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Chair

Mr. Neil Ellis

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● (1535)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): I call the meeting to order.

Good afternoon. Pursuant to Standing Order 108(2), and the motion adopted on September 29, the committee will resume its study on mental health and suicide prevention among veterans.

As members probably know, we've had a couple of cancellations today due to personal reasons. Jody Mitic and Joseph Brindle will appear at a later date.

Today we have two witnesses, Brian Harding and Marie-Claude Gagnon, founder of It's Just 700.

Today, process-wise, we'll give both witnesses up to 10 minutes for their statements. We'll do one round of questioning, and then we have a little bit of committee business after that.

We will start with Mr. Harding.

Mr. Brian Harding (As an Individual): Good afternoon, and thank you for inviting me today.

Like most people, I have colleagues, friends, and family who have struggled with mental illness. I consider it a privilege to be invited to testify for this study.

As an introduction, I'll give a brief summary of why I am sitting here at the table today.

I've been an army reservist since 2004. I have 13 years of mixed part-time and full-time service, including a deployment to Afghanistan in 2008. For just over three years now, I've also served full time as a civilian police officer.

In December 2013, after four very public military suicides, I and other serving soldiers started an initiative called Send Up the Count. Our intent was just to push out a message to other soldiers to re-establish contact with those they had served with, try to maybe find some members who had fallen through the cracks, and drag them out with some friendly human contact. We accidentally ended up creating an online network of soldiers, veterans, and first responders with the dual purpose of suicide prevention and mental health peer support.

We've had many interventions with veterans in crisis, including a number of instances in which suicides have been stopped as they were occurring. Unfortunately, we've lost some too. This remains a right-now problem. In fact, just this morning I learned of another soldier here in Ontario lost to suicide over the weekend.

In 2015, as a result of my work, I was invited by the Minister of Veterans Affairs to join the newly formed ministerial advisory groups. Since then, I've periodically met with other veterans, researchers, and military and VAC staff to provide advice from the coal face, as it were, directly to the minister and senior levels of VAC. I presently sit on the mental health advisory group.

There is no standard for a veteran in crisis. Veterans can have the same mental health issues and face the same stressors as the civilian population: anxiety, depression, family trouble, financial or legal issues, accidents, violence, all potentially unrelated to service.

On top of that, they may struggle with traumatic experiences in their service and stressors unique to the military as well. These compound each other. When you add the normal stress that anyone faces and then throw in tours overseas, months away from home, and family disruption from moving, the stress can get considerably more burdensome and complex.

Our first suicide intervention involved a veteran who was medically released from the army after a training injury. He had no tours yet, but he went from being partway into what should have been a long career to being badly hurt, sidelined and forgotten at work, medically released, having his identity as a soldier stripped, and being punted into the bureaucracy of Veterans Affairs. He fell into deep despair.

One day he made several suicidal comments on Facebook and made reference to being armed. Several of us saw it, confirmed through family that he had access to a gun, and were able to contact police in time to intercept him. He was safely arrested in possession of a loaded handgun before he was able to carry out a plan to publicly shoot himself.

Social media let this veteran reach out to a support network that previously didn't exist and give enough warning signs for us to act. Those of us involved in the call were spread from Yukon and British Columbia to Ontario.

I will highlight a few points here.

Mental health problems and suicide don't have to be linked to operational trauma. The loss of identity that comes from release and transition is a huge risk factor. An informal peer network of veterans connected online with people awake at any hour of the day was also crucial for identifying a veteran in crisis and getting him help in an emergency. This has happened many times since.

Crisis and suicidality happen when stress or trauma surpasses a veteran's capacity to cope. While numerous resources exist, veterans face serious barriers in accessing them.

VAC is the gatekeeper to many treatments, and they insist on their own medical evaluation for disability determination. Other witnesses have brought this up as senseless and damaging, and you've acknowledged it. Add my voice to theirs, but I won't beat a dead horse.

Another major barrier is a profound shortage of veteran-specific care. A friend of mine was referred some years ago to full-time residential treatment for mental health. There this Afghanistan veteran, alongside a police officer, shared what was supposed to be a therapeutic environment with criminal gang members attending treatment on court order. This is disgustingly inappropriate, and dangerous for people expected to open up about trauma suffered in service to their country or community. The police officer, incidentally, has since died by suicide.

I'll echo my friend Debbie Lowther and the other witnesses who testified last week to the critical need for veteran-specific treatment facilities.

Stigma and discrimination against mental illness are still killing people. There is a pecking order in veterans' circles, even among the injured and ill.

Recently a veteran was going to execute a detailed and effective plan to kill herself. She has struggled with PTSD since working overseas in an intelligence role. She was responsible for identifying enemy targets, identified by unmanned aerial vehicles, and then watching them get killed on live video. She has faced scorn and skepticism from other veterans who developed their operational stress injuries from personal involvement in close-quarters combat. Neither injury is more or less legitimate than the other; they're just different. Just as a broken leg from playing football and a broken leg from slipping on the ice differ in how they happened, you have the same result. Despite this, she was hounded by other vets to the point where she became convinced she was faking her own PTSD, which had been diagnosed, and decided to kill herself. Luckily, she reached out to me in time, again through social media, and I talked her down and into accessing care.

I use this story to highlight how far we still have to go with stigma in the military, in the veteran community, and in society as a whole. External stigma from others becomes internalized. People who are simply injured come to believe that they are weak or useless. That's agonizing for anyone, never mind somebody who comes from an environment as utilitarian in attitude as the military.

A struggling or suicidal vet will often reach out to other vets first and perhaps last, reaching out to other people who they believe will “get it”. They may not survive long enough to walk into a doctor's office unless a buddy or a family member helps them through the crisis and gets them there.

I'm not a clinician or a researcher. I'm a part-time soldier and a full-time cop. Since I began to find myself intervening with veterans in crisis, I've had to get as much training as I could to catch up. I received training in mental health first aid, a course I've since helped the Mental Health Commission of Canada adapt for the veterans community. I instruct a course called “Road to Mental Readiness”, which teaches soldiers and first responders mental health resilience skills.

I've been lucky. These and other courses, plus professional experience, have given me tools for crisis intervention. Peers and first responders don't substitute for proper clinical care, but we constantly find ourselves as mental health first-aiders when we get a phone call or a text message or see a social media post at some ugly hour of the night and realize that a life is in danger right now.

The skills I learned in mental health first aid have saved lives. A slow start has been made in pushing this sort of training out to veterans and family members, but much more is desperately needed. None of us knows who is going to be awake and able to respond to the next suicidal comrade. We need to see increased mental health literacy and first aid training in the population at large and the veteran community specifically.

I want to touch very briefly on veteran suicide data.

On November 17, Mrs. Lockhart asked another witness if we have data on the suicide rate among veterans. We do not.

Every death ruled by a coroner as suicide is compiled provincially and sent to Statistics Canada for their mortality database, but the data is stripped of personally identifying information. At present, nothing causes a coroner's determination of suicide to be compared against a list of those who have served in the Canadian military. Nothing reliably and consistently flags the fact that a veteran has died by suicide.

