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# Standing Committee on Veterans Affairs

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Chair: Marie-France Lalonde





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Thursday, October 2, 2025

• (0815)

[*Translation*]

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

Welcome to meeting number four of the House of Commons Standing Committee on Veterans Affairs.

Pursuant to Standing Order 108 and the motion adopted on September 18, 2025, the committee is meeting as part of its study on suicide prevention among veterans.

[*English*]

Today's meeting is taking place in a hybrid format pursuant to the Standing Orders. Members are attending in person in the room and remotely using the Zoom application.

Before we continue, I would ask all in-person participants to consult the guidelines written on the cards on the table. 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.

[*Translation*]

It's always a pleasure to have you with us, our esteemed interpreters.

[*English*]

You will also notice a QR code on the card, which links to a short awareness video.

[*Translation*]

I would like to outline a few rules for witnesses and members to ensure that the meeting runs smoothly.

Before speaking, please wait for me to recognize you by name. If you're participating by video conference, please click on the microphone icon to turn on your microphone. Please mute your microphone when you aren't speaking.

As for interpretation, Zoom users can choose floor, English or French at the bottom of their screen. People in the room can use their earpiece and select the desired channel.

Remember that all comments from members and witnesses should be addressed through the chair.

As always, the members in the room must raise their hand if they wish to speak. The members on Zoom must use the "raise hand" function. The clerk and I will manage the speaking order as well as

we can. We would like to thank the members for their patience and understanding.

I would now like to welcome the witnesses.

• (0820)

[*English*]

With us from the Department of National Defence is Major-General Scott Malcolm, surgeon general, Canadian Armed Forces; and Brigadier-General Serge Ménard, commander, Canadian Armed Forces transition group, Canadian Armed Forces.

From the Department of Veterans Affairs we have Steven Harris, senior assistant deputy minister, service delivery; Cyd Courchesne, director general, health professionals and chief medical officer; and Dr. Amy Hall, senior epidemiologist, who is joining us virtually.

Thank you very much for being here. We look forward to hearing your comments.

[*Translation*]

We'll start with Mr. Harris.

Mr. Harris, you have the floor.

[*English*]

**Steven Harris (Senior Assistant Deputy Minister, Service Delivery, Department of Veterans Affairs):** Madam Chair and members of the committee, thank you for the invitation to appear today as you launch your study of suicide prevention among veterans.

I would like to begin by acknowledging the veterans, service members and families who join us today, and express condolences to those who have lost a loved one.

Suicide among veterans is not just a statistic; it is a tragedy that is felt through families, our communities and our country.

[*Translation*]

However, it should be noted that Canadian veterans, particularly younger veterans and women, face a much higher risk of suicide than the general population.

The 2024 report on suicide mortality in the Canadian Armed Forces showed that 65% of people who died by suicide had at least one mental health condition, and many had more than one. The most common conditions were addiction or substance use disorders, depressive disorders and trauma and stress-related disorders.

The research also confirmed that veterans experience significantly higher rates of mental health issues compared to the general population. Approximately 17% of regular force veterans reported mood disorders, compared to only 6% of civilians.

[English]

What are often called operational stress injuries, or OSIs, capture the persistent challenges resulting from service. OSIs can include PTSD, depression, anxiety, trauma and moral injury, and they can disrupt daily functioning, work and social relationships.

PTSD is particularly prevalent among the veterans receiving disability benefits. More than 48,000 veterans currently receive a pension for PTSD. Since the end of Canada's mission in Afghanistan in 2014, we have observed a steady rise in these claims. Approximately 29% of veterans receiving a disability benefit for PTSD—

[Translation]

**The Chair:** Sorry to interrupt you, Mr. Harris.

**Steven Harris:** Am I speaking too quickly?

[English]

**The Chair:** Mr. Harris, you're *trop rapide, s'il vous plaît*.

[Translation]

Our interpreters are trying hard to interpret your remarks. Please slow down a bit.

**Steven Harris:** No problem. I'll slow down.

**The Chair:** Thank you.

[English]

**Steven Harris:** Since the end of Canada's mission in Afghanistan in 2014, we have observed a steady rise in these claims. Approximately 29% of veterans receiving a disability benefit for PTSD served in Afghanistan, underscoring the lasting impact of the mission.

[Translation]

Veterans Affairs Canada, or VAC, understands the impact of service on physical and mental health and provides a range of support measures designed to address these challenges.

These include treatment and care options, financial support, rehabilitation support and support measures to provide assistance throughout a veteran's transition process.

For example, since April 2022, a new mental health benefits program has been in place. This program automatically covers treatment costs for veterans with mental health issues while their application for disability benefits is being reviewed.

[English]

VAC also offers access to a network of 21 operational stress injury clinics and satellite locations as well as to thousands of regis-

tered mental health professionals across Canada. Veterans can take advantage of in-person, virtual one-on-one supports and online options.

Families play a central role in supporting mental health outcomes. The operational stress injury social support program provides confidential support to military members, veterans and their families through trained peers who have lived through similar experiences.

Leaving the military is not as simple as changing jobs. It is a complete shift in identity, structure and community. Service members may lose their daily routine and missions that have defined their lives for years. They move from a close-knit team environment to a civilian world that often may not understand their military culture.

Our national client survey shows that 33% of clients transitioning out of the military have reported difficulty transitioning to life after service. Of these, 64% attributed this difficulty to health challenges, while 60% felt as though they lost their sense of purpose.

● (0825)

[Translation]

To provide support during this critical period, VAC is working closely with the Canadian Armed Forces to ensure continuity of care and mental health support during the transition from service to post-service life.

It is thanks to this collaboration that the Joint Suicide Prevention Strategy was launched in 2017. The strategy builds on VAC's seven domains of well-being and the strong foundation of existing programs. More psychologists and psychiatrists have been added to health care teams, and improvements now allow for remote consultations.

[English]

Ultimately, preventing suicide is not only about programs and policies but also about building a culture of care that values our veterans and their families, recognizing the warning signs of mental health challenges and providing the support and connection that can save lives.

Families, peers and communities are essential to this work, ensuring that veterans are not navigating these challenges alone. It is through this collective effort that we honour the service of our veterans, protect their well-being and uphold our commitment to those who have given us so much.

Thank you, Madam Chair and members.

We are happy to take your questions.

[Translation]

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

We will now begin the first round of questions and answers.

[English]

Mr. Richards is the first to start, for six minutes.

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

I appreciate the presentation.

One thing that I think can often lead to poor outcomes for veterans and therefore down the road sometimes lead to things such as mental health challenges, addictions or, unfortunately, in some cases, suicidal thoughts or actually the act itself, is what many refer to as sanctuary trauma. That's when the trauma comes from those they expect to care for them.

In the case of VAC, it's something we, unfortunately, hear too often. Veterans come for support and then they face outrageous wait times. They face piles of forms and paperwork, constant changes in their case managers, denials of care and on and on. Often it leaves veterans feeling betrayed and uncared for.

Do you believe that sanctuary trauma is a real concern and something you need to take into account when you're considering your processes and changes at Veterans Affairs?

**Steven Harris:** Madam Chair, the thoughts, the feelings and the perspectives of veterans always need to be taken into consideration by our department as well as the services and all of the staff who work to deliver services to veterans and our colleagues in every area. I accept that sanctuary trauma is absolutely something that veterans feel and has an effect on whether or not they want to come forward and work with Veterans Affairs to obtain the services that they need.

**Blake Richards:** Taking that into consideration, what sorts of things have you done to improve? We often hear about the lengthy wait times, the delays, the denials, the massive amount of paperwork. There's even the fact that family doctors refuse to take veterans on in many cases because the VAC paperwork is so burdensome that they can't navigate it. You can only imagine how the veterans themselves feel.

What sorts of improvements are you working towards to try to make sure that veterans aren't experiencing that sanctuary trauma? It's great to recognize it, but something has to be done to make sure it doesn't happen.

**Steven Harris:** I would agree 100%. What we have done and what we are continuing to do is identify and work on the things that members have suggested here. These are things such as cutting wait times in half over the course of the last four years; cutting the amount of time it takes to get approvals on a whole range of programs from Veterans Affairs; working directly with veterans through case management and our veterans service agents to make sure they understand what might be necessary to go through a process, while also reducing the amount of paperwork to go through that process, whether that's reapprovals or other services that veterans might come back for; and going to the veteran with another ser-

vice that might be of benefit to them as opposed to the veteran having to identify something or a need that may be unaddressed.

