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Chair

Mr. Neil Ellis

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● (1705)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): Good evening, everybody.

I would like to call the meeting to order and to thank everybody for coming out tonight.

This is the Standing Committee on Veterans Affairs and tonight, pursuant to Standing Order 108(2), we are here for our study on service delivery to veterans. In front of us we have Walter Callaghan and Brenda Northey.

We'll start with each committee member introducing themself. We'll start with Ms. Lockhart and we'll give each member a minute or two or five to say who they are.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): I won't give you a five-minute spiel about who I am.

I'm Alaina Lockhart. I represent the region called Fundy Royal in New Brunswick.

I have an interest in serving on this committee because our community has always had lots of veterans, more so in the First and Second World Wars, and the Korean War, but we are transforming into this new age. Like many other Canadians, I feel that we have a duty to serve our veterans.

That's why I am honoured to be here, and I thank you for taking your time to come and I want you to know that we have open ears.

Mr. Colin Fraser (West Nova, Lib.): My name is Colin Fraser. I'm the member of Parliament for West Nova, which encompasses the southwestern part of Nova Scotia and contains 14 Wing Greenwood.

Prior to going to law school and becoming a lawyer and then getting into politics, I worked at Vimy Ridge in France as a tour guide. Since that time it really has become a passion of mine to learn about the important contribution that the Canadian Forces have made in our history, and it's our obligation to make sure that those who serve our country so valiantly, the men and women, get taken care of properly.

That's why I'm so pleased that the first thing we're doing as a committee—and I am honoured to be on this important committee—is to undertake a study of service delivery to see how we can improve the way that our men and women in uniform, who become veterans afterwards, are treated by our government and to make sure that we're doing the absolute best job we possibly can.

I'm pleased that everyone could be here this evening. We certainly welcome all of your thoughts and opinions and look forward to hearing constructive criticism so that we can put forward recommendations to the government and try to move forward in a way that responds to the needs of our vets.

Thank you very much for being here. I certainly welcome all of your comments.

● (1710)

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): My name is Bob Bratina. I'm the member of Parliament for Hamilton East—Stoney Creek. I was the mayor of Hamilton.

As the mayor of Hamilton I was the only mayor in Canada who had a senior advisor on military heritage and protocol, because Hamilton has a tremendous military heritage coming right up to the present day. But it had started to be forgotten to the point where the cenotaph where Remembrance Day is held was actually crumbling and in danger of falling down. We have completely rebuilt and rededicated that area and it's called Veterans' Place now.

The gentleman who was on my staff as an advisor for military heritage and protocol was the commanding officer of the Argyll and Sutherland Highlanders. The sad irony, given my wish to reacquaint Hamiltonians with their military heritage, was to have faced the very sad occasion of the loss of Nathan Cirillo's life at the National War Memorial, and all that entailed.

It's a very important thing for me.

I have a 95-year-old Dieppe veteran and I have 26-year-old Afghanistan veteran and other veterans in my city, and we intend to see that they're looked after.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): I am Robert Kitchen. I am a member of Parliament for Souris—Moose Mountain. My riding encompasses the southeast corner of Saskatchewan, roughly 43,000 square kilometres.

I come from a very strong military background. I am an army brat. I spent many years travelling around with the military and while I was in the cadets, and then worked as a civilian instructor.

I think I bring a very rural focus to the committee rural focus. I dealing with a lot of veterans, whether they're aboriginal or first nation, who are returning to their communities. I focus on how we encompass and include them in the program and to make sure that their wishes are followed through.

I'm extremely honoured to be on this committee and I look forward to hearing what you have to say to us.

Thank you very much for coming.

[*Translation*]

Mr. Alupa Clarke (Beauport—Limoilou, CPC): Good evening, everyone.

[*English*]

Thank you very much for being with us tonight. It's an honour to have you here.

My name is Alupa Clarke, and I'm the MP for Beauport—Limoilou. It's a riding in the beautiful Quebec City, the oldest city in Canada. I'm also the official opposition critic for Veterans Affairs. I come from a military family. My father was military, my brother went to Afghanistan, and I just released last November.

My goal, and our goal, is really to be able to see what has happened since 2006 with the new Veterans Charter, how the system improved or did not improve the situation for veterans, and to make sure that we make a report that will put forward new changes to the NVC so that veterans have the delivery of service they should have. I also think it's very important that we take a look at the internal workings of the department to make sure there's a culture that's open to veterans.

These are some of the subjects I would like to hear about tonight, if you have anything to say about them. Thank you very much for being here. I very much look forward to hearing what you have to say.

Thank you.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you very much for being here. I appreciate your taking this time to come and talk to us.

I'm Irene Mathyssen, and I'm the member of Parliament for London—Fanshawe. I am also a vice-chair of the committee. I'm a member of the New Democratic Party caucus.

Unlike others on the committee, I have a long history with this particular committee. I've been an MP for ten and a half years. What has become very clear to me in those intervening years is that we've had lots of discussions, lots of reports, and lots of witnesses, and still we haven't been able to arrive at the solution to what are, I recognize, very complex problems, but the solutions are there.

I am eternally optimistic, despite ten and a half years of being an MP, that if, this time, we listen carefully and have the courage and the political will to make happen the things that should happen, we can get there. I'm determined that this is what I want to do, and no matter how much longer I have in this job, I want that to be part of what I and this committee accomplish.

Thank you again for being here.

● (1715)

The Chair: Everybody didn't use up their two minutes, so I have about 22 minutes for my bio, so bear with me.

I'm a first-term MP, a former mayor of the city of Belleville. It's a great pleasure to be on the veterans committee and also an honour to be the chair. I'm a son of a World War II veteran who served and lied about his age. He served in the navy on the *Uganda*. I grew up in a neighbourhood in a navy house, with an army and air force house beside me. Being there made for an interesting childhood.

We're here tonight to listen to you and your story, and that's all you need to know about me.

I'll flip over to Mr. Callaghan.

Welcome.

Mr. Walter Callaghan (As an Individual): Thank you.

I'm going to read a statement I prepared. It may be easier instead of my going off on a long-winded, antagonistic rant.

To members of the Standing Committee on Veterans Affairs, thank you for this opportunity to provide a statement regarding service delivery to veterans by Veterans Affairs Canada.

My name is Walter Callaghan, and I served in the Canadian Forces from March 2001 until my medical release in August 2010. I suffer from chronic pain due to a severe back injury and struggle daily with the psychological distress symptomatic of my post-traumatic stress disorder diagnosis. Currently despite my injury, I am a Ph.D. student in medical anthropology at the University of Toronto, with my research focused on the subject of the experience of PTSD.

Despite being classified as permanently disabled several years ago, I still have to face constant paperwork to obtain approval for treatment of my condition. As an aside, I received a huge bundle of paperwork this morning that I have to fill out once again. It's aggravating.

I was taken off the rehabilitation program in January 2015 because my pension condition was deemed to have “reached the maintenance stage”. In other words, no further improvement was expected. The letter I received notifying me of this also stated, and this is a direct quote from the letter: “As your participation in the rehabilitation services and vocational assistance program is completed, your earnings loss benefit under the financial benefits program is no longer payable”.

In effect, I was told that because my injuries were permanent and that no further improvement was expected, I was no longer eligible for a key benefit. However I was not informed of the extended earnings loss benefit, which I was eligible for, because I was deemed permanently injured. This lack of information caused extreme anxiety, something that I think most of you have heard or can understand, is to be avoided when you have PTSD.

However, I would suggest that even having had access to the rehabilitation program in the first place makes me one of the lucky ones. I say this because I managed to get VAC to approve my claims for benefits, albeit it was a lengthy and arduous fight to obtain those approvals: it took four years for the back condition to be covered, and seven years for the major depression; and they're still not acknowledging the PTSD despite numerous reports and clinical material on it that have been sent to them.

Instead of the benefit of the doubt being applied, many veterans, especially those like me who served in the reserve force, face an adversarial bureaucratic system that amounts to little more than an insurance-minded scheme of denial by design.

A key example of this is that reserve force veterans almost immediately have their claims questioned as to the connection of their injuries to military service on the basis that the medical reports that are submitted with their claims are predominately written by civilian doctors. This being because reservists are largely unable to access doctors within the Canadian Forces, instead being required to use the civilian medical system.

Judgments frequently made by Veterans Affairs Canada in denying these claims is that the very nature of the supporting documents having been completed by civilian doctors indicates that the injuries are due to non-service incidents, because if the incidents were service-related, then a military doctor would have signed off on the documents.

Even when claims are finally approved in favour of the veteran after lengthy appeals and reviews and reapplications, they are generally done so at a lower level on the fifth scale, with the argument being made that the injuries weren't fully due to military service; that there was some factor from our non-military life that played a role in our injury, even when there is nothing to indicate this. This is particularly prevalent in cases of operational stress injuries and post-traumatic stress disorder.

Associated with this and aggravating to veterans with PTSD is the challenge of malingering or non-compliance when the veteran chooses treatment modalities other than pharmacotherapy. The reality is that the side effects of pharmacotherapy are often worse, both subjectively and objectively, than the condition for which they're being prescribed. When the veteran, in consultation with their clinical team, decides to opt for alternatives to being drugged up, this seems to be an immediate red flag for Veterans Affairs Canada, which then challenges the severity and even the reality and authenticity of the veteran's injury.

● (1720)

This argument has also been used to deny initial claims for benefits, asserting that since the veteran is not on medication, then the veteran does not have a claim condition or that a condition is not severe.

Given that many veterans, again especially reservists, are required to pay out of pocket for any medications prescribed until their claims are approved, and with the awareness that the initial diagnosis, if it can even be called that, is done through a very brief assessment, frequently by a non-specialist medical doctor, generally not a psychiatrist or psychotherapist, it should not be at all surprising that many veterans, particularly with an operational stress injury, do not have the extensive records of pharmacotherapy when applying initially to VAC for benefits.

These systematic forms of denial by design impact the physical and psychological health of far too many veterans. In the cases of PTSD or other operational stress injuries, these denials tend to occur at a time of increased vulnerability, when the veteran has finally reached out, likely while in a state of near crisis. To have the authenticity of one's claims questioned at such a time does little more than aggravate the level of psychological distress, potentially increasing the severity of that psychological distress to the point that suicide occurs.

In the end, it doesn't really matter what programs or benefits are available if the veteran cannot access them. It is incredibly problematic that a key barrier to access is this failure by Veterans Affairs Canada to operate under the auspices of benefit of the doubt instead of relying on an insurance-minded bureaucratic culture of denial by design.

Thank you for listening to me.

The Chair: Thank you.

Ms. Northey.

Ms. Brenda Northey (As an Individual): To follow that presentation is going to be very difficult, but I'm presenting, actually, from a different perspective. I've tried to be a service provider to veterans, and people like Walter. I just want to talk about my experience going forward so that it may help other service providers.

My background is that I have an MBA, but I am also accredited in an area called logotherapy, which is based on Viktor Frankl's meaning base. I'm not sure if a lot of you are familiar with him, but he wrote probably the most famous book on that, *Man's Search for Meaning*. It was all about his experiences as a prisoner in some of the worst concentration camps in World War II. It talked about how if people had a sense of purpose, something to look forward to, they were able to survive the worst suffering. I've applied that theory as well. I've been a patient at the Mayo Clinic, and I've experienced the world's best case-management system, which puts our own medical system to shame. I used both of those combined to work with the homeless, single mothers, and also with people with severe mental health issues to get them employed.

Part of the committee that I created for those with severe mental health.... We had an integrated approach, so we had at least 10 or 12 organizations involved. The goal at the end was to absolutely work with the client to be able to move a client forward. I was asked by some of the veterans' case managers there to come and work for veterans. That's my background.

Going forward, I applied to what's called the MDC service delivery model. I don't know if you know of that. I hear a lot of talk in your meetings about the JPSU service stream. This is a separate service delivery stream. Multidisciplinary clinics, I think, is the long term for it. It's a great idea. What it does is it allows us to combine the medical and the psychosocial together, which I think is wonderful. That's similar to the JPSU site. What it does not allow, though, is employment. I think that's a critical aspect for going forward. Whether it's part-time, full-time, or even if it's unpaid, volunteer, it's critical, from my experience, that people have a reason to get up in the morning, to have some value to contribute.

I've been at this for two years. I went through the political stream first, and the politicians said that I was duplicating my service. I then went through the bureaucratic stream, and I was told that I couldn't do my service, which was to do that three-pronged approach, providing the medical, the psychosocial, and the employment, similar to the JPSU stream. They didn't allow it, and the reason that they didn't allow it—if you speak to the bureaucrats—is because the employment services are offered under the new Veterans Charter, and the MDC service agreement is provided under the old Veterans Charter.

