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Chair

Mr. Neil Ellis

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● (1140)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): Good morning, everybody. I would like to call the meeting to order. Could we get everybody in their positions.

I apologize to the witnesses today that we did have to stay in the House for a vote. With trying to run the meeting to time today and maybe cutting some of the time allotments down for all of this and getting our questions out there we can get both groups in and get this done.

I would like to welcome our Ombudsman, Guy Parent, again, and Sharon Squire here.

We'll start with your testimony.

[*Translation*]

Mr. Guy Parent (Veterans Ombudsman, Office of the Veterans Ombudsman): Thank you.

Mr. Chair and members of the committee, thank you for inviting me to appear before you today and comment on your study, “Barriers to Transition and Measurable Outcomes of Successful Transition.”

[*English*]

This is not the first time I have come up to Parliament Hill to speak about the transition of servicemen and servicewomen in the Canadian Armed Forces to civilian life. I do hope that this time that this committee's work leads to action rather than further study on the subject.

As a 37-year veteran of the Canadian Armed Forces, I know the challenges of transition on both the personal and professional level. I know transition from my own experience and also from that of my son who served in Bosnia and Afghanistan, and also from many experiences of thousands of veterans I have met and worked with across Canada since being appointed Veterans Ombudsman in 2010.

I last discussed transition with this committee in 2015 and appeared before the Senate Subcommittee on Veterans Affairs to present on transition in 2017. On both occasions I emphasized that the transition process from the CAF needs to be as vigorous as the recruiting process to the Canadian Armed Forces.

I also say that transition needs to support releasing members and their families to begin a new life with purpose, a life tailored to their needs, individual goals, and offering the best future possible whether they go back to school, go on to another occupation, retire or volunteer in their community. I should also mention that the majority of my recommendations related to transition have not been acted upon. I'm not saying that progress has not occurred, what I am saying is that we are moving at a snail's pace.

I have been at this for a long time pushing as hard as I can to modernize transition. In 2014, I launched a joint project with the National Defence and Canadian Forces Ombudsman to review the entire transition process from an evidence-based perspective. Our key findings threw a spotlight on why transition is often such a confusing and frustrating experience for veterans and their families. We have provided the committee, Mr. Chair, with infographics on this particular study.

We produced the first complete mapping of the transition process for medically releasing regular and reserve force members. It highlighted that the transition programs and services rely heavily on forms and bureaucratic processes rather than the needs of the members and their families. There are multiple players and organizations involved in transition. Each has its own accountability framework, mandate and process, which is confusing for veterans who do now know where to turn for support.

We found also that available services are not consistent across the country. Service partners are not always co-located under one roof, resulting in multiple stop shopping for the transitioning members and families. The Canadian Armed Forces and Veterans Affairs Canada each have different case management systems and multiple consent forms.

[*Translation*]

Integrated Personnel Support Centres (IPSCs) only provide support to members with a complex medical release but only 10% of all medical releases are deemed complex. Those 10% receive the advantage of a tailored integrated transition plan and individualized support. Should not all releasing members have the opportunity to access the same standard of planning, coordination and monitoring during their transition if they need it?

[*English*]

As well, despite several reviews and my recommendations from 2013, there remains a duplication in vocational rehabilitation programs, education and long-term disability programs across the Canadian Forces and Veterans Affairs Canada, adding complexity and confusion to transitioning members. There are in fact three vocational rehabilitation programs, the service income security insurance plan, Veterans Affairs Canada, and the Department of National Defence. Each program has different eligibility criteria, assessment requirements and benefits. There is, unfortunately, no mechanism to ensure the coordination of benefits or to verify that a member is getting the best support to meet their needs.

There has been much talk of Veterans Affairs Canada engaging earlier with medically releasing members. Initial engagement now begins with a transition interview, generally within six months of the release date. While I believe this earlier engagement is an improvement it is still too late to adequately support medically releasing members in the development of a new lifelong plan to ensure benefits and services are provided prior to release.

● (1145)

Finally, our analysis showed that the release process was designed for regular force members. There are only 24 integrated personnel support centres across the country, whereas there are 263 reserve units. This means that reserve force members have to rely on the support of their units to facilitate the transition process. This results in reservists being offered varying levels of expertise and service. In my opinion, that is not good enough.

I envision a transition process for all releasing members, regular and reserve, medically and non-medically released, that would have elements similar to those of the recruiting process, including transition centres across the country that are accountable to one authority and offer a single point of access for all releasing members, which would ensure that all benefits are in place at release. As well, it would include a real live person—or navigator—who would be assigned to all regular and reserve force members, whether medically releasing or not, to help fill out forms, plan members' release, provide advice on organizations that may offer support, and provide follow-up after release at predetermined intervals to ensure evolving needs are met. It would also include a single program for vocational rehabilitation and long-term disability that offers a professional counsellor to help determine the education, training, or employment needs of the member, as well as to assist them in finding a new purpose in life. It also would include issuing to every releasing member a veterans ID card that recognizes their service.

My vision also draws from a small qualitative study that my team completed last year to better understand the lived experience of medically released veterans and what contributes to a successful transition. Again, we have provided an infographic on this particular study.

My vision is also backed up by what I hear at the many outreach activities that I hold each year across the country, where I talk face to face with veterans and their families, as well as with national, regional, and local veterans advocates, organizations, and municipal leaders. We've found that the major contributing factors to a successful transition are planning ahead, being proactive, owning their transition, and having a supportive relationship.

The key challenge for transitioning veterans was finding a new purpose post military service. One veteran said this: “The military was my life, my family, my everything. I joined the army at age 19. Before that, I was in high school. I was never really a civilian adult. I don’t feel that I am transitioning ‘back’ to civilian life, but becoming a civilian for the first time.” Another veteran said, “The biggest part I'm struggling with is integrating into an unfamiliar society [and] culture where the social behaviours [and] norms I've learned from 15...years in the [Canadian Armed Forces] aren't applicable.”

It's much different from just changing jobs on civvy street: it's a complex cultural transition to a society with different norms and rules in many cases. It's not simple.

As I said at the beginning of my remarks, we have to ensure that when members leave the Canadian Armed Forces they are equipped to begin a new life with purpose, a life tailored to their needs. Not all will need assistance from Veterans Affairs Canada, but those who do should receive the benefits and services they need, when and where they need them. This should apply to regular force members as well as reservists, whether medically releasing or not.

This will give veterans and their families hope for their future. Without hope, there is no forward movement. Our veterans have served their country well, and they deserve no less.

Thank you, Mr. Chair. I stand by for your questions.

The Chair: Thank you.

We're going to start with four-minute rounds.

Mr. McColeman.

Mr. Phil McColeman (Brantford—Brant, CPC): Thank you, Chair, and thank you for being here today, Mr. Parent.

The position you've stated publicly and the one of the DND ombudsman are very close together: that this has been overstudied. I think you've said that or have implied it today in your words.

