served this country on multiple combat deployments in Afghanistan, three tours in Iraq, and a bunch of international and domestic deployments other than those. I was in for just shy of 22 years, and I retired in January 2024. I was released, primarily, for PTSI and TBI, as well as a whole slew of musculoskeletal injuries.

Last year, I actually went to Parliament. I went public about a letter that VAC sent me. VAC sent me a letter ignoring the science and denying that explosions cause TBIs. The same letter was sent to many of my friends. The day I got that letter, I began to plan my own death.

Although I had been experiencing thoughts of suicide, it was VAC and its ignorance that pushed me to the planning phase. I was brought back from that edge because of my amazing family—my wife and my two beautiful daughters, who are with me here today—and also because of the Concussion Legacy Foundation, which put the full weight of its organization behind this and helped me fight back against Veterans Affairs when I had lost all hope.

The ADM of VAC later said that the letter was a mistake, that it should have never happened. I'm not sure that I believe that. It was sent to too many veterans, in my opinion, to be a mistake. There are a lot of reasons that I'll chalk it up to, but I don't have time to get into them.

The problem has since been rectified, but there are a lot that continue to persist, which is why we're here today. A lot of the issues that I'd like to bring up, like the bureaucracy of the pay coming through three different sources, the multiple organizations that vets need to deal with, and Manulife harassing vets and weaponizing pay and benefits to its advantage, etc., have already been touched on by other witnesses. However, I'd like to start by talking about PCVRS, as I believe this is a case of a well-intentioned program that does more harm than good, based on my experience and that of my fellow veterans I have spoken with.

PCVRS is a program more akin to parole than a support system, in my opinion. PCVRS holds veterans hostage by threatening to take away pay and benefits if you refuse to comply with their program. It refuses to let veterans use any care provider but a Lifemark facility—more on that in a bit.

In my opinion, PCVRS is a mostly redundant program that duplicates many benefits already available to members with Blue Cross B-line coverage and, in many cases, A-line coverage. It creates a system, through its current contract, that basically justifies itself, in my opinion, like a giant self-licking ice cream cone. The contract that was signed with Lifemark and Loblaws went against advice given by case managers, veterans, public servants and many others. Since the contract was signed, Loblaws and Lifemark stocks have soared. I challenge the MPs of this House to look into the relations and dealings that led to this contract being signed; it was rammed through, despite opposition to it. Given the fact that this government already has a track record of scandals, with SNC-Lavalin and the green slush fund, I think it's a worthy investigation. Anyway, that's an aside.

With respect to the contracting of PCVRS, it forces veterans to use Lifemark—and only Lifemark—facilities, even if they don't exist in the veterans' communities. I was forced to do my occupational therapy physio assessment virtually by standing in front of my laptop, raising my arms and moving around while the guy on the other end tried to see my range of motion through a grainy video. This was despite the fact that I am currently seeing a physiotherapist through my Blue Cross benefits, and I had literally done a proper assessment the week prior. They wouldn't take that, because it was unacceptable to have an assessment that was done through a non-Lifemark facility.

I brought up these points with the ADM and the head of PCVRS, Danica Arseneault. I questioned the ADM as to why I am forced to use Lifemark. I asked if it was for adherence to a contract, and he said that, yes, it was a contractual obligation, that I had to use Lifemark. I asked if that was so even though Lifemark couldn't provide services in my area. There's one in Grande Prairie, which—it's a long story—I can't use, and they won't allow me to use any other provider. This, in my opinion, is just one of the examples of things that are leading to difficulties for veterans.

I think that's my time, in about five seconds, so I'll just leave it there.

● (0920)

The Chair: Mr. Nedohin, thank you very much, and thank you for your service, sir.

Dr. Held, you have five minutes.

Dr. Nicholas Held (Interim Scientific Director, Canadian Institute for Military and Veteran Health Research): Thank you.

Good morning, Madam Chair and honourable members of the committee. It is an honour to be here speaking with you today.

My name is Dr. Nicholas Held. I serve as the interim scientific director of the Canadian Institute for Military and Veteran Health Research, otherwise known as CIMVHR.

CIMVHR exists to enhance the lives of Canadian military personnel, veterans and their families by harnessing the national capacity for research and mobilizing this evidence into care, policy and practice. We were established by Veterans Affairs Canada as an arm's-length, expert knowledge mobilization centre that facilitates research to address the unique demands of military and veteran health.

Since 2010, CIMVHR has built a network of 50 Canadian universities and colleges, in addition to global partners, which have agreed to work together to address the health research requirements of the military, veterans and families.

For the sake of time, I will just highlight a couple of things but will try to skip through some of this.

