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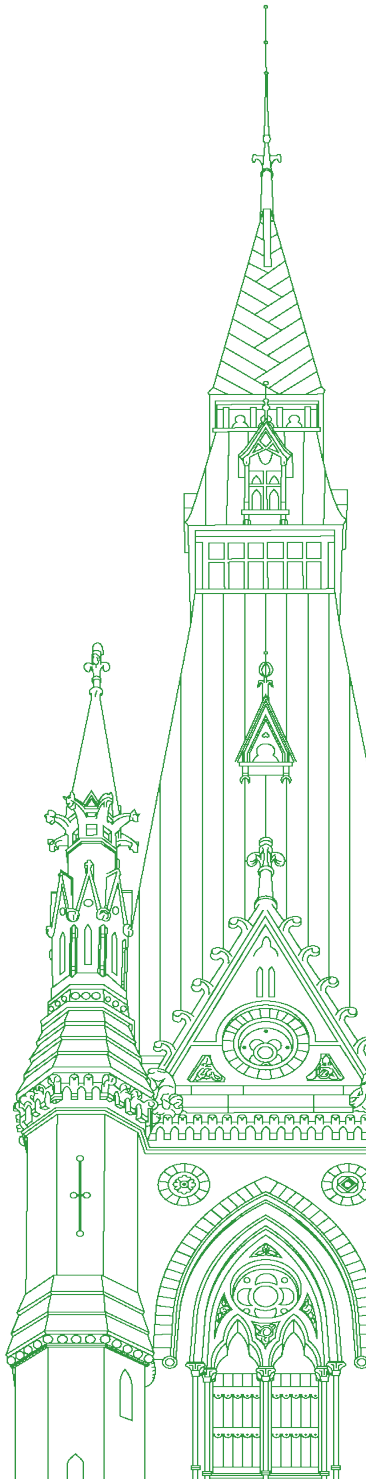

Chair: Marie-France Lalonde

Standing Committee on Veterans Affairs

Tuesday, October 7, 2025

● (1530)

[*Translation*]

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

Welcome to meeting number five 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 by 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 our dear interpreters.

[*Translation*]

I want to thank them very much once again.

[*English*]

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

[*Translation*]

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.

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.

A reminder that all comments by members and witnesses should be addressed through the chair.

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.

[*English*]

I would like to welcome our witnesses. We have four organizations today, and we thank all of you.

From Atlas Institute for Veterans and Families, we have Fardous Hosseiny, president and chief executive officer, and Gabrielle Dupuis, director of research partnerships and government affairs. From the Veterans Association Food Bank, we have Marie Blackburn, executive director. From the Veterans Transition Network, we have Oliver Thorne, chief executive officer, who is joining us by video conference. From Wounded Warriors Canada, we have retired captain Philip Ralph, director of clinical services. Sir, thank you for your service to our country.

[*Translation*]

We will begin with presentations by witnesses. A round of questions from committee members will follow.

We will begin with opening remarks from Mr. Hosseiny and Ms. Dupuis. Afterwards, each witness will be asked to do the same.

You have the floor for five minutes.

[*English*]

Fardous Hosseiny (President and Chief Executive Officer, Atlas Institute for Veterans and Families): Thank you, Madam Chair and members of the committee. My name is Fardous Hosseiny, and I serve as the president and CEO of the Atlas Institute for Veterans and Families. It is a privilege to join you today to speak about suicide, a subject with very real and immediate consequences for veterans, families and communities across Canada.

Atlas is a federally funded intermediary working at arm's length from Veterans Affairs Canada to strengthen mental health supports for veterans and their families. We collaborate with veterans, families, researchers and service providers to codevelop practical, evidence-informed resources. We also lead and fund research to build national capacity by supporting new knowledge, skills and networks so that organizations across Canada are better equipped to serve veterans and families.

Suicide among veterans is a serious and persistent challenge. Male veterans are about 1.4 times more likely to die by suicide compared to civilian men, and female veterans about twice as likely as civilian women. For men, the highest risk is often in the first four years after release, while for women, risk peaks much later, often around 20 years post-service.

While veteran-specific data remains limited, CAF reported that in 2023, there were 17 suicide deaths among regular force members and four among reservists. The suicide rate in the regular force that year was about 27 per 100,000 person-years, higher than in 2022. These figures show suicide prevention requires long-horizon planning and sustained support across the veteran life course.

I'll now pass it along to my colleague Gabby Dupuis, director of research partnerships and government affairs.

● (1535)

Gabrielle Dupuis (Director, Research Partnerships and Government Affairs, Atlas Institute for Veterans and Families): Thank you, Fardous. I will briefly speak to some of the work that's been done within Atlas.

In our most recent release related to suicide prevention, Atlas worked alongside veterans, family members and the Centre for Suicide Prevention to co-design a suite of resources. The veteran tool kit offers guidance on recognizing warning signs, building protective factors and finding care, while the corresponding family tool kit helps loved ones support veterans while also caring for themselves, with advice on burnout, self-care and safety planning.

We've also developed conversation guides and wallet cards to help start suicide-related discussions in clinics or peer support groups, or even within your home. These were released in September 2024. Since then, these resources have been downloaded about 10,000 times in both English and French, and and we have further distributed printed copies to CAF transition centres, military family resource centres, OSI clinics, VAC offices and Legion locations across Canada. Additionally, recognizing the importance of safe communication, we've co-produced media guidelines with McGill University, veterans and journalists to help organizations and media outlets report on suicide responsibly and safely, not only to reduce stigma but also to reduce the risk of contagion.

We've also created fact sheets showing how families are affected by suicidality and the critical role that families play in prevention. In parallel, Atlas is collaborating with Queen's University on research into military and veteran family suicidality. This work highlights that family members may face a heightened risk of distress and mental health challenges, often compounded by limited access to dedicated supports and services. It underscores the need to better identify and address the unique mental health needs of families as part of the broader continuum of care for the veteran community.

Our work extends beyond suicide-specific resources. Experiences such as military sexual trauma, post-traumatic stress disorder or traumatic brain injuries are all connected to suicide risk. The resources Atlas has developed in these areas are part of the broader fabric of suicide prevention, because they help to address the underlying injuries or traumas that can contribute to despair and isolation.

Suicide prevention requires not just tools but also sustained collaboration and system-level thinking. Atlas will be hosting a national round table on the intersection between suicide prevention and substance use, recognizing that these risks are often intertwined. Within the veteran community there is sometimes a culture of turning to alcohol or other substances, perhaps to numb psychological pain, which can mask distress and increase vulnerability. This round table will be supported by a rapid evidence profile to ensure that the discussions are grounded in the latest research and practice insights.

I will now pass it back to Fardous to offer some insights into some international work and to give a closing statement.

Fardous Hosseiny: Thank you, Gabby.

I'll be very quick, Madam Chair.

Internationally, I want to highlight two streams of work. The Australian Royal Commission into Defence and Veteran Suicide offers a strong model of systemic inquiry. It collected thousands of submissions, including from Atlas, heard directly from veterans and families, and issued more than 100 recommendations. Its findings emphasize accountability and oversight, longitudinal care, the centrality of lived experience and the need for robust data systems.

Separately, Atlas also contributes to and learns from the Five Eyes nations. We are part of the Five Eyes mental health research and innovation collaboration. A recent commentary, "Suicide in Military and Veteran Populations: A View Across the Five Eyes Nations", reviewed suicide trends, risk and protective factors, and challenges in prevention. It underscores that despite decades of study, we still struggle to predict and prevent suicide with precision, especially in the transition from ideation to attempts. Canada can benefit from these insights—in particular the emphasis on longitudinal research, better data integration and cross-jurisdiction learning—as we refine our own suicide prevention strategies.

The statistics we have shared today underscore the urgency of this work. Even one suicide is too many. Atlas and our partners have demonstrated that practical, evidence-informed tools already exist, and with your support, we can expand our reach, integrate families more fully and strengthen prevention across the veteran life course.

Thank you.

● (1540)

The Chair: Thank you very much.

I would like to invite Ms. Blackburn to give an opening statement for five minutes.

Marie Blackburn (Executive Director, Veterans Association Food Bank): First of all, thank you for having me here today. It's an honour.

It's unfortunate that we still need to talk about this topic, but it is real and it needs to be addressed.

Is there any magical solution to prevent suicide? No, there is not.

The high number of veterans who talk about, attempt or die from suicide is alarming. As Fardous mentioned, the suicide rates are higher among our male population between the ages of 18 and up. It's the highest suicide rate among all groups. Female veterans are two times more likely to commit suicide than women in the general population.

I tried to research how many veterans died by suicide last year, and it seems hard to get an accurate number. Some of the contributing factors are mental health issues and substance abuse, which can be significant among those contemplating or committing suicide.

As I said, there is no perfect solution to this tragedy, and I'm certainly not an expert, but we do have some programs that may help. At the Veterans Association, we strive to ensure veterans are safe and to provide services that help them understand there is a better way.

I can only share with you some of our experiences through our programs. I think the most important component of our program is the peer-to-peer support. As I've stated many times, veterans have a unique understanding of one another and have a bond that we will never fully understand.

Our goal and mission when we started was always to try to prevent homelessness, hunger, isolation and, ultimately, veteran suicide. We try to keep it simple: Our first goal is to provide hope.

