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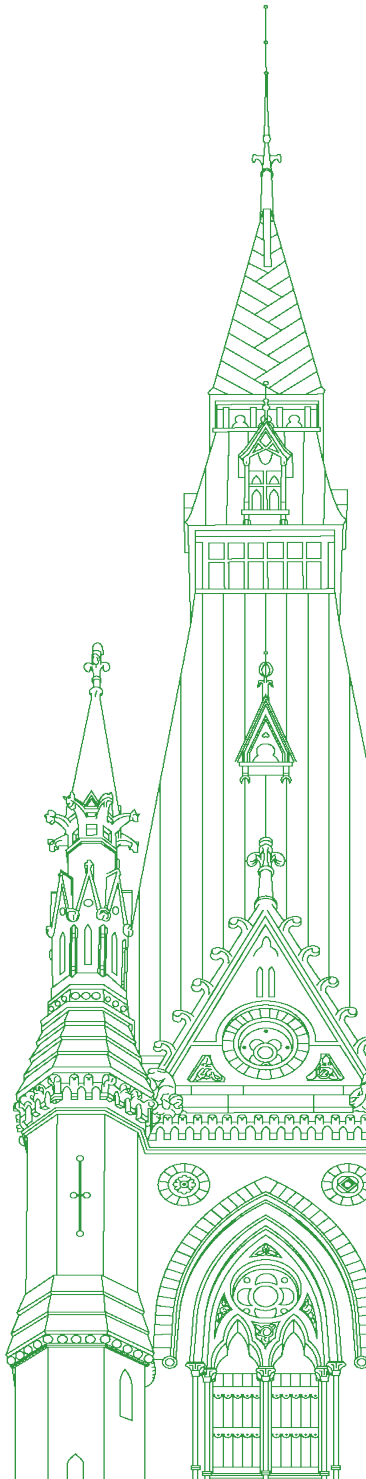

Chair: Marie-France Lalonde

Standing Committee on Veterans Affairs

Thursday, October 23, 2025

● (0820)

[*Translation*]

The Chair (Marie-France Lalonde (Orléans, Lib.)): Good morning, everyone.

[*English*]

I call this meeting to order.

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

Pursuant to the motion adopted on September 18, the committee is meeting to resume its study on suicide prevention among veterans.

Before we welcome our witnesses, for people who are viewing, I would like to provide a trigger warning. We will be discussing experiences related to suicide and grief. This may be triggering to viewers with similar experiences. If you feel distressed or need help, please advise our clerk. For all witnesses and members of Parliament, it is important to recognize that these are difficult discussions. Also, for our witness, if you do not feel comfortable at any point, please let us know. We can pause our committee for you.

I just want to make sure that everybody is aware.

Thank you very much.

[*Translation*]

Before we continue, I would like to ask all in-person participants to consult the guidelines written on the cards on the table in front of them. These measures are in place to help prevent audio and feedback incidents and to protect the health and safety of all participants, including the interpreters. You will also notice a QR code on the card that links to a short awareness video.

[*English*]

I would like to welcome our first panel this morning.

[*Translation*]

We have with us Noémie Veilleux, a licensed sexologist and policy consultant.

[*English*]

We also welcome Ms. Jessica Ruth.

Thank you very much for your service to Canada. Thank you for everything you do, Ms. Ruth.

[*Translation*]

Each witness will have five minutes to make their presentation. We will then have a round of questions and answers with the members of the committee.

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

Noémie Veilleux (Licensed Sexologist and Policy Consultant, As an Individual): Good morning Madam Chair, and committee members.

Thank you for inviting me today.

My name is Noémie and I am a sexologist specializing in sexual violence. I am appearing before you today not as a veteran, but as an ally.

In partnership with Pembroke Psychological Services and Valhalla Visions Counselling Clinic, I co-wrote a report entitled “Veterans First” in which we addressed our current policies regarding Canadian veterans' mental health. In speaking with veterans both here and elsewhere, we discussed certain very important points that right now amount to shortcomings in our system.

I am here today for three reasons.

First, I am here to discuss the fact that for veterans, sexual violence is not just an abstract concept in the Canadian Forces, it is a reality. It is a painful reality.

Second, I would like to address the big problem that nobody is talking about: the culture of silence, both within the Armed Forces and when the time comes for the transition to civilian life.

And third, I would like to address the question of quality of care.

What might this sexual violence against serving members of the Canadian Armed Forces look like? It is not always dramatic. It is woven into the everyday things people do, into degrading comments or jokes about someone's body or manner of dress; it ranges from coercion to silence when the comments are made, or to exclusion of people who say “no”. It may even go as far as repeated physical assault, whether by superiors or by colleagues.

These violent acts are destructive because they take place in an environment where loyalty and trust and absolute obedience come before all else. When that trust is betrayed, the result is not just psychological injury; it is also an identity wound.

I believe it is difficult to see what sexual violence is, because, in a way, it has crept into a kind of normality. It hides behind humour or camaraderie. It is hard to call out in a place where a person may not want to rock the boat, particularly as a woman.

Unfortunately, sexual violence becomes the price that one woman in three must pay in order to serve. It is also important not to forget the men in the armed forces, because they too can be victims of sexual violence.

Why is this not talked about more? Women tend to keep quiet in order to survive, to keep their jobs, and not to be marked as unstable or unable to serve. They are not believed. They are labelled inadequate or incapable of protecting the country or integrating into their corps. They try to avoid jeopardizing their career. This is a survival strategy that then becomes a risk factor, which contributes to perpetuating the violence, over and over.

This silence amplifies the shame, cuts people off from the network, and transforms pain into isolation. When a wound exists in silence, the person tends to develop institutional trauma, trauma that consists of being injured not just by a person, but also by a structure that is supposed to protect us but fails to do so.

What is the connection between sexual trauma and suicide? The numbers are clear on this point. Women who have suffered sexual violence in the armed forces are three to four times more likely to develop symptoms of severe depression, anxiety and suicidal ideation. Sexual trauma breaks down the connection between one's body, the feeling of safety, and physical dignity. On top of the trauma suffered in the armed forces there may be a very serious psychological and institutional injury.

Experiencing sexual assault while serving in the forces amounts to being on constant guard. To put yourself in the shoes of a person who may have experienced this kind of assault, you need to imagine that every day, you have to manage your emotions so you don't appear fragile. You have to avoid acting in a way that attracts attention or saying things likely to endanger yourself. You have to go to work and go right back into the very environment where the sexual asault took place, day after day, and not be able to say anything. It means crossing paths with the person who assaulted you, obeying his orders and living in a constant state of hypervigilance.

When a person leaves the military, the strategy adopted for protection becomes a source of isolation. When a person is a veteran, they no longer have a structure, a mission or a team. They are well aware that they are on their own. Veterans go on being inhabited by trauma.

● (0825)

It affects sleep, sexual health, relationships with family and friends, and the ability to ask for help. Sometimes there are also problems tolerating physical contact and constant problems feeling safe, including at home, and holding down a job. So there are really very far-reaching consequences. Some women veterans develop symptoms of post-traumatic stress, chronic pain, anxiety and depression disorders, a loss of meaning, shame and even suicidal thoughts. The reason we have come here today is to talk about that.

What role does quality of care play in this?

First, if we acknowledge that sexual trauma is a determinant of mental health, we are already part way there. We realize that there may not be good trauma-informed professional training available in the mental health programs offered to veterans here in Canada. Veterans Affairs Canada says that professionals are all trained and there is at least a minimum level of services, but, in truth, that may not be the case on the ground. When attempts were made to change the system several years ago, quality of care was neglected and professionals who were already offering trauma-informed care, tailored to military culture, were ignored.

Second, we have to think about another point that came out of the report: interprofessional collaboration. Given the present system and existing infrastructure, it is very difficult to facilitate collaboration with the professionals who will be supporting women veterans.

The third and final important element that must not be neglected when it comes to the health care provided is access to in-person care for women veterans who have experienced sexual violence and live with trauma every day, whether sexual or not. This proximity between care providers and front-line personnel creates a connection that is needed for healing.

In conclusion, I will say that requiring that women veterans prove their courage over and over by maintaining their silence is asking a lot. We need to work toward recognition and toward building a system around them that honours their resilience without demanding that they suffer in silence.

The Chair: Thank you, Ms. Veilleux.

[*English*]

I would like to pass the floor to Ms. Ruth for five minutes.