We lead competitive calls for research and conduct independent peer review. We also have a large scientific conference known as the CIMVHR forum. It was in Ottawa a couple of weeks ago. We had about 800 people come in from Canada and all across the world. I want to highlight that suicide risk and support continues to be an area of work at these conferences. This year, there were eight dedicated presentations and a suicide theme to understand the impact on military and veteran health.

We also founded the Journal of Military, Veteran and Family Health, which is a peer-reviewed academic journal. It's through these avenues that we connect the research, care and policy systems so that evidence moves into clinical practice, policy and community practice. The journal itself has published a body of work related to suicide risk and prevention across serving members, veterans and families.

A search of the journal will yield over 160 items that mention suicide. A quick summary of those, since I don't think anyone has probably read all 160, is that key areas of focus might be the military-to-civilian transition, complex comorbidities of other health-related challenges, the impact and support of families, improving the cultural competency of our health care providers and improving data linkages to larger datasets that we need available in this country. There needs to be continued investment into this population data so that we can understand the health needs and outcomes of service members throughout their service, across various conflict cohorts and in the years of life after service.

Suicide among veterans continues to be a persistent challenge that deserves considerable attention. It has been reported that male veterans are 1.4 times more likely to die by suicide compared to civilian men, and female veterans are 1.9 times more likely to die by suicide compared to civilian females. Further research suggests that when that occurrence of suicide might happen is at a different time point. Male veterans die by suicide, roughly—on average—three years after transitioning from service, while females, on average, die by suicide 20 years after service. This is one example of a critical point.

These differences point to two important areas of understanding. First, exploring veteran suicide as an entire group is not enough, as we need to understand that diverse experiences in service can relate to ideation, attempts and death by suicide. Second, there needs to be a continued investment in suicide prevention that does not consider suicide as a single point in time but as a long-term approach to understanding and managing risk.

The literature pinpoints many different factors that increase the risk of suicide, such as traumatic brain injury, chronic pain and depression, to name a few, but it's critical that we consider suicide from a whole health and whole life course perspective.

In 2018, CIMVHR co-led a round table with Veterans Affairs Canada and the Canadian Armed Forces to engage a whole-of-community approach to suicide prevention. A lot of this was based on Dr. Jitender Sareen's work and funded by CIMVHR. Recommendations that came from this round table—and again, this was 2018—were that we need to provide education, training and information for practitioners; improve support for transition across the life course; provide support for identity challenges across transition; promote whole-of-community communication, collaboration and knowledge sharing; explore policy considerations for suicide prevention; evolve whole-of-community approaches to care for the suicidal person; and reduce barriers to services. At that time, seven years ago, it was highlighted that we need more information in several areas. That includes people who need the care, the role of families, understanding gender differences, developing methods for improving the listening skills of our health care providers and finding ways to effectively turn research into action.

More recently, we co-lead the Five Eyes mental health research and innovation collaboration with Phoenix Australia, aligning research priorities and bringing policy-facing synthesis to ministers across Canada, Australia, New Zealand, the U.K. and the United States. In 2024, the collaboration published a concise Five Eyes view on suicide in military and veteran populations. The report highlighted that, while numerous risks have been identified, it remains challenging to determine who will attempt suicide. After decades of investigation, understanding of the causes, prediction and prevention of suicide among military personnel and veterans are still limited. The report highlighted risk factors. They include the presence of mental and physical health problems, cumulative trauma exposure and medical or involuntary discharge from the military.

● (0925)

The report did highlight recommended next steps during service, which might include early identification of mental health problems and suicidality, starting from enlistment with interventions throughout the career and life cycle; easy access to evidence-based personalized care; reducing stigma and other barriers to help-seeking; and education for the individuals, peers, families and communities.

Following service, similar prevention strategies have been recommended, including providing support during and after the transition from military to civilian life; considering the specific circumstances and environments that veterans are transitioning into; and strengthening our support system for families, equipping them with knowledge and skills to aid in this transition.

Thank you.

The Chair: Thank you very much, Dr. Held.

I'm sure there will be lots of questions regarding the testimony we just heard.

For six minutes, we have Mr. Richards.

Blake Richards (Airdrie—Cochrane, CPC): Thanks.

Shane, I want to ask you a little about the Lifemark stuff, but let me ask you about a couple of other things first.

Can I ask you to describe...? Those of you who've had to go and fight for our country then come back and have to fight with the government in order to get the help and support that you need. What does that do to a veteran? Speak from your own experience or that of your friends.

Shane Nedohin: It's just frustrating, because you think they're supposed to be on your.... Honestly, I think it's well intentioned. I understand that bureaucracy is required to run the government—it's necessary—but I think we put up lots of barriers, and we've seen a lot of institutional abandonment. It degrades our trust, our belief.