Now, I found that interesting, because the old Veterans Charter obviously started many years ago. This new MDC agreement was started about three years ago, which is after you moved into the new Veterans Charter. So there's a little bit of confusion as to why you would set up a new funding stream based on an old charter that—I think I hear—you're trying to eliminate. That's one suggestion or thought I'd bring forward to the committee.

The second is that when you look at the employment services, they're being offered under the public works department. From what I gather, there's really not many criteria, because there are no outcome measures. I've heard that from the top. I've heard that from the bottom line and front line. I've also heard it sideways, from the ombudsman. So in terms of my question, when you choose to have a service agreement with employment agencies, if you're not basing it upon client results, why are you giving exclusive contracts to organizations that are not having to come back to you and prove their client results?

I hope I haven't confused you.

I looked at a Veterans Affairs report on rehabilitation that came out in December 2014, in which they measured how many of the veterans in the rehabilitation stage got jobs. The number had increased to 28%. So 28% of your total are the people who got jobs. That was an improvement from 20%.

● (1725)

To give you a standard, in the civilian population in Ontario now, employment contracts have about an 85% success rate. That to me is extremely high, but it's also looking at the fact that they keep those jobs for now six months as opposed to three months. In the civilian population we're looking at higher standards.

I hear around the table how some of you have had veteran experience. When I think back, I was ignorant when I started this. I was told by some veterans of how great the veterans are who got world-class training. Looking at the history of Vimy Ridge, I didn't know enough about the Canadian contribution. General Currie at that time told 40,000 of his troops the night of Vimy Ridge that each soldier had been given their purpose, information, and I believe a map. The importance of it was that each person had a purpose. They knew exactly what they were doing. It was the first time in history, I believe, any soldier, forget even Canadian, had been given this sheet.

The role of purpose, the role of feeling valued, is something that I think has been lost in a lot of these service providers. I think it's focused a lot on what we call performance measures. I have submitted to the committee a briefing that was all about an outcome-driven and meaning-based approach. It can be applied through the JPSU stream. When I first started, it could be applied as one stop, separate from and outside of the defence department and the veteran, but funded by the veterans department.

I'm not sure how far to go. I was expecting two minutes.

I'll just cut it off there.

The Chair: Okay. Thank you.

We'll start off questions with Mr. Kitchen.

Mr. Robert Kitchen: Thanks to both of you for your presentations.

Hopefully throughout this we can hear a little bit more from you, Brenda, and you can expand on your comments. I look forward to hearing more. Hopefully, the questions will prompt some of that.

Walter, we've heard throughout this about the medical incidents that are not reported, especially in our reg force. When they're not reported, they never happened. You alluded to that a little bit in your talk. I'm wondering if you can expand on the reporting mechanism that you recall was available to you at the time.

I assume with the reservists it was the same thing, or were the forms different? Were they the same forms, whether you were a reservist or reg force, with that same concept that if you fell and hurt yourself, and you didn't report it, then it never happened?

● (1730)

Mr. Walter Callaghan: The form is the same. It's the CF 98, as I recall. That's for reporting any incident that causes injury. In general those are only used for physical injuries. With psychological injuries, it's not that you're on the field, you see something, and it's “Oh my God, I'm hurt”, because that's not there.

For the physical injuries the forms are exactly the same. The problem is that especially with the operational stress injuries, those occur generally a lot longer after the offence. There's no real ability to go back and say it was this or that incident. On top of that, the idea that we can actually track these back to a single incident only applies in certain forms of PTSD. There's this misconceived idea that all PTSD is identical. There are so many different causative mechanisms to it. When you have one that's coming out of the extended wear and tear of seeing one thing after another, or from being in stress for long periods of time, you can't identify that single moment, which makes it almost impossible to actually utilize the CF 98 in the first place. For the physical injuries we have the reporting mechanism.

In the case of reservists, when we're doing our weekend exercises, which is what the majority of our work involves, or when we're doing our training nights, and we get injured, we don't want to leave our guys, and so we don't necessarily report it. A number of times, when I was with 25 Field Ambulance reserve unit here in Toronto, I had to drag people away and say, “No, sorry, you're injured. We have to treat you.” There was an avoidance. When the weekend or the training night was over, and they went to see their GP, there would be no CF 98 reported from that unless the member came back and said, “By the way, here's a doctor's report.” It becomes such a quagmire that a lot of it's not even there.

Mr. Robert Kitchen: I hope you don't mind my mentioning that we had a chat beforehand. You indicated that part of your service was almost as if you were a first responder, in the medical aspect of it as a first responder. We talked a bit about first responders and the service.

Again, I realize you're doing a Ph.D., so I'm going to sort of pick your scientific brain.

Do you see a potential where there might be a form, or some way that we could provide a way for that to be reported right away?

Mr. Walter Callaghan: For the single incident type of situation?

Mr. Robert Kitchen: Yes, or even an accumulative one.

Mr. Walter Callaghan: I'll speak first to the idea of the single incident. There should be a mechanism in place to figure out which med techs, the corporals, master corporals, and sergeants in the medical service, are actually on site when something happens. That would be one way of tracking that. You may have a potential down the road, as this person was involved.

It is the same with the small-level hospital sites that we set up, the medical reporting centres, and the field hospitals when we're out on exercise. Having an idea of who was actually out there and then tracking that back, having some mechanism of knowing that an incident occurred, someone was injured, that these medical techs, people in the medical service, were handling it or were there and present, could be one way of generating that kind of material.

With regard to the sustained, long-term form, the wear-and-tear form of an operational stress injury, I don't think there is any real way of tracking that, because there are situations that don't bother us.

In my case, it's more the knowledge of soldiers that I recruited, trained, or commanded who were injured. That's what tore me down. How do you record that? There's no mechanism to go I was involved in training this person and they went off a year later and got hurt. I know this, and I turn around and start having intense guilt moments.

There's no way of recording that in any form within the Canadian Forces. It became a situation where I was questioned as to whether it was really that bad. “Well, yes. It damn well was that bad.”

● (1735)

Mr. Robert Kitchen: Great, thank you.

I'll turn it over.

The Chair: Ms. Lockhart.

Mrs. Alaina Lockhart: Both of you bring really interesting perspectives, and I hope we get to touch on both as we continue.

Mr. Callaghan, I would like to thank you for your service to begin with, and also for articulating so easily all of the things that we have been talking about over the last little bit.

If I had check boxes, you kind of hit a lot of them when we're talking about service delivery, paperwork being one. With regard to receiving a letter, for instance, when there's a change in your benefits, or notification that you're not going to receive benefits, do you think it would be helpful if you had one-on-one contact with a case manager or what have you, to walk you through this process, rather than receiving documentation in the mail?

Mr. Walter Callaghan: Here's the funny thing: the documentation was signed by my case manager. This is a case manager that because of the overload that each case manager is handling, I hear from maybe once every six months. Previous case managers broke the rules by actually providing me with their phone numbers or their email to make it easier for me to contact them when something was happening.

The rules within Veterans Affairs require me to call a 1-800 number that is only operating from 9 a.m. to 4 p.m. eastern standard time. Even if the people on the other end of the phone are in B.C., if the call is from Toronto, they cut it off.

I have to leave a voicemail message because she's so busy that she's never available to take a call, and then I have to wait for her to call back, which of course uses up the minutes on my phone. I'm not exactly wealthy enough to have a high-end plan, so I ration out the 200 minutes a month that I have.

The My VAC thing that's being set up is so problematic that I've never actually managed to sign in through it. I have a case manager. She could have been able to put this through one on one with me. It was when I freaked out and went through the entire system and managed to get a hold of her—thanks also to the ombudsman's office who helped intervene—that I found out I was not actually being cut off of benefits; I was being shifted. This was a form letter that was sent out.

Mrs. Alaina Lockhart: So for you this could have gone much better had you been able to meet with your case manager either by phone or personally, to walk through what the decision was and to talk about what future benefits you were eligible for. Is that fair to say?

Mr. Walter Callaghan: If I could have contacted her immediately by phone or by email and actually been able to get an immediate reply instead of spending a weekend freaking out. I say this because I believe the letter arrived on a Friday, so good luck actually getting someone then.

Mrs. Alaina Lockhart: Maybe we could fix that. Not knowing creates a tremendous amount of anxiety as well. I can appreciate that.

Mr. Walter Callaghan: Had the case manager signed it, it would still have been a disaster having that happen.

Mrs. Alaina Lockhart: We're talking about mental health and ways to check in and ways for that to be recorded and what have you, when you were serving, did you talk about mental health as a group when you would get together?

Mr. Walter Callaghan: No. It was something that was kept under wraps. My service was from 2001 until 2010. When my demons started surfacing in 2005, I did approach some people in my unit to say, “Hey, this is happening. I need help,” and the first officer I approached said, “I have that too. Don't let anyone else know or you'll be out of the military faster than you can finish this sentence.”

When things got worse, there was still no conversation going on. I turned around, thanks to an incident with General Dallaire. He kind of kicked me in the ass to actually seek more help. I went through the civilian system at first but I ended up having problems in the military workplace. I ended up going through CAMH here in Toronto to get a psychiatrist.

Of course, I ended up leaving my civilian job at the time because I could not function, and it eventually had to come out that I was having problems. I was immediately stripped of my platoon. Right after that, I was shifted to a desk job. Funny enough, suddenly the computer at the desk disappeared. Then the chair at the desk appeared, and then the desk itself disappeared, and it became a never ending Kafkaesque circle of "Yeah, we're kicking you out as fast as we can". Thankfully the padre in my unit fought back on my behalf, but to my knowledge there was not a single briefing moment on what PTSD was prior to my release in 2010. I understand that it's changed since. Also, the commanding officer of my unit turned around and tried to keep me active and involved, and seeing that I was becoming very knowledgeable about operational stress injuries tasked me as a special projects officer; that was the title. Normally the situation is that they don't know what to do with you, but in this case it was more like "Study up on this and brief me". Unfortunately I never managed to get the full thing finished, and then I was out the door.

● (1740)

Mrs. Alaina Lockhart: All right. Thank you.

The Chair: We'll go to Mr. Fraser and then Mr. Clarke.

Mr. Colin Fraser: Thank you very much, Mr. Chair, and thank you both for your attendance and your excellent presentations.

Ms. Northey, I'm just going to ask you a couple of questions first. Are you familiar with My VAC, the online service for people that was mentioned earlier?

Ms. Brenda Northey: I'm familiar with it, but I haven't used it.

Mr. Colin Fraser: As a person who is involved in service delivery, do you have any experience with financial counselling or services that veterans may require, or are you familiar with services that are delivered to veterans for that?

Ms. Brenda Northey: Yes. Two years ago when I was putting this report, this one-stop centre, together, I worked with people like a former Brigadier-General Don Macnamara to find out information on the military. I also spoke to a senior case manager of VAC to find out about all the services that were being offered and how good these services were, and what some of the barriers were. You're absolutely right that accessing accurate information was very difficult. I tried to access all of Defence's services, and I had a hard time getting access to those. I also went through the bureaucracy of VAC to try to get information, and I found that we were moving two different streams. I'd have the political side talking about the JPSU, and then the bureaucratic side would be talking about this MDC contract. So it was a very confusing process. When you ask that question, I'm not really sure which stream we're going through.

Mr. Colin Fraser: I've heard from several veterans or veterans groups who have testified, and I have learned a little bit more today about the importance of having financial counselling for a lot of veterans who are transitioning after release from the forces. I know that on top of everything else they're dealing with, there's stress involved in dealing with financial difficulties and worrying about paying their bills. Do you have any knowledge of that? Do you have any suggestion as to how counselling services or services related to finances could be delivered, which might be helpful?

Ms. Brenda Northey: What I was proposing was to integrate all of the necessary services in the one-stop centres. One of the steps did include the financial budgeting. We brought in credit counselling to talk about the financials with the people involved in that program.

In the brief that you have before you, there is a list of all the programs we would be offering at the one-stop. Financial investments would be one of them.

Also, just to clarify this, it's not about our offering all of the services. It's about integrating the best local services. The only way we know if they're the best is if they're delivered with the same outcome-driven philosophy.

Mr. Colin Fraser: Thank you very much.

Mr. Callaghan, I'm going to ask you a couple of questions. First, you mentioned the number of appeals you had to go through and that it was always an uphill battle to get the benefits you were entitled to. Did you deal with the Veterans Review and Appeal Board in doing those appeals?

Mr. Walter Callaghan: In the end, for the back injury, yes.

Mr. Colin Fraser: How long ago was that process, if you don't mind sharing that information?