Again, thank you very much, Ms. Ruth, for being here this morning.

Jessica Ruth (As an Individual): Hello. My name is Jessica Ruth. I am the widow of Constable Lee Ruth of the RCMP. Lee and I knew each other since we were children and were partners in life before he entered the RCMP at 23 years old. Lee's first posting was in 2006, and he medically retired in 2022.

During his career, Lee experienced people and incidents that would never leave the back of his mind, no matter how hard he tried.

In 2014-15, Lee started seeing a psychologist, followed by a psychiatrist. He was diagnosed with PTSD, anxiety, depression and attention deficit hyperactivity disorder. Throughout his years of policing, there was a gradual change in my husband. He became hypervigilant, irritable, angry, sad and disconnected from his family. He pushed others away when he obviously wanted and needed connection. Lee was determined to get better. He received services from his doctor, three different psychologists at different points in time, a psychiatrist and various Veterans Affairs case managers and clinical care managers.

From 2014 to 2025, Lee was prescribed approximately 37 different types of medications to address his mental health concerns, with many of these having several dosage changes. Lee attended a seven-week residential treatment facility for trauma and attended ketamine treatment. After many years of fighting for his mental health with no positive results, he decided he could no longer fight.

On June 4 of this year, my husband died by suicide, leaving behind me, our children, his parents, his brother and countless others who loved him.

Today I will speak about two important issues: prevention and intervention, and access to resources.

I think it is important to discuss prevention of operational stress injury. Often, police officers, my husband included, work shifts alone. There were many times when backup was located an hour away, placing their lives in unnecessary danger and contributing to poor mental health. When members are off work due to health reasons, this often leaves the unit or the shift short on staff. This creates a workplace environment of animosity, and members are made to feel guilty for taking time for leave or to attend any family-related needs.

As far as I know, RCMP members do not need to attend regular counselling. A debriefing after a traumatic event is great, but from my observations, many do not know how the event has impacted them until later, when they are experiencing struggles.

Before we relocated to Iqaluit, both Lee and I were required to complete psychological assessments. There was no psychological testing required when we transferred out of the north. I believe that if a thorough psychological screening had been completed by an experienced psychologist, there would have been signs that his mental health was at risk.

As a note on access to resources, for veterans fortunate enough to have a case manager, most are not provided with the case manager's direct line but are expected to send an email or navigate phone menus. When someone has significant mental health concerns and legitimate questions about a service, not being able to make a simple phone call to their case manager can have negative impacts. Lee was eventually provided with the direct line to his last case manager.

After Lee medically discharged from the RCMP, we relocated back to western Newfoundland to be closer to family. This transition was not easy for him, and he began to decline even more in his mental health. Lee was very aware of his decline and was active in seeking treatment and resources, but the onus was on him to find these resources. On one occasion, Lee provided consent for me to speak with his case manager, and it was at this time that I learned the case manager's awareness of resources, groups and organizations was based on the information they had received from other veterans or conversations they had with co-workers. There was no list and no database of resources for different areas and locations. If there was a cost associated with accessing this resource, it was my husband's responsibility to have his family doctor or psychologist write a letter stating how this resource would benefit his mental health.

Often, my spouse would talk about sanctuary trauma, a type of psychological trauma that occurs when a person who has already experienced a stressful event is further harmed by the place or institution they expected to be supportive. After years of serving his country as a trusted member of the RCMP to uphold the law, he felt that his needs were often questioned and felt like he had to prove them to be true. The amount of complex paperwork and justification to get benefits approved, which he was entitled to, was very discouraging. This can impede a veteran from obtaining services.

Through CAF and RCMP members, Lee learned of VAC's clinical care managers, who assist clients with complex health needs in forming case plans to build supports and access programs and services. At first, VAC denied him this service, stating that he did not meet the need. Lee would say that though he was considered 100% disabled, he was not ill enough to receive this service.

● (0830)

After much advocating from his psychologist, Lee was reassessed and approved for a clinical care manager. He was reminded on a frequent basis that the services of a clinical care manager were only temporary and an inability to complete tasks could cease the service. Many things he could not follow through with, due to his mental health, and this made him feel more hopeless and caused him to fear that his services would be revoked.

When Lee's clinical care manager planned to be on extended leave during this past summer, he requested the services of another clinical care manager until her return. He was told that now he was too ill for another clinical care manager and that he should consider a local home care worker. I cannot express enough the harmful impact this had on Lee. He felt like people were giving up on his healing and his recovery. At a time when he was the most ill, VAC wanted to switch him from an educated professional with a master's degree who specialized in mental health to a generalized home care worker. Though Lee had a psychiatrist, a psychologist, a VAC case manager and a clinical care manager, they mostly worked in silos, until he became very sick. Then they began to have some care team meetings.

On two different occasions he attended the local hospital. On the first visit, we waited for eight hours to speak to a psychiatrist, who told us that there were no beds available, and because he had a psychiatrist already, there was not much more they could do for him there. The second time we visited, my husband spoke privately to an attending physician and was voluntarily admitted to the psychiatric unit. At 3 a.m., he checked himself out. He explained that they would not provide him with his prescribed sleeping medication and offered no alternative. Lee approached his psychiatrist and suggested admission to another hospital in the province. His psychiatrist advised that there was nothing they could do in the hospital that she was not already doing for him as an outpatient. It was at this point he vowed to never again attend a hospital looking for mental health support, because what would be the point?

At times when I feared for my husband's safety and suggested that we attend the hospital or call an ambulance, he told me that he would not be going and would threaten to kill himself before they would have time to arrive. I expressed this concern to members of his team. The ongoing response I received was that they were not an emergency service and that if I feared for his safety, I had to call emergency services. This was an unbearable cycle of pain and uncertainty that we lived in as a family.

Lee still searched for further service providers and services that might help him, and consulted with different members of his care team. One time he was advised that he would be overserviced. Once again, he was discouraged. He might have been overserviced in VAC's opinion; however, from my position as a widow whose husband took his own life, he was not receiving the appropriate services or care.

The impact PTSD has had on a family unit is significant, and it was suggested that I receive counselling covered by VAC as well. The only way this could be approved was if my husband's psychologist were to state a case for how treating my mental health would help his mental health. Once again, the onus was on Lee to communicate and arrange treatment, adding more for us to navigate.

Families should be given mental health benefits in their own right, not dependent on the veteran. This would give the family the skills to deal with complex PTSD, increasing their ability to support their veteran. In cases like ours, where the worst outcome became reality, it is vital that mental health treatment be in our own right and that we are able to maintain our existing therapeutic relationships. I had to engage with the Office of the Veterans Ombudsman to continue care with my existing therapist after Lee died. We were given six months. Having to fight for continued benefits is already weighing on me.

Since I lost the love of my life and my children lost their dad, we are getting through each day one moment at a time. I assure you that this is going to be a lifelong journey of healing and recovery from the trauma that I have experienced. I will live the rest of my life wondering what could I have done differently that would have saved my husband.

Our children are young and have so much to process with not only the death of their father but also the years of living with a parent who had PTSD. This process will not be a short one. Children need years. They need time to build relationships with counsellors, to open up about their feelings and thoughts. Kids are not often able to connect their feelings with their grief. This is a vital time to help them learn and practise positive coping skills to safeguard their own mental health.

● (0835)

After sharing my experience of losing our mental health benefits with a group of RCMP spouses across the country, one started a petition and connected me with a CAF spouse whose husband had died while deployed. The goal of petition e-6654 is for families and survivors to obtain mental health benefits in their own right for conditions related to service. Together they have created a Facebook group dedicated to advocating for families and survivors to obtain mental health treatment benefits in their own right. When the petition closed, it had 5,420 signatures from across Canada.

Anyone who knew my husband, Lee, knows that he would be the first person to stand up and fight for what is right. He had an ability to connect with so many people on a personal level. He liked the realness in people and wanted to “pump their tires.” This was a term he used for making people feel good about themselves.

Before Lee became unwell, he was a happy person who loved life, his family and his friends. Lee loved our children more than life itself. I believe that he made the ultimate sacrifice in fear of what the impact of prolonged exposure of his complex PTSD would have had on our children and me. Lee had more courage and resilience than anyone I have ever known.

Now that he is no longer able to fight, I feel that it is my journey now to help advocate for better mental health services for the veteran community in the memory of my husband. I am hoping that Lee's legacy will be improved mental health services for RCMP and CAF members and that families and survivors obtain mental health treatment benefits in their own right for conditions related to service.