There is, therefore, no comprehensive data available on the rates of suicide among veterans. Changing this could be straightforward if the name and date of birth of every recorded suicide were run against a database of former military members. That would get us close enough to 100% to be useful and valuable. All the necessary information exists; it just doesn't exist in the same place, so that concerned parties can turn it into data.

To sum up, veterans suffer from all the same mental health issues as the civilian population, plus unique challenges linked with service. Suicide and crisis are not always going to be linked to operational stress injuries, but may stem from depression, anxiety, or other mental health issues linked to normal life stressors that the military lifestyle adds to.

Veterans are going to their buddies first as a familiar source of support, and they're doing it using new modes of communication. Those of us providing the support need to be better trained to get that vet through the first few hours of an unexpected crisis while we guide them to appropriate professional care.

Veterans struggle to access care due to bureaucratic backlog, a massive residual problem with stigma, and a lack of dedicated residential treatment options tailored to their unique needs. The veteran suicide problem is a long way from going away and has yet to be even properly defined, but the data is within reach if the government decides to make it happen.

Canada as a whole has a lot of work to do in mental health. Injured and ill veterans are a very concentrated, high-need, high-risk target population for this work. We must learn how to save those in crisis, support them through recovery, and reintegrate them to or transition them from the workplace. Canada will advance in mental health; it's just a matter of how fast. Just as civilian paramedics learn from and use techniques developed on the battlefield, any and all effort put into helping the situation of veterans with mental health disorders will pay dividends for the rest of the Canadian population.

Thank you.

● (1540)

The Chair: Thank you.

Please go ahead, Ms. Gagnon.

Ms. Marie-Claude Gagnon (Founder, It's Just 700): First I would like to thank the committee for letting me present here today.

My name is Marie-Claude Gagnon. I am a former naval reservist, a military sexual trauma survivor, and founder of the group It's Just 700.

Created in 2015, our group allows men and women suffering from military sexual trauma to connect with peers. We are the only network dedicated to MST survivors in Canada.

We offer meetings; inform people about VAC and other services, such as legal and financial aid; connect victims to the Canadian Armed Forces sexual misconduct response team; provide in-person support for depositions, medicals, and meetings; provide collaboration with therapists to develop services for MST survivors; and carry out consultation and awareness projects.

I would like to start with the definition of MST. Since there is no information about military sexual trauma on the VAC website, I had to borrow the definition from the American VA website. Military sexual trauma is defined as:

> psychological trauma resulting from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training.

Now I would like to address this topic by borrowing quotes from the 2014 “Caring for Canada's Ill and Injured Military Personnel: Report of the Standing Committee on National Defence”.

> It is necessary to address prevention and treatment not only of combat-based PTSD in the CAF, but to address other causes of service-related PTSD such as sexual assault.

The link between sexual assault, either in theatre or at home, and PTSD is well established, particularly for female service members. We know practically nothing about other aspects of female veterans' experiences in Canada.

Colonel Gerry Blais assured the committee that all the programs offered by the CF joint personnel support unit are for everyone; however, Colonel Blais' statement that we treat all our injured and sick members in the same way does not reflect the specific psychological and social aspects of women service members experiencing PTSD and other mental health issues, particularly those who have suffered military sexual trauma.

Regardless of these recommendations, the 2014 Surgeon General's report on suicide mortality in the Canadian Armed Forces persisted in looking only at men. This report, approved by our newly appointed Surgeon General, did not include female suicide due to the very low number of females killing themselves while in service.

Since the majority of my group was forced to medically release after reporting their sexual assault, it is fair to advance that the 2015 research on mental health did not reflect MST survivors' reality.

The 2015 “External Review into Sexual Misconduct and Sexual Harassment in the CAF” stated:

> a common response to allegations of sexual harassment or sexual assault seems to be to remove victims from their unit.

Doing so can potentially lead to an unanticipated and involuntary release.

Please allow me to quote members of my group who are currently going through this experience. One said, “My military doctor started pushing for a medical release at my first appointment with her, following the assault, before I had even seen a psychiatrist, started meds, started seeing a psychologist, or even wrapped my head around the fact that I had been raped.”

Another one stated, “How can I start to heal when on the one hand I am being pushed out the door, and on the other hand I am still seeking justice?”

I have another quote: “I had to take sick leave for four days this week. It is hard to cope with the demands of work and deal with the aftermath of the investigation. At times I feel that the organization is trying to break me.”

Research published in 2014 by the *American Journal of Preventive Medicine*, however, did look into military sexual trauma and suicide mortality and found a high risk of suicide associated with military sexual trauma. It was recommended to continue assessing and considering MST in a suicide prevention strategy.

According to the *Journal of Military, Veteran and Family Health*, learning from the Deschamps report, female veterans tend to be underdiagnosed and undertreated. Consequently, they may face challenges accessing appropriate health services and may experience victim blaming and secondary victimization when seeking help for MST.

I have another quote: “The medical personnel told me that rape victims were not sent to see psychologists and that the priority was given to soldiers with combat-related trauma.”

Regarding the consequences of lack of care, I have other quotes from people who have had experiences. This is from a mother: “My youngest son found me unconscious in my room after a suicide attempt. In 2012, I was forced to do some terrible things to provide for my two children.”

● (1545)

Approximately 85% of married female soldiers are married to military men. This is another set of specific stressors that are unique to female soldiers. When was the last time we heard a male spouse advocating on behalf of his female soldier wife?

Operational stress injury social support staff do not receive MST training and are not responsible for conducting assessments on MST survivors and their caregivers, as is done for combat-related OSIs. We all heard that OSISS includes MST, but here is what members have to say about that: “I have PTSD but was denied going to OSISS. I was told I would not fit in the program. It seems we get lumped in with all the Afghan vets when the PTSD diagnosis comes down. Not all trauma should be treated the same way. When you're constantly fighting for people to believe what happened to you, it is not beneficial.”

OSI clinic support groups are also based on goals, such as improving sleep, which does not allow people the ability to create groups for MST survivors.

My recommendations to this committee are to implement GBA+ throughout VAC policies, programs, priorities, and research; implement mandated female veterans gender representation at 15% as a minimum to all the DVA advisory committees, since right now female veterans represent only 3.5% of all the advisory groups for VAC; implement science and data collection to determine the sex-specific needs of female veterans, including on MST issues; train front-line and educator staff in gender-specific needs and treatments, including MST, ensuring that taxpayer-funded research is addressing both sexes; conduct a formal evaluation of the response process and support services available to MST survivors; post the services for veterans dealing with MST online; post online the number of medically released personnel who reported a sexual misconduct; and track how many MST claims are granted or denied every year, as acknowledged by retired General Natynczyk during the 2015 stakeholder meeting.

As an example, today I have somebody who is contemplating suicide. I'm dealing with this at the same time, so I may be looking at my phone once in a while just to make sure he's okay.

Thank you.

● (1550)

The Chair: Thank you.

We'll start our first round with Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you both for coming today and presenting to us. It's heartfelt. We hear what you're saying and we definitely want to know more about what we can do and what we can recommend.