Mr. Walter Callaghan: We finally got approval through VRAB after a long fight in 2007. The injury occurred in 2003.

Mr. Colin Fraser: Sorry, I thought you served until August 2010.

Mr. Walter Callaghan: That's when I was finally released.

I served for quite a few years with a back injury. It's one reason I was never deployed.

● (1745)

Mr. Colin Fraser: Okay, so you went through VRAB before you were released.

Mr. Walter Callaghan: Yes, for the back injury.

For the operational stress injury, the lawyer assigned to me by the Bureau of Pensions Advocates advised me that, given how VRAB was working and how their decisions were coming out, it would be a waste of time to ask for an appeal at that time. You get only a certain number of appeals, and if you use them, that's it. So I decided with the lawyer and my psych team that it was just not worth going through.

I had received an initial approval after a lengthy fight. Right around the time of my release, I was finally approved for major depression by Veterans Affairs. We're still in the process of trying to get them to accept and acknowledge the PTSD.

Mr. Colin Fraser: Have you had experience with the operational stress injury units, then?

Mr. Walter Callaghan: When I was being released, they were toying with the idea of studying an OSISS unit up here in Toronto. For a variety of reasons, it was decided it would not be the most beneficial place for me.

I have a lot of concerns over how that unit is being run. But at the same time, it does work well when it works. I'm not going to speak badly of it. To me, anything that's out there that can help our guys, my brothers and sisters, give them the access to it.

Mr. Colin Fraser: Were you offered access to the one in—

Mr. Walter Callaghan: When it was being set up, yes. But at that time, when I had that initial interview with the person who was going to be the peer support coordinator for it, they tried to find people. I was the only one who came forward, saying, I could use this. Six months later they finally had a few other people, but at that point, things had become so rough for me that I could not attend.

Since then, there have been other issues that maybe make it not the best route for me to take. I have participated in other forms of peer support and have worked as a peer support counsellor, though I would say that because my PTSD is so guilt based, turning around and being involved in that group setting can actually trigger me rather badly and amplify the guilt.

Again, part of this is that we're not having a discussion of the different forms that PTSD takes. All of the models that are being used tend to look at very specific forms that do not acknowledge or accept the variety of what this condition is.

Mr. Colin Fraser: If I may, could I ask one more question?

The Chair: Yes. We have lots of time. We'll flip back to you, or—

Mr. Colin Fraser: You mentioned something, though, that I just wanted to ask you to clarify. I didn't quite understand it, and I apologize for that.

You talked about doctors in DND and then civilian doctors, and about your lacking access to doctors in DND, which caused you some problems. Can you expand on that? I wasn't sure I caught the point of how that would have helped in the long run?

Mr. Walter Callaghan: The way that a service provision is dealt with in National Defence, or at least the way it was done when I was serving.... It may have changed since then. Six years is a long time, and a lot can happen. But while I was serving, if you were a reservist on a class A contract, which is what most of us were, and you were injured, it was not a medical doctor who was your primary care. We were required to use the civilian service.

Mr. Colin Fraser: Because you're a reservist.

Mr. Walter Callaghan: Yes. Class B and class C get some care through the military medical service, but even that, especially for follow-up, once you're injured your class B, pseudo-fulltime, contract tends to end. The class C guys who went overseas, if they got injured badly enough that they needed a lot of care, were being repatted here. It gets complicated whether or not they will receive continued care through the military service, or have to go to the civilian service.

Even as a class B, when my back injury occurred during a training course at CFB Gagetown, I was stripped from course and shipped back to Toronto three days after the injury occurred. No imaging was done at the base hospital. They never took me into Fredericton to a civilian hospital to do imaging. Instead they just doped me full of morphine, gave me a whole bunch of anti-inflammatories, and eventually shipped me back, and said I should go back to my unit.

There was no provision of military medical care once I was back here. I was immediately shunted out to the civilian service, so there's a very brief record from the medical service indicating that I was attended to at the base hospital, that I had complained of back pain, but that's it. The diagnosis of the back injury came from a doctor up at Sunnybrook, and that is being used by Veterans Affairs, and that's why it took four years of fighting because a civilian doctor said I was injured on this military exercise. What does a civilian doctor have to do with the military? Why are they doing this? A medical doctor out of Gagetown should have written this document.

The way the system worked and the way I was shunted back so quickly created a situation where there was no medical doctor originally signing off on it. On top of that, the medical doctors here in Toronto, whom I was eventually able to access because of the temporary categories that I had to be placed on because of the injury, didn't believe the injury occurred.

● (1750)

Mr. Colin Fraser: Thank you very much for your help in understanding that.

The Chair: Mr. Clarke.

Mr. Alupa Clarke: Mr. Callaghan, you said you received a bunch of papers each year.

Mr. Walter Callaghan: Sometimes it's yearly, sometimes it's every few years. Because I'm a reservist, this is a whole other complicated ball game that I don't know if I'll have time to get into, the way that our benefits are done. Because I was permanently injured, I'm still on SISIP, but because of the changes that occurred last year with Bill C-58 and Bill C-59 , I'm also receiving financial benefits from VAC. Because I was deemed permanently injured, the provision of stuff like psychotherapy or the approval for psychotherapy, massage therapy, physiotherapy, all those go through VAC. So I'm receiving annual documents from SISIP, much like Paul Franklin being told that he must prove he has no legs anymore. In my case, I'm having to prove that I still have a demon haunting every living moment, and my back injury is still here.

With VAC, the package I got this morning contained the documents for the two-year mandatory review of permanent status. My original classification as permanently disabled with VAC occurred in 2012-13, so it's not even two years. There's a discrepancy on when they're sending out documents, but because I was removed from the rehab program, to maintain my weekly massage therapy and physiotherapy, both of which are used for pain management, and the biweekly psychotherapy, we're having to submit documents every four to six months saying I'm still injured, I still need this help. It is getting ridiculous.

Mr. Alupa Clarke: That was my next question, whether your paper work was from SISIP or the ministry—

Mr. Walter Callaghan: Now it's both.

Mr. Alupa Clarke: Okay. From the beginning until last year, before Bill C-59, were you receiving money from SISIP?

Mr. Walter Callaghan: Only from SISIP, yes.

Mr. Alupa Clarke: Then since last summer, you started to receive earnings loss benefit from the new bill. Is that right?

Mr. Walter Callaghan: I'm receiving both.

Mr. Alupa Clarke: Both?

Mr. Walter Callaghan: The initial part works out to $2,050 a month, 75% of the old deemed salary of $2,700. That's coming from SISIP. The increase as a result of Bill C-58 brought reservists up to the equivalent of corporal basic, the base minimum that regular force personnel get. There was an argument between SISIP and Veterans Affairs over who would handle that. SISIP refused. VAC decided, okay, you guys are now eligible for ELB, on top of your SISIP, to top you up to this amount.

There's some really funny stuff going with the numbers. It's a problem also for reservists and it's been going on, and I just mentioned the deemed salary aspect. I do not know a single reservist who is getting paid the rank equivalency. All of us are being paid, regardless of our rank, as corporal basic, which in some cases can be a difference of thousands of dollars per month.

Mr. Alupa Clarke: Mr. Callaghan, obviously you're well educated, with a Ph.D. in anthropology—

● (1755)

Mr. Walter Callaghan: I'm working on a Ph.D.

Mr. Alupa Clarke: My wife is an anthropologist. I just wanted to ask, is it hard to fill out the papers as a Ph.D. candidate?

Mr. Walter Callaghan: It is bloody overwhelming at times, with some of the basic paperwork. There's one annual form that we get from Veterans Affairs just to confirm that you're still alive, to confirm that you're actually receiving benefits, that you haven't been buried or anything. That one's the easiest. It's a check and a signature, and that's fine. But the ones to apply for new or different claims, the ones to continue claims, the ones to continue receiving benefits, I'm overwhelmed by.

Mr. Alupa Clarke: Are those all part of the bunch you received this morning, for example?

Mr. Walter Callaghan: Yes. I looked at them. The ones from this morning I'm supposed to take to doctors to get filled out. But of course, I have to work back with them. They're all based on whether you are able to go back to work. Also, there's a disconnect on what "work" actually is. That could be a whole other rant of mine. But even looking at those, how am I going to communicate these issues and these barriers to a doctor? Thankfully, I think my psychotherapist understands it well enough to help fill in that paperwork.

Mr. Alupa Clarke: You said also that you find there's a lack of information coming from VAC to you, but they ask you for a whole load of information.

Mr. Walter Callaghan: They ask probing questions, sometimes questions that don't even seem appropriate. But it's more on your end of their actually trying to go, "You know what? You should be on this. You should be eligible for this." There are case managers who do go out of their way to let us know. There are also some case managers who don't tell us anything.

Again, in a lot of how I've been speaking, except for some of the personal experiences, when I speak of "we", I do that in my role as an anthropologist who is studying people like me, studying other veterans, working as an observer-participant, doing ethnography with them. I've heard so many horror stories coming back over the last five years, ever since I started grad school. This is not just me. This is problematic across the board.

Mr. Alupa Clarke: You said the diagnosis of the PTSD you are suffering from was not accepted by the ministry?

Mr. Walter Callaghan: It's still not.

Mr. Alupa Clarke: Who did the diagnosis? Was it a provincial doctor?

Mr. Walter Callaghan: The initial one was done by my psychiatrist, who hinted that he was of the opinion that he really thought I had it. There were problems with psychiatry, especially at CAMH, with the requirement in 2012-13, when they decided that all patients at CAMH must also be receiving pharmacotherapy. At that point we had already gone off the psych drugs, so I got shifted over to a psychotherapist. Thankfully, my case manager at the time, the first one I had, went out of her way to ensure that I got the psychotherapy covered, because I had been accepted under major depression.

Mr. Alupa Clarke: Were there external...? Not from DND?

Mr. Walter Callaghan: These clinicians are not at all associated with the Department of National Defence or Veterans Affairs.

Mr. Alupa Clarke: Did you pay for that?

Mr. Walter Callaghan: No. Again, my case manager...because I had received and been approved for a claim for major depression, and under that, we were able to get the coverage for the psychotherapy. The first assessment with him was approximately four hours long, going through and trying to figure out what was actually happening.

We have since done a reassessment, in August or October of last year, and in both cases PTSD came up as his primary diagnosis. We have submitted the paperwork twice now.

Mr. Alupa Clarke: Did they explain why they don't recognize the diagnosis?

Mr. Walter Callaghan: I've gotten no answers back from Veterans Affairs yet, despite the fact the first application we made with my psychotherapist was back in 2012 or 2013, and we reapplied last year. We have not received any answer. My case manager can't find anything to let me know on this.

Mr. Alupa Clarke: Just before turning to Madam Northey, I have a last question for you. I would first like to let you know that it would be good if you could send us the list of each of those papers that you have to fill out. I would like to know what exactly those forms are.

My other question for you is in regard to your saying you have concerns about the OSI clinic. You said you didn't really want to talk about it because you don't want to put it in jeopardy, but it will not be in jeopardy; it will stay there. I would like to hear those concerns you have about the way it is run.

● (1800)

Mr. Walter Callaghan: Again, where you say these conversations “stay here”, the veterans community is very aware of these meetings and do access them. I don't want to misspeak in any way or discourage any veteran from seeking the help, because there is help available. The OSISS clinics do work. They don't work for everyone, but they do work.

Mr. Alupa Clarke: Could you please write those concerns to the committee and send that through the clerk? Thank you very much.

Madam Northey, I'd like to hear what you have to say concerning the effectiveness of VAC. I think it might be true that they're not plan-centric, outcome driven.

I would just make note of this brainstorming here, so you know. There is the law that has services and benefits. On the other side, you have the veterans who are recipients of these delivery services or benefits, and you have VAC in the middle.

I'm mean I'm just going out there to try to find solutions. When I meet with VAC employees, they're all good people. I might say bad things right now, but it has nothing to do with the people working there.

Sometimes it seems that the ministry is more of an organization there to deal with the restraint budget and to allocate, in the most restrictive manner, the allowances and benefits and the service delivery. It seems it is that instead of being an organization which has to make sure that the people who most need it will receive the benefits and services and that they reach out to the most possible number of veterans.

In a way, its logic is more serving the state than it is serving the beneficiaries, who are the veterans. I think that's what you're saying.

Ms. Brenda Northey: I think what I'm trying to say is that this is not even just about VAC or DND. I speak as an executive director of a social services health field, and I've also done some workshops across Canada about an outcomes-based model, so I speak from the point of view of a cross-section of agencies that were output driven. People don't understand what “output driven” means, or even what “performance driven” is. People think performance means outcomes. There's a lot of confusion about language.