Thank you for listening to my story.

● (0840)

The Chair: Thank you very much, Mrs. Ruth, for sharing Lee this morning with us and sharing a little bit of your life with us. I really want to say on behalf of our committee that our sincere condolences go to you, your family and your friends.

We will now start a round of questions with Ms. Anstey, for six minutes.

Carol Anstey (Long Range Mountains, CPC): Good morning, Jessica.

I just want to thank you for your courage in being here, and again say sorry for your loss from all of us sitting here today.

Jessica, you reached out to our office. One of the things that struck me from our communication was this feeling that you had about feeling disrespected and abandoned in this process. Veterans often feel that way in this journey. I just think it's important that you expand on that a little bit for the benefit of the work that this committee is doing right now around these supports, if you can.

Jessica Ruth: Days after my husband passed away, I was in contact with Veterans Affairs to ask, “What next? This is what's happened. Where do we go from here?”

My biggest concern was continued counselling for me and my children. It was at that point that I was advised that we were no longer eligible for this benefit to be covered under VAC. We only receive counselling if it benefits the veteran; we do not receive counselling in our own right.

I could not believe what I was hearing, because, at this time of immense grief when I could hardly put a sentence together, I was thinking about what I needed to do to continue this counselling with our counsellor. I was advised that there is the VAC assistance line, but that is very different from long-term, ongoing mental health counselling with someone you've already formed a relationship with.

I had to start thinking about either applying for my children to be under my work benefits or reapplying under Lee's benefits. Though that does not seem like a lot to some people, when you're in immense grief and you have to think about these things along with everything else that needs to be done, it's a mountain. It's tremendous.

I just felt like, after everything he had done for his country, that we as a family.... You know, they say, “The member serves; the family serves.” I don't feel like they thought we were serving.

Carol Anstey: Thank you.

To pick up on that point, we're both moms. Our kids play hockey together. Can you describe a bit more what it's been like for your children—their experience as his mental health was deteriorating and also now. I know it's difficult, but I think it's important that we understand that component as well.

Jessica Ruth: As his mental health deteriorated, my children, and we as a family, were affected. The kids could see. They would ask questions such as, “Why is dad angry?” “Why is dad crying?” “Why can't dad do these things with us?”

It was very difficult to explain that to our children. We tried our best, but we were in a household where PTSD is living. We requested that my oldest child receive counselling as well. It was covered by VAC because it was in my husband's best interest for our children—our youngest one was not receiving counselling at the time—just to try to help him cope with the environment, his dad's mental health and what that looks like in the family home.

● (0845)

Carol Anstey: Thank you.

I want to give you an opportunity because when we walk with people through grief, oftentimes when they see something positive come from something that is extremely painful, I think that helps in the grieving process.

What would you like to see happen differently from all of this that can make a difference in the lives of other people who are potentially in the same situation as you?

Jessica Ruth: There are a few things.

One I've discussed is mental health benefits in our own right as a family, as survivors, that are not dependent on the veteran. Some veterans do not want to engage in treatment, are sick and do not feel that they can, or are divorced. In my case, it was death. It cannot be dependent on the veteran.

I'd also like to see more involvement for VAC case managers. Right now, with regard to veterans who have mental or physical illness, family members have to be the ones to find resources in their areas. Veterans are dependent on them to get notes from their doctors, fill out paperwork and try to find out what they're eligible for. These are things a case manager should be more involved in. Veterans should have easier access to their case managers.

All these resources should be up front. They shouldn't have to log in their data, their security info, to send an email so that someone will call them back, or to use a voice menu. These things are not helpful when someone has a severe mental illness.

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

I would now like to pass the floor to Mr. Clark for six minutes.

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

Ms. Ruth, thank you for being here this morning with all of us. Thank you for sharing your own story and Lee's story. I would like to express my sincere condolences for your loss as well.

[*Translation*]

Ms. Veilleux, forgive me for asking my questions in English, but I want to be very clear.

[*English*]

First, in your opening statement, you touched on the culture of silence, in your words. We've heard about that in previous meetings on this study. It's been praised by other witnesses as a stoic culture, but it's the same general concept, which is a problem, as you correctly point out.

As you've said, there can be a culture of silence within the act of service as well. In your experience, does that persist once an active duty member moves into status as a veteran? If so, how does it persist, and how can we crack that shell a bit and break through that problem that you rightly pointed out?

Noémie Veilleux: I'm going to switch to English. I think it's good that we alternate a bit between languages.

Your question about the culture of silence puts on the table something very important, which is that it's not only in the forces that there is a culture of silence. It's present everywhere in and out of the forces. I see it as layers. When you're in the forces, you have a certain layer of this culture, and when you transition to civilian life, you also get all of the other layers that you see in the general population as well.

It persists because your body in certain ways gets so used to these protection mechanisms, if I can call them that, that when you step out of work, you have so many things that change in your life that this becomes your anchor and your new normal. You will try to hold on to what you know in your nervous system, and that is staying silent and coping with your emotions, mostly in unhealthy ways.

How do you crack this? First, I think the other testimony was very moving. It speaks to how important prevention is. We need to understand that even if it is difficult putting numbers to prevention policies, we have to go forward with strong, robust and holistic policies that do include sexual trauma but also sanctuary trauma, and we have to understand that this silence that we carry just becomes part of who we are. It's such a big waste of our identity. From working with sexual violence victims, you get to understand that losing the sense of self becomes the new normal, and this is what we want to avoid at all costs with policy.

We're supposed to be world leaders in veterans mental health. In theory, our policies are some of the strongest in the world. Where we get carried away is in the deployment of those policies, so from a policy standpoint, we can definitely do better. It's not about starting over. It's not about building from scratch. It's about building properly on what's there and understanding that the metrics we use to do policy evaluations are not necessarily appropriate.

I remember hearing ADM Harris talking about the fact that wait times have been halved since the new policy was deployed. If the normal waiting time is three years and you bring it down to one and a half years to get service and proper mental health support—if it's proper—that's the other problem. What type of service and what type of quality do we offer our veterans? There are ways, even if we cannot magically resolve this problem going forward. If we look at the U.K., for example, there is this amazing peer support system that can really make a difference. It is proven that veterans can benefit from having good infrastructure for peer support and mentoring and helping with proper support to transition to civilian life. When we talk about sexual violence victims, this also offers a space for healing. We need to stop medicalizing trauma. We need to understand that we're working with humans who went through very difficult experiences.

When looking at policy, we're starting to lean more toward a people-first policy and not process first. What Ms. Ruth talked about shows so adequately how we put the processes first in our policies. It's not normal to be on the verge of a mental breakdown and go through a phone menu to get support. How can we do better as a country to help both veterans and sexual violence victims in the forces? That is what belongs to us as a community and you being here today and working on this issue.

● (0850)

I would like to conclude on this question. How many stories of suicide do we all need to hear to move on this piece? We shouldn't have to listen to one more story. We should understand that this is real and that the sources of these suicides are anchored in different life situations and experiences, but, if I may conclude, sexual violence is part of them.

[*Translation*]

The Chair: Thank you, Ms. Veilleux.

I'm truly sorry, but it is my job to manage speaking times.

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

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

On the subject of prevention, the deputy minister told us that it was difficult to identify the causes and that it was intangible. It is difficult to find the correlation between the pain and something that was done. I want to offer you my sincere condolences.

Would it be possible to do a literature review, as part of your research, to show that there is a direct cause-and-effect relationship between sexual assault or other traumatic events and suicide among veterans? We are told that it is difficult to identify.

● (0855)

Noémie Veilleux: Mental health is the easy excuse for evading responsibility: say there is no sufficiently clear cause-and-effect relationship for action to be taken, and there is not enough evidence.

But it seems to me that you have heard accounts that do comprise evidence. I am here today to remind you that sexual violence is an insidious and very painful thing. If someone really wanted to collect that data, it would get done.

Marie-Hélène Gaudreau: It exists.

Noémie Veilleux: Yes, this violence exists. The first step, on your part, would be to collectively acknowledge not only that it exists, which is self-evident, but also the difficulties it causes later in life. Sexual violence and trauma are things a person carries with them all their life. There is no point at which a person can say they are healed. Some policies would have it that we could stick a seal on a document declaring that this or that person is healed and will not have a mental health relapse.

