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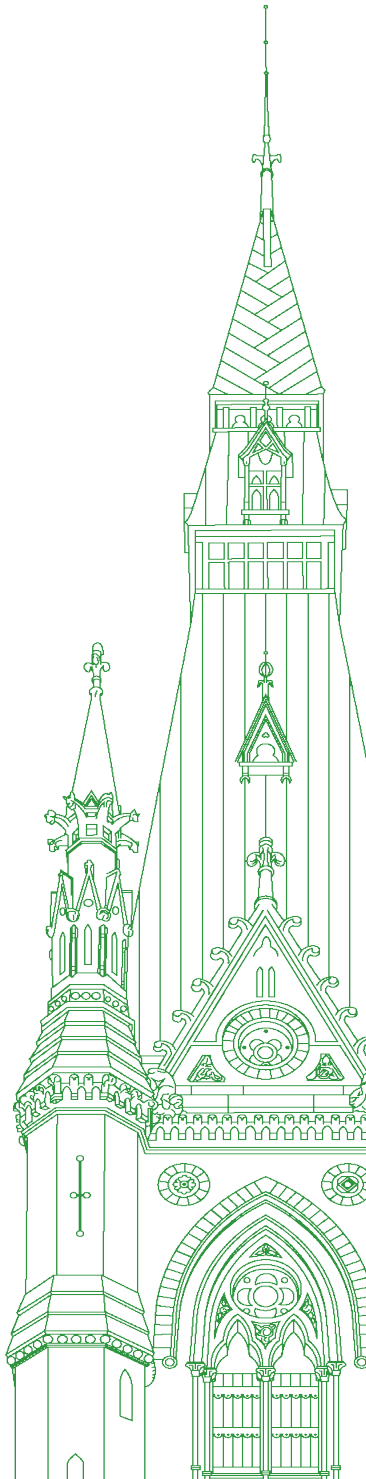

Chair: Mr. Emmanuel Dubourg

Standing Committee on Veterans Affairs

Thursday, May 18, 2023

● (1850)

[*Translation*]

The Chair (Mr. Emmanuel Dubourg (Bourassa, Lib.)): We will now resume the meeting.

Welcome to the 53rd meeting of the Standing Committee on Veterans Affairs.

Today's meeting is taking place in a hybrid format. Some committee members and witnesses are therefore participating online.

[*English*]

Pursuant to Standing Order 108(2) and the motion adopted on Monday, October 3, 2022, the committee is resuming its study on the experience of women veterans.

[*Translation*]

I remind you that all comments should be addressed through the chair.

In accordance with our routine motion for connection tests, I wish to inform the committee that all witnesses have completed the connection tests with the exception of two members of the Canadian Veterans Chronic Pain Centre of Excellence team. We'll do those checks.

Given the study we are doing, and before we welcome our witnesses, I'd like to issue a warning. We will be discussing experiences related to mental health, which can be a trigger for people here with us, the viewers, members and their staff who have had similar experiences. If you feel distressed or if you need assistance, please let the clerk know.

Before welcoming our witnesses, I'd also like to welcome the people who are participating with us on this committee. Online we have MP Patricia Lattanzio, who is replacing Darrell Samson.

Welcome, Ms. Lattanzio.

We also have Randall Garrison, who is replacing Rachel Blaney.

I'd also like to acknowledge the presence of Naaman Sugrue as clerk, who is assisting Mr. Vassilev.

As for our guests, we're pleased to welcome them this evening:

[*English*]

MP Stephen Ellis is here for MP Terry Dowdall.

Welcome, colleagues.

as an individual, Dr. Alisha Henson, clinical psychologist, supervised practice, and Alana Jaquemet, registered social worker and registered psychotherapist.

By video conference, we have, from the Chronic Pain Centre of Excellence for Canadian Veterans, Dr. Ramesh Zacharias, chief executive officer; Hélène Le Scelleur, captain (retired), co-chair, Centre of Excellence advisory council for veterans; and Dr. Joy MacDermid, professor.

We're going to start with Ms. Henson.

You have five minutes. The floor is yours. Please go ahead.

Dr. Alisha Henson (Clinical Psychologist, Supervised Practice, As an Individual): We are actually going to be sharing our time today.

The Chair: That's great.

● (1855)

Ms. Alana Jaquemet (Registered Social Worker and Registered Psychotherapist, As an Individual): I'll be starting.

The Chair: Go ahead.

Ms. Alana Jaquemet: Chair, Vice-Chair, committee members and fellow speakers, thank you for this opportunity to participate in this important conversation regarding the experiences of women veterans.

We're happy that this committee has recognized the importance of including clinicians in the conversation regarding women veterans' experiences. My colleague and I have collectively spent 30 years working with veterans, CAF members and their families. As clinicians, we are often the knowledge brokers, trained to hold veterans' experiences without any agenda beyond healing, yet our collective voices are rarely heard.

We were invited here following a call of concern from a group of clinicians regarding the new Lifemark-PCVRS contract with Veterans Affairs for the rehab program. Our key apprehensions are, one, the program's lack of focus on cultural competency or trauma; two, the need for more transparency between VAC, PCVRS and the clinical service providers; and three, that the depreciation of the clinical expertise of current providers will have a negative implication for the veteran's treatment.

We will reserve the conversation regarding the lack of transparency in VAC programming and concerns about devaluing current service providers' expertise for future meetings. Today we will focus on the importance of cultural competency in women veterans' rehabilitation programming, and we will close by providing recommendations to the committee.

Since our initial communication with PCVRS, we have had multiple meetings with various stakeholders and have attempted to educate ourselves in all aspects of the program. The PCVRS program needs more detailed requirements for training backgrounds for those hired. We feel that clinicians hired for the new program must understand PTSD and complex PTSD, the sexual misconduct lawsuit and the institutional trauma experienced by many women veterans. We have provided definitions of these concerns in the endnotes of our statement.

Many women we work with release not because of deployment-related trauma but after experiencing sustained systemic trauma, feeling silenced or forced to soldier on despite moral and physical injuries, or they voluntarily release because they feel the slow release process increases their risk for suicidal ideation or attempts, thus creating trauma for their families, or they sense that they could no longer survive the process.

We want to quote a veteran who shared her experiences with us.

Dr. Alisha Henson: "I endured multiple traumatizing situations while I was deployed to Afghanistan. To this day, most of my comrades know that I was released for mental health reasons and most probably assume it's combat-related, which isn't true. It's 100% mental health issues stemming from prolonged military sexual misconduct. I could no longer be strong. So many years of unacknowledged trauma came flooding to the surface. I tried for almost seven years to get back to how I functioned before, where I could suppress everything and 'soldier on'. That led to years of depression, suicidal ideations, and multiple suicide attempts. No amount of therapy helped, and I eventually ended up with a medical release which I didn't have the strength to fight anymore."

Currently, PCVRS has mandatory training, none of which speaks to the unique experiences of women veterans. We believe this is a glaring error that they should rectify. Although understanding women veterans' experiences can be learned over time, PCVRS's failure to prioritize women puts them at risk for sanctuary trauma.

Women veterans often report coming forward with their concerns, only to be met by non-culturally competent clinicians. We recognize that the new PCVRS rehab program is vocationally focused, not-trauma focused. Still, we do not want to risk retraumatizing women in a system that is supposed to focus on healing and new beginnings.

When clinicians are recruited who are not culturally competent and who do not understand the complexities of CAF releases, those clinicians are unable to treat women veterans holistically. We would like to bring forward this call for culturally competent clinicians from this spectrum of women and those in the Canadian military colleges, CAF members and veterans.

We will now present our five key recommendations.

We must engage women veterans, clinicians, case managers and other stakeholders when developing and modifying programs for women, using community-based participatory research methods. These methods will promote women veterans' knowledge mobilization in hopes of reducing gender blindness and honouring women's needs and experiences.