You've also underscored the focus on bureaucracy. If you were redesigning or re-engineering the way things are set up today, what would be your one or two key recommendations? Along with that, I'm going to be very up front about the fact that when I've spoken with veterans around the country they are so frustrated with the process and with the fact that it doesn't change even after all of these studies, after all your recommendations, and after Mr. Walbourne's recommendations over and over again.

If this is indicative of how government is run, which is that there are top people in management positions who refuse to make the changes that you continue to recommend to them, I want your views on this subject. This drives down to what I hear over and over again out of veterans' mouths and the mouths of other people who have studied the subject matter repeatedly, which is that there's a top management structure, sometimes referred to as the Four Horsemen of the Apocalypse. Have you ever heard that term used to describe some of the people at Veterans Affairs?

● (1150)

Mr. Guy Parent: No.

Mr. Phil McColeman: I've heard it over and over again out of veterans' mouths. Why do you think there is such resistance to make these comments and changes?

Mr. Guy Parent: I take your point. We're dealing with two different departments, and the transition has really two aspects to it. One is leaving the forces and the other is when you're an injured veteran entering a system that will look after you for the rest of your life.

Certainly, on the side of leaving the armed forces, I believe that what is needed for the transition process is a live person, preferably somebody who has retired from the forces already, who is successful, to actually guide the people through the process, because it's very complex, very frustrating.

On the other side, to reduce the complexity of the programs and offer a bit of simplicity, it's to have one application and that once people have applied and they've actually qualified for benefits, then everything that they need should come from Veterans Affairs Canada. They should not have to actually keep asking questions about what they could qualify for. The information should be pushed out of Veterans Affairs Canada, and not pulled out.

That transition, I mean, it's difficult to look at how you transition an injured person when in fact there was never any process developed for uninjured people leaving the Canadian Armed Forces.

Mr. Phil McColeman: Thank you. I have very limited time.

You know, the reality is from even people inside, witnesses we've had here, who have said that the duplication of those forms is necessary. People who are inside working on the subject matter have said, “No, no, we can't do that”. That's been testified here by some of the top people who run these programs. There appears to be something. Another witness, when we asked questions, said that it's easy to criticize the bureaucracy. Well, you're damn right, it's easy, because you know what, they don't make any changes.

You just said one simple change, the DND ombudsman could simplify things for veterans, yet we can't get that one simple change done.

I think there's a much deeper problem. Do you sense there is as well, in the bureaucratic structure that we have?

Mr. Guy Parent: I'm not sure that the structure is really the issue, but departments working together. What I don't understand is the fact that we do have other departments of government working together. One good example is fisheries and the search-and-rescue centres, for instance, where you have different government departments working together providing a service.

Fortunately, I was at a joint steering committee yesterday between veterans affairs and national defence, and there is certainly some willingness to go forward and do something about the transition. I think to this point it's been a bit lethargic, in my mind.

Mr. Phil McColeman: You made the comment, it's not even a snail's pace. It's no pace.

The Chair: Thank you.

Mr. Fraser, five.

[*Translation*]

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

My sincere thanks to the witnesses for being here today.

[*English*]

I appreciate very much your being here again. I know this is your first time being here to talk about transition in particular before this committee.

I want to talk about a couple of different issues. The first is the military family resource centres. I know the government has now opened up all 32 to medically releasing veterans and their families. The good work that the military family resource centres do, usually in military communities, is a phenomenal resource that we have on the ground that can actually help transitioning members and their families.

I'm wondering what more can be done to support families in addition to the MFRCs. Do you have any concrete examples? I note that the government has initiated a caregiver amount of up to $1,000 tax-free a month to assist family members who are taking care of ill and injured veterans. Do you have any concrete examples of other things the government should or could be doing to support these family members, who do such an important job ensuring that this transition enables forces members to find a new purpose?

● (1155)

Mr. Guy Parent: Thank you. I certainly think that one very positive thing is the fact that now we finally realize that veterans don't transition by themselves. The families transition with them. I welcome this change of having veterans now being able to access family resource centres. Certainly, in my visits throughout Canada and all the bases I make a point of visiting the family resource centre, and I find that they are very open to looking at veterans' issues and helping them transition. Again, I think the important aspect there is that people don't always leave the family resource centre where they were actually serving last. For instance, a lot of people may be serving in Ottawa but they may be retiring in a community near another family resource centre. That's the opportunity now to go in to have information on this particular area when it comes to education, benefits for children, employment opportunities, and that sort of thing. Certainly I would expect that the government will continue, with Veterans Affairs and DND working together, to broaden the access and the integration of services in family resource centres to families as well.

I think an important aspect to realize as well is that this family caregiver benefit is one of the few benefits that people can now access in their own right, which was not possible before for caregivers who were family members.

One last thing, too, is this funding for research on what will benefit both military members and families will also certainly provide an opportunity to do something for families of transitioning members.

Mr. Colin Fraser: Thank you.

Ms. Squire, you had a comment on that.

Ms. Sharon Squire (Deputy Veterans Ombudsman, Executive Director, Office of the Veterans Ombudsman): The other thing that we noticed in our study is that the families didn't get much information during the transition process. It was solely the responsibility or the option of the serving member to provide them with information. They said if they had known what they knew now they would have engaged their partners and families throughout the transition process. So, more support to those families with information and support during the transition process would be helpful, too.

Mr. Colin Fraser: Excellent.

I want to turn to something I've noticed in my time on this committee and working on veterans' issues. Many releasing veterans find solace in being able to talk to somebody who has been through this before. I think peer support is a huge element in successful transitions for many members. Do you have any comment on what more we can be doing to identify and support peer support systems in transition? You mentioned a navigator, somebody who can help guide a medically releasing veteran, for example, or any veteran through the transition period. Do you envision that perhaps being a peer, somebody who has been through this before? What could we recommend, as a committee, that would help engage more peer support?

The Chair: If you could answer that very quickly, I would appreciate it.

Thank you.

Mr. Guy Parent: What I suggest is that the peer support should come from somebody that has successfully transitioned already. If I'm military and leaving the forces and somebody has left the military and is successful, certainly there would be an element of trust there to say okay help guide me through the process. I would think also in the terms of peer support that the OSISS program that provides support now for people that are suffering from psychological distress certainly should be looked at as being a program that could be improved and maybe broadened to be offered to more people.

The Chair: Thank you.

If there is anything that you want to add you could get that back to us in writing with any of the answers.

Mr. Guy Parent: Will do.

The Chair: I apologize for trying to keep it on time today.

Mr. Johns, you have four minutes.

Mr. Gord Johns (Courtenay—Alberni, NDP): Thank you. Thank you for being here today and for the important work that you're doing.

There was a Toronto Star article in December that stated there's a backlog of 29,000 vets who applied for disability benefits. We had a previous witness here from VAC on two separate occasions and I had asked him to confirm this number as correct. We haven't received an answer yet about this number. Do you think it reflects the actual backlog of veterans waiting for their claims to be processed? If so, maybe, what is your estimation? Do you think the 29,000 is an accurate number?