As a society, if we want to support veterans appropriately, we can start by recognizing that sexual violence is one of the causes of the mental health problems they experience.

This is a societal choice that does not cost very much. People may be reluctant, they may not know how to proceed, because the evidence is not sufficiently complete, but recognizing the presence of sexual violence in the Canadian Armed Forces means that we, as a country, would have the benefit of robust suicide prevention measures we can be proud of and that enhance our presence on the world stage. We do still have work to do to earn the title of leader when it comes to our veterans' mental health policy.

Marie-Hélène Gaudreau: Care providers work in good faith, so might we imagine that there is compassion fatigue or they do not have the necessary expertise?

Noémie Veilleux: To answer that question, I will say that no one puts up their hand so they can go to work thinking that today their work will be bad.

At present, responsibility for hiring health care professionals for veterans falls under a program that might not put the veteran first. Yes, these professionals have received training. But when we look at their terms of employment, we quickly realize that what is offered is designed for people starting out in the field. It is meant for people who are still to some degree mental health generalists.

In addition, we realize that people who were actually well trained to do this work are not offered terms of employment that resemble what existed before the new policy. So they were not able to jump onto the train in motion.

This situation creates a degree of tension on the ground. For example, clinicians who have received training could mentor new clinicians, but they are not doing so, because the system has excluded them.

Unfortunately, the new policy failed to take into account their desire to be included. That is very unfortunate.

That being said, we can go back and bring those people back on board, with us, so there can be real, significant changes.

Marie-Hélène Gaudreau: I don't really have a lot of time left, and I would like to talk about something else.

You said that one woman in three is a victim of sexual violence. What about sexual violence in the LGBTQ2+ community? I am looking for data. Is there even more of a culture of silence, or does this not exist?

The Chair: Ms. Veilleux, you have 20 seconds.

Noémie Veilleux: It is even more prevalent. When we look at the data, we see that there is sexual violence within the general population, but prevalence peaks in that subgroup. In addition, it is even more difficult for someone to report when it means disclosing their sexual orientation.

● (0900)

Marie-Hélène Gaudreau: Thank you, Madam Chair.

The Chair: Thank you, Ms. Veilleux.

[*English*]

Now we'll go to Mr. Richards for five minutes.

Blake Richards (Airdrie—Cochrane, CPC): Thank you to both of you for being here.

I'll particularly thank you, Jessica, for your courage. I know it wouldn't have been easy to share your personal and family story. It's important because it's the only way we make change. I know you know that and that's why you're doing what you're doing.

I'm going to start with you because you mentioned a number of things.

You've made it very clear that there's a need for the families to have mental health counselling in their own right. I agree with you. It's actually something that was part of our Conservative platform in the last election and I certainly hope it will be a recommendation in this report.

I wanted to talk a little bit about the veterans themselves. You've obviously had a lot of experience there, too. You mentioned a number of different things. You talked about how the various professionals that Lee was working with were all working in silos. You mentioned that for the resources that seemed to be available, he was finding out about them himself or, for the Veterans Affairs' case workers he was working with, the only information they seemed to have about resources was stuff they'd gathered from other veterans.

It seems to me like there's probably a good suggestion right there. Veterans Affairs needs to work better with partners and make sure that there's more access for more options for services, counselling and various other things for our veterans.

I want your thoughts on that, first of all. Beyond that, are there other things that Veterans Affairs could do differently that would have helped your husband or others in a better way?

Jessica Ruth: When it comes to case managers and VAC offering services, we as a family were very grateful for the support that Veterans Affairs provided. However, there are flaws. One of them is that although people are eligible for these services due to their mental health condition and their service, the onus is on the veteran to find out what these resources are and to request them.

For instance, the first time I found out about it, I had spoken to one of the case managers and I was so surprised. I asked if they could give me a list of all the available resources that he was eligible for. I wasn't talking financial; I was talking about support. It was then that I was told there is no list; there is no database.

Blake Richards: If I can interrupt there, that was shocking to me when I first heard that. I've heard it a number of times from a number of different veterans and family members.

How surprised were you by that? I mean, is that clearly something that needs to change?

Jessica Ruth: Yes. I was extremely surprised. I asked, “Well, then, how does he know about this?” They said the resources they know about would be from having a veteran on their caseload who's already used a service, or if another caseworker or a case manager discusses something that one of their veterans had utilized. My concern is this: How many veterans with severe mental health illness and their families can locate these resources and know how to get them? Not everyone has the ability to find them.

Blake Richards: That's a great point right there. The onus should not be on the veteran or their family members. I hear so often that when veterans finally do get help, it's because they just happened upon another veteran who gave them a recommendation. It just seems crazy to me that there isn't that access to resources in that list that needs to be there, or a repository of service providers, at Veterans Affairs.

Thank you for raising that. I think that's an important recommendation that we need.

I don't have much time, but you both mentioned “sanctuary trauma”. Can you each speak briefly to the sanctuary trauma that you experienced or that veterans experience when they're dealing with VAC? What's at the heart of that? What can we do about it?

● (0905)

The Chair: Madam Ruth and Madam Veilleux, I apologize sincerely. You have 10 seconds for both of you.

Mr. Richards, I'm thinking that maybe this is something to come back to in the next round of questions.

You have five minutes, Ms. Hirtle.

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

Thank you, Ms. Ruth, for sharing your story with us today. You have my condolences.

My questions are for you, Madame Veilleux. My French isn't great either, so I'll ask you in English. We've heard from Ms. Ruth about difficulties for families to access services. I've also heard from a number of Legion members in my riding that there are gaps identified in the continuity of care for military families. In your experience, and in consideration of things like sanctuary and institutional trauma, how do organizations like the Legion best serve veterans or their families when they're facing a crisis?

Noémie Veilleux: First of all, I think they're kind of responsible for creating a space where it is okay to talk about mental health issues. Right now, there is so much stigma around this that even just naming it is so, so difficult for veterans. When they do, they're laughed at. They're not taken seriously. They're being told to be strong and step up and go through it and it will be okay.

If we can create a space where it's okay to say that we're not doing well and we need support, and where it's not seen as something bad or as something that makes us less of a good person or less capable, then we will take a huge step toward healing and preventing suicide. I touched a bit earlier on peer support. This is what I mean. The story you just told about not having a list of resources is not surprising at all to me. These veterans understand each other. They went through similar experiences. What if we create those spaces so that they can share and be supported, at least a little bit, while they wait for proper services?

Alana Hirtle: Thank you.

Switching gears a little bit, our new government has implemented a new cabinet post devoted to artificial intelligence. I noted that in your report you referenced AI in relation to mental health supports. Can you expand on where you believe AI can be applied to mental health services for veterans, please?

Noémie Veilleux: We need to remain careful about the place of AI but also not be blind about the space it's starting to occupy in care and, in general, in workplaces.

As clinicians, how can we leverage this tool to make care better? That is one question we need to ask ourselves. That could look like clinical guiding principles or clinical support, for example, or a system that can flag when we may have missed something, like a sign of suicide or trauma.

While we need to be careful of AI and not replace clinicians with robots and machines, we can still use it as a tool to be better clinicians and share the knowledge with each other.

When we also look at the infrastructure of care, AI can be used to facilitate interprofessional collaboration. We must not neglect how useful this can be if used properly.

Just to conclude, demonizing AI will not get us anywhere. If we want to remain in front of the wave and keep thinking about innovative policies and ways to support our communities, we need to harness it the best we can.

The Chair: You have 30 seconds.

Alana Hirtle: Quickly, how can the VAC minister work with the new AI minister to adopt trauma-informed supports to enhance and impact mental health?

● (0910)

Noémie Veilleux: There are two ideas here. The first would be having conversations, starting to talk about it and understanding what it means to be trauma-informed. It's easy to say, “This practice is trauma-informed,” but is it really, or do you want it to be so you can check that box?

Being able to create this iterative process and ask ourselves the good questions about what is trauma-informed—what do we need to put in place and how can this evolve with the situation in the world?—is how we'll be able to offer quality services to our vets and work with the technologies that exist.

[*Translation*]

The Chair: Thank you, Ms. Veilleux.

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

Marie-Hélène Gaudreau: Thank you, Madam Chair.

Thank you for stressing stigmatization, Ms. Veilleux.

Let's look at the words. We talk about “strengths” when the subject is the Canadian Armed Forces. But here, we are talking about weakness, which varies depending on what stage of life we are at. It may be an injury, for example. In our system, I get the feeling that using certain words amounts to being weak when you can't be weak. I think a lot, in the awareness-raising process, about this culture of silence where you have to be tough.