I recognize and I appreciate that you're caring enough to look at that phone during this trying time, so by all means do.

Ms. Marie-Claude Gagnon: Thank you.

Mr. Robert Kitchen: We've heard a lot of times throughout this committee about how we build our soldiers. We take them in and, for lack of a better word, we indoctrinate them into becoming soldiers. We're finding, once we release them, as you've said, it's "Thanks for coming." We kick them out the door and tell them not to let the door hit them on their way out.

Brian, can you comment a little more on how you see deconstructing these soldiers from that military mind? What we've heard, and I think what we're all thinking about, is that the lack of deconstruction is why we're seeing a lot of these issues, or some of them at least.

Mr. Brian Harding: I believe that was spoken to quite eloquently by a few of your witnesses last week.

A lot of guys get in when they're 17, 18, 19. They might literally recruit into the military out of their parents' place. It's certainly not all of them, but you find people transitioning into adulthood at the same time as they transition into the military. They go into an environment where a lot of things are structured for them, provided for them. They have people to meticulously track their personal administration and make sure all their boxes are ticked for anything they need to do in life. Especially for the regular force, being a member of the military is a core part of your identity, and most of your life revolves around that.

When someone unexpectedly finds himself now needing to emerge into the civilian world, in some cases they—and I'm not trying to sound condescending in saying this—may have a lack of basic life skills. There's nobody to tell them they have a medical appointment coming up, to make sure they take care of this, that, or the other thing.

Of course, now that I'm on the spot, I struggle to think of other examples, but I think there would be merit in a structured assessment of what competencies releasing soldiers are lacking as they transition into the workplace, where those gaps may be exacerbated by medical factors, and of what specific training or development could potentially help them on the way out the door. That's not to say that it needs to be mandatory, but give them a buffet of options: here are things we can teach you how to do for yourself that we have previously been doing for you. That's just a thought.

● (1555)

Mr. Robert Kitchen: Then we would put them through a boot camp as they come in and put them through a boot camp as they go out. Would that be a...?

Mr. Brian Harding: I would not be quite that firm. When you say "boot camp", you are taking somebody who has previously been potentially unstructured and ill-disciplined, and you are turning them into that. That's exactly what we're trying to deprogram, though. You want someone who doesn't need to be told, "You will show up at eight o'clock. At 12 o'clock you have lunch. At 12:35 you're done stuffing your face and you carry on."

If there is to be training on the way out the door, to my mind at first glance, it should be structured in such a way that it helps to build the competency to look after your own affairs. Truthfully, though, this is not something I've really given much thought to before, so I'm a bit at a loss beyond that.

Mr. Robert Kitchen: I appreciate that. We're looking for comments coming from your heart from someone with your experience. It's worthwhile to see.... I appreciate that.

You talked about stigma and you talked about how it hounds within. Marie-Claude, I think in a way, although you didn't say it, there is that stigma as well when we're dealing with MST. I'm wondering if both of you might be able to comment on that stigma and how you see it playing in a situation dealing with mental illness.

Marie-Claude, I'll let you go first.

Ms. Marie-Claude Gagnon: I'm going to mention only MST, just because it hasn't been addressed as much, let's just say. I'm giving the example of Bell Let's Talk. We haven't heard anything about military sexual trauma there. OSISS once had a campaign going on that had no military sexual trauma survivors. They willingly wanted to offer their testimony, and they were denied. They were not called back to put their information out there.

You see pictures on peer support and things like this, but on veterans day, we don't mention MST. We show the successes on women's day for veterans or soldiers. Women's groups usually go with the ones who have achieved success, but we neglect the ones who didn't. These are not the kinds of things we talk about.

The military itself, obviously, unless it's talking about the specific subject, doesn't integrate it. Even in the month of crime—I think it's March—we don't mention sexual trauma then either. It's never mentioned. It's not on our web page. It's not on VAC's web page.

If you look at the American VAC website, there's a whole section. I've been asking for over two years now to have one web page on our Veterans Affairs website just to tell us that, yes, we do accept MST, and these are the resources available for you. That never happened.

Mr. Robert Kitchen: Brian, you talked about being hounded from within on the issue of stigma. I'm assuming that what you mean by that is someone is being labelled as having PTSD and his fellow soldiers are basically chastising him and putting him down because of that. Can you quickly comment on that?

Mr. Brian Harding: It's an environment often dominated by alpha male mentalities. The military, of course, revolves around the ability to kill people and break their stuff in defence of the national interest. There is a certain mentality that comes around toughness, around self-resilience, and I have seen this too many damn times. If you were not outside the wire, on the ground and inflicting violence on the enemy personally, there is no way that your trauma can possibly be as legitimate as my trauma.

That comes from ignorance, it comes from ego, and it needs to be crushed.

Mr. Robert Kitchen: Thank you. Is my time up?

The Chair: Yes, you are over. Sorry about that.

Go ahead, Ms. Lockhart.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Mr. Harding, I want to talk to you a little bit about the peer network that you talked about. We have been talking, through our service delivery study we conducted on mental health, about the importance of peer support, peer networks, and how times are changing. People are certainly reaching out online. You spoke of better training for peer support groups. How do we do that? Is part of the effectiveness of those peer support groups the informality of them, and if so, how could VAC provide more training?

● (1600)

Mr. Brian Harding: More training would be excellent. Better training would be excellent. Any training would be a splendid start.

There exists an abundance of courses out there to help laypersons with these issues. Probably just about everyone in the room at some point has learned standard first aid and CPR. There is a course called ASIST, or applied suicide intervention skills training. There is mental health first aid. There is psychological first aid. Within military and first responder circles, there is Road to Mental Readiness. There are a ton of courses that teach people how to identify that someone is struggling or in crisis. Just as you assess airways, breathing, and circulation in first aid protocols and intervene as appropriate, likewise when you detect that somebody is in crisis, there are structured approaches that guide you through how you actually interact with that person. If an infantry idiot like me can get them, anybody can.

The Mental Health Commission of Canada last year adapted mental health first aid for the veterans community. I helped review their material to give it some military flavour, as it were. That is very slowly getting pushed out now. The first batch of instructors has been qualified. The Royal Canadian Legion is helping to spread that, but it's very much a side project. It's slow.

That is just one option that's out there. There are, as I said, many different possibilities. The Royal Canadian Legion service officer training that they give to all their service officers to help guide people into the Veterans Affairs process, and to deal with crises should they emerge during that, is also excellent. That potentially could be part of a prototype for training that could be broadly offered. How they would go about doing it is probably beyond the scope of what I can answer in a brief question here.

All the necessary training exists. It just needs to be collected and packaged, and a viable delivery model determined.

Mrs. Alaina Lockhart: I appreciate your bringing up the Legion. I actually attended a meeting of several of the Legions in my area, and they were talking about this, about how they wanted to make sure that everybody in the Legion had it, from the bartender to the service officers. To your point, I think there is a long way to go, and it can be far-reaching. It never hurts to have more people trained than not.