To back up, why does a person join the military? They want to fight for their country. I believed in Canada. Then you come back, and it erodes what you believed in. Every time a vet has an incident with VAC, like my incident, for example, it slowly erodes trust in the system. Then it breaks down that belief in your country and what you fought for. It makes you lose hope in your country.

● (0930)

Blake Richards: It saddens me to hear that. I understand it, from your perspective and from many veterans' perspectives, but it shouldn't be that way.

You mentioned the experience you had, which led you to have some thoughts about ending it all. I'm sure you have friends who, unfortunately, weren't able to battle through it like you were, and did do that. Every veteran we meet seems to have friends who have done that.

Do you think those losses, at least in many cases, were preventable, if our government didn't treat our veterans the way they do?

Shane Nedohin: Yes and no. Suicide could be caused by any number of things. Yes, maybe some are preventable; some are maybe inevitable. I don't know the answer to that question.

I can tell you that contributing factors that have been brought up during this committee certainly have pushed many vets to the edge. Well, if you have a vet who is already on the edge, who then gets a kick in the teeth from VAC, it further provides him, in his own mind, with the evidence he's searching for to end it all—yes, nobody cares, nobody wants to look out for the vet, so whatever.

Again, well-intentioned programs sometimes do the opposite of what they're trying to achieve, in my opinion.

Blake Richards: That's a good segue into the stuff with PCVRS and Lifemark. You talked about it in your opening, of course.

Maybe just talk a little bit more about the effects it has. Speak to your own experience or that of your friends in terms of not being able to utilize the service providers that you've already dealt with and trust, that would be more convenient for you or that would better help you, and instead having to use ones that you're forced to because of a contract. Maybe speak a little bit to the problems that it causes.

Shane Nedohin: It's almost two years that I've been out now, and I have yet to receive a single rehab session from PCVRS because of bureaucracy. It's always something. It had to be this provider, but I refused to use that provider, because it was going to be somebody off in Halifax who specialized in 2SLGBTQI indigenous allyship and had never dealt with veterans. I was like, "No, I'm not dealing with this person as a psychologist because they don't understand me."

That caused another four-month delay. There are already limited providers. Why can't I just use the people in my area, or people I'm comfortable with? I want the ability to choose, but PCVRS says, "No, you will use us, or we will take away your IRB. Gone." I've been told that many times, and that's unacceptable. The government is weaponizing our pay and benefits against us. That shit has to stop, yesterday.

Blake Richards: I couldn't agree with you more on that. I couldn't agree with you more.

Dr. Held, can you tell us how important it is, when someone is experiencing suicide, to be able to access care quicky? It's not just the emergency stuff that needs to come right away, but the follow-up care. How important is that, and what happens when someone has to keep going back five, six, seven times to get that care?

Dr. Nicholas Held: I think care is quite important. That's a challenge in this country across many different aspects of health. The cultural competency piece of somebody who understands military service, at least at a basic level, is something we need across the country. That's something our work actually does. We look at informing health care providers about cultural competency and military experience.

Veterans have said that within 90 seconds, they can tell if their health care provider understands even a little bit about their experiences. We're not saying every health care provider has to live in that military experience, but they have to have some basic knowledge.

● (0935)

The Chair: Thank you very much, Dr. Held.

Next, we have Mr. Clark for six minutes.

Braedon Clark (Sackville—Bedford—Preston, Lib.): Thank you very much, Madam Chair.

Gentlemen, thank you very much for being here this morning.

Mr. Nedohin, thank you very much for your service. Do you suffer from persistent or chronic physical pain as a result of the injuries you sustained during service?

Shane Nedohin: Yes.

Braedon Clark: In your view, what impact has that had on your life since you sustained those injuries, the pain piece of it in particular?

Shane Nedohin: You live with pain every day. Anybody who has ever lived with chronic pain knows it affects your mental condition. It affects your mood; it makes you irritable. Do you know somebody who has a toothache? They're cantankerous and irritable. You couple the physical pain with the TBI and what's going on there. I suffer from vertigo and dizziness. Some days I'm good; some days I'm bad. It's something you live with, and it impacts you greatly. You figure a way through it.

Braedon Clark: Thank you for sharing that. I wanted to ask about it from a personal standpoint.

Dr. Held, from a clinical standpoint, you've done a lot of work throughout your career as it relates to chronic pain. In your view, from a research standpoint, how does chronic pain impact veterans from a physical standpoint, but also in terms of mental health care?

Dr. Nicholas Held: That's a great question.

Chronic pain, as we know, affects Canadian military veterans at almost twice the rate it does the Canadian general population. It is highly comorbid with mental health concerns. Mental health is going to exacerbate the pain symptoms that you might feel, and vice versa. There's a relationship there that's independent. There's also a relationship between chronic pain and suicide. All of these things are connected. That was one of the pieces of my opening statement that were important. Suicide is not a point-in-time thing. It's important throughout the lifespan of somebody, with all of these conditions coming together.