I want to take a slight detour. I don't know whether you have seen the film *Out Standing*, Ms. Veilleux. I would urge everyone to see it and then read Ms. Veilleux's report. I think that all of the remarks and all the answers to our questions give us a bit of insight into this world.

What is it that makes us so afraid and prevents us from taking action?

Noémie Veilleux: People are afraid of failing. They are afraid of the political cost of doing something that does not achieve enough. They are afraid of putting policies in place that will make the situation worse. They are afraid of recognizing the problem.

When people look at the mental health services provided for veterans, they are only thinking about completing the to-do list, and they think they have done their job. Then they are afraid to look at the results. They are afraid to face the things that have to be improved and the shortcomings of the system, because working in this field sometimes feels like climbing an impossible mountain.

But really, instead of looking at the mountain and not having the courage to climb it, we just have to start by putting one foot in front of the other, and another, and another. After a few years, we will be able to see that each one of those steps has led to a fairer system that acknowledges the pain. Those steps will truly have made the difference.

Marie-Hélène Gaudreau: Thank you.

The Chair: Thank you, Ms. Veilleux.

[*English*]

MP Richards, please go ahead.

Blake Richards: I do note that we have a couple of minutes.

Could I get unanimous consent to have the witnesses answer the question about sanctuary trauma?

The Chair: Do we have unanimous consent?

Some hon. members: Agreed.

The Chair: Excellent.

Blake Richards: Thanks.

You both mentioned sanctuary trauma in your remarks. I wanted to ask this specifically in terms of Veterans Affairs. What could they do differently in order to reduce the sanctuary trauma that veterans and family members experience when dealing with them?

I'd like both of you, if you could, to give a response.

Jessica Ruth: For myself, as a family member of someone receiving these services, a lot of it is the burden of proof, having to retell their story time and time again. It's having to prove the disability, sickness or diagnosis every year.

We talk about stigma and mental health services or resources to help make us feel better. It's things like being denied the request of a weighted blanket or the request to see a nutritionist to help with how the PTSD has affected nutrition.

It's a lot of having to prove and prove again. It's not taken as believed or.... It's difficult to explain.

● (0915)

Blake Richards: I think you've done a very good job of explaining it. It's having to retell and re-prove.... That's something we hear all of the time from veterans. You've explained it well, thank you.

Madame Veilleux.

[*Translation*]

Noémie Veilleux: I would like to add something.

The Chair: Please finish up briefly, Ms. Veilleux.

Noémie Veilleux: Right, I will try to be brief, but that is not my forte.

Actions have to match promises. When we invite people to join the Canadian Forces, we promise to support them for life. Strangely, however, those promises are forgotten over the course of their service. Once people are veterans they are left behind, on their own, and do not get the services they need.

First, to prevent this sanctuary trauma, we have to make sure that care is put in place and is appropriate. Ms. Ruth clearly illustrated the pace at which support moves when it comes to mental health. If we try to do everything in three sessions, the trauma will persist. There is even a risk of retraumatization.

How many times does a person have to recount their story before being taken seriously and moving from one care level to the next? In sexual violence cases, for example, they will have to prove over and over that it really happened.

If these various points can be addressed, I think we will then be on the right track for preventing sanctuary trauma.

The Chair: Thank you, Ms. Veilleux.

[*English*]

Again, Ms. Ruth, our sincere condolences for your loss. Thank you for your courage. Thank you for coming here this morning. We appreciate it.

[*Translation*]

Ms. Veilleux, we are pleased to have met you.

[*English*]

We will be suspending to prepare for our next panel.

[*Translation*]

Thank you.

● (0915)

_____(Pause)_____

● (0920)

[*English*]

The Chair: Thank you very much for your service, Ms. Hills.

From the Canadian Mental Health Association, we have SM Sansouci, national government relation lead, and Robert Olson, research librarian.

I would like to invite Ms. Hills to start for five minutes. Then, we'll invite Mr. Olson and Madame Sansouci for the remainder.

[*Translation*]

Thank you.

● (0925)

[*English*]

Judith Hills (Corporal and Aviation Technician, Canadian Armed Forces, As an Individual):

I would like to thank you for giving me a voice at this committee on behalf of my son Sam.

My name is Judy Hills. I'm a corporal serving in the Royal Canadian Air Force in Comox, but I'm being released medically in January. I'm also a mother of four. My youngest son, Corporal Samuel James Hills, was serving in the Canadian Forces as a signaller at CFB Trenton when he died by suicide on August 19, 2021.

Sam had gone to mental health in Petawawa for help with anger management. Immediately, he was prescribed Prozac. Within a few weeks, Wellbutrin was added to his prescription. He was posted from Petawawa to Trenton in 2020 while on both medications. While in Trenton, they kept adjusting the medications. I'm not sure if he was being treated for depression, anxiety or anger, but he seemed fine to me. While he was adjusting to life as a single man after a marital breakdown, I'd never have suspected that he was experiencing suicidal thoughts at the time of his death.

In late July/early August of 2021, he told me that he was afraid he was starting to have psychosis. He was having difficulty telling the difference between what was real and what wasn't. He didn't elaborate much at the time, but he spoke to the MIR the following morning and was prescribed an antipsychotic drug called Latuda in addition to the Wellbutrin and Prozac. These drugs should never be prescribed simultaneously. I'll elaborate shortly on that. Within a few short weeks, he ended his life by hanging.

An hour or so before he died, he called me. He told me about a recurring nightmare he had been having for weeks. In the dream, he was being chased by a hell-hound. In the last dream, the hound was old and tired. He tamed it by showing compassion and care. It curled up in his lap. He died shortly after our call. The coroner's report listed his death as August 19, but I feel he died the night of the 18th, within the hour after our call. I knew he was having a difficult night, but I had no idea he was contemplating suicide or I would have called the MPs to do a wellness check. I live with so much guilt. As his mother, I feel that I should have known. In his two-page suicide note, he spoke in detail about this nightmare. I have nightmares now and I can't tell if they're real or not, so I think I understand what he meant.

When Sam was posted to Trenton, he had a warrant officer who began very early on to harass him. The schedule they worked was brutal. It gave very little time to allow for any kind of social life or rest. He and a co-worker came up with a few options that he discussed with the warrant officer. He told me she became angry for suggesting a change and that she wasn't changing anything. The captain of the unit did, however, change the schedule on a trial basis. This upset her, and the working relationship went downhill from there. He would often call me frustrated and even in tears after having a difficult day while at work because of that relationship. I told him he should talk with a harassment adviser, but he didn't want to stir the pot or be known as a complainer.

Within a day of his death, my oldest son, who had also been a signaller, received a call from a mutual friend—another signaller—of his and Sam's. He told my son that the warrant officer needed to be looked at regarding harassment of Sam prior to his death. I was also told that apparently the warrant officer submitted her release the morning he died when the news hit his unit. She also hired a lawyer to represent her at the board of inquiry. During the board of inquiry, the allegations of harassment and bullying were brought up during her interview, which I was present at. She denied any harassment, saying that she and Sam had gotten along fine. She denied any wrongdoing.

At the completion of the BOI, once the findings were presented to Winnipeg, the president of the BOI was told to redact any piece regarding the alleged harassment based on her interview. He refused, because he felt there was truth in the allegations. Instead, they wrote in their report that there was no evidence of harassment. My son, obviously, didn't have a chance to tell his side of events, because he was dead.

The medications Sam had been prescribed were not even discussed in the BOI. Wellbutrin has long been known as a drug that can cause both nightmares and hallucinations. Rather than weaning him off the drug, he was instead prescribed Latuda, the antipsychotic, as an addition to the two antidepressant drugs he was already taking. The psychiatrist who saw Sam just days before he died did not prescribe the drug. Somebody at the MIR did, and did not consider the contraindications of mixing these three drugs together.

After he died, I spoke with a pharmacist and asked if it was safe to prescribe all three at once. He said, no, not unless the patient is in hospital and is under observation. Sam was not even on sick leave, let alone under any kind of observation. Mixing Latuda and Wellbutrin is known to cause confusion. Combining antidepressants and antipsychotic medication also can increase the risk of suicidal ideation and behaviour. This is a well-documented risk, a risk that was not calculated prior to my son's death.