All clinicians should be required to have training in two to three trauma-focused modalities and have three years of experience with CAF or veterans. They should be required to participate in training focused on women veterans' experiences and have information regarding the LGBTQ+ community and the sexual misconduct lawsuits.

Clinicians should use progress monitoring measures to evaluate clinician-client relationships, such as the PCOMS.

There should be more shared resources and transparency in research with women veterans and CAF, and education and resource packages on VAC programs should be provided to clinicians.

Finally, we are recommending that CAF allow students of psychology and other accredited programs identified under the Psychotherapy Act to have the opportunity to participate in internships on Canadian Armed Forces bases. This would provide excellent training opportunities for trauma-informed and culturally competent care, increase resources on bases and help develop clinicians who can provide quality care to veterans and civilians upon graduation.

Thank you for your time. We look forward to your questions.

● (1900)

The Chair: Thank you very much.

Before going to our next witnesses, we're going to take a really short break. We have to make sure that the sound of our witnesses is okay for our interpreters.

Stay tuned.

[*Translation*]

I will suspend the meeting.

● (1900)

_____(Pause)_____

● (1900)

The Chair: I call the meeting back to order.

[*English*]

I would like to welcome our two witnesses on Zoom.

We have with us Dr. Ramesh Zacharias, chief executive officer, and Dr. Joy MacDermid, professor. They are appearing by video conference.

I don't know which one would like to do the opening remarks. Previously it was supposed to be Dr. Zacharias or Madame Le Scelleur.

You have five minutes for your opening remarks. Please go ahead.

● (1905)

Dr. Ramesh Zacharias (Chief Executive Officer, Chronic Pain Centre of Excellence for Canadian Veterans): Thank you, Mr. Chairman and members of the committee. Thank you for the privilege of presenting to your committee today.

My name is Dr. Ramesh Zacharias. I am the president and CEO and medical director of the Chronic Pain Centre of Excellence for Canadian Veterans. We are an independent not-for-profit organization that was established on April 1, 2020. We are funded by Veterans Affairs Canada to study the effects of chronic pain in Canadian veterans and to focus on improving pain management and overall well-being of Canadian veterans and their families.

Chronic pain affects 20% of the general population of Canadians. That number increases to 40% of veterans, and sadly it affects 50% of female veterans. In addition, 60% of veterans suffering from chronic pain also suffer from mental health issues, and 63% of veterans suffering from mental health issues also suffer from chronic pain.

In the last three years, CPCoE has funded 43 research projects involving 24 institutions across Canada, including seven postgraduate research projects with master's and Ph.D. candidates. One candidate is our next presenter, Hélène Le Scelleur, a veteran of the Canadian Armed Forces. She will share her remarkable story shortly.

Sixty to seventy per cent of my clinical practice involves veterans at the Michael G. DeGroote Pain Clinic at Hamilton Health Sciences. The statistics I have presented are reflected in the population of patients I treat every day. It is critical that both pain and mental health issues be treated concurrently to achieve any relief from these debilitating chronic conditions. Our clinic has the best success in treating veterans through an interdisciplinary team using a biopsychosocial model of care.

I will now have the co-chair of the CPCoE's advisory council of veterans, Hélène Le Scelleur, share her amazing story of resilience.

Ms. Hélène Le Scelleur (Captain (Retired), Co-Chair, Centre of Excellence Advisory Council for Veterans, Chronic Pain Centre of Excellence for Canadian Veterans): Thank you, Mr. Chairman.

Thank you to all members of the committee for inviting me to testify on this important study for women veterans.

I joined the Canadian Armed Forces in 1990 at the age of 17, as one of the first women to join the combat arms in an effort to increase the number of women in service. Needless to say, our presence in the infantry was not welcome. As soon as I joined the forces, I had to work harder than any man just to be treated as their equal. In this very homogeneous male world, I shed my femininity to make room for the identity of being a soldier and gain respect.

I would like to mention that at the time, the harassment guidelines were not yet very developed, which kept the environment very toxic for us women. From the beginning and throughout my career of 26 years, I was subjected to misconduct by men. In the beginning, it was to make me give up, but later on it was to appropriate my body—from verbal harassment to touching to forced kissing by superiors. It was also the invasion of my private life as a way to force me to accept the unacceptable. However, I consider myself lucky: I am not one of those who was raped.

This introduction is important, because it represents the often forgotten reality of women veterans. This is in addition to other suffering that may be more predominant, such as psychological or physical injuries.

For my part, I live with both. I developed post-traumatic stress disorder following my mission in Afghanistan and I believed my chronic pain was directly linked to it. However, I realized that I had been abusing my body for a long time to perform and maintain my hard-earned position. For example, when I joined the forces, I had to accept boots that were too big for me and equipment that was inadequate for my size. I had to overtrain despite injuries and hide my physical pain so as not to be judged or rejected by my team. All this was because we had to succeed in the mission. We had a duty to “push through the pain”.

That being said, suffering in silence in order to perform becomes a huge barrier to seeking help. I am one of the many women who learned to keep our hurt, abuse and suffering quiet in order to gain respect as a military member—but what happens when our careers are forced to an end that we did not choose, and our wounds, whether physical or psychological, become symbols of the end?

I believe it is important to consider that this transition to civilian life is not without its challenges for women veterans, because in addition to coming out, they must also face justification that they are also wounded veterans and they deserve respect. It also becomes crucial to realize that it is impossible to address chronic pain without exploring the underlying suffering that is experienced in a career as a woman in the forces.

Once again, Mr. Chairman and members of this committee, I am extremely grateful for this opportunity to testify before you. I sincerely believe it is important to consider that the needs of female veterans differ from those of men and that the response to chronic pain must be adapted and allied to that for psychological pain.

I will now turn the floor over to Dr. Joy MacDermid.

● (1910)

Dr. Joy MacDermid (Professor, Chronic Pain Centre of Excellence for Canadian Veterans): Thank you.

I will echo the thoughts of thanks for sharing the work. I am actually one of the researchers funded by the Chronic Pain Centre of Excellence to investigate issues in chronic pain. I focus on understanding the impact of sexual harassment, using a recent confidential survey by which we surveyed 300 Canadian veterans.

What we found was that the odds of a woman veteran experiencing sexual harassment during her military service were more than 20:1 compared to the case for her male colleagues. Women were also at double the risk for verbal abuse.

Our research and other reports, and the lived experience you've just heard about from the female veterans, show that women who come forward are often dismissed or even punished for reporting these problems, so many stay silent, unlike the people we've heard from today.

Our research was unique in that we also measured psychological distress and the severity of chronic pain. What our study illustrated was that there is a pathway between sexual harassment and psychological distress, and there is a pathway between psychological distress and having persistent severe chronic pain. This data supports what you've just heard from the experiences of veterans: that sexual harassment and abuse result in not only long-standing psychological problems but also long-standing physical pain, so we cannot solve chronic pain without managing the underlying causes.

Therefore, we confirm that there is a need for protection for those who report discrimination, for systematic changes to culture and training, and for specialized interventions for people experiencing chronic pain that has been aggravated or caused by discrimination.

I thank you for listening.

The Chair: Thank you very much for your opening remarks.

[*Translation*]

I'd also like to take this opportunity to thank you for your service, ladies, which you shared with us in your opening remarks.

We will now go to the first round of questions. There will be six minutes per speaker.

[*English*]

I would like to invite Mrs. Cathay Wagantall for six minutes.

Go ahead, please.

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

I do thank you all for being here tonight and for sharing your life experiences and your concerns. I hope we can learn a great deal from you.

Ms. Le Scelleur, thank you. I've read your stories and what you've shared in the media. There was a Globe and Mail article in which you said, “so just as she was working on a hypothesis that the military exacerbates mental illness and suicidal thoughts by cutting soldiers off from their social support system.”—just as you were working on that—it says, “she turned in her ID card and was escorted to the door of National Defence Headquarters. 'I started to cry,' she said. 'It was hard to believe that's how it ends.'”

Were your superiors aware of what you were working on?