On this mental health first aid and how it's been adapted, Ms. Gagnon, do you think there's an opportunity to do that for military sexual trauma as well? Is there another level of sensitivity that needs to go along with that?

Ms. Marie-Claude Gagnon: I was offered peer support training, for example, but it would have taken me away from work for four days or a week. I work full time, and you know, after redoing your career, you don't have as many days off at the start. As a military spouse, I have bounced around as well, and I've had to start from scratch all the time. I don't have time to take a week off to go for training on my own.

It would be nice if there was distance learning. Maybe over a weekend I could finish it up. That would allow many more people in my group to be able to attend. The women in my group—we have men as well, but it's mostly women—usually have a family. They won't leave them alone to go and pursue that training for a week. It would be nice to have something for distance learning.

Mrs. Alaina Lockhart: You said you were offered training. Which organization offered it?

Ms. Marie-Claude Gagnon: That was OSISS.

Mrs. Alaina Lockhart: It was OSISS, so it is something that they're starting to push out there.

Ms. Marie-Claude Gagnon: No.

Mrs. Alaina Lockhart: No? Okay.

Ms. Marie-Claude Gagnon: It was just that in my situation, because I was operational when my assault happened, they considered that an operational thing. For a lot of people that is not the case, but I was allowed to go in because of it. I was invited to take the training; I just couldn't do it.

Mrs. Alaina Lockhart: Okay. Fair enough.

To that point, you mentioned several recommendations that I thought were very good. Some of them were very familiar to us from other testimony we've heard. As far as our front-line Veterans Affairs staff are concerned, what do they need? What do we need to do to make that first contact better?

That's actually a question for both of you.

Ms. Marie-Claude Gagnon: I would say the information needs to be online, because people need to advocate for themselves now. Then we can actually check what's going on. We call, and the information differs, depending on whoever is answering the phone. We get people who have been told they can't have VAC rehab, and they have to wait, but they were at school, so by the time they get it, they don't know that they will not reimbursed for their school.

Most of the MST people are young. The average is between 17 and 19 years old. This is when they get assaulted. When they leave, they are going back to school, and this is different process, so the information has to be there.

There are a lot of females in the reserves. We're falling through the cracks when the information comes, so we always end up in this waiting game where we get put on hold for a specialist who never calls back. Those are the kinds of things we experience. I think if it's online, we'll know what to expect and we'll be able to access care.

The forms, also, are only combat-related. I was asked to do a gynecological test 10 years afterward. I had to go. That's the process, even though I had two kids after that. What can you find? It was intrusive for no reason. It took me eight months to fight this, just to be allowed to pursue it. I was allowed to pursue this after they initially told me I couldn't. I couldn't go to the BPA because my claim wasn't denied, so here was no recourse for me. The only recourse I had was to gather 19 other people like me, and then we got reconsidered, but it took over eight months just to be allowed to proceed. That kind of stuff needs to change.

● (1605)

Mrs. Alaina Lockhart: Thank you.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you, Mr. Chair, and thank you very much for being here. We appreciate this testimony. It's going to help us to come up with a report that we hope will help veterans.

Madam Gagnon, I have a number of questions for you. You talked about other veterans websites, the American website specifically, as clear examples of what Veterans Affairs could be doing. What was it in the American website that gave you or American veterans better information?

Ms. Marie-Claude Gagnon: First of all, they had the definition. There was acknowledgement that it happens. They have explanations of what can be considered as proof that are different from what would apply if you went into combat. For example, if you contacted a help line and you can prove it or if you went and asked for help during that time, those can be proof.

Those are the kinds of things you can ask for to get your claim ready. Right now the people who help with claims are the Legion. By the way, 19-year-old women won't necessarily feel like going to the Legion to get help. The Legion is not well versed there in how to address those cases. They make a case just like a combat case, and then we get denied. Once it's time for an appeal, we can't bring new information. We need a proper person, or at least something online that tells us what we can do if we did or didn't report it or if our med file is gone for some reason. We need to know what can be done.

Ms. Irene Mathyssen: You launched your group two years ago. What has changed in regard to the services for veterans living with military sexual trauma? Is there anything positive? Have you seen a difference in two years?

Ms. Marie-Claude Gagnon: Do you mean within our group or outside it?

Ms. Irene Mathyssen: I was thinking about outside, with VAC.

Ms. Marie-Claude Gagnon: I have recently seen more VAC claims being accepted. It's when people push and push and are about to come out in public that they get accepted, so I guess that's a good start.

Before, you had to almost fake another trauma. It was so hard to get a hearing for military sexual trauma that people would find another thing—a loud noise or something scary, something easier to prove. Military sexual trauma was rarely the real case. They were using other ways to get access to services.

However, they are starting to accept the fact that military sexual trauma can be a case. Also, if the act happened, let's say, after work, but you get repercussions at work and you have proof of that, these cases can also be considered. Before, if the act happened, say, at a mess dinner, then you were not covered. Now they are starting to look into whether they should cover people in mandatory mess dinners at night and people who got assaulted in the barracks. Right now they aren't. Those things are being reviewed.

● (1610)

Ms. Irene Mathyssen: It sounds as if it's very difficult to prove this assault happened and that it was part of being in the military.

Ms. Marie-Claude Gagnon: Well, there are three filters, I would say. You have to prove it happened. You have to prove your condition is linked to what happened, because sometimes they will find childhood trauma and say you were already injured before. Then you have to also prove it was service-related.

A lot of people have been told that if they lose in court, which requires proof beyond a reasonable doubt, it technically didn't happen. Some people have been told if you lose in court, you will not get anything. That's not really fair, because if you're in combat and you have been told you have PTSD, you are allowed the benefit of the doubt, but if you're in military court or under any kind of criminal law, the burden of proof is much higher.

Ms. Irene Mathyssen: It sounds like you were assaulted in the first place, and then it was made even worse by the process you had to undergo.

Ms. Marie-Claude Gagnon: The BPA also treats people.... I didn't bring all the quotes, but I get people saying, “The lawyer said I would have screamed if I were you” or “If I had been raped, I wouldn't need psychological treatment.” There is a lot of victim blaming during BPA or when seeing a military doctor. There has been a lot of that going on.

Ms. Irene Mathyssen: That brings me to a question about a woman seeking help for sexual trauma. Would it be easier if you were able to get help from a female support worker? Does the military or does Veterans Affairs ensure that if you are seeking that kind of help and support, there is care available from a female if it's asked for?

Ms. Marie-Claude Gagnon: Actually, it's a male who brought this into my group, because he was assaulted, obviously, by another man, which often happens, and they prefer to talk to women. They would like to have the choice.

Also, it is proven—I don't have the research on that—that in peer support, women heal better when it's women alone, but if it's with other men, they tend to stay quiet and let the guys talk, so the healing process is not as good.

The Chair: Sorry. That's your time.

Mr. Fraser is next.

Mr. Colin Fraser (West Nova, Lib.): Thank you very much, Mr. Chair.

Thank you both for coming and sharing your experiences and also for your service to Canada. It's greatly appreciated that you come and share your experience so we can hopefully make recommendations to make things better for veterans.