Mr. Guy Parent: We don't have an actual number. I think you can probably get that from Veterans Affairs Canada. But I think what's important here is that, yes, this is one of the biggest issues of complaint we have received now in our front line. It has to do with turnaround times and the time it takes for an application to be resolved. We certainly appreciate that Veterans Affairs Canada may have a standard for service. But if they cannot meet that standard, at least people who are applying for benefits should be informed that it is such a situation. I think that's an important aspect, because then you create expectations that you will be delivered a service within 16 weeks when, in fact, it may be at 24 weeks. The important part is for the people to know that this is right now the reality and that it's going to take that long for your application to be looked at.

● (1200)

Mr. Gord Johns: Earlier, you talked about a single application. In April 2015, you made a recommendation to the committee that we should have a single authority to make decisions about releasing. Could you expand on both the recommendations and whether there has been any progress on implementing the recommendations that you made back in 2015?

Mr. Guy Parent: There's been no movement at all in the implementation of that recommendation.

Mr. Gord Johns: Hold on. Can you expand on what the hold up is?

Mr. Guy Parent: I think it goes back to a comment that was made before. What has happened is that over the years programs and benefits have been developed to meet the needs of people who are coming back from a certain mission. We segregated. A lot of those benefits are now based on where you serve and when you serve, not on what you need. I think until we go back to that area of meeting the needs of people and having a suite of benefits for everybody, it's going to remain very complicated. It's one of those things. There are a lot fewer forms than there used to be, so there is an improvement. There has been a reduction in some of the complexity, but again, with the announcement of new benefits coming into play one or two years down the road, it adds to the expectations and confusion.

Mr. Gord Johns: You talked about having people who are retired from the forces on the front line understanding veterans' needs—case workers, for instance. We're hearing that from veterans all across the country. We just had veterans camping out here and they're saying that their biggest obstacle is people on the front line not understanding their needs and experiences—the familiarity and empathy that you talked about.

Maybe you can speak a little bit more to that. I know in the U.S. they have a program where one-third of their case workers are former veterans. I don't know how strong our return to work program is in terms of getting veterans back into the fold. Maybe you can speak to that a little bit and the importance of it.

Mr. Guy Parent: Certainly. I think the issue of case workers and service agents.... You're probably aware that there's now a program of guided support. This means that some of the people in VAC who are providing the service will also help guide our veterans through the system.

A case manager is really managing the person, not managing the situation. Obviously, a lot of those case managers over the years have been burdened with doing more than just looking after a particular case, both the individual and the challenges of psychological care and medical care; they're looking after the whole situation, including giving information on programs. Let us hope that what's happening now is that with the service agent giving guided support, the care manager will be able to actually put their effort on the people themselves as opposed to on the situations.

Mr. Gord Johns: They can be a navigator, yes.

The Chair: Mr. Johns, your time is up. I don't know if you had one quick question that you wanted to ask. Then the ombudsman could get back to us on that.

Mr. Gord Johns: No. That's okay.

The Chair: Thank you very much.

Mr. Poissant.

[*Translation*]

Mr. Jean-Claude Poissant (La Prairie, Lib.): Thank you, Mr. Chair.

Mr. Parent, thank you for your testimony.

A number of my friends are veterans. There is one with whom I go motor biking. Also, when I was a city councillor, I was on the council with a veteran. He explained to me that the United States has a program to help veterans go into business and start businesses. He himself has opened up an office to help veterans start a business.

Is that something we could do here? If so, how could we do it?

Mr. Guy Parent: That’s a good point.

It's already happening. A number of companies provide veterans with services to start a business and the training they need to run a franchise or something like that.

One of the problems with the transition is that, while there are many companies and opportunities for them, there is no central point where people can go for information. A number of things are available, but there is still a communication problem and there is no central point where they could get all this information.

● (1205)

Mr. Jean-Claude Poissant: Thank you.

You also said that veterans should have a satisfying job. What do you mean by “satisfying”? Is one type of job better suited for them than another?

Mr. Guy Parent: I mean work that meets their financial and cultural needs, as well as their need to feel that they are contributing to the country.

Often, what people are looking for after a military career is to continue serving. They can do so by working in the public service or in a company, but they want work that is satisfying in all aspects, not just financially.

Mr. Jean-Claude Poissant: Are there any statistics showing that veterans have a better chance of succeeding in one sector over another?

Mr. Guy Parent: Studies do not show that sort of detail. Let's say it varies. That said, because of their military culture, most veterans want active work. When they are offered a job or training, the important thing is to meet both their needs and those of the company that hires them.

Mr. Jean-Claude Poissant: Thank you.

[*English*]

The Chair: Thank you.

Mr. Eyolfson, we'll go to three-minute rounds with you.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair.

This was a good segue into what I was going to expand on from the previous question regarding the kinds of careers or jobs that people want when they're transitioning. We've talked very often about the concept of universality of service and how we're hearing some indications that the Canadian Armed Forces is reviewing this policy.

Have you heard from veterans who have been released medically but would be able to perform certain jobs in the military, that things might be better in their transition if they were still in the military family, military culture, but in a non-combat role?

Mr. Guy Parent: Again, that's a good point.

Universality of service is an approach that's been used by the armed forces to make sure they have the required assets to go to missions and perform duties in conflict areas.

I am not in DND right now, but I believe that the chief of the defence staff is looking at how universality of service affects veterans. Certainly now the people who are released medically can go from a period of six months to maybe three years where they are in transition. During that time, they are still employed and paid by the armed forces.

There are some administrative duties. There are tasks that could be carried out by injured members. However, I understand that in the armed forces you need to have boots on the ground. I think that's always the challenge with the people.

One thing about universality of service is that if it exists as an approach and then you are forced out of the forces because you don't meet the universality of service, then you are in fact....Your release, to me, is attributable to service.

I think that's the context of universality of service that's very important to look at.

Mr. Doug Eyolfson: I would agree completely.

One of the pieces of testimony we've heard from multiple veterans is that they noticed health problems, either mental or physical, but did not report them because they were afraid they wouldn't meet universality of service. Again, the example I use ad nauseam is the paratrooper who's starting to get back pain but doesn't see a doctor about it because if the doctor finds something, then the soldier can't do this anymore, so he's out. He doesn't say anything until he's crippled with back pain, and then they find that there are fractures.

There's also the person who is having a bit of trouble sleeping and doesn't refer to it, and then has full-blown PTSD by the time he's out.

Do you find that there would be an easier transition if in fact service members were not afraid to report their symptoms because of this?

● (1210)

Mr. Guy Parent: Certainly.

In our study on the determinants of successful transition, one of the barriers was the stigma that prevented people from divulging the full extent of their injuries. Therefore, by the time they did, recovery and treatment were even harder than it would have been had they come in earlier.