Let me put it in a very simple form. A lot of organizations are based upon.... I hear from Walter, and it's funny: in the report, they said that access had improved immensely in Veterans Affairs. I'm not really sure on that end. I'm just reading reports. What government tends to focus on is the number of participants. What I've heard is that we offer the most services of any NATO country. The question I would ask, as a follow-up to that, is not about how many services you're offering, but about how great those services are that you are offering. That's the point that's always missed.

As for what the focus should be when you talk about a client centre, if I can be indulged just a little, I'd like to talk about my experience at the Mayo Clinic. I was very lucky to be able to experience it, but it relates a bit to PTSD, which is that grey area.

I had some symptoms of inner ear dizziness. It was diagnosed. I also had some other issues, such as flushing of face. They couldn't define what it was. It was a grey area. I went from doctor to doctor. One of them closed the door and said, “You know what, we're going to test you for cancer.” Another one said, “We're going to test you for MS.” In terms of the anxiety, I understand what the veterans are saying when they're waiting. The anxiety level increases even though your diagnosis at the end of the day may not be so great....

At the end I was tested for one thing in a pure scientific test. I was told that I had a carcinoid tumour, for which there is no cure. I was going to be dead. The doctor I went back to with this test said, “It's all in your head.” I thought, how can you make up a science thing and it's all in your head? We tested again, and it turned out that it was negative. He said, “You see, it was all in your head.”

My family doctor at that time said it was disgraceful and that I needed to do one more test to make sure, because I had the symptoms. Luckily, I was able to get to the Mayo Clinic. Let me talk about this experience so that you understand. I think it would be wonderful to be able to put that in the JPSU site going forward.

They asked me what my symptoms were and said they wanted to know because they wanted to know whether or not they could cure me. Well, that was interesting. I mentioned my symptoms and heard back in a couple of days. They said, “All right, Ms. Northey, we don't know if we can cure you, but we will make sure we can manage it so you can work again, and we will do that in three to five days.” I thought, right, I've been going at this for a year and a bit, and they say three to five days, come to our site....

I showed up. When I arrived, I had a team leader who was a doctor. That team leader explained all this through manuals. There was not a lot of software at that time. With the manual, they said, “All right, Ms. Northey, here is a list of all the people you're going to see today and here are the locations, and you just need to show up.” That's what I did on that day. I had appointments booked for me by the team leader, who could be a case manager. They could be called a team leader and they could be called a navigator.

I went to these appointments. My sheet with my information didn't go by software. It got sent through this fancy kind of departmental bullet. The package did not follow me as a patient. I did not carry those files. It went indirectly, but it got to the next appointment. The information was opened up and the doctors read through all the previous notes, so they were not asking the same questions. They were not wasting my time and not wasting their time. It was all written down in terms of further tests that needed to be done.

Once I'd gone through it, the team leader summed it up at the end of the day by saying, “Here's what they have said, here's what's left to be done, here are the results of the tests we have to date, here's tomorrow's schedule, and off you go.” This went on for three days. After about a day and a half I started smiling. I didn't know why. I could still be dying, but the thing is that I started to relax. Somebody was paying attention. Somebody with expertise was managing my process. I found that the symptoms.... Anyway, at the end of the day, they said, “Ms. Northey, your symptoms have actually left.” It ended up that they were right: it was in my head for part of that, because I thought I still had the dizziness. It was because of the anxiety that it was prolonged. He said, “We can give you these drugs to manage it. In two months, though, you're going to be fine.”

● (1805)

In two months, I was fine. In that interim period, however, I struggled with one of the tests and I was quite sick. I put a call in thinking I was going to have a secretary or receptionist. I got the key doctor; he was paged. He was thought to be the best doctor in the Mayo Clinic for this area. He personally called me back and said, “It's okay, we'll see you in the operating room.”

I come back and I look at the homeless situation. I look at people with mental health issues. I hear poor Walter's story, and I hear this from the civilian side. Hospitals are not geared for long-term crisis care. They're geared to the short-term. They're fantastic at doing that, but the resources, including CAMH, don't have the outpatient services to help people with mental health issues. CBT, cognitive behavioural therapy, is being looked at as an alternative to taking a lot of the drugs, which would help resolve the situation of people like Walter.

All that information, all the research, is there. The problem is, it's all in all these different spots all over the place and we don't access it. The Privacy Act comes into play. People do not want to share, so when you send somebody from one organization to another, the first organization doesn't have to share the information with the next one.

Going back to the Mayo Clinic, that was a critical link. Information could be shared from one physician to the other, making a team approach more likely. Drummond, in his Ontario provincial health report, wrote about the doctors being the quarterbacks. We need to create a system where there's a quarterback for every single veteran or soldier leaving. Who's paying what, this is something that should be worked out in the department. It should not be the client's issue to resolve. This way, clients can relax—they know somebody is paying attention, somebody is managing. It's all based on the first conversation, in which they hear your expectations, and they tell you theirs. At the Mayo Clinic, they told me they were going to be able to manage or solve my problem in three to five days.

Just imagine if we were able to offer that kind of service to our veterans and soldiers. All this paperwork would become the department's role. It should not be the client's role to manage the paperwork on top of managing the anxiety surrounding the problem.

● (1810)

The Chair: Thank you.

Mr. Callaghan, I've heard about medication and how it's paid for by the service provider. Could you clarify that? I believe that we farm this out to an agency, Sun Life, Met Life, whatever the company is. Are you dealing with them directly? If that's the case, how often are you turned down for meds after the fact? In your statement here, you say that you're paid after the fact. Are you paid 100% on medications? Are some approved, then denied later? Other vets have told us they've gone to the drugstore with their card and been standing there on a Saturday night at 11 o'clock, only to be refused help.

Mr. Walter Callaghan: When I was taking pharmacotherapy for the psychological issues and for the back injury, Veterans Affairs was the one that the pharmacies turned to. Veterans Affairs paid the pharmacies. This, however, only occurs once you actually have a diagnosis and the claim is accepted by Veterans Affairs. Until the claim is accepted, Veteran Affairs doesn't pay crap.

So it gets a little problematic there. I've long since gone off meds. Because of the nature of my demons, I ended up developing an opioid dependency, so I ended up going off pain meds quite some time ago. Damn near killed me. Of course, Veterans Affairs and the military said, “Here, have some more meds.”

I ended up going off the psych meds because the side effects were even worse than waking up every morning wanting to kill myself. Living in a fog, though, was worse yet. Some days I didn't even know what my bloody name was. So I ended up going off meds. Since I went off meds, I know the system has changed. Now the coverage is being farmed out to Medavie Blue Cross, I believe. I had one veteran contact me this morning, going up and down the walls, freaking out because Blue Cross and Veterans Affairs were not willing to pay for the meds they'd previously approved to treat his condition. These meds cost upwards of $100 a day.

Even when we have the claims accepted, we're still being denied. There's some magical list out there that we're not always able to get. The list is with Veterans Affairs, and we used to be able to look at it. The guy from Canadian Veterans Advocacy, Sylvain Chartrand, was excellent at digging up all this material, which allowed us to see what was being approved. With the shift over to Blue Cross, it seems to have become a bit of a black hole. It's not until we put something in that we're getting told whether or not it's covered.

Did that answer your question fully?

The Chair: Yes.

Ms. Mathyssen.

Ms. Irene Mathyssen: Mr. Callaghan, thank you for your service.

Ms. Northey, thank you for creating that context because, in your description of your experience at the Mayo Clinic, it very much seems that there is a solution there.

One of the things that the defence ombudsman recommended was that we start from scratch. We take this very convoluted system and we simply start from scratch and build something that works. One of the things that bothered me, and I never really got an answer that I could understand, was the fact that DND does the analysis. You go to the doctor if you're a reservist or if you're a member of CAF and that individual takes note of what's going on with you.

When it comes time for the benefit piece, those medical reports are transferred to VAC. I was assured that VAC had the expertise to look at those medical reports and make a good decision. It struck me that if I'm going to a medical specialist, they shouldn't just be charting what is going on with me, they should be making observations and be able to submit a clinical report based on their expertise. There seems to be a gap there.

Walter, did you feel there was a gap and were you thrown into an adversarial situation in your struggle to get what you needed?

● (1815)

Mr. Walter Callaghan: As a reservist, I was not really able to access the military medical system. With the back injury, going through my GP, he's the one who turned around and sent me up to Sunnybrook to an orthopaedic specialist who took one look at me walking in the door and said I had done something to my back. She could tell just from looking at the way I was walking. She worked everything up. Again, because all that came from the civilian sector, the military was saying that I had a back injury, they didn't really know what to do with me, so I was put on light duties.

That's the official stuff that exists in my military medical records, which of course was then sent over to VAC. They then said that it all came from a civilian doctor. The military doctors weren't saying that it's due to military service. They were making no mention of it at all other than acknowledging that there is some physical limitation. It gets screwed up.

The psychiatric part ended up going through my GP. He made the referral to CAMH because here in Toronto it's pretty much the only way of getting a psychiatrist. I ended up waiting a period of time, but a few people who I knew were in slightly higher positions of power pulled some strings and got me fast-tracked into CAMH.

Again, because I wasn't being seen by a military doctor, all the reports coming out were asking what this really meant on top of that. In an effort to protect me from the system itself, the military, those who were aware were trying to hide my diagnosis for me, so that if I was not immediately ejected...That's why, even though my demons started surfacing in 2005-06, I managed to stay on until 2010. The moment that things shifted and people became aware that I had these diagnoses, my days were numbered.

The moment of people finding out, certain people at the higher level finding out that I had depression, had PTSD, the PCat system was initiated and very shortly after that my medical release notification came in, even though I was finding a way of functioning.

Having said all that, there's also this weird disconnect that's occurring with Veterans Affairs where when we're being medically released, it states in our medical releases the nature and the reasons why we're being released. Yet, we're still having to fight with Veterans Affairs frequently after our release to get those benefits, to get claims done.

Especially with the OSIs, those can be so discombobulating that sometimes when you end up full on facing your demons, you don't know what day it is. Trying to figure out that you should apply to VAC before you're released, sometimes that's not happening. VAC is not simply taking those release documents and saying that there is obviously something there. If the military is releasing them for injuries, they should be given the benefit of the doubt, they should be put into the program, given the care they need, and then they can start questioning once people have stabilized, and then ask, especially on the OSIs, where the actual source of it is.

I've got other issues with how psychiatry even tries to figure out causation. That's actually the topic of my Ph.D. thesis, so we may not have time to go into that.

Ms. Irene Mathyssen: You released in 2010.

Mr. Walter Callaghan: Yes.

Ms. Irene Mathyssen: Do you still have connections with comrades who may be still reservists or haven't released yet?

Mr. Walter Callaghan: Yes.

Ms. Irene Mathyssen: Do you get any sense from them that things may have improved or changed? Do you have any idea if it's gotten better?

Mr. Walter Callaghan: The ones who are open about their own mental health are scared shitless about coming out. It has not changed. The moment you come forward, the moment you have a severe diagnosis, the days are numbered. Even for reservists, the military is a life; it's not just a job. Coming forward and knowing that by coming forward your current life is going to radically change and not under the design of your own doing, it becomes so problematic that, no, there are people who are suffering in silence. Thankfully for reservists, we are able to access the disability and health care system. However, that also causes problems because the psychiatric system is so pharmaceutically heavy that you end up with those drugs, which can mess you up. Eventually people find out, so we either suffer in silence and hope that peer support gets us through the day, or we risk losing our lives, our livelihood.

● (1820)

Ms. Irene Mathyssen: We've heard in a number of situations about the reticence to identify the need for help among either CF personnel or reservists, and that nobody wants to admit to that stigma. But you seem to be suggesting that it's more than that, but that an individual has now become a liability.

Mr. Walter Callaghan: It is both. The stigma is also still real. There have some been some shifts in it depending on what trades and what units you're looking at. There's still quite a bit of stigma in the infantry and the combat arms, but within the service trades the stigma seems to have alleviated a bit, but there's still that issue of, am I polluted, am I sick, am I diseased? The language itself creates an actual level of statement. The fear of being termed weak, or incapable, or not capable, especially with the hyper-masculine identity that all soldiers have, becomes a thorn that causes more harm.

On top of that there is a liability issue that's occurring and there's also—as I was alluding to in my previous response—this fear of losing their job, of losing your place in life, your meaning. This has to do with the whole thing of the universality of service—which I know you guys have heard about before—that the moment you're not able to be deployed, that's it, you're out the door.