When you feel you cannot get through another day because you can't pay your bills or put gas in your car and you need extra money for your kids or need pet food for your dog—all the simple things we go through in life—we just provide the necessities. It wouldn't matter if you were a veteran or not; not being able to provide for your family or yourself is devastating and can lead to thoughts of giving up.

Having a physical location where veterans can come in, have a coffee and talk about whatever they want, knowing that other veterans will understand what they've been going through, makes a world of difference. On many occasions, veterans have told us it was so good to have somebody who understood exactly what they were feeling.

Our facilities are alcohol- and drug-free. We have designed the Veterans Association so that all veterans feel they have ownership. When you have ownership of something, you tend to nurture it, respect it and ensure you leave a legacy for all veterans from the past and for the future.

We all know that veterans need a purpose. During their time in service, they always had a purpose. At the Veterans Association, we encourage veterans to volunteer, attend community events or simply be there for their fellow veterans and be supportive of them.

We do a full intake for every veteran who comes in. One very important things we do is make sure we fill out their Veterans Affairs paperwork. Numerous times, we've been very successful at finding benefits for veterans. This certainly helps with their financial situation, and their overall mental health improves dramatically. This may sound a little strange, but it does give them the sense that their service was important.

Our outreach team is made up of veterans themselves. The communication among veterans is instrumental in discovering if a veteran is at risk. When they determine that a veteran is struggling, we provide home visits, counselling and an opportunity to volunteer. Removing them from the four walls they stare at constantly helps them take away dark thoughts. Many veterans have come in just to volunteer, have a coffee or go to our Thursday dinners. They feel like they have a purpose again.

Working with Veterans Affairs offices and caseworkers, we're starting to build a better relationship for veterans who have been struggling with their caseworkers. At times, if it means replacing a veteran's caseworker with someone else, then that's what we will do. Many veterans have told us that the disconnect at Veterans Affairs and the lack of understanding have been very difficult to deal with. This is not to say that every veteran experiences this, but for those who do, we ensure that we find someone who will communicate with them and understand them.

There are many programs available for veterans struggling with mental health or addiction, and many of them are instrumental in getting the veterans the best help. We have other resources that can address some of the more complex issues they are going through. We provide financial assistance for any costs, because this will alleviate their financial burden.

Our emergency funding program has always assisted the homeless population. Many people think that homeless veterans are addicts or alcoholics, but the truth is that many are homeless because of unemployment, divorce, sale of property or mental health issues.

● (1545)

I am happy to report that in the month of September, we were able to restructure the lives of six veterans. Those six veterans indicated that they might not have been here today had the program not supported them. All six are now housed and thriving.

Do I still have time?

The Chair: Yes.

Marie Blackburn: Veteran suicide is very complex, but at the Veterans Association, we believe that if we address all the issues a veteran may be experiencing, we have a better chance of giving them hope. I cannot tell you how many times a veteran has said to me, “I don’t know where I would be without you—perhaps I'd be homeless, or possibly dead.” We provide a service of hope.

I remember that my board once asked me if I could write a small manual on how to deal with veteran suicide. The truth is, you can't. Each veteran's experience is something different.

For example, I had a veteran who posted on Facebook that he was going to end his life that day. The immediate reaction from a fellow employee was to call the RCMP. Knowing his history with authority and that it had always been very toxic, and knowing this gentleman myself, I called him and told him to get out of the house immediately because the RCMP were on their way. Had they shown up, it most certainly would have been suicide by police.

The lesson we learned from this is that every veteran with any kind of mental issue is now red-flagged in our system. Before one single person makes a decision on how to handle a volatile situation, it is discussed with no fewer than two people.

In closing, I think the most important thing to do is listen, even if you feel like you're too busy or too tired. If someone is looking for a way out, put everything aside and just listen. Do your best to reach out to other resources and follow the amazing work they do. Working together might not save every life, but it can certainly save one.

That's all I have to say.

The Chair: Thank you very much, Ms. Blackburn.

Marie Blackburn: You're welcome.

The Chair: Captain Ralph, you have five minutes.

Captain Ralph, you have five minutes.

Captain(N) (Retired) Philip Ralph (Director, Clinical Services, Wounded Warriors Canada): Good afternoon. Thank you for the opportunity to address the committee.

The ongoing discussion we're having today is critical and long overdue. To say that I'm honoured and humbled to be asked to comment is an understatement.

As important as this discussion is, I cannot help but confess a sense of inadequacy as we approach this topic together. I have struggled to frame this discussion in a manner worthy of the topic's gravity. This is a difficult discussion, which is further complicated by the fact that all of us as human beings struggle even in the broadest terms to come to grips with our own mortality. We have all seen what happens when we throw an object into a body of water. As the ripple radiates from the epicentre, the point of contact, and continues towards the shore, so it is with suicide. Powerful and profound are its effects on family, friends and larger society.

My remarks today are informed by over four decades of pastoral ministry, 26 years as an army chaplain and nearly two decades of experience in various roles within Wounded Warriors Canada. Historically, suicide in our society and in many others has been the proverbial elephant in the room. The families I have dealt with over my career have informed and shaped my remarks and, in fact, have profoundly impacted my life.

As essential and as important as this topic is, we must admit it is one that, as individuals and as a society, we still struggle to address because of the flood of colliding emotions, including loss, grief, guilt and shame, all coupled with trauma. The complicated and conflicting emotions and issues surrounding suicide were, for the longest time, only spoken of in society, if at all, in hushed tones. I want to state unequivocally that the very fact that today's committee is addressing this issue is a positive and hopeful sign.

Early in my career as a pastor of a small congregation in Toronto, I remember feeling ill-equipped to deal with a number of families affected by suicide in my community. In my career as a Canadian Armed Forces chaplain, I was often tasked with the sacred responsibility of going to the door to inform loved ones that it was the worst day of their lives. In my career, notifications ranged from those who were killed in action to those who died by suicide.

Towards the end of my career, I noticed a sharp increase and change in the number of notifications related to suicide. I know that is true for many of my fellow chaplains as well. This fact was key in the early decision of Wounded Warriors Canada to focus solely on mental health.

Today, Wounded Warriors Canada is a national leading mental health service provider dedicated to serving trauma-exposed professionals and their families. Wounded Warriors Canada specializes in providing culturally informed services that utilize a combination of education, counselling and training approaches to support resiliency and recovery from post-trauma injuries.

Personally, I vividly recall my personal guilt and confusion at the loss of a serving member by suicide only a couple of days after I talked to that member. It haunted me for a long time. I was angered when senior members of the chain of command, as late as 2003, denied the rise in suicide rates among Canadian Forces members.

We are indebted to the work of those who have gone before us. I think of an article in The Globe and Mail by Renata D'Aliesio called “The Unremembered”, which brought all these things to light.

A review of nine police suicides in Ontario in 2018 said that the realities of the police mental health ecosystem had to change. The same needs to be said about veterans and serving members of the Canadian Forces. Strides have been made, like the naming of the 2024 national Silver Cross mother, Maureen Anderson, but we all know that much more needs to be done. This committee, the department and the Government of Canada need to focus their efforts. This includes policy, programs and, most importantly, proactive prevention.

● (1550)

Items that this committee must consider, I would suggest, include the impact of stoic culture on the mental health of members; the need for safety and a whole-of-person approach to consider physical, emotional, cognitive, relational and spiritual elements of those experiencing trauma so that they can feel and say, “I am safe and I feel safe”; the role of organizations and leadership when it comes to mental health, as when it comes to mental health, leadership is every bit as much of the issue as the individuals themselves; and the immediate implementation and funding of the evidence-informed resiliency programs available right now. The example has been set by the Government of Ontario in the area of public safety with the funding of Warrior Health this past spring. It gives 24-7 access to mental health resources for trauma and operational stress and is specifically designed for trauma-exposed professionals.

Ladies and gentlemen, if you don't deal with trauma, nothing else matters. Again, if you don't deal with trauma, nothing else matters. I would love to talk to you about how Warrior Health works; maybe I can with your questions.

I want to thank the committee for its attention. This government has rightly highlighted the need to adequately fund and equip the forces. I would submit that a failure to invest in the mental health readiness of serving members and veterans will constitute a mission failure on the part of the government if it's not done. I look forward to sharing with members the resources that are deployable now and will have a significant positive impact for both serving members and veterans.

Thank you.

● (1555)

The Chair: Thank you very much, Captain Ralph.

As you can see, members—and I hope you're okay with it—we've been open to a bit of extra time, but I will reiterate that it's five minutes.

Mr. Thorne, it is your time.

Oliver Thorne (Chief Executive Officer, Veterans Transition Network): Thank you for the opportunity to speak today. My name is Oliver Thorne. I am the CEO of the Veterans Transition Network, a charity that provides free group counselling and transition programs for members and veterans of the Canadian Armed Forces and RCMP across Canada.

[*Translation*]

At the Veterans Transition Network, or VTN, we work with many veterans who are at the highest risk of suicide. Our goal is to provide them with the care, human connection and hope needed to prevent this tragic outcome.

Evaluations of our programs show that more than two thirds of the veterans who participate have experienced suicidal thoughts, most in the past year. Those same evaluations also show a significant and sustained decrease in suicidal ideation among veterans who have participated in our programs and responded to our follow-ups.