Those are all parts of the kinds of things we have been trying to do and succeeding at over the last number of years.

• (0830)

**Blake Richards:** I appreciate the efforts. I'm not certain that I hear the same kind of sentiment from veterans about succeeding at it, unfortunately. Hopefully you can continue your efforts, and we'll see better results as a result of that.

Along the same lines, we often hear veterans report how much they struggle when they watch Veterans Affairs fail at some of the really simple and basic things. I'll give you an example. We're going to talk about commemoration in this case, although it's not the only area.

When the 10th anniversary of the withdrawal from Afghanistan came around in 2024, there were a lot of veterans who reported not receiving invites or that they were only invited 24 hours before. It seemed like the ceremony was really thrown together and was even criticized by the CBC because it appeared rushed. Also, when they look at the Afghanistan monument announced 11 years ago, nothing has been done on the site at all. I think it's been three years since there was an announcement of a contractor being chosen. We'll put aside all of the controversy around that, of course, but for three years it has sat there and nothing has happened.

Veterans often watch things like that and say, "If they can't even do that, how can I expect them to properly care for my injuries and the needs that I have?" What would you say to veterans who are feeling that way?

**Steven Harris:** It's more than efforts; we've actually cut wait times in half. We have cut the backlog in half as well. It's more than just efforts on that front.

With respect to commemoration, that's not entirely my area of responsibility in the department. I know the team that works on commemoration. It works very diligently to make sure it's inclusive and moving forward on all of the projects in terms of inviting folks to attend commemoration ceremonies. On the Afghan monument, I know recently the NCC announced their approval for going forward in the next stage of the project. It's a multi-stage project. I know that was just done recently as part of moving ahead with the construction of the monument. I would just offer that.

**Blake Richards:** I guess it's one thing to say we're moving [Technical difficulty—Editor].

**The Chair:** Mr. Blake, I'm going to be very diligent this time.

Thank you very much.

I will now give MP Sidhu the floor.

**Sonia Sidhu (Brampton South, Lib.):** Thank you, Madam Chair.

I'm pleased to join this committee today for the important study regarding suicide prevention among veterans.

First, I would like to thank the officials from the Department of National Defence and Veterans Affairs Canada for appearing at this committee today to share their important insights with Canadians. This month is also Women's History Month, and I would like to use this opportunity to thank all women members of the Canadian Armed Forces and servicewomen, past and present, for their sacrifice and for safeguarding Canada and its interests.

In the last Parliament, I had the honour to serve on the Standing Committee on the Status of Women. I was pleased to see the report, "Invisible No More. The Experiences of Canadian Women Veterans."

I have a question for the officials from both departments.

Can you share with the committee what existing programs there are for women veterans in terms of suicide prevention?

**Cyd Courchesne (Director General, Health Professionals and Chief Medical Officer, Department of Veterans Affairs):** Madam Chair, we really appreciated the report of the study on women veterans. That came out after we had considered our suicide prevention plan. As my ADM mentioned in his opening remarks, we have known since we've looked at the numbers that women veterans have a higher rate of suicide than male veterans and women in the Canadian general population. We had that knowledge when we created the suicide prevention plan.

Since then, we've established a unit of women veterans, looking at their issues and listening to women. We've had several forums where we've heard their particular issues. Based on that information, we've looked at our business processes, looked at our criteria for looking at applications from women veterans, taken that into consideration and made changes. Through going back and looking, we knew that applications from women veterans were more frequently turned down and took more time. We've made efforts to look at our table of disabilities and our entitlement eligibility guidelines, taking into account differences between men and women.

I like to say that women are not small men. They're different physiologically. They present differently clinically. We've taken all that into account to bring changes.

• (0835)

**Sonia Sidhu:** Thank you.

Can you share with this committee what Veterans Affairs Canada's plan is with respect to suicide prevention especially for women veterans?

**Cyd Courchesne:** We continue to look into our numbers and to research. The veteran suicide mortality study, as I said, has shown that the rates are higher. What it doesn't tell us is why. We know that male veterans are at higher risk within five years of leaving the military. For women, it's 20 years.

Because all veterans are not clients of the department, it's difficult for us to predict who's at risk, which is why we focus on pro-

grams and offering mental health services that are accessible for women at any point after they leave the military, whether they're our clients or not. For example, there's our VAC assistance line. You don't need to be a client of the department to access those services. Making our services known is very important to promote that anybody can come to the department any time after they leave the military.

**Sonia Sidhu:** Mr. Harris, you referred to a "culture of care". Could you elaborate on that?

**Steven Harris:** Throughout the organization it is making sure that everybody is focused on the well-being of the veteran and their family. That includes things like trauma-informed training.

Madam Chair, the committee had an opportunity to have a session on trauma-informed training. That's something that is front and centre for us. All our frontline staff go through trauma-informed training. It's care throughout. It's looking for opportunities to help serve and support veterans, when they come to us and when we're working with them.

**The Chair:** Thank you.

I have the great but also very sad role of making sure that our time is respected, so I apologize in advance to all of our witnesses and also to my colleagues.

[*Translation*]

I would now like to invite Ms. Gaudreau to take the floor for six minutes.

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

I would like to thank the witnesses for being here to answer our questions.

It's not easy, because you deal with all kinds of situations on a daily basis.

As members of the Standing Committee on Veterans Affairs, we are studying the issue of suicide prevention among veterans. First and foremost, it is important to demystify the facts. Here on the committee, we must have immense respect for veterans.

I have an important question about the consideration we give to our veterans, and I also have a very specific question about statistics.

Over the past 10 years, has there been an increase in the number of suicide attempts or suicides? Do you have any data on that?

• (0840)

**Cyd Courchesne:** Yes, we have that data. We have been collecting it as part of studies we have been conducting since 1975. These studies are conducted jointly with the Canadian Armed Forces and Statistics Canada. That is why we know that this rate is higher than in the Canadian population in general: Among female veterans, the observed risk of suicide is 1.8 times higher than among women in the general population; among male veterans, it is 1.4 times higher than in the general population. These figures have remained constant since 1975. That is the big challenge. We need to identify the trend and the causes. We know that the causes of suicide are multifactorial. There is not just one factor, there are several.

Although we have these figures, we cannot investigate the exact causes, because some of these veterans may not be clients of Veterans Affairs Canada. These people live in their communities, and it is thanks to Statistics Canada that we can do this triangulation.

That said, I can assure you that this rate did not increase between 1975 and 2016, the last year for which we have figures, I believe.

**Marie-Hélène Gaudreau:** Okay.

So after the war in Afghanistan, the numbers remained constant. We say we have great respect for our veterans. How is it, then, that we have not been able to reduce the suicide rate and take the necessary preventive measures?

Can you explain why?

**Cyd Courchesne:** I thank the member for her question.

Prevention is the big challenge. It is the big challenge for psychiatry, medicine, and the community in general.

We have the Canadian Armed Forces and Veterans Affairs Canada Joint Suicide Prevention Strategy. However, the difficulty with prevention strategies is that we cannot assess what has not happened. We can only rely on the rates that we continue to monitor.

There has been no increase since 2016. Next year, we will publish another report, which will add more years. We will continue to monitor this very closely.

**Marie-Hélène Gaudreau:** We talk to specialists. If we had specific recommendations.... This upsets me greatly. We should honour our veterans more for what they have done for us. Basically, what you may be lacking are resources.

Can you tell us, right here, what we could do for you if we were able to make a 180-degree turn? You may tell me that you need resources, psychiatrists, or people who can respond quickly. We know that suicide can happen quickly. Do we need to invest more money?

Are there certain things that could help us change the situation?

**Cyd Courchesne:** The big challenge is identifying a specific cause. If there were one and we knew what it was, our prevention programs would be very effective.

However, this is a multifactorial problem, and we do not know all the underlying causes. Often, it is not necessarily mental health issues that lead to these acts. It is therefore difficult to implement

measures when we do not know exactly what the causes are. We can make many assumptions and base our programs on these assumptions. That is why our strategy is based on the seven areas of well-being, such as financial security and employment, among others.

Commemoration and recognition of service are also important aspects and are included in the department's mandate.

• (0845)

**Marie-Hélène Gaudreau:** How much speaking time do I have left, Madam Chair?

**The Chair:** You have one second left.

**Marie-Hélène Gaudreau:** In that case, Ms. Courchesne, could you forward your recommendations to the committee?

Thank you.