That is one of the barriers to transition that we have.

The Chair: Thank you.

Ms. Wagantall is next.

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

It's very good to see you again, Mr. Parent.

Presently with transition, DND determines, first of all, if there is an injury, and then, if that particular individual can no longer serve, they are basically then transitioned out of the service. It's clear that at this point they do not determine if the injury was service related or not, correct?

Mr. Guy Parent: Correct.

Mrs. Cathay Wagantall: We've had two witnesses come to us on this particular study. The ombudsman for DND has said, “As I have said, the Canadian Armed Forces knows when, where, and how you have become ill or injured. The Canadian Armed Forces should tell Veterans Affairs Canada that the illness or injury is attributable to their service, and this determination be accepted.”

Then we had Ms. Elizabeth Douglas, General Director, Service Delivery and Program Management for VAC, come to testify as well. I asked her that question very directly. Would it not be better, if we're truly concerned about making services better for veterans, to have that determination made on the reason that they're leaving the service before they come to VAC? We know that they then have to go through all the records, which are much less accessible. Dealing with proof of service takes months. There's a great deal of stress around that when that determination could be made prior to their releasing so that at least they're off to a better start. Who do you agree with there?

Mr. Guy Parent: I think that attribution of injury to service is really a moot point. In fact, if I go back to the universality of service, if you release from the armed forces, there's such a thing in the legislation of Veterans Affairs Canada that says that, even though your injury is not due to service, it might have been exacerbated by your service. In fact, really, if you release under this business of universality of service, you are releasing because an injury is attributable to service.

Mrs. Cathay Wagantall: In fact, it's determining whether or not you will qualify for their services, because you have to deem it service related. That whole process takes additional time, when already that could easily be determined, as the ombudsman said, prior to their leaving the service. To me, this is why we're studying this again.

Mr. Guy Parent: Yes, but the majority of veterans do not really become clients as they release. This might be an easier way for people who are in the process of releasing. Most veterans, a great majority of them, get out of the forces, are out for two or three years, and then—

Mrs. Cathay Wagantall: I understand there is that point when additional things accumulate. I'm talking about the one way that we could make the whole process more streamlined for veterans who are leaving, to have it determined in advance that the reason they're leaving—whatever, a helicopter accident—is that their injury is due to service. Then that would take that step off, and VAC case managers could begin to determine how to best care for this individual. Their injury is service related.

I have another quick question. The parliamentary budget officer has pointed out that only 8% of the $147 million announced by this government has been spent on opening up the family resource centres to veterans. Is that a concern? Does that add to the whole delay process of our veterans getting the supports that they're announced they're receiving, but then only 8% of the funding has gone out to resource centres?

Mr. Guy Parent: I certainly have no information on the cost, on the expenses. All I can tell you is that the outcome is evident. We have a lot more veterans now going to family resource centres. They're benefiting from the services. Everybody seems to be online as far as where they're supposed to go and what the outcome is. I'm not really an advocate of looking at costing, because fairness doesn't have a price.

● (1215)

Mrs. Cathay Wagantall: At the same time, the family resource centres that I've visited have said this adds another whole layer of responsibility and expense to them. That's where I'm going with it, so it's important we fund them.

Mr. Guy Parent: That would be a DND issue as far as the funding is concerned.

Mrs. Cathay Wagantall: Okay, and that was my question, too. Where is the funding coming from? In that case it's DND, but they're servicing veterans.

The Chair: Thank you.

Mr. Bratina.

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

You made a comment with regard to reserve units in the context of 24 support centres, but with 263 reserve units across the country, it's hard to do the complete intake. Would you make some other comments? I have five units in my particular riding. I wonder what other things you would comment on with regard to the reserve units and the veterans process.

Mr. Guy Parent: Certainly the reservist who is transitioning to civilian life has a challenge as well. I think what's important is that they need the communication, they need information, and in many cases it doesn't come from a source that is knowledgeable, it comes from their own chain of command, sort of thing.

The transition centres that are being proposed now by DND and VAC are actually probably going to help out in that respect, of having some central point where people can go for information and communication on how to best transition. The footprint of the armed forces of having reserve units all across Canada is an important one, but we should make sure they're not isolated just because they have to serve in different parts of the country. The communication needs to be better for reservists.

Mr. Bob Bratina: Over and over again we've heard testimony and discussed and had questions from all of our members of the committee with regard to the two silos, the Department of National Defence and the veterans.

We had an incident in our city where we had a young man who did a seven-month tour in Afghanistan. A very short time after coming back he took his own life in the armouries. He obviously had PTSD. It was quite a sad story, and eventually the right thing was done. But it seems that in this case with this reservist there should have been an intervention, having come seven months prior, and then just a very short time later taking his life.

What we keep, I suppose, harping on, is, how can we bring together the active duty experience with the potential for transitioning to the veteran experience?

Mr. Guy Parent: I think one of the issues there is tracking. Very important in looking after a reservist is the fact that as opposed to regular force members who go back to their own unit within the comfort of their own base, for instance, a reservist goes back into society and doesn't often have the support of their peers and their unit. I think there needs to be a good tracking system there when people come back from missions, especially for reservists, so there is somebody who looks after them especially if they have complex cases. We advocate for all complex cases, in fact, that there should be a follow-up by Veterans Affairs Canada and DND, consistent follow-up to ask, “How are you doing?” two or three months down the road, and that's not happening. I think the tracking and peer support are important.

The Chair: Great. Thank you.

That ends our speed day today and I'd like to thank both of you. If there is anything you'd like to elaborate on some of the questions, you can add to it and get it to the clerk.

I do apologize, and I'd like to thank the members for their co-operation today.

I'd like to recess and clear the room as quickly as possible so we can get the next witnesses up and get that done.

I will adjourn for 30 seconds. If there is any conversation, could you take it out to the hallway and we'll start in one minute.

Thank you.

● _____ (Pause) _____ ●

● (1220)

The Chair: For the second panel we have Dave Bona, Teresa Untereiner, and Jenny Migneault. Thank you.

We're going to start with testimony from Mr. Bona and then we'll skip to Jenny, and go from there.

The floor is yours.

Mr. Dave Bona (As an Individual): Hello.

I'll begin by explaining what I've been doing since the last time I testified. Directly as a result of the media attention I received the last time I testified, a lot of people have been reaching out to me. In this past year and a bit, I've talked to well over 100 veterans and civilians, not just from Canada but also the States, Australia, Ireland, England, and New Zealand.

What has emerged is that there's an actual pattern to the injury from those who've been poisoned by mefloquine. First and foremost, they have PTSD that is resistant to treatment. Second, they have gut issues, balance and dizziness issues, tinnitus, body temperature regulation issues, numbness and tingling in the extremities, sensitivity to light, and extreme, extreme difficulty in moderating moods. All of these injuries are indicative of a brain stem injury.