[*English*]

My testimony today will focus on the risk factors, potential solutions and current shortfalls of the government effort to prevent veteran suicide. I bring the perspective of an organization that has worked closely on this problem for over a decade.

Although suicide is extremely difficult to predict at an individual level, research from the Canadian Armed Forces and Veterans Affairs identified several risk factors that are consistently associated with suicide among veterans. Service in the junior ranks, in the army and in combat roles places veterans at elevated risk. It peaks for many within the four years after they leave the service. A difficult transition to civilian life, mental health injuries, a loss of identity and purpose, social isolation, and disconnection are all associated with increased risk of suicide among Canadian veterans.

[*Translation*]

In our experience at VTN, this series of risk factors often has a domino effect that can lead to suicide.

A psychological injury increases the likelihood of medical release. This release deprives the veteran of the identity, meaning and sense of belonging they find in military service. Those losses amplify the effects of psychological injuries, complicate transition to civilian life and lead to social isolation and disconnection. When that disconnection turns into despair, the risk of suicide becomes dangerously real.

[*English*]

Veterans Affairs and the Canadian Armed Forces have taken steps to reduce suicide risk by improving transition education and access to one-on-one counselling and by investing in peer programming, but we don't yet know if those efforts are working. The veteran suicide mortality study, published in 2021, found no significant change in suicide rates between 1975 and 2016, the last year available data was published. More concerning, data shows that veterans who left the Canadian Armed Forces between 2015 and 2018 reported higher rates of medical release, mental health injuries and transition difficulty than those who had left in the previous 15 years, so we may be entering a period of increased risk for veteran suicide in Canada.

If the risks are suicide, injury, isolation and hopelessness, then the solutions are treatment, social connection and renewed purpose. Group-based counselling can provide all three. It can provide culturally competent specialized clinical care for mental health injuries, delivered in a format that is experiential and socially connected. In a group, veterans don't just receive help. They help one another, rebuilding community and rediscovering the self-worth they had in the military, the very factors that present against suicide. At VTN, we see this every day in our programs across Canada.

[*Translation*]

However, Veterans Affairs Canada's approval process for allowing veterans to participate in specialized programs or groups like ours is often hampered by a bureaucratic and complex process. That approval process has become increasingly complex over time.

[*English*]

In the past 10 years, we have seen the funding approval rate for Veterans Affairs clients who attend our programs fall by over 60%. We are routinely denied funding for eligible clients, with Veterans Affairs case managers citing unfamiliar, complex and time-consuming approval processes as the reason for the denial.

● (1600)

At VTN, we know the risk is suicide, so we don't turn away those veterans or delay their participation until funding is approved. Instead, we use the funding we raise from donors to ensure that veterans can receive help when and where they ask for it, but that financial constraint reduces the number of people we can help every year.

We know who is at risk, and we know this risk is urgent. My major recommendation for the committee today is to work towards creating greater access for veterans to attend specialized root-based transition programs and trauma programs by implementing an automatic approval for veterans who are medically released from service due to a mental health injury. By doing so, we can get the veterans who are the most at risk quickly into the care and community they need before the dominoes of suicide begin to fall.

Thank you very much.

The Chair: Thank you very much, Mr. Thorne.

We will now start with the rounds of questions.

We will start with six minutes, and I will invite Mr. Richards to go first.

Blake Richards (Airdrie—Cochrane, CPC): Thank you, all of you, for your very helpful remarks today.

I want to start with you, Marie, if I may.

You were before this committee for a previous study in a previous Parliament, and you told a story that I think is very appropriate. If you recall the story, I'm talking about the veteran you discovered in a parking lot. I would like you to just briefly tell that story to this committee so we can have it included in the evidence for this study.

I have some questions that relate to it. If I could, I'll let you start by telling the story, and then I'll ask you some questions about it.

Marie Blackburn: It was a really hot summer day, and the air conditioning had broken down in the building. All I wanted to do was to go home and sit near my little mister and have a drink.

I had seen his car coming and going all day long. I couldn't really figure out what he wanted. When I left, he came up to me and asked if he could talk to me. I said, “You absolutely can.” Back into the hot building we went, and he just broke down, saying that he was losing everything he could possibly lose—his wife, his kids, his home—and he was at the very end of his rope.

I asked him what would help the most. We ended up paying all of his bills and getting him a hamper. By the end of the conversation, he was pretty stabilized and doing well. Off to home I went, and he went home. About six months later or thereabouts, I met him at a navy pipe band ceremony. He came up to me and asked if I remembered him. I said that I did.

He thanked me at that time. He almost broke down when saying thank you for everything I had done for him. He said, “Seriously, if you hadn't done that, it would have been the last day of my life.” He said, “I was waiting for you to leave, and if you had left, I would have pulled into your parking stall and blown my brains out. I had a loaded handgun under the seat of my car.”

Just knowing that people are resorting to that because there are no resources available is heartbreaking. That's why we spend so much time on addressing even the little issues, like not having food on the table or whatever the case may be. We get a few stories like that.

Blake Richards: First of all, thank you. That's not easy to share, I'm sure.

You pointed out that it's not isolated; it's not the only story you've had like that. I wanted you to tell us that story because I want to see it included in the report, obviously, but I also think it drives the point you were just making. You provide more than just food and clothing and help like that. You provide all kinds of help to veterans.

My question is in relation to that. When veterans are struggling with the basics of shelter, food and finances, does that make it more or less likely they'll get help with any suicidal thoughts they might have or with other mental health challenges or addictions? Do you think it's less possible for someone to get help with those things when those basics aren't taken care of?

● (1605)

Marie Blackburn: From our experience at the food bank, it's about when you lose all hope and you're going to lose everything. Part of the story I forgot to tell you was that he had struggled for a long time with Veterans Affairs to try to get his benefits. They just weren't coming through. When people come to the food bank and we can pay their rent so they know they won't be facing homelessness, or they can put food on the table for their children, or they can feed their dog, I don't know—there's no scientific study on it or anything—whether that truly prevents them from committing suicide. Some will just commit suicide. We had a couple we worked with for a long time and they still ended up committing suicide.

Overall, though, through our program, we know that we've stopped a lot of people from thinking that this is the end. I think that's important to say.

Blake Richards: Let me ask you about the challenges you face in being able to continue to do the good work you do for veterans. You told us previously that the cost of living is a challenge that has made it more difficult for you to continue to do your work. Does that remain a challenge? What impact does that have on a veteran when they're in these kinds of situations?

Second, what other challenges do you face? What are some of the bigger challenges you face in order to continue to do the work you do and serve all the veterans you wish to serve?

Marie Blackburn: Our busiest time of year is October, November and December. That's when we get the majority of our funding. It's going to be a little squeaky this year, because there's a strike with teachers, and we get a good portion of our food from schools. Then we have the postal strike on top of that. A lot of our elderly folks would rather send a cheque. That's the only way they know how to make a donation. That will be a struggle.

We've always done fairly well just as our own little company with our own emergency funding programs, and then along came the veteran homeless program. They have designated $1 million a year for us to now work in Manitoba, Saskatchewan and B.C., but $1 million doesn't go very far when you're trying to help people. We get constant referrals from Veterans Affairs—at least three to five a week—asking if we can help with a veteran, but we get zero dollars from Veterans Affairs to fund any of our programs, which seems a little strange to me.

I think the biggest challenge is always maintaining that we'll have that money to help veterans.

Blake Richards: Thank you, Marie. Thank you for all that you do.

Marie Blackburn: You're welcome.

The Chair: I'm sorry about that. I was listening actively and forgot the time.

I would like to invite Mr. Clark to go ahead for six minutes.

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

I'm directing my questions to you, Captain Ralph. First of all, I want to thank you for both your service as a chaplain and the work you talked about in your opening statement, which I think is exemplary, of course.

You touched on a couple of things that piqued my interest. One was the need to deal with “stoic culture”, as you phrased it. Obviously, you've been exposed to veterans in the military for decades. Can you explain what you meant by stoic culture?

As a second piece to that, over your career in the military and working with veterans, have you seen change in that? What do the trends look like, in your view?

Capt(N) (Ret’d) Philip Ralph: First of all, there's a positive element to the stoic culture. The military, like all uniformed services, is tasked with getting stuff done. When things are going sideways, we're those strange people, as you know, who run towards danger when all of the smart people run away from it.

When I talk to people who haven't been in uniform, I like to put it very simply to them. You have to realize that those who have served in uniform think differently. That's not better. That's not worse. It's just different. If you're going to meet their needs, you have to be able to speak their language and speak to them in a manner that resonates with them.

I've had veterans phone me and say, “Can you find me a clinician? I went and found one. I thought I needed help, so I put my hand up, but I went into so-and-so's office, and they can't spell ‘veteran’ or ‘first responder’.” That's because we come from a culture where we're trained that when something happens, there is an SOP for it. You do this, and then you do that, and then you do this. They want a plan. They want to see that there's something there that makes sense and that there's a goal. When it gets all lofty and fussy they think, “This civvy doesn't understand me.”

It's one of the reasons that Wounded Warriors Canada has great partnerships with other organizations, like Homewood Health and Trillium Health Partners. If they are going to see a veteran, every member of Homewood's staff has to take the introduction to trauma-exposed professionals course that Wounded Warriors Canada offers online.