Knowing there's a psychiatric condition, you're likely to be put on meds that are going to mess with your mind, which creates a liability issue, which in turn invokes the issue of universality of service; or, if you're not on meds, you're going to be on long-term therapy. My psychotherapy has been going on for several years and we're still just scratching the surface of the hell that occurred. If you're stuck in a position of requiring ongoing treatment for longer than six months, you can't be deployed, and therefore you breach the universality of service and you're out the door.

On all these levels there's a self stigma, there's a societal stigma, there's a liability issue, there are all these things. It's not one single thing that's actually causing all of it; it's this interwoven mesh that, especially when you're in crisis, makes it that I can't do that, I can't continue, but I need to continue, I can't reach out for help or it's all going to end.

Ms. Irene Mathyssen: Thank you.

While you were talking before I had a sense that you had two messages, and I just want some clarity on that. You talked about the fact that your caseworker had failed to tell you that when one set of benefits was exhausted you were entitled to extended benefits. But you also said that your caseworker went above and beyond in trying to help you. I'm wondering, is it a matter of caseworkers being harried, overworked, with not enough resources, or did you have a sense that it could be training? What was your...?

Mr. Walter Callaghan: I've had three different case managers. The first one went above and beyond. She was a saving grace for me and got me benefits I hadn't even been aware of. She also helped me get through all the paperwork and, in some cases, did the paperwork for me. She went way beyond. I don't know what happened to her, because she got transferred. All of us who had been working under her ended up pretty pissed about that, because here was someone who was actually taking an active interest in our well-being.

My second case manager was pretty good but a little scatter-brained. He had been working in Veterans Affairs. He ended up retiring, so that's how I ended up losing him. He was pretty good at figuring out what needed to be done but didn't always follow up in a timely fashion.

My third case manager seems to be so overwhelmed by the sheer number of clients she has that she's scattering all over the place and is having that much more difficulty following up.

● (1825)

Ms. Irene Mathyssen: Is your third case manager someone you still interact with?

Mr. Walter Callaghan: We interact when I actually manage to get through to her, or when she finally decides, “Oh, wait. I should call Walter. I haven't talked to him in six months.” I finally heard from her two weeks ago, or last week, and it had been almost a year since I had previously heard from her. Again, because I was removed off of the rehab program, that also causes a complication where, as I understand it and as she explained it to me, technically I'm not eligible for a case manager.

Ms. Irene Mathyssen: As part of a case manager's duties, would the protocol be that you must indicate and be able to show that you have contacted each of your clients on a regular, monthly or bi-monthly, basis?

Mr. Walter Callaghan: That would be nice. It may be even better if there were an easier mechanism for us to contact them.

Ms. Irene Mathyssen: Email?

Mr. Walter Callaghan: Email. The VAC thing and the 1-800 number thing do not work. Give us the ability to contact our case manager by email.

I do understand, from talking with my three different case managers, that one of the reasons behind not letting veterans contact their case managers directly by email was that, especially with people when they're in moments of psychological distress, sometimes they can be overbearing, make demands, and just hound the hell out of their case managers. I am aware that it happens.

However, we should actually have the ability to have that immediate contact or on a weekend to type up an email because I had forgotten this or I had heard about that and send it off. Okay, they work Monday to Friday, so you're not going to get the response until Monday. However, as a veteran, at least you know you've reached out, asked that question, and can track when they come back to you. If there's something that comes after 5 p.m. on a Monday, it's like, “Oh my God, what's going on? Why hasn't this happened?” or “I suddenly need this”, then the very next day you're going to get a response.

The way it happens right now with My VAC is that half the time you cannot get into the system in the first place. I've never managed to actually get into that system. The 1-800 number, from 9 a.m. to 4 p.m.... Give us email.

The Chair: Process-wise, we have Mr. Argue in the audience, who would like to join the panel. What I'd like to do, then, is just break for five minutes. Then Mr. Argue will come in and give his statement, and then we'll start with questions again, if we have the unanimous consent from the committee to do that.

We'll have a break for five minutes and then come back.

● (1825)

(Pause)

● (1845)

The Chair: We'll call the meeting back to order and welcome Mr. Argue to the committee.

Welcome this evening. We'll give you five to ten minutes for your opening statement.

Mr. Reginald Argue (As an Individual): I served in the Canadian military from October 2, 1986 to August 3, 1995. I joined the military a few months after I graduated high school, shortly after my 19th birthday. Barely a month after my 21st birthday, I was sitting over in Iran, only days after the eight-year war between Iraq and Iran ended. I saw the horrendous end result of war and in 1995 I found myself wanting to leave the military. I left the military with an honourable discharge. I had knee problems and I found out later that my lung problem originated in the military.

Since leaving the military, I've gone through homelessness, I've gone through a whole bunch of different stuff. When I went to Veterans Affairs and applied for my pension the first time in 1996, I ended up getting 5% for my knees. Since that date I now have 30% for both my knees. I was told at that time, in 1997, don't apply for anything else, that I would never get it again.

Since that time my health went downhill severely. At the end of 2006 I was put on the earnings loss benefit. Since that time they sent me for rehab. They decided that they were going to throw a medicine ball with me. I explained to the person they sent to do this with me that I had two bad shoulders and please not to do this. After three or four times of telling her no, she persuaded me to do it. At that time I heard a loud snapping sound in my shoulder. I tore my right shoulder right there.

You have to excuse me. One problem I have is that I don't get enough oxygen in my brain at times. I basically have between 50% to 74% breathing capability, so sometimes my mind will go in and out on me.

Even though I have these problems, I did talk radio from 2007 right up until November 23, 2010. I've also done the occasional video interview from 2011 right up to now. In 2014, I formed Veterans in Politics Canada and I go out and do the occasional interview.

I was told about a year and a half ago by my case worker that they had removed me from the earnings loss benefit, and they put me on the permanent impairment allowance. Because of the health problems I have, they say I may never work a full-time job again in my life.

I'm sorry. Sometimes my mind goes in and out on me. I do apologize for that.

One of the problems that I'm noticing with doing all these interviews—we did an interview with Retired Major Mark Campbell, who tragically lost both his legs over in Afghanistan; one with retired Master Corporal Paul Franklin; and with David MacDonald and others who have been injured—is that Veterans Affairs at times has not done everything they could have done to help the veterans. The lump sum payment has really come up short. A lot of the veterans who are hurt right now should be getting the monthly medical pension.

I agree that the new Veterans Charter is vastly different from the old veterans charter, but it's a living entity that we have to constantly improve upon. It's nice to see there is a standing committees like this that is listening to people and their input and everything.

I was going to say a whole bunch more stuff, but I'm sorry, my mind just went out on me. What I'm trying to do is to show people who have health problems and have disabilities to never to give up, and even with Walter here, I say never give up, because we have to show the rest of the world and the rest of Canada that other changes are possible. We also have to be proud of people who served in the military. The veteran community is an important part of what Canada is.

● (1850)

The Chair: Thank you.

We'll start the next round of questioning.

Mr. Bratina.

Mr. Bob Bratina: Thanks for your presentation.

I have lots of questions. Can either of you tell me whether there's any clawback when you get these allowances. You said you can't work full-time, but you may have other sources of income. Do you have other sources of income other than your military...?

Mr. Reginald Argue: No, I don't have any other sources of income. What I've been told is that if I make any money at all, even a penny, it will be claw backed from me immediately. That's with Veterans in Politics Canada, a non-profit organization I formed. There's no money made at all. There's my money that's being put in there. I've created a platform for people who have amazing stories to come and share them, whether it's first responders or other veterans, or even ordinary Canadians.

Mr. Bob Bratina: Go ahead, please.

Mr. Walter Callaghan: With the clawbacks, there is a slight issue of how SISIP and VAC work on this as well, and what stage of the rehabilitation programs you're at. My understanding, as it is right now, is with the rehabilitation program, so long as you're on it, you're able to make a certain amount of money, up to a certain tier, then it starts getting claw backed. The initial amount is 50¢ on the dollar, then once you hit a certain amount, it's dollar per dollar.

Now, again, one of these issues that does not tend to get talked about is where the reserves fall in with a whole different ball game, a whole different kettle of worms of it being messed up.

Prior to 2012, with Bill C-55 coming in, which changed our deemed salary from $2,000 to $2,700, regardless of the stage of rehabilitation that we were at, we were able to work with an offset of 50¢ on the dollar. That allowed us to make up that gap, because the way the ELB, the earnings loss benefit, and SISIP's long-term disability work is that it's 75% of your salary, or the deemed salary in this case. The way that the 50¢ on the dollar offset worked was that it actually allowed you to make up to that amount, to make up that 25% difference. Then you started getting dollar for dollar docked off.

You could actually get back up to that level, and it was an incentive to go back to work. With the changes that occurred with Bill C-55 in 2012, when they shifted us up from $2,000 to $2,700 as a deemed salary, the way that SISIP turned around and managed this change, and the way that VAC managed this change, the 75% of $2,700 was $2,050. It was more than the previous deemed salary. They turned around and argued. I actually have correspondence from a former minister of Veterans Affairs under the previous Harper government, trying to go, oh no, this is actually what we mean to do. You're losing all of this because, well, your 75% is above the previous deemed salary. This increase that we gave you under Bill C-55, that makes up the difference that you could have actually made, the offset amount.

I don't want to swear. I nearly swore, I'm sorry about that. It did create an adverse situation for me. In it's current iteration, because Bill C-55 only shifted things last year, and I only finally got approved for the increase, the addition of ELB on top of the LTD—that whole confusing thing—I have not had employment income since that came into effect. I've been a Ph.D. student. I do occasionally get the opportunity to work as a teaching assistant. When I previously did that, it was docked dollar for dollar, thanks to the Bill C-55 change. I have not had a TA shift since Bill C-55 occurred, so I don't know yet whether I'm going to be docked dollar for dollar. The indication that I've had, because I'm also no longer on the rehabilitation program, is that I will automatically be docked dollar for dollar.

Did I make a confusing situation more confusing?

● (1855)

Mr. Bob Bratina: No, no. It's similar in the municipal world with Ontario Works people who are getting assistance. When they get a job and they lose their assistance, they might lose their subsidy on their apartment and so on. I think that's something we need to consider and get even more documentation on.

With regard to the culture, I was in radio too. For 20 years I did football broadcasting. Military is military; the only thing that comes close is professional football. A starting fullback got on the plane to Winnipeg for one game, and shared with me that he had been diagnosed with a broken rib. He was afraid to tell the coach for a couple of reasons: one, you don't want to let the team down and not be there, and two, you're gone—"Next." On another occasion, a player who finished the season with an injury was told, "We like you, and we're going to sign you to a new two-year contract." Great; he signed the two-year contract. Then he was told that he now had to pass the physical.

The culture seems to be a problem in many cases that we've heard. We've heard a very positive approach to culture from Ms. Northey. Have you any suggestions on how the military could adjust that culture? It seems to be a tough one.

Mr. Walter Callaghan: This will probably be controversial and get me a lot of hate mail, but let's maybe shift it out of the toxic form of hyper-masculinity that's there and get rid of the idea of "Suck it up, sunshine." Let's get out of that hard-core aspect. We can do these jobs without having that toxic form of behaviour.

Mr. Bob Bratina: Reginald.

Mr. Reginald Argue: I've gone through just what Walter talked about. I've seen that.

When I was serving in the military, there was this form of "suck it up". I saw a lot of the people who used to go to the MIR because they had health problems be called "MIR commandos". We need to stop that. The fact is that a lot of people get injured in the military, and they can prove it, but if they're not allowed to go to the MIR because of the fact that everyone else will call them MIR commandos, then when it comes to pension time people will go, "Oh, that's not service-related." We need to get away from that.

At the same time, I'd like to suggest that Veterans Affairs create a platform whereby other veterans and people getting out of the military can come together and share what's happened to us. We can see that we're not alone. One of the biggest things I'm noticing out there, when I'm talking to people....

Take Glenn Cumyn, the person who started Heroes Hockey Challenge. His father, Jim Cumyn, served 35 years in the military. When he started talking about serving over in the Suez Canal, he started crying during the interview. That right there tells me it's time that we come together. Let's get all of us veterans together, sharing our stories, and let's create that community. Let's start the conversation. That's one way I can see that would help to finally bring the healing.

● (1900)

Mr. Bob Bratina: I have a final thing, and then we can move on to other questioners. This is with regard to the notion of the reserves versus the regular service.

We have a large reserve group in our city. As far as I know, the men and women I talk to consider themselves soldiers. We had the terrible incident of Nathan Cirillo being shot and killed at the National War Memorial. I've always wondered and worried about his colleague standing just a few feet away, about how he might have to deal with the post-traumatic stress that would likely come from being in that situation.

So is it the same for reservists?