● (1915)

Ms. Hélène Le Scelleur: No. At the time I was still doing my master's, and it was afterwards, when I was transitioning totally out of the military—six months after—that I decided to pursue my work to the Ph.D. level.

Mrs. Cathay Wagantall: Thank you.

You turned in your ID card. We don't know what that's all about. Did you suddenly get told, “Come here. Drop it here. Goodbye.” How does that happen?

Ms. Hélène Le Scelleur: Thank you for the question.

I hope that today it's different. I released in 2016, and back then when you were doing your last day as military personnel, you entered the building at 101 Colonel By Drive in Ottawa as a military person, so as a trusted person. The minute I went up the stairs and was meeting the last person with my piece of paper saying that I had quit—my quittance to every department—the civilian person who took my card in the ID section just said to me, “From now on you have to be escorted.”

I felt as though I was no longer trusted, as though I was no longer part of anything. It was like I was a prisoner or something and I couldn't be left alone in the building that five minutes earlier I was trusted to be in. My clearance level was top secret, and in a minute I had to be escorted out of this building, so it felt awful.

Mrs. Cathay Wagantall: Okay. I understand what you're saying now. Thank you. It's hard to discern from this exactly what you're saying here. Thank you.

You had a desire then to work on finding ways to improve that transition so it wouldn't be so stark and whatnot.

Ms. Hélène Le Scelleur: Thank you again for the question.

It was mentioned in the opening remarks from the person before us. When you leave the military, it's....

Can you repeat the question again? I lost my thought.

Mrs. Cathay Wagantall: I guess I was still basically making a comment about the fact that you want to see things improve, and I think that they are.

Do you want to explain just a little bit about how that encouraged you to go in the direction you wanted?

Ms. Hélène Le Scelleur: The person talked about that before. The vocational part of the transition is really well addressed and so was a portion of the health services, but for me, the psychosocial portion of it, the identity portion, was not addressed. When I left the military, I felt that I had been built as a soldier, but nobody helped me to become something different from the soldier I was. That was the identity crisis that I faced. I decided to study that and to do my research based on that.

Mrs. Cathay Wagantall: Just on quick consideration of that, you say you were built into a solider. Does it require removal of that civilian sense of values to become that solider and then not have the opportunity to see yourself kind of made whole again as a civilian?

Ms. Hélène Le Scelleur: Thank you for the question.

I joined when I was 17. I was not even an adult. The army became my parent. The army became the family I needed, with the structure and all the guidance. When I got kicked out at 43 years old, I got kicked out without anything—nobody telling me where to go, what to do, how to behave. I was still waiting for my mission. I don't know if you can understand what I mean.

Mrs. Cathay Wagantall: Can I just ask you why you are saying "kicked out"? That was kind of where I was heading with that first comment, but you indicated that you had to go through all those procedures to leave the building. When you say "kicked out", do you mean basically you were no longer qualified to serve because of health issues? Was it a medical release? Is that what you're saying?

Ms. Hélène Le Scelleur: It was a medical release. At the time, in 2016, the fact that you received a diagnosis of post-traumatic stress syndrome automatically meant that you were being released for medical reasons with no way of being accommodated.

● (1920)

Mrs. Cathay Wagantall: Thank you.

The Chair: Thank you, Mrs. Wagantall.

Now I would like to invite Mr. Wilson Miao for six minutes, please.

Mr. Wilson Miao (Richmond Centre, Lib.): Thank you, Mr. Chair.

Thank you to all the witnesses for appearing today for our important study for women veterans.

Thank you for the service you provide to all the veterans and to our country.

I would like, through the chair, to direct my first question to the Chronic Pain Centre of Excellence.

With more than 40% of Canadian veterans suffering from chronic pain, the centre focuses on pain management research and on evidence-based therapy that addresses veterans' complex chronic pain challenges and needs.

After Dr. MacDermid's remarks, are there any recommendations that you would suggest or that you would provide to our committee to be included in our study report?

Dr. Joy MacDermid: The one study that we just reported on has implications for us. We know that it confirms what we believed—that there's a link between psychological distress caused from sexual discrimination and the experience of chronic pain—but it also means that when people.... The first recommendation is that people of course have to be able to come forward without concerns about retribution or about being safe. Also, then, when they come forward, they have to know that they're going to get treatment, not just for the psychological distress but also for the physical pain that is often going to be accompanying that.

We can't treat all cases of chronic pain the same and we can't treat them like they're coming just from a physical injury. Chronic pain can also come from sexual assault, sexual discrimination and chronic stress from these kinds of traumatic psychological exposures that women veterans are exposed to. They're going to need special treatment programs that help them deal in an integrated way with the psychological trauma as well as the physical pain.

I think that really confirms that the Chronic Pain Centre of Excellence needs to put forward and test new treatment approaches that incorporate a specialized approach that takes into consideration the unique nature of chronic pain when it's associated with sexual harassment and assault problems and the psychological distress that arises from them.

Ramesh is the expert in chronic pain management and is seeing many of these patients, and I'm hoping that he will also confirm what I've just said to you.

Dr. Ramesh Zacharias: Thank you, Joy.

Also, thank you for your question, because, as I mentioned in the opening remarks, about 60% to 70% of the people I treat today are veterans. About 25% of them are female. The remainder are male. In fact, just today I saw four veterans whom I treat and who are in the program.

You cannot separate the two. As I mentioned, 60% of veterans with chronic pain also have mental health issues, and 63% with mental health issues have chronic pain. It's really two sides of the same coin, so if you're just going to give them a physiotherapy clinic or treat the musculoskeletal issues, you will not get the success.

In fact, the research goes back to 2012, when the International Association for the Study of Pain looked at 43 countries around the world. Their conclusion was that the best model is a biopsychosocial model, with physicians, pharmacists, psychologists, psychiatrists and addiction experts in one facility.

I feel very blessed to be working at the DeGroote, where we have 12 different health professionals, including addiction experts, psychiatrists, psychologists and psychometrists. When a veteran comes into our program, they get all the resources in one place, and that's probably why our success has been published in peer-reviewed journals. We have the best success.

Interestingly enough, veterans do better than civilians in our program, partly because of what Hélène said: They're “mission first”. They're very committed. They're dedicated to things that will help them. That was the remark:from the four veterans I saw today: “You tell me what to do and I will do it, and, by the way, I am feeling better.”

In just treating the physical aspects without addressing the psychological issues, you will not succeed, and that's been our mantra for three years with Veterans Affairs Canada. You must send people to interdisciplinary care as opposed multidisciplinary care. In multidisciplinary care, they see different specialists in different locations without a holistic one-centre approach. That has been part of our recommendations.

● (1925)

Mr. Wilson Miao: Thank you for sharing that with us.

In your opening remarks, you mentioned that this is being funded by our government and that it started in April 2020. Can you give us a sense of how many female veterans since then you have served in that 20% you just mentioned? Also, what is the success rate and how long does the pathway to recovery take? Could you give us some insights on that, please?

Dr. Ramesh Zacharias: The centre itself does not provide care. The centre is a research centre. We fund researchers like Dr. MacDermid. We fund master's and Ph.D. students like Hélène, and others who are involved. I have a clinical practice apart from the CPCoE, but the CPCoE is a research centre. It is not a treatment centre.

I can give you a response on the basis of my clinical practice at Hamilton Health Sciences, but the CPCoE is not involved in treating veterans.

Mr. Wilson Miao: Thank you.

The Chair: Thank you, Mr. Miao.

[*Translation*]

I will now turn the floor over to the second vice-chair of the committee, for the next six minutes.

Luc Desilets, the floor is yours.

Mr. Luc Desilets (Rivière-des-Mille-Îles, BQ): Thank you, Mr. Chair.

Good evening, colleagues.

Thank you to all of our guests for giving us this time.

Mr. Chair, I'd like to begin with some brief remarks out of context.