Mr. Harding, I would like to start with you. When you talk about peer identity and contacts within the veteran community and reaching out to those veterans who may not otherwise come forward and express their difficulties, how does that work across the country with your group in particular, in Send Up the Count? Is it focused right across Canada? Do you see any difficulties or challenges reaching out to more rural or remote areas?

Mr. Brian Harding: My particular group does everything online. When we started this thing, we did not expect or intend to create this group. It emerged organically. A couple of us pushed out this message. Our third founder created a Facebook page, which within days in excess of 9,000 people flocked to, so we realized we had to run with it at this point.

The intent we initially set out to promote was to proactively go out. We said, “Hey, that dude who was in your platoon in Bosnia, or Croatia, or Afghanistan, the guy you haven't talked to in three years? Just call him up or shoot him an email or whatever, and just say, 'Hey, how are you doing?' ” Just open up a conversation.

We have a lot of veterans who have dropped off the radar, and they are suffering unbeknownst to anybody. Particularly in the military, and in my case the army reserve, we all scatter back to various bases and communities.

We don't have any structured, formal thing. We were never a structured or formal thing. It just seems to have helped anyway. We encourage people to just seek out the people they have been in touch with and find out how they are. That's on an ongoing basis, not one day a year—I'm not trying to pick on Bell—but every single day. When they say, “I'm doing okay”, but you don't think they are being completely forthright, you say, “No, how are you really doing?” Give them that opening to realize that okay, here's someone who is safe to talk to about the fact that this, that, or the other thing has been going on.

Mr. Colin Fraser: In the follow-up, I believe you're suggesting that post-release there should be this ongoing engagement and follow-up and that veterans generally will have more confidence in a fellow soldier, and therefore these individuals would be the best to do that outreach.

Do you have any recommendations on how that follow-up could happen after release? Is this something you foresee in the future being structured through VAC, or is it better to leave it to individual organizations like yours to do that?

● (1615)

Mr. Brian Harding: Well, that's a doozy. “I'm from the government and I'm here to help” is not always going to play over well.

Mr. Colin Fraser: Right.

Mr. Brian Harding: Most of these contacts just happen informally. We just talk to our friends.

After I came back from Afghanistan, some months later I began getting hounded by emails to attend a follow-up appointment with a military social worker. After long enough, they were eventually able to pin me in a room and get me talking, just to make sure things were good, and they were. When you're still serving in the military, there is at least a mechanism to compel you to do that. Once someone is out, they can't be compelled. That said, once someone is out, there is no reason, to my mind, that someone couldn't just check up and say, “Hey, you've been out for a while. Has anything emerged since your release that you think might benefit from access to supportive resources?”

When you release from the military, you do not automatically become a VAC client. There are probably privacy firewalls somewhere in policies or regulations that preclude names and contact info from getting sent from DND to VAC. I can't provide a solution to that.

Hypothetically, that wall could be knocked down and VAC could be enabled, on a proactive basis, to reach out one or two years post-release just to say, “Hey, we're following up with you. You've been out for a while. How are you adapting? Do you know we have this and that?” Frequently, I find that veterans are completely unaware of the options that are open to them.

As to how this would be done, I would need to do a lot more thinking on that.

Mr. Colin Fraser: Okay, but in your experience, having former soldiers, colleagues of these individuals, doing that outreach means that the response is much better. The credibility and the trust are there, so to speak.

Mr. Brian Harding: I cannot speak in a comparative way. I can't say a soldier in every case will be better than a VAC employee.

Mr. Colin Fraser: Right.

Mr. Brian Harding: I do know that proactive outreach from soldiers on an ongoing basis saves lives.

Mr. Colin Fraser: Okay.

For veteran-specific treatment, which you talked about, we have OSI clinics and other things that are available. Can you make some recommendations or give me some idea of what you mean by veteran-specific treatments that VAC could perhaps do a better job of, to ensure that veterans are getting the help they need?

Mr. Brian Harding: I sure can. I'm speaking specifically to residential or in-patient treatments. Those two are not necessarily the same thing.

There are many facilities—places like Bellwood, Homewood, Sunshine Coast Health Centre—that provide longer-term in-patient treatments, but as I said, there are mixed populations in a lot of cases in these facilities. The researchers likely have a fair bit of familiarity with vets, but their work is not necessarily tailored to them, nor is the program delivery.

The Minister of Veterans Affairs' mandate letter actually pledges a “centre of excellence” for mental health—

Mr. Colin Fraser: Yes.

Mr. Brian Harding: That, in my opinion, is a weasel word. What was actually demanded by veterans' advocates was specifically a treatment facility, yet that's what it turned into in the mandate.

On the mental health advisory group that I'm a part of within VAC, we are pushing very hard for that to be a brick-and-mortar facility. We need something in a therapeutic environment filled with safe people who veterans can open up to. I'm not denigrating other people who have suffered from mental health disorders or trauma, but certain people are not compatible with each other. Vets also include former RCMP members. We need brick-and-mortar facilities that are unique to the VAC client population and have a constant ability, on a demand-driven basis, to get vets into full-time treatment.

Mr. Colin Fraser: It could be a walk-in clinic, or it could be by appointment, servicing all these different needs. Is that how you would see it?

The Chair: You will have to make it very short.

Mr. Brian Harding: That could be, but the main effort has to be something for treatments of 30 days or more.

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

Mr. Bratina is next.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): Thank you very much.

Ms. Gagnon, I think all of us are concerned every time you look at your phone. I certainly hope no one has....

It's good of you to share that with us. Is that something that occurs on a weekly or a monthly basis?

Ms. Marie-Claude Gagnon: No, it's bi-weekly.

Mr. Bob Bratina: Can you tell me how you felt when you graduated into the services? Was there a golden era of becoming the sailor that you wanted to be?

● (1620)

Ms. Marie-Claude Gagnon: I actually wanted to be in the artillery initially, but at recruitment they laughed at me and said, “How about the navy?” I enjoyed the navy, but I just honestly wanted to do boot camp to see if I could make it at that point.

I ended up liking the sea. Then I went back to school and transferred to intelligence officer. I wanted to be a public affairs officer, but that got cut short, so I had to rethink my whole career. My husband is in the military, so we were following each other.

There was a plan, and now that plan has changed as well. You lose your pension and you lose the prospect of having all these things, so it's kind of a do-over. It changes a lot.

Mr. Bob Bratina: What do you think you would say to a group of young recruits, the people that you were, as they're entering into service? Would you have a message for them with regard to the issues that we're talking about today? Is it something you could talk to young recruits about?

Ms. Marie-Claude Gagnon: I wish I could say, “If something happens, talk”, but I can see what happens when people do and I don't know if it's a good time yet. I don't think we're there yet. There are still a lot of medical releases. There are still a lot of repercussions. There are still a lot of people being penalized for talking, and the retaliation part has not been set yet. We've pushed people to report, but we haven't actually provided support when they do, so until that is installed....