I suggest that members of the committee email me their contact numbers, and I'll enrol you in the course for free. You need to take it just to understand. It's five hours. It's asynchronous. It's online. It's taught by our national clinical director, Dr. Tim Black. That's important. I know we had the same relationship with that program with Atlas because we're collaborating together.

The problem with stoic culture is, of course, that when you bring something out of the “doing your job” atmosphere and bring it into your home and wider society, A, people don't understand it, and B, it doesn't really work that well in other situations. We need to understand where they're coming from and treat them in a manner that....

The other thing is that if you don't deal with trauma, nothing else matters. I emphasized this line twice. I did that on purpose. It's not because I forgot that I said it. That is the truth. If you don't deal with trauma, nothing else matters.

● (1610)

Braedon Clark: I don't want to speak for members of the committee in general, but I assume we would all be interested in taking you up on the offer that you mentioned, first and foremost.

With Wounded Warriors Canada, there are obviously a lot of different programs. You mentioned the trauma-informed experiences. There are programs for the spouses and kids of veterans, which is fantastic. In your opening statement, you also talked about Warrior Health as a model that exists. It sounds like it's only in Ontario. When I was looking through the website, I took note of that as well. I believe you said it started in the spring. Could you just give us an overview of that program and what it looks like? How do you, I assume, think it can help?

Capt(N) (Ret’d) Philip Ralph: The public safety side of the house uniformed service has many of the same struggles as military uniformed people do. WSIB was not getting traction. People weren't returning to work. They were going off work with mental health injuries. Premiums were going up. Nothing was happening, and people were frustrated with WSIB. They said exactly the same things about WSIB that veterans say about Veterans Affairs Canada. We said to them, “It's because you're not speaking their language.”

We began with a number of programs and inputs. We started with the first responders speciality program, which is another program. Finally, we said that we needed to get a resource into the hands of every single first responder and their family members in the province of Ontario, one that is trauma-informed, culturally appropriate and anonymous so that nobody in their chain of command would know about it. That's Warrior Health.

You can go on your phones right now, in your apps, and you can download Warrior Health. You can see the resources there. What's wonderful is that it's been accessed, since its launch, 200,000 times. The only information we get back at Wounded Warriors Canada is on how many times it's been accessed.

It's done with our partners. Collaboration is important. We have a great partnership with Atlas. That program is a partnership with Homewood, Trillium Health, CAMH and Boots on the Ground. They're leading places.

That's a solution, and it can be implemented today.

The Chair: I'm very sorry to do this, sir. I have to give equal time to all the members of Parliament.

[*Translation*]

Ms. Gaudreau, go ahead for six minutes.

● (1615)

Marie-Hélène Gaudreau (Laurentides—Labelle, BQ): Madam Chair, we should keep the witnesses with us until late this evening.

I think we have to start with the basics, from what I understand. I agree with my colleague Mr. Clark. Not only should this training be taken, but I would go even further. I don't know if you agree with me, Captain Ralph, but I would say that this training should be taken by anyone who needs to deploy a program for veterans or contact them, whether it's a departmental employee, an elected official, a minister or someone else. The offer to take this training should not be limited to us.

How can we make real changes if the average person, not necessarily because of ill will on their part, doesn't understand or appreciate the situation of veterans?

Perhaps it would be a good idea to include this proposal in our report—that absolutely everyone, including public servants and elected officials, should take this training, as it provides the basis for understanding the situation.

What do you think?

[*English*]

Capt(N) (Ret’d) Philip Ralph: There's a simple answer: absolutely.

There you go. Is that short enough?

Voices: Oh, oh!

[*Translation*]

Marie-Hélène Gaudreau: Yes, thank you.

Is that a unanimous response?

[*English*]

Fardous Hosseiny: Thank you, Madame Gaudreau, for that fantastic question.

I completely agree. As I think Captain Ralph was sharing earlier, when it comes to cultural competency, not many service providers have it. When veterans get care, it's a courageous step they're taking. They're finally putting their hand up and saying they need help. But when you get a service provider who doesn't understand your realities or who doesn't understand your world or your culture, you'll never go back. If that's your first experience, unfortunately it means you're not getting the care you deserve.

We have to ensure that health care providers who are working with veterans and their families have cultural competency. I agree that everyone should get it, starting with case managers. We hear from veterans all the time that if you get a great case manager who understands your world, then you're going to get the care you want and need, but that's a lottery sometimes. Unfortunately, you might not get an individual who has the training.

Atlas is working on developing cultural competency training that's building off the trauma-exposed professionals training we did in collaboration with Wounded Warriors. This is one that Australia had developed. It was shown to be quite promising. We're now adapting it to the Canadian culture. Although there's overlap, there are some very distinct differences here in Canada. This is training we want to offer completely free to the community, to service providers. I think ultimately, if you're getting good care, that will help with suicide prevention.

[*Translation*]

Marie-Hélène Gaudreau: I think it starts with that.

You probably feel that we are very empathetic, and we're all here to listen to you. No matter how much goodwill we show here, as soon as we leave, that will disappear. We have a budget and constraints to stay within. The goodwill is there, but what does it take to make the choice?

We are studying Bill C-11, which seeks to make changes to the Criminal Code, among other things. That's great, but what about the services available to veterans and the respect we owe them? That's the first thing I'm going to ask. I'll be told that there are mental health problems everywhere, as well as homelessness issues. There's certainly a lot going on. Whatever the case may be, I feel there is a lack of respect for the service provided by veterans and their contribution to our country.

It's important to look at the situation in countries where people say they're proud of their veterans. That pride goes hand in hand with the fact that veterans don't need to seek services or help, unlike the situation here, where two thirds of veterans attempt suicide. I'm thinking, for example, of Mr. Thorne's comments. A close-knit community and investments being made will lead to fewer vulnerable veterans who don't feel understood.

I am making a heartfelt plea. I don't even have any questions for you. We need to wake up. We know what needs to be done.

I invite you to call on all the veterans who have used your services. You mentioned six cases that have been identified through your services. You have to help us help you. I'm putting myself in the minister's shoes. She has to have as complete a picture of the situation as possible. That way, if the time comes to make the decision to increase defence spending by 5%, everyone will be able to say that's fine, but the reflex will be to ask what needs to be done in terms of prevention and what is being done for people who are still alive, including veterans who went to Afghanistan.

I'd like to hear your thoughts on my insights. This affects me, but what affects me the most is knowing that we'll leave here, we'll table a report on our study, but we won't harvest the fruits of our labour. We have to tell it like it is.

● (1620)

The Chair: I'm very sorry, Ms. Gaudreau, but the witnesses can keep that in mind and provide you with an answer next time you have the floor.

I will now give the floor to Mr. Richards.

[*English*]

You have five minutes.

Blake Richards: Thanks again, Chair.

Let me start with you, Captain Ralph.

It seems to me—if you have a different opinion, please feel free to share it—that right now VAC does a fairly decent job in the initial contact when it encounters a veteran in crisis. Frontline staff have the training and are able to recognize and generally de-escalate someone who, in the immediate circumstance, is suicidal. I think where there seems to be a gap or where there is a lapse is past that stage, when the veteran needs prolonged care. You mentioned, of course, your program.

Can you briefly talk about the importance of follow-up when it comes to dealing with a veteran who's struggling with trauma or suicidality and about what needs to exist beyond that initial contact and initial de-escalation?

Capt(N) (Ret'd) Philip Ralph: If we're talking about treatment and our downstream programs, as we call them, similar to what Oliver Thorne talked about with the group-based operational stress intervention programs, it's a sad state that these programs that are essential to veterans' recoveries are funded largely off bake sales, bike rides and other community-based fundraising. Wounded Warriors Canada has wonderful support throughout Canada. As the director of clinical services, I get to spend almost $6 million every year on these services, but we have a huge waiting list.

These programs, although not cheap, are affordable when you look at the alternatives, such as long-term in-patient facilities, because they deal specifically with trauma. It's no different from a physical injury. The earlier you get care, the better the outcome. It's pretty simple. We need to be proactive in the preventative stuff, such as Warrior Health and the introduction to trauma-exposed professionals course. Every member of Global Affairs who goes on a foreign mission now takes trauma resiliency training provided by Wounded Warriors Canada. They were going into horrible spots in the world and had no idea what they were going to encounter.

These things need to be done up front so that people understand what they're going to encounter. That won't prevent injury, but it will certainly make people aware. It will make them seek help at an appropriate time. They'll get the care they need. Nanos Research has done research for us over the course of our programs, and we've had over 95% satisfaction. The veteran community says that when they come to our programs, they feel safe, supported and understood. That's important.

Blake Richards: Perfect. Thank you so much for that.

Mr. Thorne, what sort of impact do you think it would have on a veteran who might be suicidal, or a family member who has lost a loved one to suicide, if they were expecting the opportunity to come and share at this committee but ended up not being invited due to a lack of time? This study is set for six meetings. Would you suggest that it would have a detrimental impact on someone in that situation? Should this study be longer?

● (1625)

Oliver Thorne: Certainly, if somebody is expecting the opportunity to speak.... When we see people affected by suicide, as some of my other colleagues have touched on, it is an enormously destructive and painful experience for somebody to be close to suicide, to be affected by suicide. Yes, I would strongly advocate that if somebody has mustered the courage and taken the time to open up that very painful experience and speak to it, they absolutely should be allowed to. I think to have that opportunity and to then have that opportunity taken away would be extremely painful.