Today, we can see that the French name of the study is now “*Expériences vécues par les vétéranes*”, in which the term “*femmes vétérans*” has been replaced with “*vétéranes*”. As you recall, we had a discussion about this last week. I'd like to thank the analyst, the clerk and you for considering the request of Sandra Perron, a woman veteran who appeared before the committee. We've also received a number of other emails in my office here in Ottawa to highlight that. This request has come a long way.

Now, I hope that this term will be used across the country from now on, and that it will be the only term used.

Thank you, Mr. Chair.

The Chair: Briefly, I want to thank you on behalf of the entire team, but I also need to mention to committee members that the department has decided to adopt the term “*vétérane*” and so we opted to go ahead with it, because when we were using the masculine form “*vétéran*”, we didn't feel that women were included, necessarily, and we wanted to avoid that. So the department has adopted “*vétéran*” and “*vétérane*”.

Thank you, honourable member. Your time is still at zero. The floor is yours.

Mr. Luc Desilets: Oh, how nice. Thank you.

This goes to show that what goes on here on this committee can have a meaningful impact, so thank you very much.

My first question is for Dr. Zacharias.

I understand that your organization was founded in 2020, but one thing isn't clear to me. Whose initiative is it? Is it Veterans Affairs Canada, the Ontario government, or private citizens?

Dr. Ramesh Zacharias: Thank you for your question.

[*English*]

I will answer it in English so that you'll actually understand what I say.

This centre was funded by Veterans Affairs Canada. We have two stakeholders, one of which is McMaster University. The second stakeholder is the Hamilton Health Sciences Corporation. We are located in McMaster. All of our funding comes from Veterans Affairs Canada through a contribution agreement. Initially it was for three years, and as of April, we have signed a five-year extension.

● (1930)

[*Translation*]

Mr. Luc Desilets: Can we ask what the operating budget is?

[*English*]

Dr. Ramesh Zacharias: Of the funding we get, between 65% and 70% go toward research and around 30% to overhead. The majority of the funds are used.... As I said, in the three years, we have funded almost 43 research projects involving 25 universities and seven scholarships. Hélène Le Scelleur is one we have funded for the last three years as she has done her Ph.D.

[*Translation*]

Mr. Luc Desilets: That's perfect, thank you.

When I look at your 21 research projects currently under way, I see that none of them are being piloted by a university, a francophone centre or a centre in Quebec.

Is that correct, Dr. Zacharias?

[*English*]

Dr. Ramesh Zacharias: In fact, last month we signed a contribution agreement with QPRN, which is the Quebec Pain Research Network. We have scholarships for students who are in Quebec at Sherbrooke and Laval. Our scientific director of partnerships is Professor Luc Hébert, who is a 28-year veteran based at Université Laval. We have a significant presence within the province of Quebec.

In fact, we have universities coast to coast that we have funded, and students in New Brunswick, Quebec and Manitoba. We're a national contractor. We try to make sure there's representation across the country.

[*Translation*]

Mr. Luc Desilets: I'm very pleased to hear that. This is the first time I'm hearing this. Quebec women veterans would also like to receive information like that. It would obviously be very appropriate to share it with francophone women veterans.

My understanding, though, is that it started this year.

[*English*]

Dr. Ramesh Zacharias: No. In the very first year, we had scholarships for students in Quebec as well.

What we have done more recently is develop a relationship with QPRN, which is a large network. It's easier than finding individual researchers in Quebec. Our agreement is with Université de Sherbrooke and Dr. Hélène Beaudry, who is the head of QPRN. The contract is with them. We've worked with Ste. Anne's Hospital in Montreal, as well as McGill, over the last three years, but we formalized our relationship with QPRN this past year.

[*Translation*]

Mr. Luc Desilets: I'd like to ask a really quick question along the same lines. This has made headlines in Quebec in recent weeks. We're seeing that French is really losing ground in science and that very little research in French is being funded.

Are you experiencing this or have you seen this happen within your organization?

[*English*]

Dr. Ramesh Zacharias: Did you say more work in French or less work in French?

[*Translation*]

Mr. Luc Desilets: Since you're in research, I'd like to know whether you've noticed that research doesn't get funded as often when it comes from francophone institutes, centres. Have you observed that?

[*English*]

Dr. Ramesh Zacharias: I cannot comment on that. I can only comment on what we have done and what we are doing.

Probably the best-developed research network is QPRN in Quebec. They have a formal structure and a good connectivity among them. That's the reason we established that relationship with them. Dr. Luc Hébert, who is our director of strategic partnerships, is the one who has been driving a greater presence for us in Quebec.

● (1935)

[*Translation*]

Mr. Luc Desilets: From what I can see, Ms. Le Scelleur may want to weigh in on this.

Ms. Hélène Le Scelleur: Today, we held our first official meeting as a research consortium for francophone veterans. This is really an initiative that I'm championing as co-chair of the Advisory Council for Veterans at the Centre of Excellence. This is a very important element that I brought in when I joined the team. I made the point that we have to represent francophones, research in French.

I did study at the University of Ottawa, but I do my research in French and Quebec veterans are the population I study. This effort is gaining momentum. I believe Dr. Zacharias said that this new consortium had received funding. It's taking shape and will include veterans as partners in the research.

Mr. Luc Desilets: Thank you very much.

The Chair: Thank you, Mr. Desilets.

For the next six minutes,

[*English*]

I'd like to invite Mr. Randall Garrison to go ahead, please.

Mr. Randall Garrison (Esquimalt—Saanich—Sooke, NDP): Thank you very much, Mr. Chair.

I'm particularly pleased to be here this evening, as I represent what's probably the second-largest military riding in the country, including CFB Esquimalt on the west coast. I have a large number of serving Canadian Forces members and a large number of veterans in my riding. We do a lot of casework with both serving members and veterans. I think the most frequently heard difficulty in my office has been the difficulty in convincing either Veterans Affairs or DND that there is a connection between mental health challenges and physical manifestations. There is a presumption that those two have nothing to do with each other, which seems to inform the programming of both organizations.

My first question is for the chronic pain centre. You've been running for about three years. Do you have the research to help support those serving members and veterans in making the case that the programming has to acknowledge that link?

Dr. Joy MacDermid: I think that's one of the interesting things in our study. We used a complicated statistical modelling to show what the pathways are between different things. We showed that there was a pathway from experiencing sexual discrimination or assault and distress and there was a pathway between experiencing psychological distress and having severe chronic pain. It means that for the people who had those experiences, there was a linkage. One thing led to the next thing that led to the next thing.

It really told us that there is a psychological impact in the physical impact. We can't separate that. We see this so often, especially with chronic musculoskeletal pain. Often, for people who present with chronic musculoskeletal pain, underneath that it's like an onion skin. Psychological injuries occurred that led to that. Sometimes because of the stigma around mental health, it's easier for people to present with chronic pain than to reflect on the chronic psychological distress and injuries they've had. If they don't acknowledge these problems, they manifest as chronic pain. People may talk about their physical symptoms more than they talk about their mental health symptoms because of chronic pain, but if you treat one and ignore the other, you don't get anywhere.

It's a very western philosophy to separate physical health and mental health, but we know that's not really good in any aspect of health. They really are integrated everywhere, but perhaps nowhere is this more important than with veterans.

Mr. Randall Garrison: Ms. Jaquemet or Ms. Henson, I'd like to ask you the same question. In your clinical practice, do you see this problem for people in establishing that link in order to get proper treatment?

Ms. Alana Jaquemet: Definitely for the veterans I treat, there's always a connection between the two. We know that PTSD lives in the body. Veterans are often seeking many different ways of managing not just the chronic pain but also other psychosocial things that are happening.

I appreciate the comment earlier about having services together in one place. That's a really valuable thing that could be improved upon, having some more of those wraparound services so that our veterans don't have to go from place to place and manage and coordinate on their own. Having a more coordinated approach would be a fantastic improvement.

● (1940)

Mr. Randall Garrison: Thank you.