Of course, I am never going to stop somebody from reporting—I think for some people it's closure—but I'm not going to push somebody to report, either. I think everybody has to go at their own pace.

Mr. Bob Bratina: Could you comment, Mr. Harding?

Mr. Brian Harding: Yes, I'll put on my still-serving sergeant's hat for a second. It'll be a cold day in hell before somebody does something like this to one of my troops and I don't go to bat for them, but that's me. There are many who come from a different mindset—an obsolete, destructive mindset—who would perhaps be more tempted to shove these things under the rug.

Unfortunately, as Marie-Claude has alluded to, the process can be terrible for people who do come forward. I have seen people disclose these sorts of assaults in what they thought was a safe place to do so, and had the chain of command get wind of it, and three years later they're still dealing with the ramifications of a subsequent investigation that they maybe never even wanted, because they just wanted to try to move past it.

On the one hand, the military is absolutely tied by an obligation to act to the fullest extent of the law when these things do come forward, and perhaps the victims are getting lost in that, but change is not going to come from the 17-year-olds or 19-year-olds who are going through basic training. It's going to come from the more experienced senior leadership, who need to grow up, take the reins, and fix this from within.

Mr. Bob Bratina: Ms. Gagnon, is the exposure of married females any different from that of single women in terms of MST in the service?

Ms. Marie-Claude Gagnon: We also have to consider that our spouses usually face retaliation as well. Even if we're out and we do speak, there is a chance that they get retaliated against. I have five people in my group, and I know that this is what's going on. Their spouses are facing retaliation for it, and they feel bad.

It's something we have to consider when we talk. Obviously, relocating all the time, now that we're civilians we need to find new health care everywhere, new therapists and new psychiatrists, and this is not easy to find. If career transition is hard when you leave, and you get to pick where you live, imagine if you move to Gagetown. You have no purpose anymore, and a lot of times you get pushed to stay at home and take care of your kids. If you've been in the military all these years and you had a different path in life, this is not what you expected. There is nothing wrong with that, but it's just maybe not what was in your blood initially. To report is really a career killer.

Can I just say one thing about what you asked initially?

Mr. Bob Bratina: Yes.

Ms. Marie-Claude Gagnon: I have one message. A lot of people see things going on and say nothing. The best way to stop assaults and things like that from happening is that when you're a witness and you see something going on, you say, “You know what? I see this, and it looks pretty bad. Why don't I go with you and report this?” That provides a statement. It provides a witness and makes the person much more confident to report, and the investigation would proceed, but a lot of people choose to say nothing because they themselves are afraid for their own career.

● (1625)

Mr. Bob Bratina: We're listening intently. I wonder if, in other conversations, people sometimes think you're exaggerating and things can't be that bad. Mr. Harding or Ms. Gagnon, do you think that the general public accepts what we're hearing today or not?

Mr. Brian Harding: I'm not throwing out statistics. Some will; some won't. Those who don't can speak to me about it, and I will tell them what I have observed. Most people are okay in most circumstances, but there is still far too much going on.

The Chair: Thank you.

Mrs. Wagantall, go ahead.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you both so much for being here. You speak so articulately and so honestly and passionately about these issues. The longer we question, the more it brings up the fact again to me that we can make all kinds of recommendations, but if the culture is the culture, those recommendations probably aren't going to get very far. I'm being very blunt and honest here.

Retaliation for reporting, the fear of the responses that you're going to receive, and the actual things that are happening clearly make it very difficult for the people to come forward. If I were the minister alone in a room with you, what would you say absolutely and honestly needs to be done before any of these other steps can truly make an impact?

Ms. Marie-Claude Gagnon: We need more women in the military, because the more we have, the more secure we feel to report. You realize that when it's a male-dominated area, women seem to be in self-preservation mode.

I did it myself. Somebody came to me once and said that something had happened, and I said, “Well, I'm not going to back you up because if I back you up, I'm going to be put in the same position as you.” I didn't want to be seen this way. However, if women are at 50% or 40%, they will feel more confident. They don't have to be in self-preservation mode and show that “she is like this, but I'm not like her, and I'm with you guys”, and that kind of thing. You're using that defence mechanism less.

Mrs. Cathay Wagantall: Mr. Harding, would you comment?

Mr. Brian Harding: It's hard to say.

If I were to address these issues, I would not be speaking to the Minister of Veterans Affairs but to the associate minister of National Defence, which is the capacity that could have an impact on this.

Within the serving military, values are, I believe, shifting. I think that's more a generational thing of Canadian society shifting, but again, I'm a full-time police officer, so I know how much awful stuff is happening out there too.

I don't believe there is going to be a 100% fix on this; however, I don't have one single piece of advice that I could give on this. If you're speaking specifically to military sexual trauma, I'm woefully underequipped to speak to that.

Mrs. Cathay Wagantall: No, I wasn't expecting you to do that.

Mr. Brian Harding: Yes.

Mrs. Cathay Wagantall: Okay. I appreciate what you're saying.

Marie, you had mentioned that there wasn't information on the VAC website. I want to get this straight. Had you made a recommendation for it to happen?

Ms. Marie-Claude Gagnon: Yes, for two years.

Mrs. Cathay Wagantall: Was that recommendation taken?

Ms. Marie-Claude Gagnon: Yes. I guess I've been told that they will look into it. I was contacted by somebody about four months ago, but then that was it. I never heard back afterwards.

Mrs. Cathay Wagantall: Okay. I'm just not understanding why it's not happening. There's not a huge expense involved in any way.

Ms. Marie-Claude Gagnon: What I've been told is that the services are for everybody, so we shouldn't have to....

For me, it's more like an equity-equality kind of thing, right? Equal doesn't mean equity—

Mrs. Cathay Wagantall: Right.

Ms. Marie-Claude Gagnon: —so I think there should be a little bit more push, especially when all the pictures and all the information out there obviously don't target a 19-year-old woman, right?

Mrs. Cathay Wagantall: Exactly. Okay, thank you.

Mr. Fraser talked a little bit about the dynamics of training and equipping. You mentioned lay people.

I get really excited about all these situations of veterans helping veterans and soldiers helping soldiers and that type of thing. Clearly we hear a lot about the trust issue, and that is strongest among your peers.

Would it be effective, then, for VAC to try to implement these things or for VAC to be equipping and recognizing and facilitating these groups that are out there in a more...? No. As soon as you become organized, you start to put all kinds of conditions on things, and we don't want that because clearly it's more effective without them.

How I ever got into government, I have no idea.

However, can you see a framework for this? What would work best?

● (1630)

Mr. Brian Harding: The ones who proactively care about their fellow vets will just step up and do it with the best we've got.

If you're walking down the street and you see someone get hit by a car, most people are going to run to help them in some way. Someone who knows first aid CPR is probably going to be more effective than someone who doesn't. A lot of workplaces offer first aid CPR training for free or else subsidize it. I'm not saying that VAC needs to create tiger teams of people, cells reaching out to vets that have a quota, such as cold-calling 60 vets a day to see how they're doing, or what have you. Just fund this training; those who care about it and want it will step up. Yes, a rate of return is going to be difficult to gauge, particularly because the metrics here are going to be things that don't happen, and it's tough to prove a negative. It will be hard to show vets that never do reach crisis because someone helps them in time. It's hard to count suicides that don't happen.