Mr. Walter Callaghan: As in our response to these conditions?

Mr. Bob Bratina: No, not the response; I mean in terms of services that he might be able to access.

Mr. Walter Callaghan: That's actually a really good question, whether an individual in that situation would be able to get immediate care within the military. He's probably on a class A assignment right now. I don't know what the nature of the memorial guard contract is. I don't know if that's a class B, 180 under, or if it's a class A. If he was a class B, perhaps he should be eligible; even if he was a class A, perhaps he should if he came forward.

I can't speak to whether or not he did come forward, but just hypothesizing, he should have been eligible to receive immediate treatment the moment he came forward while he was still serving.

Mr. Bob Bratina: Could I ask you, in terms of your own service—and I'm not looking for the particular incidents that would create problems for you—for an overview of the nine years you served?

Mr. Walter Callaghan: Nine and a half years.

Mr. Bob Bratina: Nine and a half. Where were you, and what sort of things did you do in that time?

Mr. Walter Callaghan: Pretty much all of my work was done either in a training capacity, a command capacity, or a logistical capacity here in Canada. I never made it overseas. I never ended up on a deployment.

Mr. Bob Bratina: The point is that incidents will occur, whether you're deployed in different places, through the training process and so on. It's a rigorous program.

Mr. Walter Callaghan: That is correct, as is the nature of our training and the nature of our exercises where we apply our training, learn what's working and what isn't, check our training, and get better at it. Even that, because of the nature of military service, is an incredible dangerous undertaking. That's why, for medics, when we deploy in support of training exercises, we're on there testing our own skills and the basic things that we need to know, and we're also there doing real-time medical support. When bad things happen it's the medics who are dealing with it. It goes beyond our training.

Mr. Bob Bratina: Right. Thanks very much for that.

The Chair: Ms. Lockhart.

Mrs. Alaina Lockhart: I have a few questions for Ms. Northey.

I wanted to talk to you a little about outcomes, because we have talked about those, and I'm sure you've read that the ombudsman has talked about those as well. What are your views on what the outcomes should look like for our veterans? I know we all have an opinion, but I'd like to hear what your perspective is on that.

Ms. Brenda Northey: I just drew a graph. There are two aspects, I think, in the outcomes. The first aspect is that when a client signs up for any program or service, what has to be asked is “What are your expectations as a client of this program?” The second aspect that has to be clear is “What is the purpose of this program?” The client signs up based upon that. For example, if it's to get a job, “Am I getting a job?” If it's to become stable or to have a greater family reconnection, then in the end, the outcome, should be establishing not if they have completed the program, which is an output, but rather whether the purpose of the program has aligned with the outcome. When you look at an outcome, if you're talking about veteran-centric programming, a true outcome has to look at the client's perspective right from the beginning.

I did an exercise with a lot of organizations, and I said let's assess your mission statements, which in the charity field is critical, because it tells what exactly the purpose of your organization is. I will tell you that at least 50% of those organizations were not aligned with what people thought, and it was an eye-opener. If you look at some of the veterans who are coming in with PTSD, with anxiety, or with any other form of depression, then you have to be clear on what the purpose of that program is. It's the outcome, the end result, that measures that purpose. If there's an alignment, you've reduced anxiety. It's like an experience I had at the Mayo Clinic. They told me what that outcome was going to be, and it reduced my anxiety.

An outcome is not based on number of programs served, it's not based upon the number of people who have completed the program, and it's not based on the number of people enrolled in the program. Those are all good, by the way, and that's not to say that these are bad measures, but at the end of the day, if you're going to a doctor, what is your outcome? You hope to be cured, and you hope to have some way to manage your future. If the doctor just says, “Well, thanks for coming out”, and if you haven't been given me any solutions, then how are you going to feel? That's typical of a lot of the service organizations across Canada, and it's not just with veterans and DND. Unfortunately, it's widespread.

● (1905)

Mrs. Alaina Lockhart: I think that's one of the things that cause frustration for veterans and also cause stress for those working for the department, case managers. We've kind of built this house and then put all these additions on it, but they don't necessarily have doors to get from one addition to the other or windows looking out.

The veterans aren't the only ones who are frustrated, and they're frustrated because sometimes their case manager can't get them through the whole house. I'm just using that as an analogy. Then we see burnout in the staff as well and less impact there.

I want to go back. You talked about this idea of having a purpose as being very meaningful, and I wanted to relay an anecdote about a conversation I had recently with someone who does therapy. They were telling me that they had tried a pilot project in which they had a group of veterans who volunteered with some World War II vets. By having a program with that objective, and I don't know that they have the numbers to prove this yet, but at least anecdotally, veterans who had been suffering with extreme PTSD, after just three months of being in a program from which there were outcomes and through which they had a purpose, saw that reduced to mild and they were functional.

It doesn't always have to be a huge complicated program. It can be as simple as, as you said, setting the outcomes, having a purpose and then having sine leadership to guide you through that such that you're confident that what's being done and managed is for you. I think those are just great points that have come from your testimony and some of the other things we've heard recently, so thank you.

The Chair: Thank you.

Mr. Kitchen.

Mr. Robert Kitchen: Thank you, Mr. Argue, for coming. I'm very appreciative that you came up to talk to us.

One person once said to me, never say sorry if you've done nothing wrong. I want to say that to you. Never say sorry if you've done nothing wrong, and you've done nothing wrong. I appreciate your being here.

I am wondering if you could tell me a little bit more, if you don't mind, and should anything I say at any point in time...just give me that sign and I'll move to something else.

You talked about your knee injuries. I'm just wondering if you could expand on that a little bit for me.

Mr. Reginald Argue: I have one knee that 25% of my cartilage was removed from in 1989. The other knee was run over by an MLVW. The rear tire hit it. Also, Veterans Affairs sent me for one of those psychological reassessments. I've been sent for two. At the second one, the psychologist told me that I don't have PTSD but I have really bad anxiety because I'm frustrated that I can't do what I used to be able to do. I can't go out that much.

Veterans Affairs bought me a scooter so I can get out with it. But because of the health conditions I have, I'm just trying to do what I can do. I'm just trying to tell people that they're going to get frustrated at times. They're going to get angry. Yes, I do swear like a sailor. I admit that. But at the same time, I'm just trying to inspire other people because I feel....

When I did talk radio, I did it at co-op radio, it was just down in East Hastings, the poorest postal code in Canada. I used to walk down that street and I'd see people shooting up. I'd see some of the most talented people in the world. They were on the streets. Everyone has a story to share. I saw Canada crumbling right there because we weren't there to help out the people. I've seen the same thing within the veteran community. There's so much that needs to be done. There are so many talented people. They're just looking for an outlet. They're looking for something to bring them out. I'm just trying to inspire people.

I also wanted to add that I've gone through about seven or eight caseworkers because of moving. I've dealt with the Vancouver office and the Hamilton office and now the Toronto office. The way I was treated in the Hamilton office, I felt was probably one of the most appalling ways you could ever treat anyone who served in the Canadian military. What happened? I don't wish to get into it, but I do hope it's changed because an awful lot of us veterans have been treated pretty badly there.

The Toronto office has made up for it. Basically I am very grateful for the caseworker that I was working with, Sonya Wakefield. At the same time, I realize I'm no longer working with a caseworker because I'm on PIA.

● (1910)

Mr. Robert Kitchen: Thank you.

You mentioned places to share your stories and for people to come together and do that. I've talked with a number of people around the table about the issues of.... When we talked about our World War I, World War II, and Korean War vets, often they had the Legion where they had a chance to share those stories. We don't see that as much today. Whether it's a result of technology or not—there will always be debate as whether that's right or wrong—we're not seeing that. Can you expand on what you think might be of some value?

Mr. Reginald Argue: There are different groups out there. There is Veterans Voices of Canada run by Al Cameron. He does interviews with World War II and Korean War veterans. I'm doing the occasional interviews at a local Legion branch here. I've done interviews with Mike Holmes, Enrico Colantoni, and Rory Sinclair, the president of the St. Andrew's Society. I'm hoping to get the consul general from Italy to come out.

I also did an interview in the past with a World War II veteran who was a photographer. He worked for the RECCE part of the Royal Canadian Air Force. He took a picture one time of Winston Churchill. Jack Ford was his name. The story he shared was that Winston Churchill lands on the airfield and has a cigar in his mouth and is scowling at everything. The moment that Jack brings the camera up to take a picture, Winston Churchill brings his cigar down and he's smiling. To me those stories need to be shared right now.

If the Legion or Veterans Affairs could create that, it could even be a web porthole, where people could come and describe what they did in the military and what they have lived through. It could be used as an outlet for veterans to start reconnecting with old friends and, at the same, to show them that they're not alone and help them battle through any mental health issues they may be dealing with. Most importantly, it could show people that they have succeeded. Everyone who has served in the military has succeeded.

Mr. Robert Kitchen: They have. It's so true. We see that with our Canadian Olympic team and with other things in Canada where everyone signs a flag or we do these things. I think what I'm hearing you suggest is something that I'd call a “living wall”. We have memorials and why not have a living wall where people can post that information as you suggest. People are inclined to do that. It would provide different opportunities, whether it's in written or technological form, such as Twitter, etc. That's a great idea. Thank you very much.

Mr. Callaghan, many of the questions I had for you have been answered by other people, but I have one last question. You talked about filling out forms with doctors. I hate to tell you that I am a doctor, and so I know the answer to this question already. Who pays for those forms?

● (1915)

Mr. Walter Callaghan: It depends on what form it is. There are some forms where there is confusion even with the doctors about whether they are able to bill VAC. With the SISIP forms, are they able to bill SISIP? Depending on which form it is and on the doctor and their awareness, you end up getting a different answer. If you're using a walk-in clinic, a lot of walk-in clinics have never dealt with Veterans Affairs before and don't know what they can submit a bill for and what they can't submit for. There's not always that much direction.

I didn't look through the forms that I got this morning too closely because they were a little bit overwhelming, but I don't recall actually seeing any instruction to the doctors on whether or not the doctors could file for reimbursement to VAC or if I may end up being on the hook for that. It's not always that clear, and this also creates some barriers. We're not sure if I am going to have to dish out $100 for a doctor to fill out these forms that SISIP is demanding yet again, even though they've already classified me as permanently disabled, or is my doctor able to actually submit it to SISIP for coverage? It's not always clear, and this is for SISIP and VAC. So maybe that's something that needs to be worked on.

A really minor point, but perhaps a sign of how things have shifted, is that while SISIP gives us prepaid envelopes when they send out documents and ask us to send them back, Veterans Affairs does not. We have to go out and get our own bloody stamps. It's such a minor thing, but sometimes you have difficulty getting out of the house on any given day or there's a time limit on getting these forms back, and you can't make it to a store to get a stamp and you're at risk of having benefits cut because you can't manage that day to get to the store and get a dollar stamp. It's an artificial barrier that's almost.... It's disgusting.

I do want to go back to the previous question you asked Reginald about the different forms of connection that veterans can get. There is no end of social media groups on Facebook and other platforms that are devoted to connecting veterans with each other. Some of the best peer support ones are on there. Send up the Count, run by Brian Harding and his colleagues, is one of the most fabulous, outstanding methods of peer support that actually gets us drawn in and get us opening up.

Jamie MacWhirter with PTSD Buddies is going across Canada right now trying to get even more word out on there. It's another peer support group that is actually working.

The Legion—and this comment is going to result in my getting hate mail—has perhaps run out of time. Part of the reason they are not seen by the young generation joining up is that we are not made to feel welcome. We have not been made to feel welcome for quite some time. The changes that occurred.... The way the World War II veterans were treated by the World War I veterans is a similar story. The way the Korean War veterans were treated by the World War II veterans is a similar story. But the problem here right now is that it's not the peacekeeping veterans and the Korean War veterans and a handful of World War II veterans who are treating us badly when we try to go in, but the sheer number of people who have never served who are in positions of power and who make us feel so unwelcome that we turn around and ask, “Why the hell should we be part of this?” With social media, we don't need brick and mortars groups. We are able to connect.

I use social media for a lot for my research and I'm in connection on a daily basis with soldiers and veterans from all over the world. I don't need a Legion to do this. The Legion is more of a barrier.

Mr. Robert Kitchen: Thank you.

Having been a doctor filling out forms, I say in response to the question of who sets my regulations that it's the regulatory bodies. Then it's a question of who's going to pay what I expect to get paid, so I understand that part and I appreciate your comments.

There's one last thing I'll just ask Ms. Northey. I'm very interested in your concept of outcomes, and I know you sort of answered some of that in response to Ms. Lockhart. You talked about demographics, and a lot of the research might be more demographic in nature. I'm interested in knowing the parameters a little bit more in depth. Ms. Lockhart, you sort of answered my question, but in your outcomes, what sort of parameters are you looking for?