**The Chair:** Thank you very much.

That concludes our first round of questions.

Let's move on to the second round.

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

[English]

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

I appreciate having the witnesses here. Thank you for your service.

I'd like to direct the following question to the brigadier-general and major-general.

When you're in the military, part of the training—and correct me if I'm wrong—is to recognize some of your comrades going through suicidal thoughts. Is that correct? Could you share a little bit about what that is?

**Major-General Scott Malcolm (Surgeon General, Canadian Armed Forces, Department of National Defence):** I would suggest, particularly when we talk in the military about looking out for one's six, one's back, it's that idea of buddy care. Indeed, it's more than just recognizing if someone is displaying suicidal thoughts; it's recognizing if things aren't quite right. Rarely does it start with someone immediately being suicidal. There are signs that something perhaps is not quite right with them. Your buddies and your chain of command are the ones who see them every day and are best placed, including their families, to note if there's a change going on.

**Fraser Tolmie:** Thank you for answering that question.

Mr. Harris, are any of the case managers trained to recognize veterans who may be having suicidal thoughts?

**Steven Harris:** The simple answer is yes. Everybody has training in suicide assistance, ASIST training more specifically, in most cases. That helps them recognize and work with veterans or anyone else who may call.

**Fraser Tolmie:** When you're in the military, you have your comrades. When you're a veteran, you're alone, and how you access your case manager is usually by phone and by email. How can the case managers recognize someone who's having suicidal thoughts by phone or by email?

**Steven Harris:** Unfortunately, I think the answer is that the veterans are quite honest about it and share where they're at and what they're feeling. Quite often we do have calls from veterans who are suicidal, and we have case managers, our veteran service agents, even our call centre agents, who help them work through what they're facing. Of course, people can also come into our offices as well. There are lots of ways in which we can do that. We can go out and meet people as well. It's not limited to just an email or phone call, but even in those instances, there are signs we are trained to look for and be clear on even if they are not being very clear about it.

**Fraser Tolmie:** Our challenge here is that we have people who are in a buddy system, where their buddies can check and say, "Okay, listen, I think we have to have a conversation with you; something is not right." They leave, and what you're saying is that those who are forthright, who are having suicidal thoughts and mental health issues, are the ones who are going to come forward.

The problem is how we track the ones who don't come forward and who don't share and need that help. Those are the ones we're missing. How do we capture them?

**Cyd Courchesne:** Madam Chair, as part of our suicide prevention plan, we instituted mental health first aid. That's available to veterans and their family members. This is a way of continuing...because it's not just on one individual. It's educating the surroundings.

This has been ongoing since we released the suicide prevention plan. It's very popular. All of our sessions fill up very quickly.

We also have the peer support program. They're also available to veterans and we promote that.

• (0850)

**Fraser Tolmie:** Thank you.

I'm glad that you touched on that because that's the peer group those vets have.

Are you doing training for spouses? How is that rolled out? How is that available?

**Cyd Courchesne:** Madam Chair, yes, we do. We have family peer support and we have peer support, so we cover all bases.

**Fraser Tolmie:** Look at my time, will you?

**The Chair:** I'm sorry. I was nice the first day, but we're back to military.

I will now invite MP Clark.

You have five minutes.

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

Mr. Harris, earlier you mentioned that the wait times have been cut in half and the backlog has been cut in half.

Can you explain a little bit more about what you're referring to and what impact, in your view, that has on the work you're doing around suicide prevention as well?

**Steven Harris:** Sure. I think there are a couple of things to note as a result of that.

The very first one is that for a long time, we've had—and we continue to have; I want to be completely clear about it—files beyond our service standard. Veterans Affairs has a disability benefits program. That's usually the first intake of veterans who have had an illness or an injury in the military. They come and they apply for disability benefits related to their service.

The service standard is that we give them a decision within 16 weeks 80% of the time. We've not been successful at doing that over the last number of years. In fact, the files beyond that period grew to about 23,000 in 2020. We successfully cut that in half. We cut the time that individuals have had to wait to get a decision down to 22 weeks. It was around 40 before.

What that means is veterans are getting access to decisions much more quickly than they were before. We're still not at our service standard. We still need to get there. There's work to do on that front, but it means that people are getting decisions much earlier than they were even four years ago.

Second, that means access to treatment. I mentioned in my opening remarks that we have a mental health benefit. As soon as somebody applies for a mental health condition, they get access to treatment. That was put in place a couple of years ago.

It also means that the people who are getting a decision more quickly are getting access to treatment for physical injuries as well. When we get a decision to the veteran much more quickly... In any case, whether it's physical or, in particular, for mental health, we know that if they have to wait longer for it, the individual veteran themselves is going to suffer and probably get worse before they get better.

We need to get decisions for them quickly. That's why the investment has been made to help speed up that process and also make sure they can have immediate access to mental health supports when they need it.

**Braedon Clark:** Thank you, Mr. Harris.

I wanted to touch on the issue of data and tracking as well.

Madam Courchesne, you mentioned that the rate has not really changed since 1975, I believe. As you touched on, it's also impossible to prove a negative or track something that has not happened. How do you manage that? How do you crack that nut? I know it's a difficult thing to figure out.

The rate may be constant over time, but again, there may be many people who are living happy, productive lives who otherwise might not be.

Can you touch a bit on how you think you can figure out that puzzle?

Thank you.

**Cyd Courchesne:** Madam Chair, even though we can't get to the root cause or the trigger that pushes someone to follow through, we gather more information. We don't have just the rate. We know that for men, it's younger men and non-commissioned members. Working with our colleagues from the transition centre, we can target that population to make sure they're screened and things are in place as they leave the military.

We'll gather more information like that until we get to a point where we will crack that nut. We'll keep learning through continued research in this.

**Braedon Clark:** Thank you very much.

I have one other question around communications. With any government program, obviously letting people know that it exists and that they have access to it is really important. In these cases, it is obviously critically important when we're dealing with life and death issues at times.

I'm not sure, but perhaps this is a question for you, Mr. Harris.

Could you give a sense of how you assess the ability of veterans to know about these programs? It's not necessarily an access point. That's the second step. The first step is communicating, "Hey, this is available for you. This could really help you."

How do you communicate that to the veteran community across the country, to make sure they know what they have access to?

● (0855)

**Steven Harris:** The answer is we do it as often and in as many places as possible. Obviously we do it through channels that we would have, whether that's through social media, our website or things of that nature. We also go out and meet with veterans quite regularly, whether that's at a Legion, at military events or at ministerial advisory group committees and others that are there.

We're constantly trying to get information out not only to the veterans, but also to other military members and other military organizations to be able to share with them. In that opportunity, we try to get everybody informed as to where they can go for help. If the veteran doesn't know, maybe somebody else does, family members or others. We make sure we try to get the information out there.

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

[Translation]

I would like to invite Ms. Gaudreau to speak for five minutes.

**Marie-Hélène Gaudreau:** Thank you, Madam Chair.

I am very aware of the reduction in response times for interventions, and I am grateful for that. I know that you are making every possible effort. However, would you agree with me that delays in receiving a response in such an urgent situation are unacceptable?

Do you think there is room for improvement in terms of the speed of interventions?

**Steven Harris:** This is not our only program. Just to be clear, the disability benefits program is only one of the programs available to veterans. It is certainly one of the most important, and the response times are totally unacceptable. We are working very hard to reduce them in all areas, not only for disability benefits, but for all other programs as well.

I would like to mention the addition of human resources staff to improve the process, the reduction in the number of documents and other items, the training of our employees, and the improvement of the system to be able to process claims more quickly. Last year, we made more decisions than ever before in this program.

**Marie-Hélène Gaudreau:** That's good to hear, Madam Chair.

That being said, with the 5% increase in national defence spending, I think that before taking such significant steps, we need to consolidate our foundations. I hope that what has happened over the past year will contribute to this and also give you everything you need to do your work.

I have one last question about women. Earlier, it was said that the suicide rate was the same, but according to the report, there has been a significant increase in suicide mortality among women in the Canadian Armed Forces. How is this possible?

**Cyd Courchesne:** I will let my colleague, the Canadian Armed Forces Surgeon General, comment on this subject.

**MGen Scott Malcolm :** When it comes to the mortality rate among women, particularly in the case of suicide, it's a little difficult to explain.