One of the biggest challenges.... We've identified many different risk factors in the 10 years or longer of research. There is that understanding of what moves somebody from those risk factors into attempting suicide, but there's still more work to be done.

Braedon Clark: You touched on the research and the work that CIMVHR is doing, which is great work.

How do you translate the academic research work you're doing? How do you inform VAC to make sure that veterans are able to benefit directly from the work you're doing on a day-to-day operational level? How do you take your research and put it into practice?

Dr. Nicholas Held: That's a great question.

I'll start off by saying that there's no perfect way of doing that across all nations or across the Five Eyes nations, where there are different mechanisms. At the forum, we just hosted a panel on how to do this effectively. We facilitate research out across Canada. We also have regular meetings within CFHS in the Canadian Forces and with Veterans Affairs Canada. We have such avenues as the journal I mentioned, which is open-access. It's free for anybody to access. We have the CIMVHR forum, which brings people together. We are doing some work on the ground as well in improving cultural competency, continuing medical education, credits and things like that.

It's through constant conversation. I think there is a question of whose responsibility that is. That could be a framework that gets discussed moving forward. Oftentimes, members of Parliament and government agencies might say it's on the researchers, that they need to push that information more into government. We obviously have a piece of that, because we are that bridge in between. That's something we work closely on. Researchers feel like it's up to government to kind of grab some of this research and implement it in an evidence-based way.

The key thing here is that there's no perfect mechanism, but we all have a role to play in that. Of course, we have a significant role to bridge that gap with clinicians, with veterans themselves, with health care providers and with government individuals as well.

Braedon Clark: Dr. Held, based on what you said there, would it be fair to say that there is a consistent, regularized, formalized process for your work to be transmitted directly to Veterans Affairs—"This is what we're learning. This is what might work, and you guys can take that and implement it into your policies"—or is it a bit more piecemeal, at this point?

● (0940)

Dr. Nicholas Held: In some ways, it's a bit more piecemeal. I think it's also very simplistic to think that you can take one study and move it forward and have all the answers. We need to inform individuals, and we have to be frank. I come from a science background. I believe in evidence-based medicine. That's something that's important. However, within policy-making and decision-making, a thousand different factors are at play. Research will be only one piece of that, so it is piecemeal. There are decisions that are made, and I know that it's not always only looking at evidence. That's something we're not going to change, but we also tend to say that things are evidence-based. Many times, it becomes common nomenclature in many areas. I think we need to look at that mechanism and make sure we're able to take that research into practice.

Braedon Clark: In your opening statement, Dr. Held, you talked about the work you do with Five Eyes and our peer countries. We've heard in previous meetings during this study that, unfortunately, the issue of suicide among veterans is a familiar and consistent story across a lot of our peer countries. Have you gained any lessons learned or any insights through that work, through some of our peer countries, where they might be doing well in areas that we could be emulating? Does anything stand out to you?

Dr. Nicholas Held: I think we can look to the Australian Royal Commission into Defence and Veteran Suicide as a systemic and systematic way of looking at this. I think that's a critical piece. It's hard to answer that question fully in 10 seconds, but I think we need to think about an all-systems level in how we can approach this.

The Chair: Thank you very much.

[*Translation*]

Ms. Gaudreau, you have the floor for six minutes.

Marie-Hélène Gaudreau: Thank you, Madam Chair.

Dr. Held, do we have access to evidence that could show, if applicable, a loss of interest in enlisting in the Canadian Armed Forces as a result of what happened in Bosnia and Afghanistan? Is there any data showing that there has been a decline in interest in officially enlisting?

[*English*]

Dr. Nicholas Held: I'm not aware of any specific studies I could pull on right now that would provide that information. I think you could look at enrolment rates, at why people are enrolling and why they're not, and at people leaving service. We have a lot of information that sits internally, especially at DND, that isn't accessed by outside organizations and that might give a bit of the answer. I'm not necessarily thinking of the enrolment phase, but of the exit interviews and things about why people are releasing and the challenges we have with retention. Those things could possibly come up, but I can't speak to that internally.

[*Translation*]

Marie-Hélène Gaudreau: It's clear that there's a process of care that obviously needs to change. We realize, and we heard this during Mr. Nedohin's testimony, that the focus is on treatment: We want to treat quickly and move on to something else. When I see that there are people who, among other things, act out after 20 years, I get the impression that there is a culture that needs to change when it comes to veterans and palliative care. A head injury isn't going to magically disappear. It requires treatment.

Do we have any data that could explain why palliative care for veterans is insufficient?