We have found that for the majority of these individuals, because of the degenerative nature of their injury, a lot of their severe symptoms are not apparent, if they're not identified early on in their career and the individuals are medically released, until post-release. A lot of their symptoms are manifesting in extreme ways that basically prevent them from accessing even basic health care.

I'll used Claude as an example. He has severe difficulty moderating his moods. He cannot even be in a crowded and busy doctor's office. He's unable to access basic Veterans Affairs services because of the nature of the injury from the mefloquine. He gets worked up around a lot of people. By the time he gets in to see the doctor, he's not able to articulate what his needs are because he's so worked up. If the doctor is very contrary, is not open to a suggestion on what possibly could be wrong with Claude, and recommends that Claude do neuropsychiatric medication or go see a psychiatrist or something like this, Claude gets really worked up.

I also had this problem. I fired I think five family doctors because they tried to push medications at me and tried to do the neuropsychiatric thing. I finally found a doctor who could actually do the paperwork and would listen to what I was saying.

This injury is part and parcel of this whole transition. We've poisoned probably well over.... We've given this drug to 40,000 Canadian soldiers. A lot of the studies are indicating that up to 74% of those people who have taken this drug have actually been injured by this drug.

To give you an example of that, one of our strongest civilian advocates committed suicide on January 2. She had reached out to me in the past because she was severely struggling with the severe depression associated with mefloquine poisoning. She constantly asked me how I was able to keep my head above water, how I was able to keep moving forward.

She didn't quite make it.

I'll leave it at that.

● (1225)

The Chair: Thank you.

We'll start with our first round of three minutes, Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair. Thank you, and good to see you again, Dave. Thank you for coming.

The Chair: Yes, I'm sorry.

I apologize, Jenny.

Ms. Jenny Migneault (As an Individual): I'm used to it. I'm being ignored again.

Voices: Oh, oh!

The Chair: We'll reel that back in. Jenny, welcome here, and I do apologize. Please start with your testimony. The floor is yours.

Ms. Jenny Migneault: Thank you for this opportunity to be heard.

The Chair: It's the first time I've ever done that. I apologize.

Ms. Jenny Migneault: As a vet's spouse and a caregiver, I used to feel that I was nothing, but because the parliamentary system has turned our veterans and their families into political issues and is treating them as such, I've become a jack of all trades of advocacy.

I'm here today representing myself. Although I am a member of the VAC family advisory committee. I am also a blogger on 45eNord.ca, a public speaker, an advocate in English and a *militante* in French. I support, defend, promote, and attack causes rather than people, including JPSU, medical cannabis, caregiving, PTSD, and political situations of caregivers, all topics that have a connection or impact on families.

Since my chase after ex-minister Fantino in 2014, my life is not the same. I'm now a grandmother. My ex-husband and I are divorced, and in some ways, I am still his caregiver. Following our separation, like many vet spouses I know, unfortunately, I became homeless myself. So I made the decision to live in my car and to do a cross-country tour from Newfoundland to Vancouver Island. For six months, I met people, and visited organizations, etc., allowing me to start my own healing process and develop a much wider perspective about the many challenges veterans and their families are confronted with culturally, socially, and geographically speaking.

Finally, I'm now sharing my life with a veteran, also with PTSD, whose last name is, believe it or not, Fantini. I'm still a vet's spouse and a caregiver. The transitioning process never ends because they never become civilians again. A caregiver can be the best ally or the worst enemy to someone who's suffering. The political battle of families and caregivers is about having their identity valued and their dignity respected through support, financial recognition, and education. The collective efforts of the past few years generated a political love and a national recognition that was felt all over the country. A VAC family committee was created. More programs dedicated to families, including children, the forgotten of the forgotten—do I have to say it—were developed, and books were published. MFRCs became more accessible, and more research was done on caregivers who were also generally speaking more included, for instance, at the OSI clinics.

Because we were heard, we became better caregivers. There's still a lot of work to be done but also we were able to better protect ourselves and our families from the collateral damage.

So the new measure that will come into effect this April allowing a caregiver to receive $1,000 in his or her own name is a major political win on paper. It's a positive game-changer for many families, if it's accessible. So in the end, veterans and their families share the most important barrier preventing them from moving forward positively, that barrier being VAC with its own bureaucratic and schizophrenic way to love.

For example, take medical cannabis, a medication. On one hand, VAC makes it available, and for at least 7,000 veterans in this country, it seems to be working. On the other hand, VAC penalizes the veterans and their families with decisions that are truly hurtful, with no consideration for the pain, the impact on the quality of life, and the costs they have to pay for their medication. Everything that concerns the process of the exemption letters for medical cannabis is a shame.

Do you realize that on top of finding the one person among the three or four Canadians who can satisfy Veterans Affairs by writing an exemption letter, you have to fulfill the ridiculous and complicated requirements, and this veteran, after providing all the paperwork, will still have to wait between three to six months before he receives his approval?

In the meantime, some veterans pay more than $1,000 monthly to be able to have their medication that was prescribed and that they need. Do you think pills are that complicated? The answer is no.

So behind each delay, deny, and die, there is a name.

● (1230)

For each file, there is a person who has the power to make time either a powerful healer or a very silent killer. Who should be held accountable for the pain: VAC as an entity, or the people who come here at every Parliamentary session to tell you what you want to hear? To be honest, I don't think you realize the power that one single person working for VAC can have on a veteran's life and his family. Sometimes the barriers are closer to home than we think, and the situation keeps being ignored.

I will give you one example. The OSI clinics in Montreal and Quebec are known to penalize veterans who choose medical cannabis. Veterans will be kicked out of the clinic with no resources, and in some cases their driver's licence will be revoked. I've heard and know of at least 17 of them. There is a problem there.

Who will stand up for these veterans? Does anybody care about their transitioning? Medical cannabis works for them, yet within the system they are all being penalized and psychiatrists are untouchable in this matter.

Two weeks ago, I represented a veteran at his first appeal for his sleep apnea at the VRAB. I represented the veteran. To make a long story short, the veteran had to wait five years before he was able to gather all the paperwork to prove his condition. You have to wait in the provincial health system for five years to be tested. In 2016, the VAC pension agent received all the paperwork proving the existence of the condition, and the confirmation of two doctors who made the connection between the sleep apnea and the PTSD.

The VAC pension agent didn't seem to think it was enough, because she asked for another medical consultant hired by VAC. What do you think this person said: “Well, of course, it's not related.” After I'm done speaking, I will share with you the decision, because I have it. This single decision was made by a medical consultant who never met the client. That person has a lot of power. It means years of waiting for a veteran to fight a ridiculous system that doesn't make sense.

Would you also tell my why Veterans Affairs requires that a veteran who wants an exemption letter must meet face to face with the specialist, and yet they can ask a medical consultant who never meets the veteran for their opinion and that's good enough? This is schizophrenic.