The second thing we see quite often in our office is a difficulty, particularly for veterans but also for serving members, in connecting their symptoms to their service. There's the presumption that they must have done something somewhere else, that it couldn't possibly have been their service or their status as a veteran that caused these things. There's a tendency to point people elsewhere and say “not our fault”.

I wonder if that's reflected in the experience you've had.

Dr. Alisha Henson: I definitely believe so. I find that it takes a long time. When veterans first present in our office, the level of stress is so high that the services we do a lot in the initial stages have to create that regulation in order to decrease some of the nervous system's response so that we can actually start putting together those pieces. We are able to borrow from a large body of literature on how trauma lives in the body, as my colleague indicated. These processes take time. We need to be very supportive in helping them build that narrative. Without it, it's like parcelling someone out into many pieces.

Mr. Randall Garrison: With the one minute I have, I want to go back to the centre for chronic pain and ask that same kind of question. Do you have research that helps to support the linkages between the problems people face and their service?

Dr. Ramesh Zacharias: We do. I think probably the best data available is the data VAC produced in the Life After Service Studies in 2016 and 2019. There's a tremendous overlap between mental health and chronic pain.

The challenge often is that when veterans have an injury while they are in service, they're likely not going to report it because they're afraid it will impact their career, as Hélène has mentioned and as most veterans mention. I have assessed probably almost 600 veterans in the past five years, and, to a person, they have said they got injured in basic training but they didn't tell anybody because they did not want to get released. Part of the challenge is that the culture is “I'd better not disclose it because it could be the end of my career”, and sadly, that has happened to a number of them.

From VAC's own studies, there's clear evidence of the linkage between chronic pain and mental health, so you can't split the two and treat them separately. You have to treat them in one facility that deals with both.

Mr. Randall Garrison: Thank you.

The Chair: Thank you, Mr. Garrison.

Now let's go for the second round of questions.

I would like to invite the first vice-chair of the committee, Mr. Blake Richards, to go ahead for five minutes.

The Vice-Chair (Mr. Blake Richards (Banff—Airdrie, CPC)): Thank you, Chair.

Thank you to all of our witnesses today for their excellent contributions so far and for those still to come yet.

Madame Le Scelleur, I would like to start for sure with you.

First of all, let me say—and I know it's been said once or twice already, but it can never be said enough—thank you for your service. I am sorry, and it pained me to hear about some of the experiences that you endured during your service and during your time in the forces and since.

What I would like to focus on is your experience as a veteran. In a previous round of questions, Ms. Wagantall asked you a little bit about your transition, the day you left and in the very immediate circumstances around your release. I want to take us beyond that, if I can. I'd like to hear about your experiences in the transition into civilian life.

You mentioned in your opening remarks, although I can't remember the exact quote, something about how transition to civilian life is very particularly challenging for women veterans. I want to hear, if you're willing to share with us, a little bit of your personal story and what you experienced in that transition to civilian life. What were some of the difficulties you encountered and what would you see as some of the things that could be done to improve that experience for someone like you who would be released tomorrow, for example? How can we improve their experience in transition?

Let's start there. I have a couple of other questions for you as well.

● (1945)

[*Translation*]

Ms. Hélène Le Scelleur: Thank you for your question.

[*English*]

I'll answer in English and I'll try to do my best.

Mr. Blake Richards: Feel free to answer in whichever language is most comfortable for you. That's fine.

Ms. Hélène Le Scelleur: I would start with the fact that it's very difficult to transition from the “we” mindset to the “I” mindset. We never learned to think about ourselves in the military, and nobody showed us how to reconnect with that.

When you're transitioning out and people are asking, even clinicians, what you want to do, what you like, it's something that you cannot answer because you never thought of anything for yourself. The “we” mindset, the culture and the military mindset, are still sticking when you're out of the military.

I told you this before. I released in 2016, and I would say that I was finally successful in my transition a year ago. I've been in different programs. I've tried many, many different things. I tried the program of Sandra Perron. I tried other organizations. Eventually the program that did stick with me and finally helped me was about trying to find who I was as a person. It's something we're not focusing on.

Even when we join the military, nobody is telling you that there's going to be an end at some point. For sure you're going to be out someday, so what's your plan B? Do you know yourself enough to transition out of the military and know where to go to do something about your life?

For me, this was one of the main things: trying to transfer from the “we” mindset to the “I” mindset.

Mr. Blake Richards: I can only imagine it, especially for someone like yourself. You mentioned that you joined when you were 17 years old. Your entire adult life was in the military, so you would have been in that mindset and it would be very difficult to make a shift to a different one.

That actually leads really well into the next question that I want to ask.

With many veterans I talk to, I hear often that there's that sense of purpose when you're in the forces. You leave the forces and sometimes you can't find your sense of purpose in whatever it is you're doing in civilian life. Many tell me that volunteering, especially to help fellow veterans, is one of the ways they find that purpose.

I understand that you either volunteer or have volunteered with Wounded Warriors Canada. I wonder whether you could talk a little bit about the meaning and purpose you may have found in that volunteerism and what that meant in your post-service life.

Ms. Hélène Le Scelleur: Thank you again for the question.

You just said one word that is very important. We're “serving” in the military. We're doing things for people. This is the purpose we chose when we joined the military: It was to serve our country, our nation and our people. Doing volunteer work is exactly connecting with that.

At the same time, it's easy to lose yourself to that—to just take care of others and not take care of yourself. I was the first one saying it's easier to take care of other people because I didn't want to take care of myself.

It's a good thing for sure, because it gives you a purpose. Also, there are many organizations that you can be there for.

I would say that peer support is one thing, but you need to have someone who is successful in their transition to be able to take care of others. You have to be well established in your transition to be there and be a good guide for others.

I don't know whether it's answering your question.

● (1950)

Mr. Blake Richards: I think so.

Unfortunately, I'm getting the signal that my time has expired. I really want to thank you for sharing your experiences with us.

The Chair: Thank you, Mr. Richards.

Now let's get to Mrs. Rechie Valdez for five minutes, please.

Mrs. Rechie Valdez (Mississauga—Streetsville, Lib.): Thank you, Chair.

I'd like to thank the witnesses for joining us today and to recognize those of you who have served this great country.

Through you, Mr. Chair, I'll direct my questions to Dr. Henson.

In your clinical practice, what specific mental health challenges that you haven't mentioned yet in your opening are more prevalent among women veterans compared to their male counterparts?

You listed some of them, but if there were some that you didn't mention already, could you cover that?

Dr. Alisha Henson: I find that a lot of the women who come to my practice have been diagnosed with comorbid disorders.

Often when men are presenting, they have PTSD as their primary concern. A lot of women I end up working with have been diagnosed with personality disorders, more serious levels of disorders. It's almost as if, when they came forward with concerns and were having difficulties, they became the issue, instead of the system. They ended up in non-culturally competent care at times, where they became the problem and needed to leave the military, instead of the military addressing the concerns to help them. That's probably the most predominant thing.

I had, I think, only one gentleman who came to me who had been diagnosed in the military, and several women.

Mrs. Rechie Valdez: Thank you.

We've heard several testimonies of women veterans experiencing military sexual trauma and several other traumas. You listed those also in your opening.

With your expertise, what impact do you think that has had on their mental well-being, and on their transitions and lives?

Dr. Alisha Henson: One thing I find is that because of the "soldier on" mentality, when they experience systemic, micro-sexualized traumas, they stuff it down and lose their identity as to who they are as women and how they identify. In order to exist in this culture, they have to be okay with how things go.

You can only stuff for so many years. Then it manifests in, as we're hearing, a lot of chronic pain issues and family struggles, and not feeling supported on the family end as well. It becomes an explosive situation for them in all domains of their lives.

Mrs. Rechie Valdez: In the recommendations you listed, you mentioned what we've heard before on this committee: the importance of having the education and experience to be able to service our veterans with the type of care they need and deserve.

Can you describe what the interactions are like with veterans at your clinic, which uses your approach?