Even though one suicide is one too many, we are talking about suicide among women last year. According to the data, there were very few, but it still increased the rate. My colleagues at Veterans Affairs Canada and I continue to monitor the situation and try to find the reason behind this. However, as we have already discussed, the problem is multifactorial. Members of the Canadian Armed Forces or veterans have committed suicide, but that does not mean that all of their problems at that time began in the forces. We know very well that half of our members experienced trauma before enlisting in the Canadian Armed Forces.

Suicide is truly a societal problem that must be addressed at its source. The country must address this issue to prevent suicide rates not only in the forces, but also among the Canadian population.

● (0900)

**Marie-Hélène Gaudreau:** Thank you very much, Madam Chair.

**The Chair:** Thank you very much.

Ms. Wagantall, you have the floor.

[English]

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

Thank you all for being here.

I want to bring forward something that we discussed at our last meeting when the veterans ombud was here. She had a recommendation from 2021 regarding mental health treatment benefits for family members in their own right, for conditions related to military service independent of the veteran's treatment plan and regardless of whether the veteran is engaging in treatment. This is something that has been discussed a lot at this committee as well. That recommendation was affirmed by the government—it had a “yes” beside it—but in the last four years it has not been implemented at all.

We all know that in the most challenging circumstances, when the veteran struggles with mental health, the family struggles, and then the veteran struggles more. It becomes a very caustic and dangerous cycle for the veteran and the family members they have alienated. She affirmed VAC and the work that you do—meeting family needs whenever you can when the veteran is being treated and affirms that family members getting that assistance is required—so kudos to that. That's great, but in the end, that's all you can do because that's all you have legal authority to do, from my understanding. That's the lane you have to work in.

That means if a veteran isn't being treated, the family can't access mental health treatment. If a veteran is estranged, separated or divorced from their significant other, that individual and probably the children can't access mental health. If a veteran is being treated but doesn't support family members receiving that treatment, they don't get it. Also, right now—and this was very troubling to me—if a veteran dies, the family is immediately cut off from mental health services. If that veteran died by suicide, I would think at that point in time that family needs mental health care more than ever.

There are barriers here that need to be taken down, according to the government, this committee and, I think, you. Have you tried reaching out to the government about where you have to go to get that extended authority to provide those services? Have you reached out to the government and had any interaction with them about providing this specific care to family members? We say that when the member serves, the family serves. Have you reached out and had any conversations or interaction in this regard with the government?

**Steven Harris:** There are a couple of things. One, the member and the ombudsperson are quite correct: Legislative authority does not exist for us to provide those services in their own right to family members. There are a number of other services that are available for families, such as the VAC assistance service, which can be used by any family member who's facing a mental health issue or crisis. That can give them 20 sessions with a mental health provider and can be used at any time. There's the veteran family program through military family resource centres. All of those are correct.

I can't speak to proposals that have gone forward as recommendations to the government. I can tell you that there are a lot of ways we continue to help support families, in addition to what you said.

There are considerations in all circumstances when a family may be impacted by something like suicide, where we continue to help support that family as best as we can with access to resources.

**Cathay Wagantall:** Thank you, Mr. Harris. I appreciate that.

I think it's something specific here that would be very helpful to members who are serving as well. Knowing that it usually takes years before they really get hit hard, sometimes the younger ones who are serving in the military get hit when they realize the commitment they made to Canada. I think it's something that the armed forces and Veterans Affairs could work on together to get that extended care more specific to the family members.

The statistics that you've worked with, what were the years?

● (0905)

**Cyd Courchesne:** It was from 1975 to 2016. My colleague from research, Dr. Hall, might confirm that.

**Amy Hall (Senior Epidemiologist, Department of Veterans Affairs):** Yes, that's correct.

**Cathay Wagantall:** Okay. What we have worked with are suicide numbers from long past the First and Second World Wars and prior to our biggest commitment through Afghanistan. I'm assuming that, at this point in time, you must have some information about those numbers if you are coming up with the report shortly. We'll be looking for that. Do you have lists?

**The Chair:** You can ask about the lists, but that's it. I'm sorry.

**Cathay Wagantall:** Okay. I'm wondering if you have lists of specific veterans who have died by suicide. I know that veterans have lists, if you were to reach out to them. That's my comment.

**The Chair:** This is something that you can either provide to the committee or, through other questions, pursue.

**Cathay Wagantall:** I don't expect—

**The Chair:** I apologize. As I say, I am—

**Cathay Wagantall:** No, you're doing great, Chair.

**The Chair:** Well, I don't know about that.

Madam Hirtle, you have the floor.

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

Good morning, and thank you all for being here today. Thank you for your service.

I'd like to circle back. There was a reference made earlier to peer group support. I'd like to come back to that as an important element for veterans and CAF members to feel more connected and less alone. The transition to civilian life can be challenging, and members may experience disruptions, of course, to social connections during this period of transition.

What is the strategy of the CAF regarding the mental health of members transitioning to civilian life? Perhaps Brigadier-General Ménard could best answer that.

**Brigadier-General Serge Ménard (Commander, Canadian Armed Forces Transition Group, Canadian Armed Forces, Department of National Defence)** : The way we support our veterans is through transition centres. We build the services provided behind the seven domains of well-being. We have a group of technical experts who analyze the seven domains of well-being to come up with a portrait of the person who is about to be released. Based on the situation of the releasing members, we also have different networks of support to propose to provide services to our releasing members.

**Alana Hirtle**: Thank you.

Can you expand on the seven domains of well-being for me, please?

**BGen Serge Ménard** : The seven domains are related to the sense of purpose of the person, the situation related to health, the housing situation of the person, the person's social network, the aspect of respect and recognition, the financial security of the person and the ability to adapt and cope. Those are the seven domains that we assess when we meet the person.

**Alana Hirtle**: Thank you.

The Canadian Armed Forces transition group provides education and training on transition from military to civilian life for members. Can you tell us which transition services are offered to CAF members and their families? What impact do you think these services have?

**BGen Serge Ménard** : First I'd like to say that we try to meet the person as early as possible when they think about transitioning. It can go up to six months before they decide to retire, so we want to extend the transition period and fill the gap between their time in service and when they become a veteran. Again, based on the analysis of the seven domains, we provide support to those members related to issues or risks that we've identified through the analysis.

● (0910)

**Alana Hirtle**: Someone said earlier that not all veterans are clients. Do you have a sense of how many veterans are not currently clients? Is there any way to know?

**Steven Harris**: The census would tell us there are 461,000 veterans in Canada. Depending on any given time, maybe a third of them are clients of the Department of Veterans Affairs. We also provide supports for our Royal Canadian Mounted Police veterans as well, so they're included as part of our client group.

Not every veteran who releases from the military requires the support of Veterans Affairs, but we are here whether they need it, whether they are releasing and going through that transition process or whether somebody comes back to us five, 10, or even 50 years later. We've had people come back with illness or injury related to their service that they've been dealing with for a long time.

**Alana Hirtle**: Do you think that a period of six months is sufficient, or should we be starting earlier before they're released?

**Steven Harris**: I think it's a sufficient time. We always have to work with our Canadian Armed Forces colleagues to help make sure that when military-serving members are thinking about re-

lease, if they want to release, that's great. If they want to do something else in the Canadian Armed Forces and move somewhere else in the area, that's fine.

I think six months is sufficient as part of the transition, but what we need to do is to make sure there's follow-up post-transition in case there are issues that develop during that period of time.

[*Translation*]

**The Chair**: Thank you very much.

[*English*]

We're now in our third round.

I will invite MP Viersen to speak.

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

Thank you to the witnesses for being here today.

When we think about why people commit suicide, there's generally a whole number of questions they're asking: Why does evil exist? Why are we here? There are things I've done, things that I've seen. What's my value? Does anybody care? These are all questions that suicidal people are thinking about.

Many of our church communities have answers to all of these questions. We've seen over the last number of years a fairly hostile treatment of church communities by the government. We've seen attempts to strip them of their charitable status and perhaps attacks on the chaplaincy saying they shouldn't pray in public and things like that.

I'm wondering, Mr. Harris, what the relationship of your organization is with our faith communities, our church communities, across the country. Do you engage them at all in providing the services that your department provides? I know that our church communities have the answers to lots of these questions and have the resources to support veterans. They are also able to provide a sense of community and a sense of camaraderie to veterans.

Could you comment on that?