Finally, because I only have five minutes, sometimes the barriers come from the provinces. I know you don't have much power, but in Quebec things are sometimes very particular when it comes to our veterans. For instance, recently a veteran won a legal battle against Revenue Quebec, which is not respecting the Canadian law by forcing a certain category of veterans to pay public insurance plan for prescription drugs. In fact, to this day, Revenue Quebec still doesn't care about the judgment. Who will stand up for the veterans of Quebec who are concerned?

Once again, I will provide you with the paper. There are two things: an article I wrote about this veteran, and also an article that was published last December about the psychiatrist at the OSI clinic of Quebec, who says very openly that they are against medical cannabis.

Barriers are mostly political, if you ask me, when it comes to transitioning. There are countless stories that keep coming my way —Dave is hearing them every day, I'm sure—and five minutes is not enough to talk about the barriers.

Thank you.

● (1235)

The Chair: Mr. Kitchen, three minutes.

Mr. Robert Kitchen: Thank you, Mr. Chair.

I'll try this again.

Dave and Jenny, thank you.

Mr. Dave Bona: Is Teresa going to talk?

The Chair: Testimony-wise, I believe it was just one. If she would, I could stick it in if you have a few minutes, if the committee is fine with that.

Mr. Robert Kitchen: Yes, okay.

The Chair: Teresa, the floor is yours.

Ms. Teresa Untereiner (As an Individual): Thank you very much for allowing me to speak.

I looked at the wording in the format of today's gathering, which refers specifically to the obstacles to the smooth transition of veterans to civilian life. For so many hundreds and thousands of veterans, I believe there are two pertinent answers to that: first, and most importantly, appropriate diagnosis; second, stigma.

PTSD is very real. It's manageable with treatment, and the outcomes can be positive, but I believe we have an epidemic of misdiagnosis. Dave, and the majority of members who served for Canada who were exposed to the drug mefloquine and poisoned by it, have varying degrees of damage to their brains. They are acquired brain injuries, not just PTSD. The results of this are in mental and physical symptoms. Had Dave been appropriately diagnosed at the time of his release almost 20 years ago, I can only imagine how different and how much better our lives could have been. Even without appropriate treatment at that time, at least there would have been a starting point and at least there would have been an acknowledging of the underlying issue that was preventing his progress with standard treatment for PTSD.

This brings me to the point where stigma becomes a barrier. Twenty years ago I believe there was complicity in the desire to cover up the harmful effects of this drug mefloquine, beginning with the botched drug trial in Somalia, and then the subsequent order to halt the Somalia inquiry. The shame went unchecked for this group of veterans, and for the most part it continues today. Now, if it's not suppression of information and outright denial, then it certainly is such an absence of acknowledgement that you can hear the crickets singing in the silence. This feeds into stigma and creates its own impediment to successful treatment. I want this government to acknowledge the damage this drug has caused, because this trickles down to affect appropriate diagnosis by the medical community in general.

As a spouse of a veteran, my life has been seriously impacted by Dave's mental health. I have stood by feeling helpless at times as Dave behaved uncontrollably in ways that ended possible career futures for him, and this is due to his impossible, unpredictable, and seemingly spontaneous episodes of rage and anger. The best way I can describe it is it's like a parallel reality that he would slip into. I have watched him gather all of his emotional might and force himself to try again and again.

Physical symptoms, such as gut issues, were and are such a serious barrier as well. Having diarrhea greatly impacts your ability to work on a daily regime, and it impedes normal day-to-day functioning. Dizziness and vertigo is not only inconvenient, but downright dangerous in certain work situations.

And for myself, where to begin?

I must admit it's very hard for me to be here. I have given up my life and the majority of my dreams. I gave up many opportunities for careers, because I couldn't leave Dave alone with our twins for more than a couple of hours at a time. I didn't know his disability would be that impactful on my life, and that leads into my own personal sense of shame and stigma because I haven't had a career. I've tried many, and they've had to be halted at many different intervals throughout the last 15 years that we've been together. This is an outward rippling of the effect of the damage this drug has caused and how it has affected us.

I think it's time to recognize mefloquine poisoning and the resultant damage as a significant barrier to smooth transition. There is hope for members of our forces and veterans who have been impacted by exposure to this drug. There are therapies showing considerable promise that greatly reduce the mental and physical side effects of the damage from this drug.

That's all I have to say. Thank you.

● (1240)

The Chair: Thank you.

Mr. Kitchen, for three minutes.

Mr. Robert Kitchen: Let's try this one more time.

Teresa, Dave, and Jenny, thank you very much for coming. I appreciate it. Thank you for having come before the committee before.

Dave, we've talked in times gone by. Since that conversation, I have learned that my children, who love to travel and have that travel bug.... My oldest son informed me that he was taking mefloquine—he did not tell me that until just the other day—and he was telling me how he stopped taking it because he started getting these weird dreams and nightmares. I'm so glad to hear him say that, obviously. I have an opportunity possibly to go to Pakistan in the next little while. When I was there as a child, the medication we had for malaria was different. Definitely, if they offer me mefloquine, it's not even an option as far as I'm concerned.

We know the impact it has had on your life. It's had a tremendous impact, and you have relayed that to us.

This discussion is about transition. We've heard from the ombudsman, basically saying we've studied this to death and nothing has come out of it. We've come up with all sorts of recommendations, and nothing has been done about them.

When we first started, I talked about taking a look at the transitions we've recommended, and whether they have actually been done.

Can you describe to us your transition as you relate from when you transitioned as much as you can.

Mr. Dave Bona: Do you really want me to do that?

Mr. Robert Kitchen: Yes, please.

Mr. Dave Bona: I was court-martialled and kicked out. I was given a 5(f) release, the bad one. The individual responsible for that was a Colonel Jorgensen. He's now General Jorgensen and works at VA. I had the unit padre trying to stand up for me. I even heard him. I was at the duty desk. He was yelling at the colonel in his office, “Listen, he has PTSD,” and Jorgensen yelling back, “No he doesn't—he has a discipline problem.”

My transition was like this: there's the gate, load 14 years of your life into an old clapped-out Toyota Tercel, and don't let the gate hit you in the ass on the way out.

The only reason I'm alive is I was one of the first OSISS clients. I'm here because of them. My transition.... I don't know why I'm here, actually, other than thanks to OSISS's stepping in.

Mr. Robert Kitchen: You found OSISS to be very effective in—

Mr. Dave Bona: Originally, OSISS was an entity unto itself. It has now been taken over by Veterans Affairs, and it's mandate is directed by Veterans Affairs. OSISS at one time had its own budget. OSISS was extremely effective back then at saving lives. Now it's handcuffed by Veterans Affairs.