Blake Richards: Thank you.

Given that, I would like to move the following motion:

> That, according to the training received by the Standing Committee on Veterans Affairs on trauma-informed practices, and with recognition of the immense courage it takes for witnesses to recount their stories related to suicide, this committee extend the current study on suicide prevention to no fewer than 10 meetings in order to accommodate all witnesses who wish to give testimony to ensure that all are heard on this gravely important matter.

I have copies that I can distribute. I won't speak to it. I want to see if we can get this dealt with very quickly so we can get back to hearing from our important witnesses.

I will just mention that there are over 60 witnesses here. As has been said, anyone who's had the courage to step forward and say they would be willing to come and talk to the committee about their experience with this kind of matter, whether it be a family member who has lost a loved one or a veteran who has suicidal thoughts, really should be heard.

I would just ask that members give this consideration. We can maybe pass this very quickly and get back to our witnesses.

The Chair: Mr. Richards, I would like to suspend this meeting so we can have a few minutes for everyone to decide.

● (1625)

_____(Pause)_____

● (1625)

● (1630)

The Chair: Thank you very much.

I sincerely apologize to the individuals who are here with us. Thank you for your testimony and this great conversation.

I will ask Mr. Casey for a few words.

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

I believe the motion is premature. I believe the appropriate time to determine whether or not to extend this study is at the end of the minimum number of meetings we've set out. I don't think we can predict how we're going to feel after six full meetings. I don't think it's fair to have that discussion in front of the witnesses, who have given their time to be here.

Therefore, Madam Chair, I move that debate on this motion now be adjourned.

The Chair: We'll put the question to a vote.

Blake Richards: Can I briefly, before—

The Chair: I've already called the vote, Mr. Richards.

Blake Richards: You'd asked us if we could, and I'm saying I think we could. I'd just like to make one comment, which is that—

Sean Casey: Madam Chair, on a point of order, a motion to adjourn debate is not debatable. If Mr. Richards wishes to engage in debate, that's not permitted. You're obligated to go straight to a vote.

The Chair: I am obligated to go straight to the vote.

[*Translation*]

So that's what we'll do.

[*English*]

Arnold Viersen (Peace River—Westlock, CPC): On a point of order, Madam Chair, what is the motion we're voting on?

The Chair: The motion Mr. Casey is proposing is that we adjourn the motion of Mr. Richards and proceed with our witnesses, since they are here today—and we thank them very much for that.

(Motion negatived: nays 5; yeas 4)

The Chair: Go ahead, Mr. Casey.

Sean Casey: Is the debate now on the main motion?

The Chair: Yes.

● (1635)

[*Translation*]

The Chair: Ms. Gaudreau, you have the floor.

Marie-Hélène Gaudreau: Thank you, Madam Chair.

I am very sorry for the witnesses, but we will still have time for discussion.

I just want to say one thing about the motion. It is true that we may wonder why we should decide now. I take some offence to that. The motion isn't necessarily premature, in the sense that we may need more meetings. However, can we give ourselves a few more meetings before we decide?

I'll say it right away: I'll be voting against the motion.

In addition, during the break week, I will be communicating with the witnesses I would like to hear from in committee because, if we realize that we will need more meetings, those people need predictability.

I don't want to propose an amendment, but seriously, we could agree to talk about it again not at the end of the sixth meeting, but at the fifth meeting. I'm ready to vote and to decide when we'll talk about it again, but I'm convinced that we'll need more meetings.

I would like to hear what the witnesses have to say.

The Chair: Ms. Gaudreau, I just want to clarify something with you. You're saying you're ready to vote. Are you calling for a vote at this point?

Marie-Hélène Gaudreau: Yes.

[*English*]

The Chair: She's asking for a vote, but we'll continue.

Go ahead, Mr. Richards.

The Chair: I'm sorry, Mr. Richard. Mrs. Wagantall would like to speak.

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

I have been on this committee since 2016, when the Liberals came into government. I have been through many, many meetings. We took the trauma training specifically for this reason. We have witnesses who want to come here. I can tell the member who is new and very passionate about this that the other witnesses are beside themselves with anxiety and concern over the fact that they don't know for sure if they're coming, or that, if they do come, they have five minutes. We went through all this with trauma training to make sure that our witnesses have the opportunity they need to present here.

We can say to wait until we're done those six meetings, but in the time between now and the end of those six meetings, there is no reason to cause them that kind of grief. There are so many who want to comment here. We had multiple women—and I thank God for that—who came here for the women's study and shared incredibly difficult things in this room. We should be offering that same opportunity to these people, who have had to deal with suicide by either family members or whomever.

I do not agree with waiting until the end of these six meetings to let those other witnesses know whether or not they are going to have that opportunity. We've all invited them to come. They want to come. We should be giving them the opportunity to be at this table with us. They should be able to know that now.

That's my perspective: It's dangerous.

[*Translation*]

The Chair: Ms. Gaudreau, you have the floor.

Marie-Hélène Gaudreau: Madam Chair, I have additional information. I am not familiar with the witness list, but if we have 60 witnesses and they are people we need to hear from, then I will say yes, absolutely. If we already know that there are additional elements to consider, I will agree.

I'm ready to vote.

● (1640)

[*English*]

The Chair: Just before I let Mr. Tolmie speak, I want to say exactly what our motion stipulates. It's a minimum of six. We never said that we would stop after six.

Mr. Tolmie, you have the floor.

Fraser Tolmie (Moose Jaw—Lake Centre—Lanigan, CPC): I'm asking this committee what kind of message we are sending to those struggling with suicide and to veterans. I'm disappointed that we're having this debate. I apologize to our guests. I hope that we take this subject seriously. I hope that we give those who are watching this committee the courage to come forward, because we do need more meetings.

Thank you.

The Chair: Are we good to go to the vote?

Sean Casey: I think Mr. Viersen has something.

The Chair: Go ahead, Mr. Viersen.

Arnold Viersen: I think Madam Gaudreau asked you a question about how many witnesses were on the list. I thought we discussed this at the last meeting. I thought it was 55 or 57. Is it higher than that?

The Chair: Fifty-six organizations and individuals have been shared as witnesses. As good practice, there's an allocation for each party.

[*Translation*]

Ms. Gaudreau, we will give you a bit more time to submit your witness suggestions.

Yes, there are a number of witnesses.

As I've always said, I don't think we're limited to six meetings. The motion mentioned a minimum of six meetings.

Is there any further discussion?

[*English*]

Go ahead, Mr. Casey.

Sean Casey: I'm a bit troubled that Mr. Richards chose to disclose a conversation that happened in camera, but it seems to me that it is the objective of this exercise to try to paint, in front of the cameras, the other side as not wanting to hear from witnesses. I find it somewhat surprising that once we get witnesses in front of us for an hour, all of a sudden we have some information we didn't have when we, as a committee, made a decision to set a six-meeting minimum, so here we are.

I stand by my previous comments. What's happening here right now is pretty ugly. It's pretty ugly to paint, in front of the cameras, the other side as not wanting to hear evidence, when in fact this is 100% pure and utter gamesmanship. We shouldn't stand for it.

[*Translation*]

The Chair: Mr. Clark, go ahead.

[*English*]

Braedon Clark: The only point I would make is that, as members of the committee, we should all strive to be reasonable in how we conduct ourselves. Mr. Richards was willing to have this motion typed up and prepared, and I wish it had been shared ahead of time. We could have had a chance to build consensus and work on it.

I would ask Mr. Richards why that was not done. I think it is a reasonable thing for us to do, given the circumstances and given what we're talking about. None of us are sitting here saying that we don't want to let witnesses speak to this really important topic. What I am saying is that if he had a motion, it could have been shared ahead of time. Why was it not? That is my only question.

[*Translation*]

The Chair: Ms. Gaudreau, you have the floor.

Marie-Hélène Gaudreau: Thank you, Madam Chair.

As it happens quite often, I am the only one here who is not looking for power, is not trying to protect their government and is not trying to take back their place in government.

First, I find it pretty typical for us to be surprised by such a motion when we are in the presence of such valuable witnesses.

Second, if it turns out that we need 10 meetings, then we'll all agree, of course.

I think the show has gone on long enough. Can we actually get back to the witnesses, please? Otherwise, it would be unhealthy.

● (1645)

The Chair: Thank you very much, Ms. Gaudreau.

Is there any further discussion?

I believe we can now proceed to a vote on Mr. Richards' motion.

(Motion agreed to: yeas 5; nays 4)

The Chair: We'll continue the discussion with the witnesses.

Again, we apologize profusely for taking away valuable time from your testimony.

On that note, we will continue with the second round, which is a five-minute round.

[*English*]

You have 20 seconds, Mr. Richards—and I mean 20 seconds.

Blake Richards: Thank you.

I apologize to our witnesses that we lost time with you. I honestly believed that we would just go to a vote, that it was a no-brainer and we would pass it. Luckily, we got the result that was needed, but I apologize that it took away from your time. That was unfortunate.

The Chair: Thank you very much, Mr. Richards.

Mrs. Hirtle, you have five minutes.

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

I apologize for the politicizing you just witnessed. Let's refocus.

Ms. Blackburn, I'd like to ask you some questions. I want to begin by thanking you for your dedication to Canada's veterans and your understanding of the importance of community service. It's clear that this is foundational to the Veterans Association Food Bank.