**Steven Harris**: I'm not sure how broadly I can speak to this. I can indicate that pastoral services are available through our VAC assistance service. If individuals are facing difficult challenges and they reach out, we can help to connect them with a range of faith-based pastoral services.

I know a number of organizations were quite keen and interested in helping people who are suffering from homelessness, mental health issues, or addiction issues. I believe there have been a number of homelessness-based shelters that have a faith-based connection that are equally supported through some grants from Veterans Affairs in our veteran and family well-being fund in the past as well.

We would certainly encourage individuals to find their comfort wherever they need to find it, and that's important.

**Arnold Viersen**: I guess you can particularly pick on one of the churches. The Salvation Army has a very military feel to it. It seems like an easy bridge to cross essentially.

What's your relationship with the Salvation Army?

**Steven Harris:** I'm not sure we have a real relationship from a holistic point of view. They frequently attend remembrance and commemoration ceremonies. You'll often see them there. They are a very good charitable organization to help in areas where government or other community entities can't help, so they are a very present organization. I wouldn't say we have a whole-scale relationship on any front.

**Arnold Viersen:** Is there a particular reason why?

**Steven Harris:** No. I'd say they are just one group amongst many who help to support veterans, so we would have connections with them in that sense.

● (0915)

**Arnold Viersen:** Is there any direction given to not pursue that relationship?

**Steven Harris:** Absolutely not.

**Arnold Viersen:** Okay.

I'll switch gears. Other countries around the world have similar challenges with veterans and suicide. The Americans have really integrated that with lots of the social media companies around identifying potential suicide attempts and suicide victims.

Do you have a relationship with some of these big players, Google, Facebook, Twitter, Instagram? Not all veterans have an online presence, but some of these people are very active. I'm thinking about Instagram, in particular, where they recognized that their services were causing suicides, so they put a lot of effort into trying to prevent suicide.

Have you had these conversations with any of these organizations?

**Steven Harris:** We've had some partnerships with social media companies around things like commemoration and, in particular, Remembrance Day, where they partnered on a particular element or two. We do a very significant mental health benefit campaign quite literally often in social media to ensure that—

**Arnold Viersen:** Have they ever flagged to you, "Hey, we suspect a veteran is suicidal. Can you reach out to them?" Has that ever happened? Is there a process for that?

**Steven Harris:** No, we've not had that happen where somebody has come forward from a company or a social media point of view.

We don't monitor social media outside of the accounts that are controlled by Veterans Affairs. If there are comments on our own social networks, then we'll take action to address them if we can and follow up with somebody who might be expressing something that is troubling for them, but that would only be on our social networks.

**Arnold Viersen:** Thank you.

[Translation]

**The Chair:** Thank you very much.

Ms. Auguste, you have the floor.

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

Mr. Harris, in your opening remarks, you mentioned the Joint Suicide Prevention Strategy. Could you give us more details to help us better understand what this strategy entails and what specific issues Canadian Armed Forces members face before and after their release and transition to civilian life?

**Steven Harris:** Thank you. I will ask my colleague Ms. Courchesne to answer that question.

**Cyd Courchesne:** I thank the member for her question.

The Joint Suicide Prevention Strategy was developed in collaboration with the Canadian Armed Forces. As has been mentioned several times, we based it on Veterans Affairs Canada's areas of well-being. However, since our organizations are different, we developed different action plans.

This strategy has been published and can be found on our website. There are 63 initiatives for the Department of Veterans Affairs. I don't know them all by heart, but the strategy was to be implemented over five years, and although it is now complete, the initiatives are still being carried out. To date, 50% of the initiatives have been permanently implemented. For example, we continue to offer mental health first aid training, as this was part of our action plan.

Another initiative involved engaging with the media on how suicide cases among military personnel and veterans are reported. We collaborated with our centre of excellence, the Atlas Institute, which worked with McGill University and media specialists to ensure that this was reported responsibly.

There are several initiatives of this kind, and they have all published. We can also send them to the committee, if you wish.

**Tatiana Auguste:** Thank you very much.

Dr. Hall, could you explain your role within Veterans Affairs Canada's team of medical experts?

[English]

**Amy Hall:** Madam Chair, as an epidemiologist, I look at veteran health and well-being at the population level, so I look beyond the client population at VAC and at larger trends in the broader population.

● (0920)

[Translation]

**Tatiana Auguste:** Thank you.

How long has the department been tracking veterans' issues and concerns, and how detailed is this tracking?

[English]

**Amy Hall:** As Dr. Courchesne has mentioned, we've been looking at suicide at a population level in veterans since we started in 2015, and we've released a number of reports over time, with the most recent being in 2021.

[Translation]

**Tatiana Auguste:** Are there any important and relevant conclusions for this study, in your opinion, that should be highlighted?

[English]

**Amy Hall:** I believe they've been touched on for the most part through Dr. Courchesne's comments. Basically, we followed veterans who were released from the Canadian Armed Forces between 1975 and 2016. We saw increased risks for both male and female veterans, and those risks over that 42-year observation period have remained relatively stable over time.

[Translation]

**Tatiana Auguste:** Thank you, Madam Chair.

**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.

Ms. Hall, from 2018 to 2022, 39% of suicides in the Regular Force were related to depressive disorders and 41% were related to addiction. As a psychosociologist, I am very concerned about the use of psychotropic drugs. These drugs can be prescribed by a health professional, but they can also be used to self-medicate, which increases the risk of suicide. I would like to hear your opinion on this.

In addition, how can we better identify risk factors early on in order to better prevent suicide?

[English]

**Amy Hall:** Madam Chair, in the study that I mentioned, looking at suicide over time, we don't collect information, or I should say that the information on specific behaviours around substance use aren't available. VAC is leading and funding various research initiatives that are focused on, for instance, cannabis for medical purposes and also looking at other alternate and emerging therapies in mental health care, but we're not actually leading any studies at the moment looking at the links between substance use and veterans committing suicide.

[Translation]

**Marie-Hélène Gaudreau:** Once military personnel have returned to civilian life and years have passed, certain events or experiences can potentially trigger post-traumatic stress. The family can play a role, but often people keep it to themselves.

From a suicide prevention perspective, do you consider the programs we offer to be sufficient?

**Steven Harris:** We can always do more.

**Marie-Hélène Gaudreau:** So, they are insufficient.

**Steven Harris:** I don't mean to say that they are inadequate, but there are always things that can be tried to improve the programs. We are constantly trying to do that.

I don't mean to say that they are perfect, but I don't want to say that they are inadequate either, because that is not the reality.

**Marie-Hélène Gaudreau:** So you sleep well at night, even though they are inadequate.

**The Chair:** Thank you very much.

[English]

Mr. Richards, you have five minutes.

**Blake Richards:** Thanks.

I have a couple of questions.

First, let me ask our Canadian Armed Forces generals who are with us.

Mr. Tolmie touched on this a bit earlier. Suicide rates amongst veterans are much higher than in the general population. I believe it's 50% higher. It's 200% higher for younger veterans. If you look at suicide amongst active serving members of the CAF, it's about the same as the general population.

Can you tell us why you think it might be that the rates amongst serving members aren't much higher than they are with veterans?

• (0925)

**MGen Scott Malcolm :** Madam Chair, we have published—and it's publicly available online—our annual mortality study on suicide. We have shown, in fact, that rates for males and females are higher than those for the general public, but as was stated by my colleague from Veterans Affairs, Dr. Courchesne, those rates tend to be stable over time.

I can't really conjecture. I would turn to my colleagues from Veterans Affairs to comment, based on the work of Dr. Hall and the experience of Dr. Courchesne, if they feel there's any explanation for the rates being higher on the veterans side. I will just remind you that, again, given the multifactorial nature of suicide, it becomes difficult to pinpoint the exact drivers.

**Blake Richards:** Thanks.

If anyone from Veterans Affairs does have an answer to that, could you give it to me in a short 10 seconds? I have another question I want to ask.

**Cyd Courchesne:** Madam Chair, as I stated, if we knew, if we could only know.... It's so complex, and we don't have the possibility of interviewing anybody after the fact to figure it out.

**Blake Richards:** Okay. Let me turn, then, to the other thing I want to ask about.

You were asked earlier, Mr. Harris, about the training for case managers. Obviously, there is the contract with PCVRS. They deal with vocational rehabilitation, but they're going to encounter veterans who are in these scenarios.

What sort of training is there for those individuals, and what sort of process is in place if they encounter a veteran who they believe might be suicidal?