[*English*]

Dr. Nicholas Held: When we talk about palliative care, and especially when we talk about it in an aging context, we've had some changes within government policies so that the treatment of aging veterans has shifted over time. I think that's a key piece of consideration. We just published a report on aging veterans that I'd recommend reading. I know palliative care is not only an aging perspective, but I think that's something that we need to consider.

Within palliative care, I think it still leads into the health care system. We've worked at the level of physicians to try to increase military awareness, but it's not always the physicians who are spending a lot of time with our veterans. Oftentimes it is at different levels of health care, so we need to make sure that we are not only investing in primary care, that being frontline physicians and psychiatrists, but moving down the level of care to individuals who might see individuals in that state as well.

● (0945)

[*Translation*]

Marie-Hélène Gaudreau: Thank you.

Mr. Nedohin, I'm going to speak calmly.

How can anyone think they can have a good life after serving, after being proud of their part, returning home to their family and realizing that this was not the dream they had? How does anyone live a life full of pride and serenity when they come back with trauma? What do we need as human beings to help you and all veterans?

[*English*]

Shane Nedohin: I think it's going to be different for every individual. Speaking for myself, I just want to be left alone. Recognize that vets are injured and stop putting the onus on the vets to prove their injury all the time. That's what it feels like.

I don't know how else to answer your question, because I can only speak for myself, personally.

[*Translation*]

Marie-Hélène Gaudreau: I understand. People need to be left alone so that they aren't traumatized again by having to explain their physical and mental problems, but at the same time, people need to be provided follow-up services as needed, meaning for the rest of their lives.

[*English*]

Shane Nedohin: The way I look at it is that right now I'm capable of setting up my life in such a way that I can care for myself. If I need physio, I can go and access that. I don't need a nanny state to sit on top of me and tell me that I need a new medical assessment now because it's another 18 months and I need to still prove my legs are there.

I don't need a nanny state monitoring me. I just need to know what's available to me for my pay and benefits. It's for them to sort all that out in the first year, or whatever, of my release and then leave me alone.

That's what I want. Maybe it's not what other vets want, but it's what I want.

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Madam Chair.

[*English*]

The Chair: Mr. Viersen, go ahead for five minutes, please.

Arnold Viersen (Peace River—Westlock, CPC): Thank you, Madam Chair.

I want to thank the witnesses for being here.

Mr. Nedohin, you're listed here as “farmer”. It's an interesting—

Shane Nedohin: I didn't know that was going to be displayed. I think it said “job title”.

Arnold Viersen: I appreciate that. I'm an auto mechanic.

I was wondering if that was a choice, given that most people put their rank and then it says “retired” and things like that. Is that the case?

Shane Nedohin: I don't know. That's my past life. It's not who I am anymore. I'm now a farmer.

Arnold Viersen: That's fair.

The other thing is that we've heard from a number of family members who have had family members take their own lives. A recurring thing I hear is that they say they were on a cocktail of drugs.

Was that the case for you as well?

Shane Nedohin: I still am. As a matter of fact—and it's my own fault—I ran out of one of my prescriptions. When I flew here yesterday, I realized that I didn't have it. I'm currently going through withdrawal just because of that cocktail.

It's all stuff for my TBI and stuff like that. They're trying to help, but I don't know.... I'm not going to fault doctors for putting me on a cocktail of drugs. Some of them I need. I need my blood pressure medication or I'll have a stroke. I don't know. I'm not a doctor.

● (0950)

Arnold Viersen: For folks who have taken their own life, do you know...? We've started hearing a bit about these SSRIs. They're like an antidepressant drug, these kinds of things. It's an interesting thing that a side effect of them is suicide. While we're trying to prevent suicide with them, a side effect is suicide. You can see the circular logic there.

Do you have any comments on that?

Shane Nedohin: I don't know that I'm qualified to speak on that. I'm sorry.

Arnold Viersen: We've also heard from folks who have been communicating with VAC that they've been offered MAID. There was pretty compelling testimony on Tuesday. Do you have any experience with that at all?

Shane Nedohin: Not for me, but I personally know of a friend who was offered it.

Arnold Viersen: Dr. Held, when I talked about SSRIs, you were writing something down. Do you have a comment about that?

Dr. Nicholas Held: Yes. My only comment on it.... I'm not a medical doctor either, so I'm not trying to jump into that space, by any means. For me, it was the idea that we talk about suicide as a potential side effect, which is really important to consider, and it highlights the key piece to this, which is having that evidence where we know for whom something does work, but also, importantly, whom it could potentially harm. We could talk about many different areas where it does work for some people, but as a standard practice of health care, we also need to know for whom it may not work and put some time into that as well.

Arnold Viersen: Okay. Is that work being done that you know of?

Dr. Nicholas Held: Yes. I'm not sure about the SSRIs, but for things that were brought up on Tuesday, things like psychedelics—I'm not trying to get into that space and that conversation—there's research being done, and there's more to be done to understand that a bit more as well.