Can you share how you've achieved the successes you've seen in your work? Do you think being based in Alberta has made any unique contribution to that success?

Marie Blackburn: The biggest thing I see in our success is that it's veterans helping veterans. That's what we established from day one. I truly believe it's about having a physical location where they can gather, talk and understand each other. As everybody on this panel has said, veterans have a unique way of discussing things among each other and a bond that we will never understand.

We started in Calgary. Then we branched out to Edmonton. We are in Grande Prairie and Lethbridge now. With the VHP through Infrastructure Canada, we now do western Canada in Manitoba, Saskatchewan and B.C. It's the same everywhere. We get phone calls all the time from people asking when we're going to open in their city. I don't think being based in Alberta has any more significance. I think this would be so beneficial to have in every city.

As with anybody, a lot of our veterans don't want to go to a food bank, so we've now stabilized it as a veterans association. We have our emergency funding program, we have the pet promise program, we have a thrift store and we have Thursday night dinners. It's a whole bunch of things. If one shoe doesn't fit, then you can try something else.

I think our success is mostly because veterans run most of it. All of our volunteers are veterans, and 90% of our workforce is veterans. I think giving people ownership in something is what makes us successful.

Alana Hirtle: You're saying that you're hearing demand in other areas. How would you go about scaling your programs to other provinces or across the country? Do you have any thoughts on that?

● (1650)

Marie Blackburn: I'll use Calgary as our model. It's a very generous city when it comes to donations. We do a lot of events and a lot of fundraising. A lot of corporations now support us. To have this in every province, we would need to have a lot more government funding. As I said earlier, when Veterans Affairs calls us to help a veteran pay their rent or to help a veteran with gift cards for food or whatever and we get no funding from Veterans Affairs, it's just mind-boggling.

With the veterans homelessness program, our biggest fear—we just had a bunch of meetings with them in the last couple of weeks—is that it is only a four-year program. How well do we establish ourselves in other provinces and start building communities without having funding at the end? That's my greatest fear.

Alana Hirtle: You mentioned a school strike in Alberta. How is that impacting your ability to provide services?

Marie Blackburn: I think the biggest thing is that kids in the schools are really gung-ho every year to have food drives for the food bank. We really focus a lot on educating our youth and younger kids. I think that's gone to the wayside a lot with the education system, with veterans not being able to go into schools and have their social teas with kids or have time to speak to them about what it is to be a veteran. That's the support we need.

Everybody rushes out on Remembrance Day, which is nice, to provide food and donations, but the truth is that our veterans served 365 days a year. They need support 365 days a year.

Alana Hirtle: I gather that you have family who served in the armed forces. My grandfather served in World War II. I lived with my grandparents as a child, so I understand that the whole family serves and not just the veteran.

In Nova Scotia, where I live, the space of service to veterans is being filled greatly by VETS Canada. They have a number of programs.

I'm going to run out of time here, so I'll cut down my preamble a bit.

I'm wondering about collaboration. Does your organization collaborate with other groups on best practices? I'm wondering how that's working for you or if it's working for you.

Marie Blackburn: We do. We're in western Canada and VETS is in eastern Canada, but we still collaborate with each other if we have a veteran in need. If VETS Canada can't get to one in the east, we will certainly help. It's the same if there's a disconnect with somebody in the west; they help us.

We work with Homes For Heroes. We have referred some people to the Veterans Transition Network.

We do the day-to-day stuff. If we can keep people stable every day, that's what we do.

The Chair: Thank you very much. I appreciate that.

[*Translation*]

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

Marie-Hélène Gaudreau: Thank you, Madam Chair.

Before I put my question to you, I would like to ask you something quickly. I think it would be helpful if you could provide us with the data and the results of the research you have so that we can add it to our report. It could be, for example, correlations between traumatic brain injury and suicide attempts, the effects of pet therapy or data supporting the fact that more than two thirds of veterans have suicidal thoughts. We don't need to hear about it orally; you can just send it to the right person.

I'll go back to my earlier question. Do you think that anyone who needs to make a decision about a program for veterans or to work with one of them should at least be given the context of what veterans have experienced, to be able to provide assistance and apply programs?

There's one minute left.

[*English*]

Fardous Hosseiny: I'm happy to kick it off. I didn't get most of the question, Madame. I apologize.

When it comes to stats, you spoke to whether there is an increase in suicidality when you see PTSD and a TBI. There aren't concrete statistics, but we know that if folks struggling with mental health problems are in crisis and that crisis is significant, it will lead to suicidal ideation or suicide attempts.

Another question came up earlier about something that I wanted to highlight, which is the importance of housing, employment and a sense of purpose. We know suicide risk is highest in those first two years post-service, during that transition time. What can we do as a collective to ensure they're getting care upstream so that when they transition to post-service life, they have a sense of purpose, community, belonging and identity? When you lose that, you don't know what to do with your day and you don't know who you are as an individual, which can lead to mental health problems and a mental health crisis.

We have to move upstream. We have to think about what we can do during transition, because ultimately, humans are social creatures. We strive for social connections, and veterans are the same. They have that when they're deployed or when they're together with their colleagues or others. We need that sense of community.

I don't know, Gabrielle, if you want to speak to that.

● (1655)

Gabrielle Dupuis: Thank you, Fardous.

Thank you for the question.

The need for cultural competency training was spoken about quite eloquently when we talked about gatekeepers and people who are working with veterans. When we're talking about suicide in this study, we also have to talk about competency in understanding suicide and how to talk about it. That's a separate expertise. That interdisciplinary approach is necessary when we're looking to support and save many veterans, especially, as Fardous said, during the transition period when there is a high risk.

We don't have to reinvent the wheel. There is incredible training out there, but having a collaborative approach, cultural competency and suicide prevention training is necessary.

The Chair: Thank you very much.

Go ahead, Mrs. Wagantall.

Cathay Wagantall: Thank you so much, Chair.

Mr. Thorne, I'm going to begin with you.

I've gone back and looked at some of your testimony in the past, from 2019 and 2022. You're now here today, and I thank you for the work that your very professional organization does and for the research and follow-up that you do that makes you very reputable.

Very briefly, I'm going to speak to what you said. In 2022, you said, “Reading the news that a Veterans Affairs case manager offered medically assisted dying unprompted to a veteran is deeply troubling, and it seems to run counter to the entire purpose of the department.” I think we've all come to that conclusion. Hopefully that ripple will somehow be healed within the veterans community. We know word travels, and that sense of unrest was very real.

You spoke about your organization and said, “First, [you provide] mental health services. Suicide is the worst possible outcome for veterans suffering from post-traumatic stress disorder.”

Second, you said, “we also know that PTSD is treatable.” You talked about how your evaluations showed a significant reduction in it, along with depression and suicide.

Third, you said, “due to military culture, veterans are...often reluctant to go get help.” Of course, the sooner they can get it, the better. When they seek help, you stressed that “our system [needs] to respond quickly with quality services.”

Fourth, you said, “Finally, with medical assistance in dying becoming available for mental health disorders...we must consider the issue of access, both for MAID and for veterans services.” You spoke of that in 2022, and it was to happen in 2023. It has been delayed, and more discussion is going on about it, thankfully. You continued, saying, “We cannot have a system that offers veterans medically assisted death faster than it offers them access to evidence-informed care that they rightly deserve because of their service to Canada.”

You have a very strong statement here, and I know it's because you know that you can treat PTSD. You do a wonderful job of assisting veterans to get past the point of looking at suicide as their way out.

You are a registered service provider to VAC. Is that correct?

Oliver Thorne: Yes, we are. That's correct.

Cathay Wagantall: You were in 2019 as well. At that time, you said, “we have seen the rate of approval for veterans who are eligible drop drastically...over the past three years.” That was in 2019.

In 2022, did that get better or worse, as far as the number getting assistance through VAC goes? Is everyone who's asking for your help and who can qualify for VAC assistance getting it?

Oliver Thorne: We have unfortunately not seen that number improve. We still put a number of veterans through our programs who, as far as we can tell, would be eligible for funding from Veterans Affairs through our status as a service provider. However, we do not receive that funding because of the complexity and the time delays involved in the approval process.

One of the points I made in that testimony was that veterans often only reach out and ask for help when their symptoms and their suffering become quite severe. That's because of issues like stoicism, which we heard about earlier in today's testimony, and their resistance to seeking help. They have a strength-based culture because of the work they do. It means that, often, many reach out only when they are seriously struggling with symptoms.

We believe it's very important that they can quickly access those services, and for that reason, we do not turn them away if the Veterans Affairs funding will not be approved in time. The result, then, is that we have to use charitable donations to pay for those clients. Again, as far as we can tell, they could otherwise have been funded by Veterans Affairs.

● (1700)

Cathay Wagantall: Could you explain to me, then, if they've applied for it and—

Oliver Thorne: I'm sorry, but I didn't hear you there at first.

Cathay Wagantall: I'm sorry.

They've applied for funding that it appears they should receive, but you say that it comes too late. Basically, if they get the support they need in advance of getting that funding, they no longer qualify to get funding. Is that correct?

Oliver Thorne: In order for a client's participation to be funded in our program, they need to receive pre-authorization before the program begins.

Typically speaking, they're reaching out in a short period of time before we're able to get them on a program. The message we often hear is that there is not enough time for case managers to complete the process to basically green-light that funding.