I don't know if that could be easily quantified, the way the government and departments like to quantify things. At the same time, this isn't particularly expensive training either. In mental health first aid, as I said, already a product has been developed for the veterans community, so push that more aggressively, assist training, and apply suicide intervention training.

Again, get that out there. We've got these things; if you want to take them, if you served or worked with vets in some capacity, come on out.

Mrs. Cathay Wagantall: Thank you.

The Chair: Thank you.

Mr. Graham is next. I guess you'll be splitting with Mr. Eyolfson.

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.): I have a couple of quick questions. I just joined this committee last week, so I'm new to the file and I find it interesting, and not necessarily in a positive way. I appreciate your coming and telling your stories.

Brian, you served in Afghanistan. I'm not sure of your history in operations. Can you talk about what transition you got when you left? What did happen? When you come back from Afghanistan, is it welcome home and have a nice day, or what's the process?

Mr. Brian Harding: I left Afghanistan on March 24, or something like that, in 2009. We flew, briefly, through a staging base in the Middle East and turned in our guns, our ammunition, and all the fighting kit that we had. A bunch of our stuff went into boxes to get shipped home. They put us on a military airbus and we flew to Cyprus, where the Canadian Forces had contracted a hotel.

In that hotel we had the day we got there, three full days, and then the day we left. The first full day was a full day of mandatory briefings on various mental health and readaptation things. The second day was a half day of that and then a half day just to go and do your own thing. The third day was a full day of do your own thing.

Every two days a new batch would arrive—a plane full of soldiers—and a new batch would leave, which turned this thing into pure anarchy. Well, it wasn't quite that bad. A bunch of soldiers who have not been able to cut loose for six or eight or nine months made it a running, constantly refreshed party. It was good times. The training was not the worst, but I don't know if the timing was great.

I'm a reservist, so when I got home I was met at the airport by a couple of people from my unit and my parents, and then after that it was about how quickly I could find several friends and get out and party with them.

There was sporadic follow-up, mostly of a medical nature, and a token meeting with a social worker. With them, if you go in and just give them the right answers, they tick their boxes, and you go off and you don't have to worry about them again. Many members just did not disclose things, and in many cases issues had not emerged at that point either. We know that the mean incidence of mental health disorders can often be as long as five years after a trauma. My longest follow-up was, I believe, six months post-tour, so perhaps there's a vulnerability there.

It really felt as if they were ticking boxes just to say that they got this done. I'm not questioning the intent of those who put this in place, but I am questioning the effectiveness of the process and the lack of longer-term follow-up a few years down the road. I felt very few of the vets in crisis are still in that immediate post-deployment phase.

[*Translation*]

Mr. David de Burgh Graham: Do you also have comments, Ms. Gagnon?

Ms. Marie-Claude Gagnon: The assessment is only for those who have been in active combat. I was in the navy, personally. You have to ask for an assessment to be done, and perhaps even insist on it. In fact, this concerns people suffering from post-traumatic stress disorder, and not the mission support team.

People are not always comfortable at the thought of going to their commanding officer to ask for an assessment. These assessments are part of new procedures, and I tried to make sure they would apply to everyone, but that was turned down. Only those who have served in operational forces may receive the assessment.

● (1635)

Mr. David de Burgh Graham: I have a question for you, Ms. Gagnon.

Lieutenant-General Vance made a statement last year on sexual misconduct in the armed forces. Are you familiar with what he said at the end of November? What do you think of it?

Ms. Marie-Claude Gagnon: Are you talking about the statement made at the end of November?

Mr. David de Burgh Graham: Yes, November 28, 2016.

Ms. Marie-Claude Gagnon: Do you mean the statement about the survey involving 960 people, that had just been released?

Mr. David de Burgh Graham: Yes.

Ms. Marie-Claude Gagnon: That survey did not include recruits, or those who were taking a course for approximately the first two years. This was the highest proportion of sexual misconduct incidents ever recorded, at least according to American research, as we have no Canadian research on this.

A lot of people took part in the survey, but it excluded everyone who had left the Canadian Forces, as well as those who were in the process of being released. In my opinion, that was a bit like conducting a survey to find out if racism is an issue, and leaving out all persons of colour.

The survey does however mention that those groups were excluded. I was told that they would be heard later, but that meeting never took place, and those results are now being used in all contexts. I do not know if anyone is even planning to meet with the excluded groups anymore.

Mr. David de Burgh Graham: I have a brief question for both of you.

[*English*]

When you're trying to talk somebody down who you know is suicidal, what do you tell him that convinces him to come back down?

Mr. Brian Harding: There's no surefire way to do it. Sometimes I'm talking with them while I'm getting somebody else to call up 911 and get police and an ambulance to them, and that has been successful on a number of occasions. Other times, if I have a better rapport with the person, I'm able to feel a bit more secure and I'm able to keep talking without taking that choice out of their hands. There's no hard and fast answer. You have to hope you can just develop a connection with them, that they can trust you, that they can feel what you're saying, and that you can give them a reason to get through the next short time.

The more things they have around them—family, in particular—the more successful that's likely to be, but no matter what, you're kind of rolling the dice. It's not a fun situation to be in, and you're having to do an ongoing risk assessment. Every 30 seconds I'm asking myself whether the situation has changed, whether I need to call 911 now.

The biggest one is if they're alone. I try to get them not alone. Once there are other people physically present with them, normally they're a lot safer. You want to get them to open up to that. I do most of this, of course, online or by phone.

Mr. David de Burgh Graham: Thank you, Brian. Thank you, Marie-Claude. Is there any time left to give to Doug?

The Chair: Not really.

Mr. David de Burgh Graham: Okay. Thank you very much. I appreciate it.

The Chair: But you did well.

Go ahead, Mr. Brassard.

Mr. John Brassard (Barrie—Innisfil, CPC): Thank you, Mr. Chair, and my thanks to you both for your service to our country and for engaging in a very thoughtful discussion today about these issues.

In the first three months of being critic for Veterans Affairs, Brian, I've done some research on you, so I know that you're very active on social media, as is Marie-Claude. One of the things I found is there seems to be a lot of fragmentation among veterans groups and organizations within Canada. There are a lot of different veterans laying out their positions through social media. We've talked, certainly on our side, about a way to consolidate the information that's out there, to consolidate the concerns among veterans into one forceful group, shall we say, to put their issues forward. I'm just wondering if you can comment on the value of one voice, one veteran, to deal with a lot of the issues that you're talking about, Brian, with respect to suicide prevention. I'd like to hear from Marie-Claude as well. I'm curious to hear what you have to say.

Mr. Brian Harding: You might have perceived, sir, that I'm a little bit opinionated. Imagine a few thousand of me all trying to come to the same agreement.

Mr. John Brassard: That's the challenge.

Mr. Brian Harding: There are many groups. Some are very active advocacies. In my group, we're totally non-political. We leave that at the door quite forcefully, because it's damaging.