Arnold Viersen: Shane, do you want to comment on that?

Shane Nedohin: Yes. I used psilocybin. Obviously, I had to obtain it by alternative methods. I would say that it was one of the single most beneficial things I ever did. It was a massive turning point for me. Yes, it allowed me to process a lot of things. I don't want to go as far as to say that maybe I wouldn't be here without it, but it was a massive help, and I really, truly believe we need to be allowing that.

Arnold Viersen: You would recommend that it be pursued.

Shane Nedohin: Based on my personal experience, I would, yes.

Arnold Viersen: I was an auto mechanic in my former life. Often, when you're trying to diagnose a problem, you zoom in and you zoom out. Sometimes the problem is a very small piece, and sometimes the problem is a very large piece. You have to go upstream and downstream to find those kinds of things.

In this case as well, in trying to figure out the veteran suicide situation, one of the things we keep hearing about is the term “moral injury”. That's one of these cases where it can be a very large, 30,000-foot problem, or it can be right in somebody's individual life: Did we do the right thing? Are we part of the good guys? There are these kinds of questions.

I often hear people say they don't recognize Canada anymore. Do you think that's part of the moral injury? People went to fight for our country. They came back and they don't recognize the country they've returned to.

Shane Nedohin: Since you asked the question.... It's not going to be a popular opinion, but I don't believe in Canada anymore. I'm an Albertan and I want to leave.

Arnold Viersen: You would say that you've fought for something that—

Shane Nedohin: I loved Canada. I believed in Canada until a point. Again, I know it's not going to be popular with this side of the table, I guess, but the last decade has.... It's not what I fought for, the country I'm watching. This is my personal opinion, but I've heard this reflected by a lot of my fellow vets. They don't recognize it.

Let's take Afghanistan, for example, and the Canada we knew when we went. I believed in what we were fighting for in Afghanistan. We watched it retaken by the Taliban and go right back to the way it was. Then I come back here and our government is ashamed to even put up a war memorial for Afghan vets. They try to tuck it away and hide it behind NDHQ and not invite anybody to go to it. That's an absolute disgrace.

It's not just the vets. It's a lot of other things. That's where I'm at.

● (0955)

The Chair: Thank you very much, sir.

We are now going to Mr. Casey for five minutes.

Sean Casey (Charlottetown, Lib.): Thank you, Madam Chair.

Dr. Held, I want to start with you on a point raised by Mr. Nedohin around psilocybin. We've heard some of that testimony throughout the course of this.

Can you offer commentary on the state of research with respect to psilocybin? What we hear, anecdotally, is that it works—we heard it again today—but we also hear that we're not ready for mainstream approval, because the evidence is not there yet. As the scientific director of CIMVHR, can you tell me where we are with respect to the research into psilocybin?

Dr. Nicholas Held: I can speak to the higher-level aspects of this. It is not my intention to discredit anecdotal experience. That's not what research does. Psilocybin is something that might be beneficial to some people.

The state of the research is that there are various levels of clinical trials that are under way, some within Canada and more in Australia and the United States as well.

The effectiveness of any kind of therapeutic intervention is one piece of it. There are also challenges with implementation that we have to understand from a health care system perspective, and then we also have to understand those pieces where it can do harm. There is some research out there that suggests suicide might be a side effect. Now, I'm not saying that's strong; I don't know of that research specifically, but it is mentioned. There are things that have the potential to do harm as well, like any life-saving medicine, so we have to balance the overall picture of what is beneficial versus what could be harmful as well.

Research is clearly under way, and there is a lot of work in that area. There may be potential for that in the future.

Sean Casey: Thank you.

Mr. Nedohin, I want to come to you.

You talked about the letter you received from Veterans Affairs, which ignored science with respect to traumatic brain injury. You said that what saved your life was your family and the Concussion Legacy Foundation. Is that Tim Fleiszer's organization?

Shane Nedohin: Yes.

Sean Casey: Okay. We've heard from him at committee before.

Can you talk about their role in pulling you back?

Shane Nedohin: The biggest thing was that they believed me, first of all. It was also the weight of their organization and the amount of connections and research they have.

Last year, when I was here dealing with all that, one of the things I brought up was why we're not leaning more heavily on private industry. Private industry is always going to surpass government when it comes to research and when it comes to anything else.

Dr. Cyd Courchesne, the chief medical officer of VAC, said something in a conversation with me about how they have only a small research team and it takes them a long time to do research. I said, "Why are you not relying more heavily on private industry and accessing those resources?" There were a slew of different reasons, but that's what I would say.

I don't know if that answers your question or not.

Sean Casey: After you talked about the Concussion Legacy Foundation, you said the ADM said to you that the letter was a mistake, and then I thought I heard you say, "The problem has since been rectified". What did you mean by that?