● (0930)

The board of inquiry found no fault of the military in Sam's death. They did not consider the harassment as problematic. They did not even investigate the medications he had been prescribed. The president of the BOI flew to Comox from Trenton with the findings to deliver them in person to me. He said that he felt the findings were unfair. In the months after Sam died, I reached out to Winnipeg and requested that the BOI be reopened, since they did not investigate the medications he had been prescribed. I received a letter from a general at the office of the board of inquiry offering condolences, but they said they do not reopen findings of BOIs.

Sam was a friend to everyone, especially to those who didn't have many friends. He was empathetic and compassionate. He taught me to be less judgmental and he taught me patience. He was funny and he was charming. He was a self-taught gifted guitarist. He was kind. He was a son, a brother, an uncle, a nephew and a cousin. He loved his two dogs, Buddy and Theo: They were his boys.

He was proud to serve his country, and yet his service was not even recognized. My former husband and I did not even receive the Memorial Cross, because the military said his death was not related to his service. I beg to differ. Sam was not and is not a statistic. He was so much more than that. In the four years since he died, I have also lost both my parents and Sam's dog Buddy. I am now facing the end of my career in a few short months, because my mental health no longer aligns with universality of service. I am living in a never-ending maze of compounding grief.

Between 2021 and 2023, there were over 40 deaths by suicide in the Canadian Forces. The statistics for 2024-25 have not been officially released, but I know that those numbers are not decreasing. I have lost several friends in the CAF to suicide.

One of my secondary duties in the CAF is as a sentinel. One of my co-workers approached me because he had been to mental health, as he was experiencing thoughts of suicide. When he had gone to mental health on the base, he was told that nobody could see him for at least two weeks. He had been living in the barracks when they were destroyed by a gas leak explosion in Comox. He was struggling with his mental health as a result. I let him talk. I gave him the number for the Canadian Forces member assistance program. I regularly followed up with him. I also discussed what had happened at mental health with our chain of command. Nothing was done until I spoke to someone higher up in the chain of command a few weeks later.

I have another friend who was told to go to a civilian ER when he was suicidal. They wanted to dismiss him back to the MIR within hours because he was military. Luckily, his wife advocated for his well-being. He was admitted to a psychiatric ward on a 72-hour hold.

I don't know the answer. I don't know how to fix it. But I do know that something has to be done. I wouldn't wish what my family has gone through on my worst enemy. I wish that no parent, no mother or father, should ever receive the call that I did on the morning of August 19, 2021.

Thank you.

The Chair: Thank you, Ms. HIlls.

Mr. Olson, you have five minutes.

Robert Olson (Research Librarian, Canadian Mental Health Organization): First off, thank you, Ms. Hills, for your testimony. We give our profound condolences for your loss.

Thank you, Madam Chair and members of the committee. My name is Robert Olson. I'm a research librarian at the Canadian Mental Health Association, Alberta division, and the Centre for Suicide Prevention.

We lead community mental health in Alberta and suicide prevention in Canada. We do this by convening, educating, incubating, funding and driving systems change with myriad partners throughout our province and across Canada.

I'm joined today by my colleague SM Sansouci, from CMHA National. Thank you for inviting us to your committee to speak about veteran suicide.

Suicide among veterans continues to be alarming and persistent. This is why comprehensive, targeted and sustained mental health supports for veterans and their families are so crucial. The burden of suicide in this population is at crisis levels.

As committee members learned from previous testimony, our organization collaboratively developed a suite of resources with the Atlas Institute to address veteran suicide. These resources are supported by evidence-based research and informed by an advisory group of veterans with lived experience and their family members.

You also know of the efforts that have been made to prevent suicide among veterans and active Canadian Armed Forces members. The CAF/VAC joint suicide prevention strategy, with its seven lines of effort, first published in 2017, demonstrates the commitment to suicide prevention that the two bodies hold for their members. This is to be commended and amplified, as should the efforts around the federal framework and the national suicide prevention action plan, particularly the implementation of 988, the suicide crisis helpline.

Efficacious suicide prevention work, like bringing about any social change, relies on a balance of universal and targeted approaches. Anyone can have thoughts of suicide; however, some groups of people are disproportionately affected by it. We call these groups “priority populations”.

Universal or whole-population initiatives are needed to reduce stigma, raise awareness and address broader social determinants of health. However, universal approaches alone insufficiently serve priority populations, such as veterans. Priority populations benefit from targeted approaches designed around their unique precipitating factors, and these efforts are best implemented when underpinned by the work of a universal strategy. In short, we need a pan-Canadian suicide prevention strategy that considers all people in Canada and the populations most affected by suicide.

Canada is one of the few industrialized nations without a national strategy. Research shows multipronged national strategies that are appropriately resourced and implemented lower suicide rates and attempts. National strategies are comprehensive. They reduce stigma, drive awareness and address issues such as the broader determinants of health that contribute to suicide, such as housing and homelessness. These are exceedingly important for veterans, but they are currently not being considered in any coordinated way. A national strategy has clear deliverables and outcome targets that are regularly measured and evaluated.

Because health is a provincial and territorial responsibility, cooperation and collaboration at the federal-provincial-territorial table is crucial. A strategy must be co-developed at this table if we want to see robust uptake and implementation by the provinces and territories. Ultimately, it would be coordinated at the federal level, but dedicated yet flexible funding would flow to the provinces and territories to ensure they are able to address their own related priorities, based on readiness and local capacity.

Comprehensive cross-ministerial efforts are also key. A wide range of ministries whose remits are relevant to suicide and its prevention must be included in development, implementation and evaluation.

● (0935)

This committee has heard testimony that despite the actions of the CAF/VAC joint strategy, significant gaps and lack of resources for veterans remain. Initiatives that need to be shored up include peer support initiatives, such as CMHA's OSI-CAN program, which is a culturally relevant community-based support program for veterans.

Other elements include the need to strengthen access to timely, coordinated care and the need to train health care providers to be culturally competent and understand the unique realities of the veteran community. We also need to enhance supports in the period of transition from military to civilian life.

CMHA Alberta and the Centre for Suicide Prevention commend this committee for its interest and focus on veteran suicide prevention. We urge you to augment the targeted efforts for this critical priority population and join our call for a national strategy that serves all the people in Canada. Universal approaches lift targeted approaches: Suicide prevention involves us all.

Thank you.

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

This will conclude the testimony portion.

Ms. Hills, on behalf of this committee, I want to offer our profound condolences. Thank you for your courage. If at any point you need some time, please let us know. I don't mind suspending our committee. I just want to make sure that you're okay.

● (0940)

Judith Hills: Yes.

The Chair: As we go forward, there will be rounds of questions to our witnesses. I want to let you know that sometimes I may have to interrupt; I apologize sincerely for that. Members of Parliament know their time. We will start with six minutes.

We will start with Ms. Wagantall for six minutes.

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

Thank you to both of our witnesses today for being here.

Can I call you Judith?

Judith Hills: Judy or Judith is fine.

Cathay Wagantall: Thank you.

I cannot imagine the grief that you have experienced or what your son went through and desperately tried to deal with.

We serve veterans here. However, it's become clearer to me that veterans come with a great deal of injury, often from their service, that is very difficult to explain, prove or deal with. Stories like yours are unfortunately not rare.

You were told that his death was not related to his service. Can you share with us a little bit more about how that's beyond believable, and where you think the true intent is behind making a statement like that in regard to a young man who was serving and took his own life?

Judith Hills: I wish I had the answers.

Anybody who knew Sam or worked with him could attest to the fact that he was very proud of his service. He was very proud to serve.

What he went through with his warrant officer once he got to Trenton was hell for him. From the get-go, from the moment he tried to discuss changing the schedule to make it better for everybody, because they were working 12 on and 12 off.... There was no time for a social life, especially for a young man who was just coming out of a marriage. He had to isolate through COVID, because of the way his unit was. People knew what he was going through.

At the board of inquiry, I sat behind her during her interview. She was incredibly nervous, wringing her hands under the table and everything. I could say that you could tell she was lying. Obviously, I'm biased—I'm his mother—but from hearing what other people had said about what he had gone through at work and to have her say, “No, Sam and I got along wonderfully....”

When he was having his medications adjusted and they wanted him to just work days, she got angry at him, saying, “How am I supposed to do this in my unit, when everybody has to work 12 hours? How am I supposed to give you special treatment?” She denied that.