Dr. Alisha Henson: I often work from an approach of acceptance and commitment therapy. A lot of pieces of that practice are first to help someone identify their emotions, understand and identify their physiological challenges, and understand their nervous system responses. The stages that follow are around "What do you value? What is your purpose? What is your meaning?"

As we heard from our other presenters today, when they leave the military, they're lacking in direction. Even for some of their transferable skills, they don't understand how those fit into a civilian context. Understanding who they are as an individual—as a civilian—becomes quite a challenge.

One piece, as well, because I work up in Renfrew county, is that there is a lot of isolation. PTSD becomes a very isolated disorder, and when you've had systems that have created more sanctuary trauma, it's very easy to get lost in a rural place. It takes a long time to seek out that help.

As I said before, I'm often spending a lot of time helping with those pieces before we can even do the trauma-specific therapies.

● (1955)

Mrs. Rechie Valdez: Thank you.

Ms. Jaquemet, what are some common barriers or stigmas that you've observed women veterans facing when they're trying to seek mental health support?

Ms. Alana Jaquemet: Thank you for the question.

As some of the barriers they face, oftentimes there's shame associated. There are a lot of feelings. Some of that is the self-stigma they have. There are also some psychosocial issues, some difficulty just navigating the system. That's a difficulty for people in coming forward to seek help.

Do you have anything, Alisha?

Dr. Alisha Henson: I think one of the other challenges.... Although Veterans Affairs provides some child care services.... A lot of women veterans I work with have small children, and they're trying to balance how to go to all these different places and their different treatment modalities while having small children at home. Especially if they're a single parent, it's quite difficult to navigate all of those pieces. It becomes, "Do I support my children and focus on them, or do I focus on myself?" Most of the time, being a mom is going to outweigh the system.

Mrs. Rechie Valdez: I think my time is up.

Thank you so much.

The Chair: Thank you, Mrs. Valdez.

Now we're going to have two short interventions of two and a half minutes.

[*Translation*]

I therefore invite Luc Desilets to take the floor for two and a half minutes.

Mr. Luc Desilets: Thank you, Mr. Chair.

Ms. Le Scelleur, to help guide your research, the Chronic Pain Centre of Excellence for Canadian Veterans has established an advisory council.

When I look on the Internet, I see that there are only two women, one of whom is a veteran, out of 10 or 12 people. Is that correct?

Ms. Hélène Le Scelleur: Yes, you're right. However, efforts are already being made to attract more women, more representation from various backgrounds, be it people from the navy or the air force, or diverse people.

Mr. Luc Desilets: I'm glad to hear that because, based on the numbers Dr. Zacharias gave earlier, 40% of men and 50% of women experience chronic pain. Hearing from women, especially female veterans, would be very relevant.

Ms. Le Scelleur, what recommendations would you like to see in our report?

Ms. Hélène Le Scelleur: Thank you for your question.

First, as mentioned, the issue of chronic pain in relation to pain and mental suffering definitely needs to be further addressed.

Second, as other speakers have mentioned, women, who have a maternal role, often give priority to the services they provide to others instead of caring for themselves. I think that's what we need to look at. How can we reach women in their reality?

For example, women must always score higher to be equal to men—I was one of them. They don't talk about the abuse so they don't get left out. However, women should be able to earn the respect they deserve. Even today, it's sad to see that in Quebec, we have a beautiful licence plate that only includes the masculine form, "*vétéran*". I would have liked to see the word "*vétérane*" there, because some women veterans are still being asked if it's their spouse's car.

We really need to put some effort into recognizing the role women play in the Canadian Armed Forces, as well as the reality they experience while they are serving.

Mr. Luc Desilets: My time is up. Thank you, Ms. Le Scelleur.

The Chair: Thank you, Mr. Desilets.

[*English*]

Now I will go to Mr. Garrison for two and a half minutes.

Mr. Randall Garrison: Thank you, Mr. Chair, although of course that's not enough.

I want to go back to something that Ms. Henson said, which I found very striking.

I'm going to ask you a question. We have heard from serving women veterans that there's a failure.... If your image of a soldier is of a cisgendered straight white guy and you don't acknowledge that women's health needs are different, that will lead to misdiagnosis or overdiagnosis of problems that women veterans face. Is that something you see?

● (2000)

Dr. Alisha Henson: Definitely. There is a very clear line between women presenting with personality concerns—depression, anxiety and then PTSD—whereas when the men come in, the PTSD sort of drives the bus, so to speak.

For a lot of the chronic pain, I know that a lot of the women I work with—the gentlemen as well, but more so the women—seem to have more difficulties in getting approvals and in getting the more long-standing treatments they need for the challenges they're having on a physiological level. They seem to get a lot more things coming back, so that they need to apply again and again.

Mr. Randall Garrison: Very quickly, to go back to the chronic pain centre, on the same question of the visibility of the less well-represented parts of the military and veterans community, I know that this committee has heard some testimony that the chronic pain centre has done better in paying attention to women's health needs and to racialized and indigenous needs. Can you tell us something about what it is in your approach that has gotten you more success in dealing with the less visible parts of the community?

Dr. Joy MacDermid: I can start.

I think there are a couple of important things the centre has done.

One, it has funded studies specifically about sex and gender, and about how they affect chronic pain. That's been an important thing.

Two, in the evidence synthesis that we've done, we've mandated that sex and gender be considered when we look at the literature. Sadly, one of the first studies we did was to try to look at whether there were different outcomes for multidisciplinary pain treatment for men and women veterans, and we found that none of the studies had actually separated the data for the men and the women. Therefore, we don't know because researchers haven't been reporting that.

As we go forward, one of the things we're mandating is that researchers always report their data for the men and the women separately so we can tell if there are different treatment outcomes for different sexes and genders.

The third thing the centre does is to have very active engagement of people with lived experience in all of the research projects. For example, on the project that I talked to you about, there is a co-author on that paper who is a woman veteran. She has a lived experience of sexual assault and was very engaged in the project at every stage. We're getting, as you see, the valuable experiences that people have to share. It's important that those be part of the research process.

Those are the things I've noticed. I'll ask Dr. Zacharias again, because he can speak from a centre perspective, but in my experiences as a researcher, that's what I've seen.

The Chair: Dr. Zacharias, please be really quick, because the time is over.

Dr. Ramesh Zacharias: I have two things, really quickly.

One is that we insist on veteran partners with all the researchers in every project, because they need that perspective of the veteran.

Finally, the last comment I'd make, Mr. Chairman, is that pain is never just the problem with the individual; it's a family problem. If it's a female veteran, it will affect their partner and it will affect their children. We have been funding a project looking at the impact of chronic pain on the children of veterans suffering from chronic pain. That should be coming out later this year.

The Chair: Thank you very much.

Now let's go to Mr. Stephen Ellis for five minutes, please.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Chair.

Thank you to the witnesses.

Just by way of being absolutely transparent, I served in the military for nine years, but I got out a very long time ago. I'm a physician, and I had a chronic pain clinic. My worlds are crashing together here this evening in a very strange way.

To Madame Le Scelleur, you talked about the transition to civilian life and somebody on the team.... I'm not sure what the focus of your research is. Are you working on any topic around resilience?

[*Translation*]

Ms. Hélène Le Scelleur: Thank you for your question.

[*English*]

I'm focusing on the identity crisis that military personnel are going through while transitioning out of the military based on a personal stress injury.

Mr. Stephen Ellis: Okay. Thank you for that. Maybe I'll focus on that.

The interesting part of it is that, as I was discussing with one of my colleagues, when you're in the military, you belong to a club, and then, the next day, you're out of the club. I would imagine that for female veterans it's perhaps somewhat more difficult. I can only suspect that, because I'm not a female veteran.

My question is this: Are there times when you were really a part of the club and other times when you felt like you were looking into the club?

● (2005)

Ms. Hélène Le Scelleur: That's a good question. Thank you.

I would say that I had to prove I was reliable as part of the men's group. From the beginning, I pushed myself to the limits. I was told I was part of the club, but for sure, in some portion of my career when I was going up the ranks and changing positions, it was always that I had to prove myself again and make sure everybody had my back instead of stabbing me in the back.