Shane Nedohin: On the issue where vets were receiving these letters denying that explosions could basically cause brain damage, they have since stopped sending out those letters and have started recognizing TBI as a claimable injury. Until that point, we were not able to claim TBI, or we would put in the claim and it would just sit in limbo for years. I know mine was, I think, two years or more. For some guys, it has been like 18 months, two years or two and a half years and there were no approvals.

Then I went public and, lo and behold, they were politically embarrassed or publicly embarrassed or whatever, and boom—all of a sudden the research was good to go.

Sean Casey: Thank you.

Dr. Held, you were shortchanged trying to answer in 10 seconds Mr. Clark's question with respect to the collaboration with the Aussies. You can use the rest of the time to give us a more complete answer, please.

● (1000)

The Chair: You have 19 seconds.

Sean Casey: That's twice as much as you had.

Dr. Nicholas Held: That's almost double the time, so that's great.

I'll answer it by saying that one of the key things is that we have very similar levels of government. That's why we have the Five Eyes nations. That's from the cultural experiences of most of the countries within the Five Eyes, and military experience as well. We know that psychedelics research, and other research, is a bit further ahead in Australia than it is in Canada. There are ways we should be looking at collaborating and leveraging understanding. This work will have to be done in Canada.

It's a different mechanism, of course, but to leverage what we have within those Five Eyes nations and make sure we are collaborating with different agendas within research and outside, I think, is a critical thing for us to do.

The Chair: Thank you.

[*Translation*]

Ms. Gaudreau, you have the floor for two and a half minutes.

Marie-Hélène Gaudreau: Thank you, Madam Chair.

Mr. Nedohin, I'd like to get your impression. Given what has been experienced in recent decades, I have a concern about the increase in defence and also about what is happening with global, economic or other crises. If we talk about commitment and pride in enlisting, does a veteran like you think that the next generation will be more difficult?

[*English*]

Shane Nedohin: Sorry, did you say "fund the next generation"?

[*Translation*]

Marie-Hélène Gaudreau: No.

[*English*]

Shane Nedohin: Sorry, that's what the translation said: "Do you believe it will be harder to fund the next generation?"

Marie-Hélène Gaudreau: I said "find".

Shane Nedohin: Okay.

I don't know. When I was leaving the military, it was a sinking ship. I don't know. I've been out of it for a while.

[*Translation*]

Marie-Hélène Gaudreau: I don't have interpretation, Madam Chair.

[*English*]

The Chair: Give me just a second.

[*Translation*]

I think we can try again.

[*English*]

Please go ahead, Mr. Nedohin.

Shane Nedohin: If I understand your question, you're basically asking me where the military is headed and whether it is going to be difficult to find people to put into the military, based on.... I certainly tell people not to join the military, because of its current state. We have neglected and destroyed our military over the last.... Since we left Afghanistan in a combat role, the military has been getting defunded, basically. It's not defunded, but it hasn't had the money that it needs pumped into it. Now we're playing catch-up. It's like a student who didn't study all semester and now is cramming at the last minute for a test.

We ignored the fact that a global war is potentially coming. People have been screaming at the top of their lungs, shouting it from the rooftops that we need to invest in our military. Why would anybody want to join the military when there's no military housing available, you're going to have the worst gear, and you're going to be treated and paid not very well?

I don't know what it's like now. I'm hearing it's actually picking up pretty well, so I don't know.

People want to join to be warriors and to fight.

The Chair: Thank you very much.

We will have three minutes and then another three minutes to close this panel.

We will go to Mrs. Wagantall for three minutes, please.

Cathay Wagantall: Thank you so much, Chair.

Thank you both for being here.

Shane, you have TBI. There's no question that concussions, as every veteran knows, can cause that injury, as well as some pharmaceuticals. We know that mefloquine causes brain stem injury. It gets conflated with PTSI, and I don't understand why. I know there is some crossover, but there are areas that identify them specifically.

I don't understand, Mr. Held, why we don't push the fact that we understand and know what TBI is and what PTSI is. We are sometimes very selective in saying that Canada can't do this on its own and it needs the help of other countries to study this. Other times, we're told that they know this already, but we don't, so we need to study it. This is causing great duress for our veterans.

Can you identify a TBI versus PTSI?

● (1005)

Dr. Nicholas Held: Again, I'm not a medical doctor, so it's hard to say. I do think we need to talk.... There's common symptomatology, of course, but there are very big differences between PTSD and TBI. That's understood. This is the research-to-action piece that's important. Are those questions being asked when you go to your health care provider, whether you've had previous concussions? Again, you know the role of being a breacher or whatever it might be, where you're around blasts for a long time. These things are important pieces of health care. I can't say whether they're being asked or not, but it's important to understand this information when we're treating anybody, but veterans as well.