**Steven Harris:** It's very similar.

To clarify, PCVRS, which helps to deliver the rehabilitation program for Veterans Affairs, is more than just vocational rehabilitation; it's medical and psychosocial rehabilitation as well. The individuals who work and assist in that area have training similar to that in Veterans Affairs in terms of suicide prevention and discussions around suicide. That applies as well to all of the health professionals who work under that area to deliver those kinds of services.

**Blake Richards:** I actually had some indication that PCVRS really feels that they face a struggle when they encounter a veteran who is suicidal. What I've been told is that in those scenarios, they are under orders—for lack of a better way of putting it—to direct that person to the local emergency room or some kind of crisis service. Often what happens is the veteran is turned away, because they're supposed to come back to Veterans Affairs. What they're saying is that when they bring that into the Veterans Affairs chain, it leads to very lengthy processes and wait times for that veteran to get help.

I think that if we're going back now to this 22-week standard for someone who is suicidal, that's almost half a year. That's a real problem, and if that's what is happening, I would ask you to address that. If that's what's happening, how the heck is that considered to be proper service for a veteran who could be suicidal?

Is that maybe the explanation for why suicide among veterans is that much higher than in the general population?

**The Chair:** I will allow you, very briefly, to answer the question.

**Steven Harris:** There are a couple of different issues being addressed here.

If somebody approaches PCVRS and has an issue—suicidality, or is demonstrating that—they should actually be working with the experts and professionals in that area. While people are trained, they are not necessarily experts in mental health and what have you. We want them to be able to go there.

With respect to their disability claim, if there are elements of suicidality and suicidal ideation, there is a process to be able to accelerate their claim as well. It's not a question of sending somebody back to waiting for 22 weeks to get an answer; in cases of suicide, it's to be dealt with immediately.

• (0930)

[*Translation*]

**The Chair:** Thank you very much.

[*English*]

Mr. Clark, you have five minutes.

**Braedon Clark:** Thank you, Madam Chair.

I want to ask a couple of questions around the suicide rates that have been mentioned.

As you said earlier, they have been quite constant over time, over 50 years now, I guess. You may not know the answer, but is it the same in the general population? Is the rate flat over that period of time as well? Do we know the answer to that?

**Cyd Courchesne:** The rate is higher in the veteran population. It's a comparative rate. If there is one per 100,000 in the general Canadian population, we have 1.4. For women, if it's one in the Canadian population, it would be 1.8 here.

**Braedon Clark:** I see. I understand. Thank you for that.

On the male-female split question, am I correct to say that the rate for female veterans is higher than it is for male veterans?

**Cyd Courchesne:** It is.

**Braedon Clark:** In the general population—and this is off the top of my head, so I may be wrong on this—it's the inverse. Is it correct that the general rate is higher among men, generally speaking, than it is among women?

**Cyd Courchesne:** I would have to defer to my colleague, Dr. Hall, on that. I'm not quite sure.

**Braedon Clark:** Okay.

**Amy Hall:** The risk in female veterans as related to the general female population is higher than it is for male veterans. The risk is elevated for both, but the risk is higher for female veterans.

When we look at the rates of suicide in male veterans and female veterans, the rate of suicide in male veterans is actually quite a bit higher; it's about double that of female veterans. I'm just making that distinction. That does reflect trends we see in the general population among men and women.

**Braedon Clark:** I want to make sure I understand that, Dr. Hall. The gender split, if I can say that, among veterans mirrors, generally speaking, what we see among the Canadian population.

**Amy Hall:** Yes.

**Braedon Clark:** Okay, understood. Thank you for that clarification.

I'll share my time now with MP Hirtle.

Thank you.

**Alana Hirtle:** Thank you.

The surgeon general's health research program “directs, supports and assists in the research, technology, analysis...of outcome-based science and technology initiatives that affect the performance, health and welfare of all of the Canadian fighting forces wherever they serve, protecting Canadians at home or abroad.”

What are the objectives of the program? Can you share how it helps CAF members with their mental health?

**MGen Scott Malcolm:** Madam Chair, the surgeon general's health research and innovation board has multiple domains, one of which is mental health. Really, the focus of that is looking for either internal—meaning our colleagues within health services—or external colleagues to submit research proposals. Through a memorandum of understanding with our colleagues at Veterans Affairs, we also help sponsor other research-related programs on mental health.

There's lots of interest in mental health. Soon, through the Canadian Institute for Military and Veteran Health Research, we're going to have a forum here in Ottawa where a large amount of that research is actually going to be on display. I would encourage folks on this committee to attend and take advantage of all of that research.

There's a lot of collaboration on the research front related to mental health.

**Alana Hirtle:** What feedback have you received on the program?

**MGen Scott Malcolm:** The program is broad and not just specifically focused on mental health. It also covers all facets of military life, from deployed operations to new innovations and medical equipment. We continue to make good advancements, again, as was mentioned earlier, looking at new and novel treatment options.

Overall, it's been positive, and the engagement of the broader public safety community has been of benefit, too. We're sharing that knowledge with our colleagues from public safety, whether it's the mounted police or fire and other first responders.

• (0935)

**Alana Hirtle:** Thank you.

**The Chair:** Thank you very much.

Mr. Tolmie, go ahead.

**Fraser Tolmie:** Thank you, Chair.

I just want to recap, because I feel after going through the last questions, we have a blind spot and we need to address it.

We have someone who serves in the military. They have their comrades, their buddies, who can recognize, through their body language and their demeanor, that they may be having suicidal thoughts. They retire. Then they call VAC, and they access the services, but the case manager is contacted either by phone or email.

I know you've said they have training, but I'm finding it hard to believe that they can recognize the way a comrade can someone who's suffering from depression, unless they come forward. Those are the ones we're concerned about: the ones who don't come forward, the ones who are not stepping up to the plate.

It was shared that unless their spouses are given permission by the veteran to access, they can't help. We have a blind spot. We need to address the blind spot, because every life matters.

I don't know if that's been recognized or not, but I'd like to hear your comments on that.

**Steven Harris:** Madam Chair, I share the member's concern. We want veterans who are at risk, who may be suffering silently or secretly, to come forward. If you're not already a client of Veterans Affairs, then how do you get them to come forward? It is everybody. It takes the community. You referenced folks like battle buddies. Regimental associations have information. People get together regularly. When people leave the military, they stay in those groups. They stay connected. It does take other individuals.

A family member can't necessarily come forward and access services, but a family member can certainly help the veteran come forward and connect the veteran with services that are available to them, whether they're through Veterans Affairs or through multiple other community organizations that are there to help. We are specifically there to help veterans, of course, but so are multiple community organizations that could help as well.

I want folks and veterans to be able to come forward, supported by their families, by their battle buddies, by their former regiments and others, so we can be in a position to help them.

**Fraser Tolmie:** In the tragedy of losing someone to suicide, the prevailing comments are, "We didn't know. We didn't know what they were experiencing."

I think we have tools. I think we have opportunities here to recognize.... That's what we're talking about: suicide prevention.

With those who are serving in the military and who have been recognized as requiring help because they have been struggling with that, how is that transferred into Veterans Affairs? Is that another voluntary thing, or is it flagged on their file?

**Steven Harris:** There are a lot of different ways that can happen. The easiest way that I could identify that for you—and it's not the only way—is through the transition interviews that Brigadier-General Ménard spoke about earlier. We do get files, and if someone is being released for a medical reason which may have a relationship to suicidal ideation or attempts or things of that nature, then that information is transferred. As we speak to veterans, as they're releasing through a transition interview process, we're going to have conversations around those kinds of things, and we'll be able to identify them so that they are noted.

• (0940)

**Fraser Tolmie:** For anybody who is watching this committee, if you're suffering and need help, please come forward. Please access the services that are there for you, because you matter.

That's a public service announcement. It may seem corny, but there are people out there who we care about and who need to be looked after and cared for.

Thank you.

**The Chair:** Mr. Clark.

**Braedon Clark:** Thank you, Madam Chair.

This would be a question for the generals from DND.

Does DND also track statistics around suicide by active members? How would that compare to the rates we see with Veterans Affairs?

**MGen Scott Malcolm:** Madam Chair, publicly available is our annual study on suicide mortality. We do track those.

The data we're looking at is from 2002 up until present. The 2025 study is going to be published imminently, but all the rest of them are available online. While in any individual year there may be slight blips in the number of suicides, it's been generally stable. On average, we're looking at about 15 suicides per year. In the last published report, we were looking at 21; there were 17 in the regular force and four in the reserve. As was stated by my colleague from Veterans Affairs, Dr. Courchesne, most of those were male; two were female. They tend to be individuals within the ranks, not officers.