I'll give you an example how effective OSISS was. I was literally living in my mom and dad's basement. I could not interact with the public. I was completely non-functional. They facilitated me getting in to see a psychologist that specialized in military trauma. They facilitated my paperwork with Veterans Affairs. A year later when I was able and trying to go to school they facilitated that. There was no red tape. I didn't have to phone the March of Dimes. I didn't have to phone the Legion asking for handouts or anything. If I needed something, they supplied it, and there were no questions asked. There were no 50 forms to fill out, no doctor referral. I would like to go to school. What do you want to do? I have to go and redo my Grade 12.

● (1245)

The Chair: That's where we're going to end.

Mr. Bratina.

Mr. Bob Bratina: Thank you all. It's quite some testimony we're hearing.

Jenny, I'd like to go to you first. What concerns do you have about the caregiver allowance that we're going to be bringing forward—the $1,000 a month? I'm sensing you're still caregiving for someone—two now—but you may not be eligible. What are your concerns about, or do you have a concern? Do you think it's a good thing, or are you waiting to see how it rolls out?

Ms. Jenny Migneault: It doesn't concern me personally anymore because my spouse is with the old system. He's going to be the one receiving $600 for me. I won't have access to anything. I am represented by an amount, but he will receive it for me.

What's fantastic with the $1,000 is that it's given directly to the caregiver. When I say it's going to be a game-changer, it could be, because when people are not doing well and they have all the financial power, many spouses are left with nothing. When things go bad and he decides that he's going to buy an RV or whatever, sometimes the end of the month is very tough. This will make a difference not only in terms of dignity but also in terms of identity.

Now, what will be the criteria for accessing it? This is the core of the war. Everything is related to physical injuries. Listen, if your spouse is in bed with no arms and no legs, or they can't walk, can't talk, or can't eat—no problem: you will have that money, if it's enough. However, if he has PTSD, depression, social anxiety....

Teresa mentioned—and she was right—that the problem is with the diagnosis, of course, but also the criteria. This system does not recognize a mental wound. How can I justify to a system that I am needed when he has both his hands and to you it looks as though he can cook his supper? I know he can't do it. If I don't do it, he won't eat. If I don't clean the house, he won't clean it, because the depression, the pills, the medication—you name it—is keeping him sitting on the bench. He won't do anything. He can't.

Therefore, I feel that accessing this money will be a challenge, not to mention that I am certain that this country doesn't even know how many caregivers Veterans Affairs is taking care of. We don't know the numbers. With 200,000 clients with Veterans Canada, I say there are 200,000 caregivers. Can we afford to pay each caregiver who lives at home, who deserves that money? Can we afford it? I don't think so.

The Chair: Mr. Johns is next.

Mr. Gord Johns: Thank you.

First of all, thank you all, for your testimony and sharing your personal experiences with us. It's so important, and I'm sorry that you've having to live through this difficult challenge.

My colleague, Irene Mathyssen, asked Minister O'Regan in the House in September of last year to initiate a study to determine the long-term neurotoxicology of mefloquine.

Maybe to Dave, what is your opinion? Do you think that a committee study on a specific issue of mefloquine would be beneficial to your cause?

● (1250)

Mr. Dave Bona: I have no faith in the government actually stepping up and acknowledging this. I've actually had to write that off. My sole focus is reaching veterans individually.

We've been talking about transition for 10 years. You can pull the reports out of the archives. A friend of mine did, and it's the same thing over and over and over again. Is mefloquine going to be any different? No, it's not.

Look at the agent orange fiasco. How many years did it take the government to pony up to help these guys? Oh, yea, living a life of cancer, unable to work, unable to do anything, not able to have a family, that was worth, what? The average payout was $23,000. I have no faith in the government acknowledging this or doing anything about this. A study? Yea. Another study—

Mr. Gord Johns: Okay.

Mr. Dave Bona: —so they can order another study and do another study?

Mr. Gord Johns: Then in your discussions with veterans from other countries, and I know you've had these conversations—

Mr. Dave Bona: Yes.

Mr. Gord Johns: —have you noticed is some countries have a better method of treating survivors of mefloquine neurotoxicology?

Mr. Dave Bona: No, every country in the western world is balking at this because of the financial cost of the extended health care associated with people who have been poisoned by mefloquine.

Mr. Gord Johns: Then what can we do better in terms of dealing with it, in terms of what you would like to see—

Mr. Dave Bona: There's one thing. We need someone to stand up in the House and say, “We may have poisoned our soldiers.” That's it. Then what will happen from there is the provincial health care systems, and the funding agencies for research.... Because right now funding agencies will not give money to any mefloquine research because they don't want to go against the government and get their funding cut. That is the problem. We just need one individual to say, “We may have poisoned our soldiers.” That's it.

Mr. Gord Johns: Thank you. That's important.

I have a question, and I think either Jenny or Teresa can answer this. Does the proposed caregiver amount go far enough? You've outlined the loads that you're carrying, and they're significant. Maybe you can elaborate a little bit on that.

Ms. Jenny Migneault: Teresa, do you want to go?

Ms. Teresa Untereiner: It's interesting. The thought of having $1,000 a month sounds nice. Will I be eligible for it? I don't know, because he looks capable.

Does it take care of the last 15 years of my life that I've given up? Does it attend to that? I'm not sure. I don't know how to respond. It has such a large impact, and yet.... The offer of $1,000 is good, but is it enough? I don't know.

Also, it's if it is accessible—

Mr. Gord Johns: Is it [*Inaudible*]? You said “if”.

Ms. Teresa Untereiner: It's if it is accessible. I don't know if I'll be able to even access it.

The Chair: Could you just end quickly on this? Then we'll....

Ms. Jenny Migneault: If I may, it's not a paycheck. It's a compensation, sort of. That does not replace anything that is lost. Let's not forget that with the New Veterans Charter, my ex-husband.... I was penalized compared to the old pension. Since I had to quit my job, at least $12,000...that's not enough, but that's a good start. It's not a salary replacement.

The Chair: Mr. Fraser.

Mr. Colin Fraser: Thank you very much for being here. It's much appreciated.

I'd like to ask you, Jenny. You talked a little bit about the importance of having the family involved in a transition and some of the specifics. What other specific things do you think this committee could recommend to the government to support families of medically releasing veterans, in particular, so that we can support the families who are doing the important and vital work for a successful transition? What can we do?

Ms. Jenny Migneault: Ground zero is the Canadian Armed Forces. I believe you heard Barry Westholm here. He also defends the family. When I advocated for a case in Comox, I was welcomed in a JPSU as a family member—they didn't know who I was—and to see how I was treated...but more importantly, families are coming out of the service already wounded. Does that answer the question? It starts from there, and then the inclusion.... When you combine the fact that we are excluded medically speaking, it can be understandable, but in the end we're not educated. Our biggest problem is the lack of education and support.