Cathay Wagantall: You talked a bit about the statistics we've received on the number of suicides up until 2017, and you expressed a concern for the future. Can you elaborate a bit more on that, please?

Do I have time, Chair?

The Chair: You have 15 seconds.

Cathay Wagantall: I'm so sorry. You have 15 seconds.

Oliver Thorne: The most recent study we have was published in 2021, but it covers suicide data only up until 2016—at least the most recent study I could find—and we're approaching possibly a 10-year period for which we do not have statistics on veteran suicide.

The Chair: Thank you very much, sir, for that.

Mrs. Wagantall, thank you.

[*Translation*]

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

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

Mr. Thorne, I'd like to begin by thanking you and your team for all you do to support and provide safe spaces for Canadian veterans. It's also clear that the various partners who support you all bring something different to this very important conversation we're having.

Can you try to set expectations for the sponsorship partners when they come to you and want to get involved? How do you help these partners understand the expectations of members of the veteran community or the specific challenges they may face in successfully transitioning to civilian life?

[*English*]

Oliver Thorne: Thank you very much for the question. I apologize. My French is not strong enough to respond in French. I will respond in English.

On the expectations we try to set with partners, we have many partners that we work with: organizations that provide funding to us, organizations that provide cross-referrals and other forms of support and organizations that we refer to, like those here today, my fellow witnesses. The expectations that we begin to set regarding the importance of specialized and culturally competent care have been discussed quite well in this committee already.

Veterans have an incredibly unique experience in military training, in military service and in the experiences that can create operational stress injuries such as post-traumatic stress and moral injuries. Those injuries and experiences are often not well understood by service providers who work in the civilian realm. Bridging the gap between the experience of the veteran and the understanding of the service provider is crucial to providing quality care.

As we talked about earlier, nobody understands the experience of a soldier better than another soldier. This is the core of why our program was developed in the late 1990s as a group program at the University of British Columbia. Our founders understood that there was often a gap in the services that veterans could receive, a gap of understanding.

We pair trained, licensed, registered psychologists and mental health professionals with returning program graduates—with veterans who have been through our program and who have lived the experience for themselves. They work hand in hand to ensure the work we do is culturally competent and informed, and that we can speak the language and connect with their experience.

Beyond that cultural competency, the group format also allows people to rebuild connection and to rebuild a sense of purpose, meaning and belonging, all of which are preventative factors for suicide. One of the most challenging pieces we communicate to our partners is the importance of specialized services, and it's the point I want to underscore in my testimony here today.

● (1705)

[*Translation*]

Tatiana Auguste: Something that struck me on the list of partners was Boeing's presence as a major employer, but also as a potential major beneficiary of the skills and talents that Canadian Armed Forces members acquired during their service and that they can bring to various employers when they become veterans.

If other industry leaders are looking to work with you on behalf of veterans transitioning to civilian life, what unique advantages would Boeing bring? What opportunities can it offer future partners?

[*English*]

Oliver Thorne: Absolutely, we've worked with Boeing for many years. They've generously supported our programs across Canada, and we're extremely grateful to them. They were a major partner in the Invictus Games in Vancouver earlier this year.

In terms of what we can offer, like our colleagues at Wounded Warriors Canada and Atlas, we are working on a cultural competency offering specifically for those working in the employment, HR and mental health realms. I think it's later on this week that I have a meeting with some of our friends at Atlas to discuss collaboration. We've also connected with Dr. Tim Black at Wounded Warriors Canada. We all work closely together.

What we believe we can offer is certainly an understanding that will help to better translate veteran culture and veteran skill sets into the civilian workplace. I think what an organization like Boeing has to offer is a history and a practice of hiring veterans. We see that with many other organizations in Canada as well.

When veterans have a place where they can land, within either their educational or their work institutions, and where they can find people with a shared experience, we see a much greater likelihood of transition success and stable employment, which are, once again, key factors to veteran well-being and to preventing suicide.

[*Translation*]

The Chair: Thank you very much, Ms. Auguste.

[*English*]

Thank you, Mr. Thorne.

In the interest of time, we'll do four minutes, four minutes, two and a half minutes, four minutes and four minutes.

Mr. Tolmie, go ahead for four minutes.

Fraser Tolmie: Thank you, Madam Chair. I appreciate it.

Thank you so much to our witnesses for your testimony.

In our last meeting, one thing we acknowledged was that there is a blind spot. Serving members, when they're in the military, have their comrades, and the term for that is “we've got your six”. When they leave the military, they don't have that support system. One thing that was brought up in the testimony today was understanding the culture and language.

Captain Ralph, do you believe that VAC should employ more serving members as case managers?

Capt(N) (Ret’d) Philip Ralph: That's an interesting question.

Fraser Tolmie: I always ask the interesting questions.

Capt(N) (Ret’d) Philip Ralph: I don't think that whether or not a person is a serving member is.... In our experience at Wounded Warriors Canada—maybe I'll put it that way—we know that veterans and public service members who contact us immediately get a lot more comfortable when they find out that the director of clinical services is a veteran, that our two health services coordinators are the spouses of a veteran and a service veteran and that our director of training is a still-serving member of the Canadian Armed Forces. That has certainly been a positive thing in our experience.

Oliver mentioned the use of lived-experience peers in programming. That's also been a positive thing. It's a thing we both employ in our programs and the model. We have some shared history there, so that makes a lot of sense.

● (1710)

Fraser Tolmie: Thank you.

Is that a yes or no?

Capt(N) (Ret’d) Philip Ralph: It depends on the individual, quite frankly. I don't think just because a person is a veteran, that they're necessarily going to be a good case manager.

Fraser Tolmie: That's a fair point. I saw some other heads nodding when I asked that.

One thing I'm concerned about is that you can, through body language, understand someone who's suffering from depression and who may have suicidal thoughts. We get that training when we are in the military.

To the Atlas Institute, I'm interested in your comments on that. How do you reach people who don't want to come forward because they're embarrassed and shy? This is a difficult thing they have to face, confess or share with someone. What are your thoughts?

The Chair: You have 40 seconds.

Fardous Hosseiny: I'll take half, and I'll ask Gabrielle to speak to rural and remote veterans, because that's an important element to what the MP is asking.

If you're not hiring veterans, at a minimum, you have to have cultural competency training for case managers. That needs to be set in stone. All case managers must have some sense of the veterans they're speaking to and understand the culture so they can connect with them. Then they can actually offer them supports and services. At least, at a minimum, cultural competency training is crucial. We don't hear much about rural and remote veterans, and they're the ones who are usually forgotten.

Gabrielle, do you want to speak to that quickly?

Gabrielle Dupuis: Yes, sure, and I'll be quite brief.

What we know is that veterans reside in rural and remote areas more than the general population. Their distance to services is quite stark. One of the recommendations put forward when we did a round table with these individuals was to support peer support. We see, again, that veterans helping veterans is critical. We also need to support virtual infrastructure with coverage though the Internet; have cultural competency when it comes to not only the veteran space but also indigenous spaces, because a lot indigenous veterans live in remote and rural locations; and include competency within families, not forgetting that families deserve services in their own right as well.

The Chair: Thank you, Ms. Dupuis.

We will now have Mr. Casey for four minutes.

Sean Casey: Thank you, Madam Chair.

I'll be directing my questions to the witnesses from Atlas.

I'll pick up where you left off with your comment, Ms. Dupuis, on indigenous veterans. That's one of the groups that will have the examination of their issues pushed back further as a result of the motion today. If you really want to know what the motion was all about, just follow the social media posts arising from this meeting.

With regard to the subject at hand, Ms. Dupuis, you did a study 10 years ago about whether Facebook suicide memorial pages adhere to the World Health Organization's dos and don'ts of social media suicide coverage. I'd be interested in hearing more about that. I realize that it's 10 years old, but we have heard consistent testimony here that the rate of suicide among veterans has not moved in the last 10 years, so I'm hoping and expecting that it's still relevant.

Gabrielle Dupuis: Yes, that study was done 10 years ago. It looked at Facebook suicide memorial pages in North America in general, but I would note that the sample size of veterans' memorial pages was too small to do a subanalysis. At large, what I saw was that they did not adhere to guidelines and that, in a sense, it can create a risk of contagion. However, I think it's important to note that, typically, people who are making these memorial pages are very well-intentioned people, but perhaps they're not educated on the risks associated with publications.

What is also important is that Atlas worked four years ago with a researcher at McGill who did a study specifically on Canadian media publications specific to veterans and veteran suicide and mental health coverage, and it also did an analysis of whether they adhere to current guidelines. The findings were quite similar in that they largely did not. Some of those guidelines would be things like not mentioning the method used or where the suicide happened, ensuring that there are helplines and that we're talking about stories of resilience, and not putting it on the front page. These are all guideline that, when the study was done, essentially most publications were not following. This is why we worked with journalists and veterans to create guidelines that are specific to the coverage of veterans, and we distributed those across journalism schools.

I think Madam Gaudreau made a good point, which is that there has been a national shift in pride in our military services, and a lot of that has to do with media publications. One, the general public doesn't tend to know what our military is doing and where it is operating. Two, when we do see it in the media, it's often stories that are quite negative and violent and that don't actually represent what our Canadian military and veterans actually look like.

● (1715)

Sean Casey: Thank you for referring to that study. I was actually going to come back to it because you raised from the outset the work you've done with McGill.