Some people are going through harassment, and the military is saying, especially with Sam, “No, no. This didn't happen. This didn't happen at all.” It's basically making it okay for it to continue happening.

Cathay Wagantall: Thank you. I know that's a difficult question to try to answer.

What I'm sensing here is that from your perspective, yes, there was harassment, and I would honestly tend to agree, but the chain of command seems to be an issue within our Canadian Armed Forces, and harassment may very well be an issue from the top down through to those at your son's level of service. Not being able to have confidence that you can say that this is due to service is impacting our veterans extensively, even in regard to your son's relationship with his wife and how much of that was in regard to the circumstances of his service.

In regard to the Memorial Cross, I've had others come to me who were just devastated because they were told that there was no qualification, that the death was not related to service. I want you to know that this can be changed and that it can be fought for on your behalf.

I don't know who your member of Parliament is, but I would really encourage you, if you haven't gone in that direction, to give me a call. This is inappropriate, and we need to make that change for sure on your behalf.

● (0945)

Judith Hills: Thank you so much.

Cathay Wagantall: You are welcome.

To those of you with the Canadian Mental Health Association, thank you so much for all that you do in your research and for your efforts to prevent suicide.

We heard from a previous witness who lost her husband very recently. He was in the RCMP, and one of the first things she talked about was that he worked alone. I know that even in my riding, our RCMP members work in rural and remote areas. They're out covering 200 kilometres, and if something happens, there's no way that there's going to be help there in time.

There are a lot of things like this that are so practical. How do we integrate them into the process of making sure that suicide is prevented? There was an assessment of him, and—

The Chair: Mrs. Wagantall, I'm sorry. You are out of time.

Cathay Wagantall: I apologize. Perhaps you can answer later.

[*Translation*]

The Chair: Ms. Auguste, you have six minutes.

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

Ms. Hills, I would like to offer my sincere condolences. I can't imagine what you are feeling.

My questions will be for Mr. Olson.

If I may, I would like to talk about OSI-Canada, which is Operational Stress Injury-Canada, and the Centre de prévention du suicide de Québec.

First, can you tell us the points that this committee should take into consideration when it considers what recommendations to make to the government?

How would you translate your experience and the experience of the CMHA, the Canadian Mental Health Association, into advice for this committee?

[*English*]

Robert Olson: I'm not sure I understand the question.

[*Translation*]

Tatiana Auguste: I'll repeat it.

What recommendations could this committee make to the government, in relation to your experience and the experience of the Canadian Mental Health Association, for meeting the needs of veterans?

[*English*]

Robert Olson: From CMHA Alberta's perspective, we have the OSI-CAN program, which is peer support. We understand that there is a gap in peer supports for veterans. If those kinds of programs that we and others offer were shored up, it would enhance veterans' feelings with regard to dealing with mental health issues, because we often hear that veterans prefer dealing with one another. They prefer dealing with those who have dealt with similar struggles.

Peer supports are definitely an avenue to enhance and strengthen.

[*Translation*]

Tatiana Auguste: Regarding the Centre de prévention du suicide de Québec, has the CMHA taken other innovative suicide prevention approaches, more specifically regarding the problems veterans and former first responders have had?

[*English*]

Robert Olson: I'm having difficulty hearing the question, sorry.

[*Translation*]

The Chair: Can you repeat your question please, Ms. Auguste?

Tatiana Auguste: Right. I will ask it more slowly.

Regarding the Centre de prévention du suicide de Québec, has the CMHA taken or overseen, one way or another, other new or innovative suicide prevention approaches designed specifically to fix the problems veterans and former first responders have encountered?

● (0950)

[*English*]

Robert Olson: Taking into account the lived experience element that has been drawn into a lot of our initiatives and resources that we crafted with Atlas, as well as families, I think those are two elements that have not been robustly investigated and added in the past. That's an innovation that I think we have added to the mix with our work with Atlas.

[*Translation*]

The Chair: Thank you.

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

Marie-Hélène Gaudreau: Thank you, Madam Chair.

I am going to speak in French.

[*English*]

Robert Olson: Okay.

The Chair: Is the sound good?

[*Translation*]

The Chair: Right.

Ms. Gaudreau, you have the floor.

Marie-Hélène Gaudreau: Thank you.

I am simply going to give you time to explain why you think the seven lines of effort put in place in 2017 are inadequate, unless I misunderstood.

[*English*]

Robert Olson: Oh, I did not.... I said those are the seven objectives that were in the original 2017 CAF-VAC strategy. I didn't say they're inadequate. They've done some work. I believe 50% of those sub-actions in the seven lines have been accomplished, so that's not nothing.

We are hearing, though, that there are still gaps and deficits that need to be addressed in relation to veterans. The CAF-VAC strategy would benefit from a national strategy, which would bolster this priority strategy or else augment it with other actions for veterans within the strategy. It's doing good work; it's just that it needs some bolstering.

[*Translation*]

Marie-Hélène Gaudreau: Did you hear the testimony given by Ms. Veilleux, who explained the overall operation of the system and where it falls short when it comes to intervention and treatment for veterans who have trouble continuing to perform their duties and seeing what comes next?

[*English*]

Robert Olson: This was in the last round? No, I didn't hear it. However, I can totally agree with that, yes, that we are waiting for—

[*Translation*]

Marie-Hélène Gaudreau: Perfect.

Have you seen the film *Out Standing*?

[*English*]

Robert Olson: Not yet. I have heard of it, yes.

[*Translation*]

Marie-Hélène Gaudreau: Right.

● (0955)

[*English*]

Robert Olson: I will aim to see it.

[*Translation*]

Marie-Hélène Gaudreau: Okay.

I have one other question to ask you. Do you have any evidence as to what may happen in the case of intersectoral data about gender? I am trying to find information about suicide prevention issues among women, indigenous people and the LGBTQ2+ community.

Is there any published data about that?

[*English*]

Robert Olson: Are you asking if there are data on suicide deaths for these?

Unfortunately, in Canada we don't parse the details, and that's one of the suggestions that we've been pushing for, more granular death data because it's not presently parsed in ethnicity or occupation. Sexual diversity might be a little more difficult to ascertain at time of death. Any efforts to bring more clarity to an individual who dies by suicide and the specific circumstances and characteristics that one has is always welcome. We're lagging in Canada on that.

[*Translation*]

Marie-Hélène Gaudreau: Right. Thank you.

Can you tell us about the culture of silence in the Canadian Armed Forces and the Royal Canadian Mounted Police and among our veterans?

[*English*]

SM Sansouci (National Government Relations Lead, Canadian Mental Health Organization): I'll take that one.

As a military spouse of a veteran and active forces member, I want to thank this committee for this important study.

The Canadian Mental Health Association's centre for suicide prevention is not directly linked to the Canadian Armed Forces or Veterans Affairs, so it would not be appropriate for us to speak to that culture that you mentioned.

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Madam Chair.

The Chair: Thank you, Ms. Gaudreau.

[*English*]

For a final round we'll start with five minutes.

Mr. Viersen, please go ahead.

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

Ms. Hill, you stated that your son was on three different types on medication. I tried to write them down as you were speaking. Can you remind me of them?

Judith Hills: He was on Latuda, which is an antipsychotic, Wellbutrin and Prozac.

Arnold Viersen: My colleague, Ms. Wagantall, has a couple more questions, so I'll hand my time over to her.

Thanks.

Cathay Wagantall: Thank you so much.

Thank you, Chair.

Ms. Hills, you mentioned that you were aware that from 2021 to 2023 there were 40 suicides that took place within the Canadian Armed Forces. Within the veterans community and CAF, we find it hard to get these numbers. How are you aware of that? Can you explain that to me?

Judith Hills: It's readily available online. I was also at a wreath-laying service yesterday for Canadians who died on Canadian soil, including those who died of PTSD or suicide. The numbers are there. Those are the numbers of the people coming forward, of families who feel comfortable disclosing that their loved one died by suicide.

I took a picture of it. I wish I could show it to you. The numbers are staggering. In 2021, 2022 and 2023, in this picture I have there are a lot of black ribbons, which indicate people who have died but the family doesn't want the name released.

I believe they got their statistics through Veterans Affairs.

● (1000)

Cathay Wagantall: Would you be able to send that document to the committee?

Judith Hills: Yes, I can go online and send that, yes.

Where do I send it?

Cathay Wagantall: I would appreciate that. Thank you very much. You can send it to the clerk.

Do you have it here?

The Chair: The analyst can pull it up.