We noted within that that many suffer from mental health-related issues, be it depression, or substance abuse being the most prominent. Factors that represent triggers for them can be breakups in relationships, financial issues, problems with the law or overall struggles with work performance.

**Braedon Clark:** Thank you, Major-General.

From a rate standpoint, how does that compare to the rates that we would see at VAC?

**MGen Scott Malcolm:** Generally, they're aligned on that front. In fact, I think the numbers are almost exactly the same.

Again, we're looking at statistics. It's very clear that any suicide is one suicide too many, but from a statistical perspective, the numbers are small. This is the reason that we look at five-year blocks, as opposed to single-year blocks.

I defer to my epidemiologist colleague from Veterans Affairs to work through the nuances of how you work that data, but generally, we're looking at five-year blocks. In those five-year blocks, the rates have been generally stable, albeit elevated from the Canadian population at large, but they're stable over those periods of time since 2002.

**Braedon Clark:** Thank you, sir.

This would probably be a question for Mr. Harris.

Do we have a sense of how the rates we experience in Canada compare to peer countries, and what would those peer countries be? Would we look at the G7? If we do assess that, how do we do relative to others around the world?

**Steven Harris:** I think I would ask Dr. Hall whether she has some insight on that.

Do you have anything?

**Amy Hall:** Sure.

We have looked at trends in other countries as well. There are some similarities and some differences. We've seen, for example, that the U.S., Australia and the United Kingdom have also found that young male veterans are at the highest risk of suicide. We've seen suicide rates among veterans in Australia remaining stable over time, similar to the Canadian situation. In the U.S., the rates have actually increased. They've decreased in the U.K. There are a lot of differences.

We do work with international colleagues across the Five Eyes countries to try to understand what trends are looking like across our respective nations.

**Braedon Clark:** I appreciate that.

I have one final question for General Ménard.

You mentioned the six-month transition period. Has it been six months for as long as we know, or was it ever a different period of time?

• (0945)

**BGen Serge Ménard :** When I talked about the six months, we encourage members who are thinking about retiring to come and

see us. There's no set time frame for them to come and see us. It can be up to six months before retirement.

We encourage them to come and see us so that we can evaluate their situation and provide support options as we develop that picture about the person. It's all person-dependent. We don't have specific set standards for that.

**Braedon Clark:** I'm sorry. I'm out of time.

Thank you.

**The Chair:** Don't apologize.

Madam Gaudreau is next.

[*Translation*]

**Marie-Hélène Gaudreau:** Thank you, Madam Chair.

I would really like us to talk about the problem. For 40 years, suicide rates have remained stable, but we are making progress and implementing programs.

I think about what is happening in other areas of health care, and I think about the health care professionals who work for Veterans Affairs Canada. To improve things, we need to point out what isn't working and take action. But this has been going on for decades. So, do you think that health care professionals, and perhaps you yourself, could be suffering from compassion fatigue? It's a major problem that makes us want to do well, to improve, but we're not able to.

Do you have hope that people will take action to improve things and that you will be able to eliminate the 22-week wait? Will you try to minimize the problem, or justify the 22-week wait? No, that shouldn't happen. This is serious. We are not respecting our veterans if we are unable to provide services.

So, do you think there is compassion fatigue in your organization, both in prevention and in service delivery?

**Cyd Courchesne:** Thank you for the question.

I would like to clarify one thing: Veterans Affairs Canada health professionals do not provide services directly to veterans. Veterans receive services in their communities through provincial programs. Of course, some of the health professionals at Veterans Affairs Canada do assessments: They visit veterans in their homes, for example. They are trained to recognize warning signs, and so on. In general, we do not provide care services, unlike my colleague in the Armed Forces, who provides care directly to CAF members.

**The Chair:** Thank you very much.

I now give the floor to Ms. Wagantall for five minutes.

[*English*]

**Cathay Wagantall:** Thank you, again, Chair.

I really do appreciate the conversation taking place here today.

I have a real concern about this next report coming up that's covering the last decade roughly, over the course of 2017 forward. We know it takes a long time for veterans to sometimes come to the point where they would consider suicide, not succeeding the way they would hope. I'm concerned that the numbers you're going to see in relation to what I'm hearing as to how you can gather those numbers aren't going to be accurate. I have a good friend, a veteran who served in Somalia and has followed everyone he served with. The number who have taken their lives over the course of this last year is significant, but I don't have the confidence that you know.

Is there any mechanism or tool you can use that maintains privacy, but gives comrades, mothers, family members, the opportunity to give you that information on veterans who have for sure committed suicide, or perhaps even attempted suicide, who I'm thinking we're not aware of? We can't be confident what we're learning is accurate in regard to the number of veterans who are choosing suicide.

• (0950)

**Steven Harris:** Madam Chair, maybe I'll start.

Family members and others can report suicides to Veterans Affairs Canada, although they're not obligated to report that it was a suicide. In some cases, we may hear there was a veteran's death and not a suicide and what have you.

I'll ask Dr. Hall to answer your question specifically on the data's authenticity and its completeness in terms of where it comes from. Because it's not self-reported data, it's important to recognize it actually comes from a very reputable place and—

**Cathay Wagantall:** I'm not questioning that, but if she wants to share that, it would be fine with me, but briefly.

**Steven Harris:** Sure.

Go ahead, Dr. Hall.

**Amy Hall:** Within the veteran suicide mortality study, it's correct that we aren't able to add a great deal of additional information about risk factors or experiences to that database, although we are looking at options to expand. We're performing a new linkage this year and there might be more information on risk factors we can look at.

There's also another population-level survey called the Canadian veteran health survey. It was conducted for the first time in 2022. It looks at veterans who identified themselves as such in the 2021 census. That survey captures information on suicidal ideation and suicide attempts, so that might be another source of information we can use to understand what's going on in veterans.

**Cathay Wagantall:** Thank you very much.

When will that next report you're doing to update the information be released?

**Amy Hall:** In terms of the updated information from the veteran suicide mortality study, we're in discussions within the department for when that report can be produced and released. That would be in 2026 at the earliest. Then for the Canadian veteran health survey which I mentioned, with information around suicidal ideation and attempts, that information is available now. That will be followed

with new information from the 2024 Canadian veteran health survey.

**Cathay Wagantall:** Would those be accessible to the committee? If they could be provided to the committee, that would be great.

Do I still have a moment?

**The Chair:** You have 40 seconds.

**Cathay Wagantall:** You were talking about some of the issues for those who possibly do end up attempting suicide or committing suicide. You talked about substance abuse and addiction and depression. Is there any knowledge or understanding of whether those conditions were causal or whether they were a response to a bigger issue that ended up causing them to go in the direction they did?

We often get the impression that these individuals get into these conditions of abuse as a result of facing challenges that they couldn't cope with.

**MGen Scott Malcolm:** Trying to establish that causal link is extremely difficult. I'll just say in that vein that we've seen that while mental health figures into it prominently, at times that mental health issue is a result of a physical issue that leads them to break from their routines, which may then lead to mental health problems and other things.

It's extremely difficult to make those causal linkages. In fact, we just identify risk factors rather than the causal linkage.

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

[Translation]

Thank you very much.

You have the floor, Ms. Hirtle.

[English]

**Alana Hirtle:** You mentioned five-year blocks, and I'm wondering if COVID played into that. In the pandemic, did you see any kind of uptick or downtick in suicides during the pandemic years?

• (0955)

**MGen Scott Malcolm:** The rates remained stable through the pandemic, and again, it's how the blocks play out as well. Dr. Hall can help me out on some of the more statistical and technical terms.

What happens is we use that sliding five-year average, and while we publish the report annually, we will try to move to five-year blocks so that we can provide that firm five-year block, rather than moving...

Depending on how you line up that five-year block, it cuts off part of the pandemic. Things have remained globally stable with our data from 2002 to the 2024 report.

**Alana Hirtle:** That's interesting. Thank you.

Does the department follow support efforts that are working in the community, the service groups? Is there any liaison there?

That question is for anybody.

**Steven Harris:** We're all looking at one another.

I mentioned earlier a VAC assistance service that's provided from Veterans Affairs. It's actually delivered through Health Canada. It's the equivalent of the employee assistance program, but slightly scaled.