On the subject of bringing in more witnesses, can you give us the name of the person you collaborated with at McGill?

Gabrielle Dupuis: Certainly. It's Dr. Robert Whitley.

Sean Casey: Is that research publicly available?

Gabrielle Dupuis: Yes, absolutely.

Sean Casey: Okay. Thank you.

You also mentioned some research collaboration with Queen's University. Was that with CIMVHR?

Gabrielle Dupuis: Yes, the researcher that we work with is a member of CIMVHR.

The Chair: Mr. Casey, maybe hold that thought. I apologize.

[*Translation*]

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

Marie-Hélène Gaudreau: Thank you very much, Madam Chair. I want to make sure of something. The question I asked earlier was very specific, but there was an issue with the earpiece, so I'm not sure the witnesses understood it. I'll ask it again, so don't start the clock right now.

I know you have data and research from either yourself or McGill University on the effects of pet therapy, for example, or on some of the correlations between trauma and the increased need for support for veterans with more suicide attempts. I wish we could include all of that in our report.

I'm sorry to repeat myself, but based on the answers I received, I'm not sure you understood correctly.

I have just one question for you. What about the community and the deployment of all your services? I'm a Bloc Québécois member, so on behalf of the people listening to me right now, I'd like to know what the situation is with services for the people of Quebec and for certain unilingual francophones. Can you confirm that there are no concerns in Quebec and that you provide the same service there as elsewhere, in both official languages?

[*English*]

Capt(N) (Ret'd) Philip Ralph: I would love to answer your question. We have worked hard at Wounded Warriors Canada to ensure that all of our programs are available in both official languages. We've had slow uptake for people requesting programs in French. We have a number of qualified clinicians who are ready to run programs.

In general, every single one of the programs listed on our web page is available in both official languages, with the exception of our warrior kids programs, but we're working on that. Once we've trained clinicians whose first language is French, those programs will be available in French as well.

Every single program, from our surviving family program to our trauma resiliency programs to our couples program, is available in French and English. Our online offerings are now available in both languages as well.

Fardous Hosseiny: We're also a national organization, so of course, all of our resources are available in both official languages.

We work with partners in Quebec like Le Sentier, which should also be invited to this committee. We're also holding a round table with francophone veterans. Part of our mandate is to bring that community together, because their needs might be unique. We don't want to assume that what is happening with one population also applies to another population, so we are hosting a francophone veteran round table where we're going to gather that data and information.

To your earlier question, there are some gold-standard treatments that work, like prolonged exposure and cognitive processing therapy. There are some elements of peer support that have been shown to be quite beneficial.

Of course, when it comes to access, we need to promote more widely that these services are available, but some folks might not have access, which is an issue.

● (1720)

[*Translation*]

Marie-Hélène Gaudreau: Is it the same for you, Ms. Blackburn?

The Chair: I'm so sorry, Ms. Gaudreau, but your time is up. I've been very generous.

Marie-Hélène Gaudreau: I can get an answer when I take the floor again. No problem.

The Chair: Actually, I think this will be the last round, since we only have a few minutes left.

I will give the floor to Ms. Wagantall for three minutes. After that, to conclude, the Liberals will have three minutes.

[*English*]

Cathay Wagantall: Thank you so much for the extra time.

I appreciated what you were saying, Mr. Ralph, about how the training, even for those at Global Affairs before they go overseas, needs to be trauma-informed. That's for their benefit, I take it, with the circumstances they're going to be in. Is that correct?

Capt(N) (Ret'd) Philip Ralph: Yes. With the latest round of deployments, after the October 7, 2023, attacks, we trained the entire staff who went to Israel.

Cathay Wagantall: That's wonderful.

I'll open up this question to anyone who wants to answer. What do we do about trauma training for those who are going to be deployed within our armed forces? Is there anything that can be done?

I appreciate the challenge in that. I know they have to train to do what they need to do, but when they come home, do we reach out specifically, or should we be creating policies that say we will reach out specifically to those who end up deployed to combat zones? I keep hearing that we don't know where they are because of privacy and all these issues.

Do you agree with that, or should we be doing things more proactively?

Capt(N) (Ret'd) Philip Ralph: As much as you've heard that on the regular force side, 40% of everybody who was deployed to Afghanistan was a reservist, and nobody knows where they are. That's really—

Cathay Wagantall: It's very important.

Capt(N) (Ret'd) Philip Ralph: —important to me because I was a reservist and I am very proud of that service.

We also need to talk about prevention. There are organizations now, such as York Regional Police and the Toronto police, whose officers, before they even get into the car, have to take Wounded Warrior Canada's before operational stress program so they understand what they are going to be exposed to, what to look for and when to ask for help. We've given some organizations, such as the ranger patrol group in B.C., our trauma resiliency training so they can go out to the communities they go into.

Cathay Wagantall: I have very little time. I'm pleased to hear that.

Could Mr. Thorne respond? You're dealing with veterans who come back. Do you see opportunities to be more preventative in advance of them deploying, or at least responding immediately when they come back? Answer very briefly.

Oliver Thorne: Yes, absolutely. We still see the effects of deployment and military service causing operational stress injuries. That is a normal reaction to an abnormal event.

We know that people are going to be exposed to those risks when they do this job, so enhanced training and enhanced opportunities to learn about the effects of operational stress and how to recognize and mitigate them would be a very worthwhile investment. We see some work being done in the transition group within the Canadian Armed Forces. There's the road to mental readiness program.

We advocate as much as possible for more and more experiential programming with people, not PowerPoints. It is that connection and the experiential and personal components of this type of work that are so crucial to treating the effects of operational stress injuries and the risks of suicide.

The Chair: Thank you very much.

For the last three minutes, we have Mr. Clark.

Braedon Clark: Thank you, Madam Chair.

I want to thank all the witnesses. I think this has been really informative, eye-opening and helpful for us. Thank you for that.

Captain Ralph, I want to touch on something that I asked witnesses about last week at committee. On an issue like this, how do you track the effectiveness of your program?

We talked about this last week, as I said. If a veteran doesn't commit suicide, which of course is the goal, it's hard to track something that didn't happen. How do you assess your program's effectiveness in helping veterans deal with the issues they may be dealing with? How do you track that?

Capt(N) (Ret'd) Philip Ralph: Every graduate of the program is given an anonymous survey administered by a third party—Nanos Research—that tracks whether or not they found the program helpful.

I assume the data from the public safety space would correlate to the veteran space as well, but I would say we've noticed that when people take programs at the right time, they're no longer going off.... They're returning to work and they're staying at work, because, as mentioned here, they want to do the work. It's purpose. I remember the first time that I put on my uniform, I was like, okay, this is important; this is something to be proud of, to a be part of. That purpose thing is really important. That's another little piece.

Do we have specific data on suicide reduction? No. Do we see an improvement in the lives, the carrying-on and the reintegrating into society of people who do take our programs? Absolutely.

● (1725)

Braedon Clark: Over the course of an average year, how many veterans come through your programs?

Capt(N) (Ret'd) Philip Ralph: For all programs, I would say probably about 600.

Braedon Clark: To quickly go back to the Warrior Health model, which you talked about quite positively in the first round we had, what would be required to expand that model across the country? It's my understanding that it's only available in Ontario.

Capt(N) (Ret'd) Philip Ralph: Well, I'll tell you a little secret. You can access it from anywhere because nobody can track it.

Voices: Oh, oh!

Capt(N) (Ret'd) Philip Ralph: In order for that model to be sustained in the long term—and I think that's what it needs to be—other levels of government should come on board and fund it. The model is already proven, already works and has already been set up, so it's a no-brainer. It's pretty straightforward. It's easy to do.

We're in—excuse my language—the "get shit done" business. That's what we are in.

Fraser Tolmie: I want to go to your church.

Voices: Oh, oh!

Capt(N) (Ret'd) Philip Ralph: As my wife tells me every once in a while, "We're not in the army. We're in the church now. Don't speak that way."

Braedon Clark: I won't add to that.

Thank you.

The Chair: I will definitely not comment.

I would like to say a big thank you to all our witnesses. Again, we apologize for the small delay.

Your testimony, your candour and certainly your experiences have been extremely valuable, I'm sure, to all of our members here. Thank you for what you do for our veteran community.

Captain Ralph, thank you for your service. I know how proud you are; I can sense that, although I'm not sure our interpreters were able to translate the language you used.

To all of you, thanks again.

Capt(N) (Ret'd) Philip Ralph: I think the French word is *merde*.

Voices: Oh, oh!

The Chair: You know, we started very well. I'm only on my fifth committee meeting, and this is the language.

Okay. Thank you very much.

[*Translation*]

Our next meeting will take place on Thursday, October 9. Pursuant to the motion we adopted in the beginning, we will resume the study on suicide prevention among veterans.

[*English*]

I would like to remind everyone that we talked about submitting lists for the upcoming study after we complete this study. I will expand on that now, based on the new motion we adopted, and say that witness lists should come possibly—if it's agreeable for all of you—on Friday, October 31. We'll move it by one week and see how things are proceeding. Again, for the study on barriers to entrepreneurship among veterans, the witness lists should be sent to the clerk by Friday, October 31, 2025.

[*Translation*]

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

Some hon. members: Agreed.

The Chair: Perfect, thank you very much.