Cathay Wagantall: Oh, I see. Okay, our amazing analyst can get that for me.

I'm missing my executive assistant at the moment, and it's awful.

You're giving us numbers that are past what we've heard here at the committee. There's a new report, supposedly coming out shortly, that we were told would probably look significantly concerning.

You also mentioned that your numbers are to 2023 and that you expect those numbers would be going up further. As someone who's been through this horrific scenario, do you have a sense as to why those numbers are so high?

Judith Hills: I wish I knew. I don't know why the numbers are increasing.

I mentioned my co-worker going to mental health and being told, even though she was suicidal, “Sorry; come back in two weeks and we'll help you.”

When another friend was at risk of taking his life that morning, he was told to go to a civilian emergency room, and they told him, “No, go back to the MIR. You're not one of our patients.”

Somebody just wants help at that point. Someone's just asking for help, and they're being kind of bashed around like a badminton birdie. When somebody's in crisis, there's the frustration of not knowing who to go to or just being thrown around like they don't really matter.

Cathay Wagantall: I understand. Thank you.

There is an awareness now, I think, that has not been there—perhaps because of the public being more aware as well—that we have not done a good job in Canada of caring for the mental health of our serving members, and of course that is implicated in the conditions that our veterans are facing as well.

Thank you so much for being willing to share what you personally have been going through now, and also with the loss of your son. We really do appreciate your testimony today. There's nothing more important than anecdotal evidence that comes to this committee to be significantly weighted when we come up with recommendations.

Is there anything you would specifically say to us that we should be doing immediately to make a difference for others like your son, who was struggling so much?

Judith Hills: That's a difficult one. I wish I knew. Maybe we need to make it so that people are less afraid to approach mental health services.

I'm being released from the military. I don't want to be released, but because I require mental health services.... When I stopped going to mental health, they told me I had to keep going, and then they turned around and they are releasing me for medical reasons, for PTSD or mental health reasons. I know that at least five people who I am working with this year, some of the best soldiers I've ever served with, are being released, and guess what—they all use the services of mental health.

I don't know. I wish I knew the answers.

Cathay Wagantall: That's helpful. Thank you.

The Chair: Please go ahead for five minutes, Mr. Casey.

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

Corporal Hills, first of all, thank you for your testimony and thank you for your service.

Before I put my name on the ballot, I was a litigator with a specialty in medical malpractice. With the testimony that we heard today, you can imagine what's going on in my head in terms of going back to what I did before I came to Parliament.

Your testimony raised numerous questions that I have a professional interest in as a result of my background. We don't have the time, nor would it be appropriate in this venue, to delve into those questions at the level of detail that I would like to, so I'm going to start with an invitation. If you think it would be helpful to you to talk to a retired litigator with some experience in medical malpractice, I am available to you after this meeting, and I'll get my contact information to you. There are a bunch of things that you said that suggest there may be other avenues, should you wish to go there.

I don't think a public forum is a place for that discussion and I fear the risk of retraumatization, but that offer is open to you.

● (1005)

Judith Hills: Thank you.

Sean Casey: To our friends from CMHA, first of all, thank you for your testimony.

You talked about a pan-Canadian strategy and indicated that Canada is one of the few countries that doesn't have one. What's the gold standard so that we don't have to reinvent the wheel? What are the best practices globally?

Robert Olson: The gold standard is.... The normal trajectory is to have a framework, which we have, and then to have a strategy that has a binding agreement, resource commitments, timelines and deliverables that are mapped out. The action plan is the implementation part of the strategy.

We went from a framework to an action plan. We believe that, despite some good work that has been done, we should take the time and the energy to start again with a strategy. Do not throw out everything that's going on, but incorporate it into a renewed action plan based on the comprehensive strategy we craft. We've been calling for one since 2004, and the call continues.

The International Association for Suicide Prevention had a call in 2021—Partnerships for Life—for all countries to have a national strategy. That call continues today. I believe, at this point in 2025, there are 40-plus countries with one.

Sean Casey: We heard earlier today about one example of a peer support network that is top shelf internationally and is in the U.K. We heard that from Madame Veilleux. Are you familiar with that? I know you referenced peer support programs in your testimony as well. Are you familiar with what's available in the U.K.? Are there lessons to be learned from that, specifically on the peer support side?

Robert Olson: We're always analyzing and familiarizing ourselves with peer support programs that are done internationally. There are always lessons to be learned. I don't know if the others have anything to say on that.

To answer that more thoughtfully, I would have to examine this program in depth. I can get back to you, if you would like.

Sean Casey: That would be appreciated.

This is the last question, very quickly. We heard earlier today that when someone reaches out to Veterans Affairs, they will not necessarily get a list of available programs.

You started your testimony by saying that you have a suite of resources at the CMHA in conjunction with Atlas. Is that a list that would be of use to case managers in Veterans Affairs when dealing with veterans?

Robert Olson: Yes. There are resources listed in two of the three guides that have other avenues that someone at risk or a family of someone at risk can pursue.

The Chair: Thank you very much.

[*Translation*]

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

Marie-Hélène Gaudreau: Thank you, Madam Chair.

Corporal Hills, I want to make sure first that the interpretation is working at your end. You are indicating that it is.

Allow me to offer you my sincere condolences. It seems to me that you have been more than doubly traumatized. This is worth mentioning. I commend you for the resilience and courage you have shown in coming to testify before the committee.

For that reason, I want to offer you the two minutes I have left. Ms. McKnight and the deputy ministers who met with us this week are watching us.

If they were here, what would you tell them? What is the most fundamental thing?

● (1010)

[*English*]

Judith Hills: I don't know. Maybe it would be bringing about a change in the military where people aren't afraid to go to mental health and where people aren't afraid of their careers being affected if they were to go to mental health. Somehow, we need to end the stigma of mental health. I know we're all meant to be strong and sent off into war. It's what we train for, but at the end of the day, we're all human beings with emotions.

Our lives are difficult. We're often sent away from family. We know that we can be sent away at any given time. However, we need to be given the respect that, when we do need the help, we don't have to fear for our careers. This is something that we've seen videos about. It's been brought up that, if you need help, you get it. “We're there, and we support you.” When you turn around and use the resources, though, it feels like it's held against you. As I mentioned earlier, in the number of people released in the past year, all of us have needed the help of mental health resources. Something is not working. Something is fundamentally wrong.

[*Translation*]

Marie-Hélène Gaudreau: Thank you, Corporal Hills.

Thank you, Madam Chair.

[*English*]

The Chair: I have about two minutes left, as we are concluding this session.

Perhaps we could ask Mr. Olson or Ms. Hills to give us a recommendation, something very concrete that we could take back at this time.

Robert Olson: I would like to reiterate what we said at the outset: Continue to strengthen the efforts we're making to help veterans, and don't discount convening those interested groups to develop a national strategy. It's worth the effort to get this done right. I'd like to re-emphasize that.

The Chair: Thank you.

Corporal Hills.

Judith Hills: I'd first like to say that, in my career, I fix airplanes, but I don't know how to fix mental health. I do know that I'm not sure what needs to be done. As I say, my expertise is in aircraft, not in minds. I just want to see changes. It's too late for my son, and it's too late for the many friends that I have lost, but I want to see changes somehow made.

When I see the news come across, I've learned the language, and I can always tell if somebody has passed by suicide, even if the word is not used. It's happening far too often. Every time it happens, another piece of my heart goes with it. I would really like to see something fixed.

● (1015)

The Chair: Thank you very much, Corporal Hills.

Again, thank you for your service, and thank you for your courage today.

Mr. Olson, thank you as well.

Madame Sansouci, thank you very much.

This almost concludes our committee meeting.

I just have one housekeeping note to mention.

[*Translation*]

It is on the topic of the study on suicide prevention among veterans.

[*English*]

I'll keep this for the next time.

I really want to convey this to all of you. There was a shared emotion that you all have, so we'll perhaps talk outside of this committee to know if there are any notes that you would like to bring forward. I will hold back on that for now, Mr. Clerk.

[*Translation*]

Our next meeting will be on Tuesday, October 28, 2025. We will resume the study on suicide prevention among veterans.

Before we adjourn, I would like to remind the committee that the deadline for submitting witness lists for the study on veteran entrepreneurship is October 31, 2025, at 4:00 p.m. As you know, colleagues, you can send your list to our clerk.

With that, does the committee wish to adjourn the meeting?