We do get some follow-up from those kinds of organizations. Another member mentioned earlier whether other organizations that are assisted by Veterans Affairs or that we work with come back to us with instances or anything they might see as trends. They do, as well. When we talk with our own service providers who may have direct contact with veterans on a regular basis, we want to hear back from them as to difficulties they're encountering or difficulties they're seeing among the veteran population. There is a good discussion there.

There's also good discussion with the centres of excellence that we have. We have two centres of excellence from Veterans Affairs, one on PTSD and another related to mental health conditions and chronic pain. As Dr. Malcolm said earlier, there are a whole host of related issues, including chronic pain and perhaps issues of suicide as well. We do have those connections on a regular basis, both from a research point of view and anecdotally.

**Alana Hirtle:** Thank you.

I'll pass the rest of my time to MP Sidhu.

**Sonia Sidhu:** Thank you.

The Canadian Armed Forces and Veterans Affairs Canada launched a joint suicide prevention strategy in 2017. How will you be able to measure the strategy's success?

Either department can give an answer.

**Cyd Courchesne:** Madam Chair, as mentioned, we continue to follow it through rates, which are an indirect indicator for us of the success of the strategy. Right now, we've measured the rates up until 2016. We'll have to wait for the first five-year block to see if there was any effect of that. Regardless, we know that all the measures we have put in place were good measures, were improvements on things we had done in the past.

As I mentioned, it's difficult to prove something that didn't happen or to demonstrate or measure that something didn't happen, so we have to rely on statistics and measuring trends over time to see if there are any effects or any changes.

**Sonia Sidhu:** Do I have more time, Madam Chair?

[Translation]

**The Chair:** Yes.

[English]

**Sonia Sidhu:** Do you consider that maintaining the operations of physical VAC offices is important in providing suicide prevention services for the veterans?

**Steven Harris:** I apologize; I missed part of your question.

**Sonia Sidhu:** Do you think that maintaining the operations of office or physical VAC offices is important to providing suicide prevention to the veterans?

**Steven Harris:** Absolutely. Being able to come into an office if you want to is very important. We've had about 50,000 visits since

the office reopened since COVID-19, in-person visits with veterans and families. As an option for veterans, that is very important.

**Sonia Sidhu:** If this federal government did not reopen the nine VAC offices in 2016 that were closed by the previous government, would that have impacted veterans in local areas and access to VAC services?

• (1000)

**Steven Harris:** We would still ensure that veterans could access services. They could access them remotely, but they wouldn't have had an opportunity to come in to those local offices.

[Translation]

**The Chair:** On behalf of the committee, I would like to thank you all for coming. We will suspend the meeting for a few moments to say goodbye to Dr. Courchesne, Mr. Harris, and Brigadier-General Ménard.

[English]

Major-General Malcolm and Dr. Hall, thank you.

[Translation]

Thank you for spending nearly two hours with us on this Thursday morning.

We will now suspend the meeting to see you on your way, and the members of the committee will return shortly to review the schedule for the coming weeks.

Thank you very much.

• (1000)

(Pause)

• (1005)

**The Chair:** We will now resume the meeting.

I have a few technical details to go over with you.

[English]

I want to make sure that everybody is in sync.

[Translation]

Our next meeting will take place on Tuesday, October 7, 2025, at 3:30 p.m. We will resume our study on suicide prevention among veterans.

[English]

Before our meeting ends, I would like to briefly discuss a scheduling proposal.

Pursuant to the motion adopted on September 18, 2025, once the committee has completed its study on suicide prevention, which will most likely be at the end of October, its next study will be on barriers to entrepreneurship for veterans. This new study will likely begin sometime in November.

Is the committee ready to agree that the deadline for members to submit their lists of proposed witnesses will be Friday, October 24 at 4 p.m.?

[Translation]

We would like to have an agreement to obtain the lists of names so that our clerk can contact these individuals. That way, in November, we could begin the new study, if possible. We will see how things progress. At least we would have names to start the next study.

Do you all agree?

[English]

**Blake Richards:** For which study is it?

**The Chair:** Basically, according to our subcommittee report and pursuant to the order determined on September 18, we would go to barriers to entrepreneurship for veterans. That would be some time in November. Leading to that conversation, we would like all of you to send names of possible witnesses. The date proposed is Friday, October 24 at 4 p.m.

Is that agreeable?

**Some hon. members:** Agreed.

**The Chair:** Thank you very much.

Finally, I would like to ask if the committee is ready to adopt the budget for the September 18 briefing on trauma-informed practices and the budget for the September 23 briefing with the veterans ombudsman.

The budgets were distributed by the clerk on Wednesday, October 1.

Is it the will of the committee to adopt these two budgets?

**Some hon. members:** Agreed.

[Translation]

**The Chair:** Thank you very much.

[English]

Is it the will of the committee to adjourn the meeting?

**Blake Richards:** I have a couple of questions.

You mentioned that our next meeting next week will continue on this study. Do we know who the witnesses will be at this point?

I have another couple of questions. Maybe I'll just ask them all at once and then you can answer them all at once.

How many witnesses were submitted overall for the current study? How are we generally planning to lay out the panels for that in terms of the number of witnesses, how they'll be structured and how that will all be grouped?

[Translation]

**The Chair:** Mr. Clerk, you may respond.

[English]

**The Clerk of the Committee (Eric Glavin):** Thank you for the question, Mr. Richards.

For our next meeting on October 7, there will be five witnesses. There will be two from the Atlas Institute for Veterans and Families, one from the Wounded Warriors Canada, one from the Veterans Association Food Bank and one from the Veterans Transition Network.

When it comes to the total number of witnesses, approximately 55 names were recommended by members. The current plan is to allocate those as equitably as possible among the witnesses that were recommended by all of the parties.

• (1010)

**Blake Richards:** Typically, we're going to do about five witnesses or so in a panel. Is that our plan?

Sometimes in the past, I found what's happened is we've done four or five in two different one-hour panels. I find it doesn't leave anywhere near enough time for questions for those folks. It appears we're not going to do that. We're going to stick with a panel of four or five.

**The Chair:** It will depend. Sometimes if we have two individuals here, we will allow them a little bit more time. With three witnesses for an hour, sometimes it is enough and sometimes it is not. We'll play as to the value added.

I want to make sure that all of you, like today, go through the full round of questions and that you have as much time as possible to share your perspective and also ask the questions that will lead to recommendations for this report.

**Blake Richards:** Before we move on, I would just say two things.

First of all, I would strongly encourage that we avoid the two panels for an hour as much as possible. I find that by the time the meeting starts and you go through this whole list of things that you need to preamble, the meeting has to adjourn, the people go and thank everyone, and it takes 10 minutes before we start the next panel. That second panel especially ends up that we don't even get through a whole round of questions. I would strongly encourage us to avoid that as much as possible. That seems to be a lot of time wasted. I would strongly encourage us to do that.

I'm surprised that the number wasn't higher in terms of witnesses. I believe we submitted about that number of witnesses ourselves. I would assume some of the other parties have also submitted witnesses. Unless there was a lot of duplication, I thought it might have been higher than that. With that number of witnesses, we may want to consider whether we want to add meetings as well.

**The Chair:** As I said, for me it's to create a structure so that all of you have equal opportunities to ensure... We said a minimum of six, but if we need eight or 10, I don't think that's set in stone, Mr. Richards. For me, it's very important. However, at the same time, I just want to make sure there's a structure in place and a calendar for all of you to know how we are going forward.

[*Translation*]

Ms. Gaudreau, I would like to give you the floor before adjourning the meeting.

**Marie-Hélène Gaudreau:** I simply want to say that if there is insufficient information to decide which witnesses to invite, it is up to us, as parliamentarians, to prioritize. We know that some witnesses may have more information to share with us than others.

To facilitate the clerk's work, it would be good to keep in mind that some testimonies may be shorter. However, we should not put the names of five experts on the list. I propose that all my colleagues establish priorities and provide a little more information to make the process more efficient.

**The Chair:** I agree with you.

The clerk, with the support of the analyst, does an extraordinary job of ensuring that the range of witnesses accurately represents the requests of the committee members. We do allocate the necessary time to people, both experts and individuals who tell us their stories, so that we can present strong recommendations in our report.

[*English*]

Is it the will of the committee to adjourn the meeting?

**Some hon. members:** Agreed.

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