People see things differently. Some people can't stand each other on a personal basis and can't work well together. I don't personally believe that it would be viable to consolidate all the various veterans groups, the advocacy organizations, into one. It has been tried. I've never seen it gain any real traction. I think you are always going to have a very disparate group of voices clamouring for attention. We see that every time VAC holds another stakeholder summit, which they do twice a year. I've been to a few of them now and I'm surprised I have not seen fist fights yet.

Everyone is going to have his own perspective. Where you stand is where you sit. I'm here, and I see you one way. She's there, and she sees you from another angle. On the issue she speaks to, I buy the legitimacy of it, but I have not been able to see it the same way. Why should we all come and pretend we're going to talk to the same points when we're not necessarily equipped to do so?

● (1640)

Mr. John Brassard: Marie-Claude, would you comment?

Ms. Marie-Claude Gagnon: The Legion for a long time was trying to play that role. How many times have you heard of military sexual trauma when they were representing all of us?

Right now, the ministerial advisory groups are run by whoever they decide to put there. How many people like me have you seen there? It has never been our voices. It has always been the majority, what's common. If we always look at what's common, we never look at who falls through cracks, which is what we're trying to aim at right now.

Mr. John Brassard: Thank you for that.

Brian, there is other one I want to ask you about. The previous committee's report on transitional aspects of getting out of DND and moving into civilian life spoke about a concierge service. The DND ombudsman also spoke about a concierge service and called it a low-hanging-fruit opportunity. Effectively what it means is that we would have a one-stop shop for those who are transitioning, so that everything is effectively taken care of for them as they exit the military.

I wonder what your thoughts are on that service, because I know you spoke about transition. You spoke about the difficulty, the loss of identity. However, a concierge service is something that has some value.

Mr. Brian Harding: I heard it referred to as a navigator. I can't recall if that came from Minister O'Toole or Deputy Minister Natynczyk. That was two summers ago, when the ministerial advisory groups met in Charlottetown. We all thought it was a great idea, and presently we're still twiddling our thumbs and waiting to see it.

I think it's fantastic. Veterans are not necessarily going to be familiar with everything that is open to them, but most are not going to hit the threshold for active case management. Most are simply getting out because they have this, that, and the other thing, maybe a relatively minor disability. Maybe they have these transition difficulties, nothing in and of itself catastrophic, but it's still a hassle to deal with, so if we had knowledgeable people to do that, it would be great.

The Legion does provide their service officers, which actually has a very significant overlap with what you're talking about, but that's something that has been downloaded to an organization outside of the government.

If VAC could provide that and if those people were not bound by expectations of reducing costs, if their managers were not getting bonuses for cutting expenses, maybe it could work. However, VAC will have to earn trust on that one before anyone is going to believe anyone if they line up to help them with services.

Mr. John Brassard: Thank you. That's all I have.

The Chair: Go ahead, Ms. Mathyssen.

Ms. Irene Mathyssen: Thank you, Mr. Chair.

It's interesting. I keep hearing from both of you that it's hurry up and wait, or that you're twiddling your thumbs when there's this idea out there.

For example, Madame Gagnon, you talked about VAC saying they're going to do follow-up and pursue this issue. I take it that this doesn't ever seem to happen. What kind of information should be tracked and studied by the Canadian Forces in order to really understand the needs of veterans who are living with sexual trauma?

Ms. Marie-Claude Gagnon: How many people who have military release have been medically released or quit after reporting an assault? That would be step one. Then how many of them tried to claim from VAC, and did they get accepted or denied? That would be another one. Then, what type of services did they get? Those would probably be the first steps.

Ms. Irene Mathyssen: I wrote a letter to the minister. I won't say which one. The response back was that a medical release is completed with every member of the Canadian Forces before they're released and that this process includes a questionnaire about sexual health and mental health symptoms.

Can you comment on that?

Ms. Marie-Claude Gagnon: Sexual health is not military sexual trauma. That's just basically where somebody could have a sexual dysfunction because of medication or PTSD and be impotent or something like that. Those are the questions they have. They actually do not have a sexual trauma screening. That's what they mean by sexual health.

● (1645)

Ms. Irene Mathyssen: They're still focused on the male members of the Canadian Forces.

Ms. Marie-Claude Gagnon: Yes. It has not been designed for military sexual trauma.

Ms. Irene Mathyssen: Are they having trouble understanding and dealing with the female members?

Ms. Marie-Claude Gagnon: Yes.

Ms. Irene Mathyssen: My last question is in regard to the letters that I sent and the need for assistance for people seeking mental health care. The response back was that, well, you know, we can't deal with everything and we send our members to the public system, and they have all kinds of opportunities for group therapy.

What's your response to that?

Ms. Marie-Claude Gagnon: Our group therapy is with the OSISS program, which is mostly men who were in a combat role. If we think that it's good to send men who were in combat in Afghanistan to talk together and find support, then sure, that will be fair. I'm just saying that people who are in a combat-related role think there's a difference between them and, let's say, a policeman. They feel there's a different need. However, for us it's good enough: we need to go to the civilians, and we don't need our own group. By doing this, we're making sure that we can't regroup, we can't talk to each other. We can't bond and find our common issues. That's kind of a way to ensure that we can't connect with each other and find our strength together.

Ms. Irene Mathyssen: This sounds very much like this burden of proof that you spoke of before. You have to prove it happened. You have to prove the situation and come up with all kinds of extraneous things to even be heard.

Ms. Marie-Claude Gagnon: Take OSISS, for example. I know you talked with Frédéric Doucette a while ago, and he said he only had five cases in 15 years. I had 200 within two years, so obviously the system that they have, which is supposed to apply to everybody, is not working for us.

Ms. Irene Mathyssen: Mr. Harding, have you anything to add?

Mr. Brian Harding: I do. The question of burden of proof is interesting. I am stunned to hear Marie-Claude say that they will not process VAC disability claims without a conviction resultant from an alleged assault. I've seen a lot of criminal investigations in which a conviction did not result, but it's manifestly clear what happened.

In any case, the burden of proof for a conviction is beyond a reasonable doubt, and that's because there is going to be a penal consequence: somebody is going to lose their liberty, have a criminal record, or go to jail because of this. That is not an appropriate burden of proof to impose on somebody who is simply looking for treatment and benefits as a result of some sort of trauma or victimization.

Ms. Irene Mathyssen: Thank you.

The Chair: Thank you. That ends our time for testimony today.

I'd like to thank both of you for all you've done today in coming and testifying, and for what you've done for our men and women who have served. If there's anything that you want to add to expand on your answers, please email it to the clerk and he will get it to the committee.

Mr. Robert Kitchen: Marie-Claude made some recommendations. I would just like to ask if we could get those in writing.

The Chair: Yes. If you would do that for us, or we could pull them up....

Ms. Marie-Claude Gagnon: I'll email them to the....

The Chair: Perfect. Thank you.

We need to come back to do committee business, so we'll just recess for five minutes and come back.

Thank you.

[*Proceedings continue in camera*]