● (1920)

Ms. Brenda Northey: I'm not sure whether I clearly understand the question, when you say “parameters”. When I look at measuring outcomes, I look at there being a starting point of the process and the end process. The end process isn't just measuring the process. The actual end, which I call an outcome, is measuring the purpose of the start, of the reason why we're in the process. I'm not sure if that's what you mean by the parameters you are looking for?

Mr. Robert Kitchen: I think it does. Your answer, in a way, to Ms. Lockhart, was more about expectations of the client and purpose of the outcome type of thing. I think you answered what I was looking for, which I didn't feel I got from the earlier answer, so I appreciate that.

Ms. Brenda Northey: If I can add just one more point, we use a term called “continuous improvement” all the time. To me continuous improvement is that if each client did not meet that outcome, there are then grounds for continuous improvement. It should not be based upon a performance measure so much. I don't want to confuse this too much, but performance measures are sometimes called “process measures”. I see a lot in government. I see the time it took for a client to go from A to B. Those are all good, but at the end of the day, you want to know if a client met exactly what they were expecting to meet. The time period becomes part of that performance measure, but that comes in at the back end. It's not your outcome. You're not aiming to deliver a service on time or deliver a service. For sure as an organization you want to do that, but as a client going through you go in there based on the expectation you have of that program. I suspect that the two gentlemen sitting beside me, if they were signing up for a program or signing up for a form, would be thinking, what is this form supposed to do for me? That's their expectation. If the form is to get them pharmacology, if the form is to get them CBT, cognitive behavioural therapy, if the form is to get them psychiatric help, at the end of the day, did they get all of that, and were their needs met? Whether you want to call it an outcome or whether you want to call it a measure against their objective or a goal—everybody has terms—if you forget all and throw the terms aside, it's, at the end of the day, whether the client's expectations were met.

Mr. Robert Kitchen: That's right. There are two different entities: the services that are provided and the health care point of view. When you're doing health care, it's helpful that you've got the specialists and the right practitioner for the right assessment at the right time. You can judge that part. But when we look at the services that we provide, and part of what our discussion here is about is providing those services not just the health care part of it, I like your concept and taking the same analogy for health care and putting it into the delivery of those services.

Ms. Brenda Northey: If I could just add one more point, for all of you, as a committee, or for organizations, when you're assessing one agency against another, when you're looking at whether an agency met the client's expectations or the outcomes were as expected, you're now measuring across. Typically, what we tend to measure is whether the agency is well-known, whether the agency has been around for a long existence, whether the agency is serving more clients, not whether the quality of their service is measuring what the clients are expecting.

Mr. Robert Kitchen: Thank you.

The Chair: Mr. Clarke.

Mr. Alupa Clarke: Madam Northey, the last five minutes were really interesting because, for a few weeks on this committee, we talked about the fact that before it took one year, and now it takes 16 weeks. You said that weeks are important in the waiting time for the approval or disapproval of benefits. You said it's important to calculate the outcomes and the expectations of results, but it's not necessarily what should be looked at first. That's very interesting, because it's like we're stepping out of the paradigm right now.

You said that the most important thing is to see if the expectations of the veterans—in this case it's veterans—are satisfied. But again I feel that's not the goal of the ministry, and maybe it should be looking at what's going on right now. I don't think they're trying to satisfy the expectations of veterans, but trying to satisfy the way the state wants to deal with veterans.

● (1925)

[*Translation*]

That was just an aside.

[*English*]

About the Legion, sir, I was at the 46th congress of the Legion in Newfoundland this weekend. I was talking to a lot of commanders in the province and everything. They are also getting sick and tired of civilians in the Legion. They say good things about that, of course, but they feel that civilians have turned the Legion into a social club to fill in times when they're bored, more than an organization for getting together and talking about problems that are realized and things of that sort.

I simply want to tell you that some officials in the Legion feel the same way as you do about the Legion.

Mr. Walter Callaghan: That would be the “get the grump out” policy that they're trying to implement. I'm very well aware of that when I state that the Legion has no real place for me.

Some Legions and some people in the Legion do work wonders. I want to throw that caveat in there, but by and large we've not felt wanted, to such a degree that, well, why would we ever go back? If you touch a hot pan once and burn yourself, you're not going to do it again. To do it again and again and again and again, I think that's a definition of insanity. It's probably too late for the Legion to capture a lot of us, because of the experiences so many of us have had.

Mr. Alupa Clarke: The only problem is that the common force of veterans is weakened as a result of the fact there are so many groups going their own way, but that's the reality.

You talk about denial by design. I would like you to maybe talk about that a little bit.

Mr. Walter Callaghan: Effectively what I mean by denial by design.... I'm sorry, my tongue is getting tied in knots. I've dissociated several times already because of all this.

By denial by design, what I mean is that the very system itself is operating in a manner that is purposely trying to find any and every reason to deny benefits, to deny applications, to not grant the benefits, the claims, or the treatment. They're trying to use any possible reason.

Instead of the giving the benefit of the doubt, which is how Veterans Affairs is supposed to work, all things being equal—well, things are never actually equal—if there's any doubt at all, we should be believing the veteran. If there's any problem at all, if there's any question that can't be easily resolved, we should be believing the veteran. Instead, the moment any doubt or unanswered question comes up, that becomes the thing that gets targeted, the thing that Veterans Affairs drives into the wall to say, "Sorry, you're not getting your claim approved. You're not getting this benefit. You're not getting this treatment."

That's what I mean by denial by design. It is an insurance-minded scheme that is purposely meant to limit financial liability and to not actually pay out.

Veterans affairs should not be operating as an insurance company. The moment we start doing that, there goes the sacred obligation, the words that I know all of you have heard before. The moment you act as an insurance company or under insurance company principles, boom, the sacred obligation, the social obligation, is the first thing that's dropped on the floor and scrounged into the dog poop.

Mr. Alupa Clarke: So if the system is designed to find any possible way to deny the benefits, that means there is an unofficial rule, implicitly. Is that what you're suggesting?

● (1930)

Mr. Walter Callaghan: That is what I'm suggesting.

Mr. Alupa Clarke: Also, you talk about the disgusting practice like there being no stamp. I agree with you. I would be very, very mad if I had to add a stamp to send my information to the government, even more in the case of a veteran. Could you share with us other practices that you find disgusting?

Mr. Walter Callaghan: How much time do we have left?

The Chair: About 20 minutes.

Mr. Alupa Clarke: The most common ones that you see often. There's the stamp.

Mr. Walter Callaghan: The stamp is a really small, trivial one that is disgusting because it is so banal.

Mr. Alupa Clarke: Small...yes, exactly. Those are the worst.

Mr. Walter Callaghan: To me, ultimately, the worst one is the denial by design, which is why I focused on that in my statement. There were so many other aspects I could go after.

One that does occur, and I have given conference papers on this, is the way we use some of the language on operational stress injuries. This is associated with the stigma as well. When we refer to it as "mental illness" or "diseases of the brain", this itself is a stigmatizing form of language that ignores what has actually happened, which is that we have been hit with an injury.

Fundamentally, what is the difference between someone who has had a limb blown off and someone whose sense of self has been so fractured that their life seems like it is coming to an end? This is my challenge toward the very way that psychiatry, and the industry of providing support and care, has become dehumanized in a way that, through its biomedical drive and through the principles it uses, dehumanizes the patient, dehumanizes the person who is injured, and in a way almost blames them, or that is how it is perceived by many of us with operational stress injuries. We are being blamed as not being worthy enough.

"Oh look, you caught the flu of the mind", is almost what it feels like. "Hey, it's okay. Just take some time. You'll get over it." It is this idea of illness instead of an injury. We can learn to cope. We can learn to come back. We can find new ways of being with these injuries. When we talk mental illness, it immediately implies a cure. When those cures don't happen, that strikes us even harder. When we come in expecting that CBT will help us, it is only good or takes 6, 10, 12, 20 weeks take effect, and yet three years later we are still scratching the surface. It is not a cure. It is a way of coping.

The very language that we use—that Veterans Affairs and psychiatry use—turning around and implying mental illness, creates a situation of expectations of "outcomes", to use the wording that Brenda used. Those outcomes can never actually be met. That cascades further. When we keep having those dark, demonic moments, we are not able to come out of them.

We end up blaming ourselves, but then we end up wondering, is it really real? Then other people turn and go, "Oh, you are not better yet. Are you really that sick? Are you faking it?" Then you add in the pharmacotherapy, which is the first line. When those don't work.... I also referred to the way you end up on one drug and you need another drug to treat the symptoms of the first one. It is the Pfizer wheel of death. You need drug after drug after drug just to handle the side effects, and it just keeps getting worse and worse and worse, with the expectation that we are going to be cured.

Even if the medications are working immediately on the symptoms, it is not curing. All it is doing is masking the distress that is happening. It zombifies us. It does not actually help.

You can tell that is one of my really passionate areas of....

Mr. Alupa Clarke: I have the stamp, denial by design, language use, and stigmatization from this language. Are there any other practices you have in mind that you want to share today, right now?

● (1935)

Mr. Walter Callaghan: Off the top of my head, no. My brain feels like Jell-O right now, after going into that last one.

Mr. Alupa Clarke: I have one last comment for you. I don't know if, in your research, you have looked at *autochthone* Canadian veterans. We have had some of those groups at our committee. They have a whole other way of dealing with those mental issues, through their communities. I don't know if you saw that in your research, if you looked at it.

Mr. Walter Callaghan: Being an anthropologist, I am quite aware of the cultural methods, the cultural usages, the different ways of understanding what is happening and how to handle it. There are some very positive things going on there. I don't want to get into too much detail on that, because I'm not so much of an expert on that aspect. There are a number of professors who would actually probably be even better suited to comment on the benefit.

The issue is the very way of understanding what's going on, of understanding who we are as people. There are differences that occur there. This is also something that goes right into other committees and to the truth and reconciliation, which I don't want to speak too much on because it's not my area of expertise. There are ways of being and thinking that work, but there's a cultural relativity at play whenever you're dealing with any form of the mind, of the self, of society. This is also why I refuse to put down any group or any organization or any treatment modality, because you never know what's going to work from one person to the next.

So how about we approve everything, and let the individual have a say in what they would actually like to try instead of forcing pills down their mouth as a first resort?

The Chair: Walter, I want to go back to a question or a statement that you made, and maybe Mr. Argue can also comment on this.

Both of you have had many caseworkers. They seem to have changed their attitudes as we've gone through. You mention how your first caseworker was this.

When did we see that fundamental shift? Has that fundamental shift been with all your colleagues also? Maybe I'm reading between the lines, Walter. You said your first caseworker went beyond, maybe bent the rules, maybe stretched the rules. It doesn't seem as though that's happening now. I'm just trying to wrap this around.

Does that statement apply to all caseworkers or just to some in particular, or was there something five years, three years, or two years ago that all of a sudden through your groups—and you would know this through the Internet and so on—that everybody saw a switch overnight with caseworkers and how they dealt with you, or is it just something that's happened to you both individually?

Mr. Walter Callaghan: There wasn't really a switch overnight across the board.

The motivations and personal drive of each caseworker seem to very much tailor how they respond. Some are more than willing to go beyond or more than willing to take on the heavier caseload and still find a way. Others weren't ready or able to do it. The level of training may differ among them. Even the reasons they're doing that work may be different.

That being said, there did seem to be a moment when a sudden cutback in staff at VAC occurred, when a whole bunch of front-line workers were canned, and that may have actually affected the number of case managers who were there. That may have also caused them a bit of anxiety about whether or not their jobs were secure. I'm doing a lot of speculating, but there did seem to be a moment when, with the mass layoffs that occurred under the previous government, there did seem to be a shift. There were still good caseworkers who were going out of their way despite everything and even with the increased load.

The Chair: There's a second part to this question: were you at one time allowed to email or contact your caseworker directly? Has it always been the case that you've gone to the 1-800 number, or has that just shifted in the last...?

● (1940)

Mr. Walter Callaghan: I think my first case manager was bending to the point of snapping the actual rules. My understanding was that we were never supposed to be able to directly email our case managers, but that worked so much better. It was an unofficial twist. She probably did get reprimanded for it. That may be part of the reason why she took a transfer or was transferred. I've never really found out.

Neither of my case managers after that have been willing to do email. The first one also turned around and—I'm pretty sure this was breaking the rules—gave me her direct phone number—not her personal cell number, but her work cell number—so that I could contact her. If I missed a call from her, I could call her back and there was no problem.