It was not an easy journey, and it's something that I think every woman who is in the service is experiencing.

Mr. Stephen Ellis: Thank you very much.

Through you, Chair, to Madame Le Scelleur, after that it doesn't matter where you're posted after you leave the military, because you're never a part of that club.

Is that part of the difficulty with the transition? Is it that civilians in general just really do not understand what it was that you experienced and then what you are experiencing in a very unusual way when you are transitioning out of the military?

Ms. Hélène Le Scelleur: Part of it is also being recognized as a veteran. As a female, I find that people often don't believe that I'm a veteran, that I went to Afghanistan, that I was on the terrain over there, that an IED exploded on me. People look at me like I'm lying or telling the story of somebody else.

I guess the main thing is being recognized in our own experience. That's the difficulty.

Mr. Stephen Ellis: Thank you very much.

Through you, Chair, I think it was Dr. Zacharias who talked a bit about resilience. If I don't have that right, it must have been Dr. MacDermid.

That being said, is there any way to teach resilience? Is that something we need to be looking at, perhaps in the recruitment of military members or teaching kids in school and things like that? Are you doing any work on that?

Dr. Ramesh Zacharias: You've touched on what is an extremely important aspect of transition.

In a Canadian Pain Society meeting last week, Hélène Le Scelleur, other veterans and I talked about resilience and transition. One of the things we've found out is that the similarity between professional athletes and veterans is incredibly unique. They are all “mission first”, and then their career ends. When it ends, the applause stops and they're left on their own.

We've been working on trying to increase awareness of the role of the Canadian Armed Forces veterans. I believe if we can somehow change the gestalt of the Canadian public to understand that whenever there's a crisis in this country—whether it's the ice storms in Quebec, the hurricanes on the east coast, the fires currently in Alberta, or COVID—the Canadian military members are the first ones who run in, and we need to respect their service. However, at some point in time, their careers are over, just like the athlete's career is over, so we're looking at creating an ability to be able to create resilience in both of these groups so that they can learn from each other.

Over the next few years, I think awareness will increase for the Canadian population. We'd like to get into the schools to make sure that people understand that they live in an incredibly amazing country due in part to the service, and we want to respect that.

Mr. Stephen Ellis: That's great.

Thank you very much, Chair.

The Chair: Thank you.

Thank you, Mr. Ellis.

Now let's go to MP Churence Rogers. He's on Zoom.

You have five minutes, Mr. Rogers.

● (2010)

Mr. Churence Rogers (Bonavista—Burin—Trinity, Lib.): Thank you, Chair.

Welcome to all of our witnesses this evening.

I had many questions, but many have been answered by the witnesses in response to questions from our colleagues around the table.

I think one thing is clear, based on all of the testimony we've heard this evening. It is that when people leave the military, it's clear that the military doesn't always leave them. That's for sure.

Dr. Henson, I want to ask you this question. Why is it sometimes so difficult for veterans of 25 or 30 years, who had successful military careers in some cases, to transition to a civilian life and to maintain a strong family relationship with their spouse or children and so on? Is it because they miss the disciplined military lifestyle and maybe feel abandoned or all alone, to a certain extent?

Could you comment on that for me, please?

Dr. Alisha Henson: Thank you for the question.

I think it's multi-faceted, but I believe that a lot of individuals have missed a lot of family time with their service, so sometimes it's about how they fit back into this unit. Families at home have been doing things for a long time in one way, flexing and waxing and waning as this person comes in to support them and be present with them, but then at the end of it all, after years of service, how do you fully reintegrate and how do you become a full family person again, someone who's a part of that unit?

For some individuals, especially if you've had a very long career, your children have now grown up and moved on and are developing their own families. Not only are you trying to find your own personal identity, but you're also trying to figure out what your family identity is, what your community identity is and how you fit back into this overall system.

I don't know if you have anything to add, Alana.

Ms. Alana Jaquemet: I just want to add that suffering from trauma is a very isolating experience, and often there's a lot of disconnection from community, from social environments, from family and actually from themselves, so reintegrating and reconnecting can be really difficult.

There's that functional disconnection that happens, maybe, while serving, but reconnecting is often a really difficult thing. I just wanted to add that.

Mr. Churence Rogers: Ms. Jaquemet, this committee has been focused on the transition piece, and we're looking for some great advice, which we're getting from this witness panel.

If you could provide some recommendations for us for this study, what would they be? I would encourage you as well, as I said to some of the others, to think about the study that we are going to be preparing and to please submit any future written recommendations that you might think about.

Ms. Alana Jaquemet: I'm going to actually defer to my colleague on this.

Dr. Alisha Henson: I believe that one of the really important pieces is to think about how we develop research in collaboration with the community. The centre that we're meeting with this evening, the centre for chronic pain, is doing a really great job of having veterans working in collaboration with them. However, what we're really looking at, and one of the recommendations we have, is around communities' participatory research, which looks at individuals who feel marginalized within communities, starting with them and, in collaboration, developing the research questions: How do we access those individuals who are maybe feeling a little bit disconnected overall, and then how do we build that sort of peer mentorship to include more and more voices in this process?

It's a top-down approach that's even sometimes coming from researchers, and I'm a researcher myself. It's coming from that external place and then moving inwards. We're constantly missing the mark, so starting here and then moving outwards in collaboration, I think, is the ideal approach.

● (2015)

Mr. Churence Rogers: Dr. MacDermid, in previous meetings female veterans have testified that mental health challenges create physical health problems, and vice versa, as a result of their time in the service.

Can you speak to these types of occurrences and maybe give us some examples of that connection between the mind and the body in general?

The Chair: Once again, please answer that question quickly, in about 30 seconds.

Dr. Joy MacDermid: There are so many ways. I'll just give an example of sleep. If you think about it, physical pain interrupts your sleep and psychological distress interrupts your sleep. When you don't sleep, you have more physical pain and you can't function.

Everything is connected. We see people sometimes self-medicating, so addictions can be related to untreated physical or mental health problems. We see all these complex interactions between every aspect of physical health and every aspect of mental health.

That's as brief as I can make it, really.

Mr. Churence Rogers: Thank you so much.

The Chair: Thank you, Mr. Rogers.

Thank you, Ms. MacDermid.

Now let's go to our final round of questions. We're going to have four interventions. We're going to stop after Mr. Garrison.

Mr. Blake Richards, you have five minutes.

Mr. Blake Richards: Thank you.

Ms. Jaquemet, I want to ask you a little bit about the new rehab contract. I'd like to hear your thoughts on the impact that it's having, both on service providers and on veterans, and whether you feel that Veterans Affairs communicated properly with service providers and with veterans about the implementation of that contract.

Will you yourself continue to be a service provider under that new contract?

That's a lot of questions all in one, but I'll let you address them however you choose.

Ms. Alana Jaquemet: There wasn't a lot of information about the change. As for me, I learned about it as it was happening. I didn't really have a lot of information about it.

Also, those I spoke to who were involved didn't have a lot of information about it. It was really difficult to help when clients were asking questions, because I didn't have the answers. I also didn't know who to direct them to. That was really challenging. When there are a lot of unknowns, it puts people on edge and creates more anxiety. What helps with anxiety is that we have things that are reliable and we know what to expect.

It was really challenging. Some of our sessions were just about what was going to happen and whether they were losing me as a provider and those types of things.

There's still not a lot of information. I don't know who to contact when it comes to my clients who've been called by PCVRS. My clients don't remember the name of the person. They just remember that they spoke to somebody for three hours and had to tell their story again, but they can't remember the name of the person and they don't have a phone number. I hear that story often.

As for me, I likely will not be signing on with PCVRS. At the same time, we're hearing that we can continue with our clients and continue providing therapy to them. However, getting sessions approved is a big unknown. I'm getting phone calls saying, “Hey, you have to do this quickly because we don't know what's going to happen. Try to send in for more approvals for sessions, because we're not sure how you're going to get more approvals.” That leaves a lot of unanswered questions.