Cathay Wagantall: You would think VAC would understand that. I'm asking you a question that you'd probably prefer not to—

Dr. Nicholas Held: I think there are times when the research is there. I think it's important to have a separate medical code or understanding of different issues, yes.

Cathay Wagantall: Shane, go ahead.

Shane Nedohin: I don't know whether it's come up in any of the witness testimony, but there's something called “operator syndrome”. I don't know if anybody in this room has ever heard of that. I've heard it's an official diagnosis in the States, but I can't confirm that. I'm not sure whether it's a term that gets thrown around more loosely. It's an all-encompassing thing, especially for guys in the SOF community, who are exposed to more combat, more heavy breaching and more trauma. There's an increased likelihood of PTSI, TBI, substance abuse in order to dull the pain, and musculoskeletal disease. You have to start taking every single factor we've discussed here today, because you can't put your finger on any one thing and say, “Yes, this part over here is PTSD, and this is TBI and this is that.” They just all come together. To use your mechanics reference, your vehicle works as a unit, and if one part is out of sync it can throw off all the other parts.

The operator syndrome is something we really need to be working on with our American allies. I know there's a big push in Canada to move away from America right now, but we will never move away from America as our ally. They are, 100%, our closest ally, and we need to work with them. They're our brothers in arms, and they have stuff figured out because they have the most powerful military in the world.

Cathay Wagantall: Thank you very much.

The Chair: Thank you very much.

You have three minutes, Mrs. Hirtle.

Alana Hirtle: Thank you.

Dr. Held, I heard from Legion members in my riding about the benefits of peer support networks, but there seem to be different responses from the older veterans and the modern veterans. I am wondering whether you've seen that and what experiences and thoughts you might have.

Dr. Nicholas Held: There's a rise in peer support, which I think is really important and a great thing. There's a rise in various aspects of peer support that might be more accessible.

We do see differences between modern-day and older veterans—and the Legion is a great example—who would have relied on the Legion a bit more for that kind of peer support community.

This is more of a personal thought, but the thing that always concerns me is that, as we talked about today, hearing some of these challenges that veterans face is challenging. As a peer support member, I think that's something to keep in mind too. We have to serve those individuals with peer support—that's important—but that individual is taking on trauma as well, so support for them is something to consider, whatever that might look like.

Alana Hirtle: Thank you.

I pass the rest of my time to MP Casey.

Sean Casey: I will stay with Dr. Held.

When you were giving your opening presentation, there was a ton of information there. I was furiously taking notes, and my notes aren't that great. Before you talked about the Australian collaboration, you talked about what seemed to be a summit, in 2018, that included Veterans Affairs and a specific academic. Can you come back to that? What I noted was that one theme was educational training and the other was identity challenge.

Can you give us some more colour around that 2018 event?

Dr. Nicholas Held: Yes. I was not with the organization for the 2018 event. There is an entire thing on our website, which I will pass along, that has the full synopsis of that. There's a 2018 and a 2019...that came out of CIMVHR-funded work by Jitender Sareen, and that led to the round table that included Veterans Affairs and Canadian Forces health services as well.

I went over the highlights of critical areas of importance that needed to be highlighted, and emphasized that we've known these things for a bit of time now, since 2018. It's good to see that we're acting on them a bit, but we need to push that further.

● (1010)

Sean Casey: You specifically referenced, just prior to that, investment in suicide prevention as a sustainable solution—I believe that is the way you framed it. Can you talk a little more about that?

Dr. Nicholas Held: I think it deserves attention. Suicide is a significant topic, and we know that one veteran's suicide is too many.

We need to find ways to do two important things, in my mind. The first thing is that we need to continue to fund effective programs that support veterans and meet their needs. We also need to evaluate them. It's one thing to set up programs, but it's another thing to understand whether they're having their intended impact. If they're not, how do you change that?

The other thing is that suicide prevention strategies are hard. They're hard to evaluate, in some sense, in large datasets, but they're very important. One thing in smaller datasets is that if somebody doesn't complete an act of suicide, how is that reported? It's not reported as a suicide, so it's hard to think about those strategies. If we make this investment in longitudinal research over time, we can see at different points in time when something like this has come forward, and we will hopefully see action and reduced suicide over time in our veteran population. If we have only these small, one-year studies without that investment in the larger datasets, we're not really going to know if there's been an impact over time.

Sean Casey: Thank you.

The Chair: Thank you very much, both of you, for coming before us.

I know your kids are here, so it's a pleasure to welcome you to Ottawa, sir.

[*Translation*]

Our next meeting will be on Thursday, November 6, 2025. We will begin consideration of the draft report on the experience of indigenous veterans.

The meeting is adjourned.