My second case manager accidentally gave that to me. He forgot to block the number when he was making an outgoing call. I so rarely had any emergency while working with him, I think I only called him twice and it was completely fine. With the third one, there was absolutely no way was she going to do that. There was a barrier there. It's a barrier that's right in the system itself, that they're not supposed to have that level of immediate contact.

The Chair: Mr. Argue, did you want to quickly add to that?

Mr. Reginald Argue: I want to quickly go back to the conversation Walter had with Mr. Clarke.

One problem I've seen is over-medication of veterans. I am a living example of what can happen. I was so over-medicated that my liver started shutting down on me. I don't take any medication at all at this time, even for the pain and all the rest. One thing I'd like Veterans Affairs to look into is to make sure, with the medication, that there are no serious side effects before they start prescribing stuff.

Getting back to this question of the caseworkers, yes, I've gone through a lot of caseworkers. In Vancouver there was an awful lot of turnover. I started in 2007 right up until, basically, the beginning of 2012, when we moved to Ontario. We moved to Niagara Falls first, and then we moved to Toronto in fall 2012.

However, when we moved to Hamilton, and basically from the beginning of 2012 right up until we moved to Toronto, one problem was that the caseworkers weren't really willing to work with me or other veterans.

Then, here in Toronto, I found that one caseworker I was finally given, Sonya Wakefield, went out of her way to do stuff for me. I've heard of so many other veterans that she's helped. To me the turning point would be 2012, when I finally got put in contact with Sonya Wakefield here in Toronto.

My experience with the office they have in Toronto is very good. I've never been able to directly talk to the caseworker. I've always had to phone the 1-866 number and do it that way, or go into their office, and then basically talk to whoever is on duty at that time.

The Chair: Ms. Mathyssen.

Ms. Irene Mathyssen: I wanted to dig a little deeper with you, Mr. Argue.

You talked about when you were first released, I guess, in 1995. You had a knee problem and a lung problem. You got 5% for your knee and now you have 30% for both knees. Then in 1997 you were told not to ask for anything more. In 2006 you had the earnings loss benefit.

I just wonder if you could draw a connection for me in regard to how all of that evolved. What was the journey you undertook to get to a point where your benefits were more adequate?

Mr. Reginald Argue: In 1996 when I went to the Veterans Affairs office in Calgary, I was called a civilian. I was told I wasn't a veteran. I was told by the pensions advocate that this is what I was going to get and to not come back ever again. The mindset there, despite the fact I had served in the military and gone overseas, was that, no, I was just a civilian. I think anyone who puts on a uniform and honourably serves in the Canadian military, whether he or she goes overseas or not, is a veteran.

What I found is that it took our troops going to Afghanistan to start to change the mindset. In the nineties it was so bad that a lot of people who were veterans were despised here in Canada. I'm from Vancouver Island. My wife and I moved back to Duncan, B.C. She was informed by one of the managers at one of the businesses in Duncan that I'd never get a job on that island because I was ex-army. I was just floored that someone would say that. That wasn't a rarity; that was the norm. A lot of us in the mid-nineties right up until the late-nineties were treated really badly because we were veterans. It took our going into Afghanistan to start to change the mindset of Canadians, and to start to provide more for the veterans. I think 2006 was when all parties came together.

Whether we like the new charter or not, it's a living entity. It's a lot better than the old one. We need input from Walter and so many younger veterans who are just getting out of the military, and even veterans from my age bracket. We need to come together and come to a consensus. That's what I really love about the new charter. It's a living entity, and you're having standing committees like this to have input.

● (1945)

Ms. Irene Mathyssen: You said that the lump sum payment has come up short. Now, there are some veterans who love it, and there are some who want to go back to the monthly pension. What is your sense?

Mr. Reginald Argue: We should go back to the monthly medical pension. For example, I did a video interview with retired Major Mark Campbell, who literally died on an operating table three different times in Afghanistan. He lost both legs. He got $250,000. They brought him home and said, “Here you go. Here's all the money”. He had to buy a medically fitted van before he even got out of the hospital.

His home wasn't properly equipped, so he had to build a new home. He almost went bankrupt. He talked about this during the interview. Then his wife got kicked out of the military because she had PTSD, not because of the military but because of what she had gone through with her husband. At the same time, he's not getting any more money.

How can we do this to people who put the uniform on and are willing to stand up in defence of this nation? Whether we stay here or go overseas doesn't matter. We took an oath to protect our nation. We took an oath to protect our people. We took an oath to protect our flag.

All we're saying to the government in return is to, please, just treat us like ordinary human beings.

Ms. Irene Mathyssen: Mr. Callaghan, you talked a bit about the clawback and Bill C-55. One of the things we heard today in London was how important it is for a veteran to feel that there is purpose in his or her life, and meaningful work. Something they can do well is key, as they did things very well in the service.

Does the clawback that you talked about prevent people from seeking meaningful work? Do they determine it's just not worth it?

Mr. Walter Callaghan: Yes. There is only one simple answer. It's not quite that simple, but it is in a way.

When you are trying to find a new way of being, trying to find that new purpose, you're being told, “Well, if you try to do this, we may cut your benefits off. We're certainly going to claw your benefits back.” When you're challenged with that much more—and I speak primarily about PTSD when I make these comments, just so that's really clear. It is what I researched. It is my primary daily problem. When you're trying to find that new self, trying to find the purpose to be, and you're effectively penalized for trying, that demoralizes someone to begin with.

There is the difficulty of getting back up to pre-injury levels. Especially as reservists, we weren't paid every single day. Our pay was based on when we actually went in, except for the reserve force disability compensation program, which gets really complicated in another way in the last few months of our time in. When you're livelihood is based on how much you're able to work and then you're finally released, and finally you have some level of financial stability, you try to turn around and find a new thing to do, a new you, and that immediately challenges your financial stability. It is a barrier.

There's also a thing on what work even means, and I alluded to it briefly in an earlier side comment. There are a lot of forms of unpaid labour, a lot of volunteer-type work. If you're caught doing that, I do know veterans who have had their benefits cut: “Oh well, if you're good enough to do this, then you're good enough to go back to work.”

I've had this challenge thrown at me about my Ph.D. work. I cannot live off the small little fellowship that I get from U of T. I require my benefits to actually live. Those benefits allow me to focus on my research. With the nature of academic work, especially being a Ph.D. student in anthropology, I don't have set hours. I don't have set things that if I don't show up on a given day I'm at risk of being fired. The nature of that environment is fundamentally different from the labour market.

On top of that, being in social sciences, the previous Harper government made nasty comments that we're not going to “commit sociology”. I don't want to think what they might have said about anthropology. However, the nature of our social science is such that we are much more understanding and accommodating of each other's issues, challenges, and barriers. My PTSD does not directly impact my ability to do academic work. I'm able to do this because I set my own hours. Deadlines are more of a suggestion than a hard requirement.

When I do get the opportunity to teach, I prefer teaching the first and second-year courses. There are a lot of students. I actually get a thrill out of teaching, about lecturing. To be clear, I kind of like doing that. However, if I have a bad day where my demons are biting my ass so hard that I can't even get out of bed, there are colleagues I can turn to and go, “Hey take over for me today. I'll pick up some other day when you want to do that conference. I'll cover for you on that day.” The barriers are not there.

I cannot function in the normal work world. The set times, the requirements, and the constant threat that if you're not meeting a standard you're going to be fired, immediately get the hackles up. One thing that a lot of veterans with PTSD have—almost anyone with PTSD, but especially veterans—is anger, which goes back to our training itself.

That was long-winded. I'm sorry about that.

● (1950)

Ms. Irene Mathyssen: I have one last question to whoever would like to jump in.

Today we were at Parkwood hospital, and I'm so very fortunate that facility is in my riding. I see on a daily basis the really wonderful work they do, the expertise that has accumulated in terms of their staff, and how they are able to do remarkable things with veterans.

The problem is that post-Korean War vets have no access to long-term care. You will not have access to long-term care as those older vets have. It's something that I think we have to change in terms of the regulations, the relationship between the federal government and provincial caregivers.

Do you have any thoughts, any sense of how important long-term care is for post-Korean War vets?

Mr. Reginald Argue: I live over in the Legion apartments here in Toronto. A service officer who lives there is trying to do a campaign to write members of Parliament and bring the issue about Sunnybrook to their attention. Korean War veterans and World War II veterans are not entitled to Sunnybrook. She's trying change the mindset. Once those veterans are dead, what's going to happen is that Sunnybrook is going to revert to the province. We need to stop that. If it happens, veterans my age, veterans Walter's age, and even upcoming veterans are not going to have any long-term programs. I'd like to know what's going to happen to us then.

● (1955)

Mr. Walter Callaghan: I'll pass on this one.

The Chair: We're at the end of the meeting. We'll give you each a minute to close.

We can start with Brenda.

Mr. Colin Fraser: Can I ask a quick question? I hope it's not too trivial, but one thing we heard from veterans in my riding, and we also heard it from witnesses at our committee, has to do with the CF1 card. Do you have any comment on that card? I've heard from folks that it should be a photo ID card, that you should have proper identification to show you are a former member of the Canadian Forces.

Mr. Reginald Argue: Right now there's no card that has your photo on it unless you served over 10 years. I think anyone who has honourably served in the military and been honourably released, whether reserve or full reg force, should be entitled to that photo card.

Mr. Walter Callaghan: I fully agree with that. The previous photo IDs were a much better idea. This CF1 card looks like a Diner's Club, a Walmart, or a Costco thing. There's no real thing there.

The issue with the previous card was that you had to serve 10 years before you were eligible for it. In the same way, you can't use your rank or your retired status until you hit 10 years. However, these little aspects of identity can mean a lot to someone.

Mr. Colin Fraser: It shows the value.

Mr. Walter Callaghan: It definitely shows the value. That would have been a much easier fix . I believe it was the NDI 75 or the NDI 20. This came through National Defence, not Veterans Affairs. The current ombudsman has talked repeatedly about bringing in a card. Why could it not have been done? Or just go back and force DND to remove this stricture of the 10-year mark.

For me, this is a sore point. When I was released, it was at nine and one-half years. It was not by choice, and there was no reason I couldn't have been kept on for an extra six months. That way, I could have gotten the card and kept using my rank with the abbreviation for “retired” so that I could maintain my military identity. Having that stripped away was difficult. Mr. Clarke asked about things I find disgusting. Well, here's another one: the stripping of our identity by a medical release.

Mr. Colin Fraser: Thank you.

The Chair: We'll turn the floor back over to Brenda. Do you have any closing comments?

Ms. Brenda Northey: I want to thank you for this incredible opportunity to speak to you all and hear your wonderful answers.

We sometimes tend to look at veterans as liabilities on a balance sheet. From my experience working with the civilian population, and particularly those with high risk, I think we really should be looking at veterans and soldiers as assets. The training, the experience, the teamwork, and the values they bring to our society far surpass the qualities of many civilians I've seen in the job development world. We must find a way to involve them in civilian life, for if Canada loses their talents, we will lose an incredible asset.

Thank you.

The Chair: Mr. Argue.

Mr. Reginald Argue: I don't really have anything to add. I'd just like to thank you for letting me speak for a little while to add my tiny input to this.

The Chair: Mr. Callaghan.

Mr. Walter Callaghan: How much time do I have?

Voices: Oh, oh!

Mr. Walter Callaghan: I think I've gone on quite a bit. There's not really much more that really needs to be added. Well, of course there actually is, but I think everyone wants to go off after this.

I do want to reiterate one of the fundamental things that has to be shifted. Again, these are the closing remarks that I had in my initial statement. I will repeat them as my final remarks.

In the end, it doesn't really matter what programs or benefits are available if the veteran cannot access them. It is incredibly problematic that a key barrier to access is the failure by VAC to operate under the auspices of the benefit of the doubt, instead relying on an insurance-minded bureaucratic culture of denial by design.

Thank you for the time.

● (2000)

The Chair: On behalf of the committee, I'd like to thank all three of you for your input tonight and your service to your country.

Also, if you do wish to submit anything after you get home, you can send it to the clerk via our website. Also, for any colleagues who want to submit briefs, the briefs section is open till September 30. Those briefs can be up to 3,000 words long, but they don't have to be 3,000 words. If you have any colleagues or know of anybody who can't make it out or can't make the deadline for any of our meetings and they have comments, please encourage them to present a brief to the clerk. It will get to all of us.

Again, on behalf of the standing committee, thank you very much for the time you took out of your schedules tonight.

We need a motion to adjourn.

Mr. Colin Fraser: I so move.

The Chair: Thank you, Mr. Fraser.

(Motion agreed to)

The Chair: The meeting is adjourned.