Mr. Blake Richards: It sure sounds like it. We finished a study on it and we're working on a report for it. That's good information for us to have for it, so thank you.

I'm going to interrupt right now to move a motion.

I move that the committee order the Department of Veterans Affairs to provide any results, findings, conclusions, and recommendations related to the sex and gender-based analysis of disability benefits adjudication research conducted by Dr. Barbara Clow.

It was on notice, so it's okay to move it. I know that we don't have a lot of time left and I do apologize to our witnesses. I hope all of you understand that we get two two-hour meetings each week, and if we want to do something like this, this is the only way we can do it. I do apologize, but it's an important part of what we're trying to do with this study.

I am moving that motion. I think it's pretty self-explanatory. I know that there are others who have something they want to say about it, so I'm just going to move the motion and yield the floor.

● (2020)

The Chair: The motion has been moved, but would you like to explain it a bit? I think that members don't have a copy yet.

Mr. Blake Richards: No, Mr. Chair. I think it's pretty self-explanatory.

It has been brought up a number of times by witnesses in the committee that there is this research out there that Veterans Affairs has been reluctant or not willing—or whatever the case might be—to release. I know that witnesses have expressed that it would be useful. I don't think there's much more explanation needed than that.

The Chair: Okay. Thank you.

Mr. Sean Casey (Charlottetown, Lib.): Mr. Chair, if this motion was put on notice, I haven't seen it. I would appreciate the opportunity to suspend so that we can at least have a huddle. I had no idea that this was coming. I think we had a meeting not too long ago where we had committee business, and there were no witnesses to present it in front of. I think I'd like the opportunity to suspend, because if it has been put on notice, I've never seen it.

Mr. Blake Richards: I don't really see a reason to do that, Mr. Chair. It was put on notice. It has been on notice for some time. If members chose to ignore it, that's not the fault of the rest of the committee. We don't have a lot of time left here. I don't think there's a need to suspend.

The Chair: It was on notice on April 21, so that's right, but you are going to receive a new copy so that you can look at it.

As Mr. Richards said, I have to say for the witnesses that you can stay with us, but the procedure is that I have to deal with this motion with members of the committee before I go on.

I'd like to know if there's an intervention.

Go ahead, Mr. Garrison.

Mr. Randall Garrison: Thank you.

Just to make things even more complicated, I'd like to move an amendment to Mr. Richards' motion. I think it's being circulated electronically as we speak. It would be to add, at the end, things to make it easier for VAC to identify what we actually need in the committee.

The amendment would be to add the following at the end of the motion: the description of disability adjudication at VAC, a report from September 13, 2019; findings from key informant consultations from October 1, 2019; analysis of adjudication instruments and processes from December 20, 2019; the evolution of adjudication tools and rules at VAC, December 20, 2019; and, finally, sex- and gender-based analysis of disability benefits adjudication at VAC, a summary report, February 11, 2020.

With respect, Mr. Chair, this doesn't change anything about the sense. It just allows the committee to give more definite instructions to VAC about the reports it's looking for.

The Chair: Excuse me, Mr. Garrison. Did you say we have a copy circulated?

Mr. Randall Garrison: It was circulated electronically, I think.

The Chair: Okay, the clerk is working on it.

Could you repeat it again for the benefit of the members, please?

Mr. Randall Garrison: Sure.

The Chair: By that time, we'll receive it electronically.

Mr. Randall Garrison: It would add, simply, after "Barbara Clow", the following: one, description of disability adjudication at VAC from September 13, 2019; two, findings from key informant consultations, October 1, 2019; three, analysis of adjudication instruments and processes, December 20, 2019; four, the evolution of adjudication tools and rules at VAC, December 20, 2019; and, five, sex- and gender-based analysis of disability benefits adjudication at VAC, a summary report, February 11, 2020.

The Chair: Okay, we can take care of this amendment.

Would you like to intervene?

I have Mr. Rogers on Zoom, followed by Ms. Lattanzio.

Go ahead, Mr. Rogers.

Mr. Churence Rogers: Mr. Chair, I just received a copy of Mr. Richards' motion. I haven't seen the amended motion. I would like an opportunity to discuss it with my colleagues.

I move that we suspend.

● (2025)

The Chair: Mr. Rogers, personally, I received Mr. Garrison's amendment in my email.

Perhaps we can go to Ms. Lattanzio and then come back to deal with that.

Mr. Blake Richards: I can speak to his point of order.

It has been given to all members of the committee. It is in your email box. I don't see a reason to suspend.

The Chair: Ms. Lattanzio, go ahead, please.

Ms. Patricia Lattanzio: Thank you, Mr. Chair.

I want to receive a copy for myself. I have yet to receive the amendment from Mr. Garrison in my email. Can the clerk ensure that I receive a copy so that I can follow along?

The Chair: I know, Ms. Lattanzio, that you're not a regular member of the committee. I'd like to make sure, with the clerk, that you receive a copy as soon as possible.

He just sent it.

Ms. Patricia Lattanzio: I got the notice from the clerk.

The Chair: Okay, he will send it to you as soon as possible.

Are there any other interventions on the amendment?

[*Translation*]

Since the amendment was sent to Ms. Lattanzio, if no one else would like to speak, I will call the vote on the amendment moved by Mr. Garrison.

[*English*]

Mr. Sean Casey: Mr. Chair, we would like the opportunity to discuss among ourselves the very detailed amendment that has just been provided.

Mr. Rogers asked that you suspend to afford us that opportunity. You have the discretion to do so. I would ask that you exercise it.

Mr. Blake Richards: To that point, as you indicated previously, this motion was submitted almost a month ago. All the amendment does is simply list the research that's been referred to in this motion. If members didn't do their homework in the month they had to do it, I don't believe the rest of the committee should be required to sit around while there's a discussion. I don't think the witnesses should be interrupted for any longer than they need to be. Let's just vote on this.

If members didn't do their homework, they'll have to choose what they want to do for their vote.

The Chair: Okay.

Colleagues, let's go back. On the floor I have the request to suspend, but I have to have the full consent of the committee to suspend.

Do I have the consent of the committee to suspend?

Some hon. member: No.

The Chair: I don't have the consent of the committee to suspend.

Mr. Sean Casey: Chair, I would like to speak to the motion and the amendment.

When do you expect to adjourn the meeting? I'll be speaking until you do, without suspension.

● (2030)

The Chair: Mr. Casey, could you please repeat that?

Mr. Sean Casey: I'd like to speak to the motion.

Will we be adjourning at 8:30?

The Chair: Yes.

Mr. Sean Casey: Very well.

Thank you very much for the floor, Mr. Chair.

We have before us, in the dying moments of the meeting in front of witnesses, a motion that was apparently put on notice—well, it's been confirmed now that it was put on notice—on April 21. I don't see any apparent problem with the motion. It certainly appears there was some research done by a Dr. Barbara Clow on a matter that does appear to be relevant to the—

The Chair: Mr. Casey, I'm sorry, but because of the time, I have to stop you right here.

Mr. Sean Casey: But I have a lot more to say, Mr. Chair.

The Chair: I know, but I have to make sure that we respect the clock. We're going to adjourn for sure.

First of all, members of the committee, we have witnesses with us. Please allow me to say thank you to them for their input into our study. It was really important to listen to you tonight.

[*Translation*]

I'd like to thank Dr. Alisha Henson, clinical psychologist, supervised practice; and Alana Jaquemet, registered social worker and registered psychotherapist. They both appeared as individuals. From the Chronic Pain Centre of Excellence for Canadian Veterans, I also want to thank Dr. Ramesh Zacharias, chief executive officer; Hélène Le Scelleur, retired captain and co-chair of the Centre of Excellence Advisory Council for Veterans; and Dr. Joy MacDermid, professor.

With that, does it please the committee to adjourn the meeting? Yes? Thank you.

The meeting is adjourned.