Right now, as a spouse, I can access a number of meetings with a psychologist. That's a good start, but again, it's not enough. Once again, one of the problems is, if the veteran doesn't ask for his spouse, the spouse cannot access that help. Once again, identity and dignity. This is the core. Help me protect myself and the family. Help me be a better caregiver, and I will provide a better environment for the wounded to give him the motivation to fight whatever he has to fight for him to have a quality of life. The biggest problem is right here. They are left alone. They don't fit into society anymore. Their wives leave them. They end up alone. They have trouble accessing service dogs. It becomes very complicated at every level. We are there to compensate on many levels, and also we're the only person who truly knows the person they are inside and still fights for them. We are part of this dynamic, and we need to have...not just to be good, because we are part of the solution.

● (1255)

Mr. Colin Fraser: I couldn't agree more, Jenny, and that's very well put.

I'd like to hear Dave and Teresa on that point, involving the family and supporting the caregivers and family members to ensure a successful transition. Do you have specific things we could recommend to the government with regard to those supports on the ground and in place? Do you have any comments on that?

Ms. Teresa Untereiner: I'll just reiterate what Jenny said. It's accessibility. Until she said it, I didn't even think about it. I thought to myself, I could really use some counselling, but I had to go through Dave to ask for it. It wasn't until she just said it now that, yes, that affects my dignity. I can't even go to Veterans Affairs and say I need counselling. I need help. It has to be through him. What if he's really mad at me, or what if he's off on one of the tangents that sometimes take a week or two for him to recover from? I have no accessibility. None.

Mr. Colin Fraser: Thanks very much.

The Chair: We're going to have two-minute rounds each, for three rounds. We'll go with Mr. Eyolfson.

Mr. Doug Eyolfson: I'm going to be giving my time to Mrs. Romanado.

The Chair: Okay.

Mrs. Sherry Romanado (Longueuil—Charles-LeMoyne, Lib.): Thank you.

Thank you for being here. Many people who know me know that the reason I decided to run for office is I found that military and veterans families like mine—I have two sons serving—didn't have a voice. I'm happy to have you here telling your story. I think the story of how military service and afterservice affects families needs to be told. Thank you for giving families like mine a voice.

Speaking of families, because of course that's something that's near and dear to me, I know that if I go to an MFRC, since my sons are serving, I can get services. There's a lot that still needs to be done. I know that if I were to walk into an MFRC if I was a veteran or a member of a veteran's family, they would probably still serve me. They would just do it. When you're a member of the military, you're always a member of the military, and you're a family.

I'd like to get your opinion a little bit about how giving that access to veterans in post-transition and their families to go to the MFRC and continue that relationship will help. We've heard about the caregiver benefit, but I find that the MFRCs also have such a crucial role. Do you think letting families continue to have access to them will help? Would that be helpful?

The Chair: I apologize; you have 30 seconds, Jenny, for the answer on that.

Ms. Jenny Migneault: Yes, but don't forget that the MFRCs experience challenges of their own as well. The Canadian Armed Forces right now are putting a lot of effort into having more control over the MFRCs. Please, get them out of there. Families know what they need, know what they want, and they can rule their MFRCs.

The Chair: I stress to all three of you that if there's anything you want to add to your testimony, get it in a written brief and we'll get it to the committee. I do apologize.

Go ahead, Ms. Wagantall.

Mrs. Cathay Wagantall: Thank you.

I appreciate you all, Dave, Jenny and Teresa, for being here.

Dave, this mefloquine issue is not going away.

● (1300)

Mr. Dave Bona: No, it's actually a degenerative issue and the people are becoming more ill.

Mrs. Cathay Wagantall: I'm saying it's not going away in the eyes of Canadians. It's growing as an issue, how we've treated our veterans, how we've treated our soldiers, and continue to.

It's now a drug of last resort, which was finally announced by the Surgeon General as we were going into our summer break. However, it's still available to Canadians. There's been no change there.

Bev, who we both knew, is still dealing with that. I have nowhere to go to affirm this, but she said to me, Cathay, I have a friend who is a case manager. They were told to their faces, do not bring up mefloquine with your clients.

Do you want to say anything to that mindset?

Mr. Dave Bona: What we run into is that mefloquine doesn't neatly fall into a box. It actually straddles four or five diagnoses. Veterans Affairs doesn't like that. They like their nice little tidy boxes.

This is the same issue that we had with PTSD and Agent Orange, where the driver for change was actually the veterans. That's what we're doing now.

We're defining the injury, just like they did with PTSD way back when with a bunch of Vietnam vets sitting around the VA saying this is what I'm having and another guy saying, I have the same problem. Then a doctor going, oh, that's a pattern.

We've now identified that pattern, just like they have done.

Mrs. Cathay Wagantall: Thank you.

Jenny, you mentioned the issues with the OSI clinics in Quebec, and I've heard this first-hand, how if you need the help and you go for the help, you cannot get services if you're functioning on medical cannabis versus pharmaceuticals. We know pharmaceutical companies now are desperately looking for an alternative version of cannabis so that they can be part of that market. ...Some feedback from you on that?

Ms. Jenny Migneault: That's ridiculous. It's all about money and power, once again. Why can this country accept that ginger will help ease your stomach but medical cannabis is continued to be seen and perceived as a drug? That's the core of the problem.

The problem is, nobody accepts it, especially in Quebec. The stigma over there is so strong, it's penalizing them. Does anyone worry about why in Quebec City there were 20 suicides in just a year or two? There's a reason for that. I believe that all players have a responsibility in those deaths. Maybe for some of them they were kicked out of a clinic and left with no resources because of a choice they made.

The Chair: We'll end with Mr. Poissant.

[*Translation*]

Mr. Jean-Claude Poissant: Ms. Migneault, you talked about Quebec, but does the situation vary from one province to another?

I can understand that the situation is different in Quebec, but what about the other provinces?

Ms. Jenny Migneault: First, the only place you can see a white poppy on a red poppy in Parliament is in Quebec.

You are talking about the particularities of the provinces. In Newfoundland, for example, people know each other because that's the island's way. As a result, the problem of homelessness is masked. The problem is not perceived in the same way. Everyone knows each other and is willing to help others, but this masks the problem. That's why, in Newfoundland, a veteran was found in his home four months after his death. This had the opposite effect.

Each province has a cultural specificity, which can be explained by the various basic principles or the mentality. In Quebec, the mentality of the Royal 22nd Regiment is very prevalent and it encourages self-reliance.

Mr. Jean-Claude Poissant: You talked about doctors.

Are some of them better at detecting problems than others, and if so, are there enough of them?

Ms. Jenny Migneault: Are you talking about the overall situation or cannabis?

Mr. Jean-Claude Poissant: No, I am talking about cases of post-traumatic shock. I want to know whether some physicians are better informed than others about this issue and about the veterans' community.

Ms. Jenny Migneault: Outside the veterans' community and the operational stress injury clinics, civilians may be dealing with a stress disorder, but, from the outset, the military is already very much misunderstood. Post-traumatic stress disorder is poorly understood. It is important to mention the Desmond family from Nova Scotia; they asked for help but did not get it.

Situations like that occur in all the provinces. This is because people have not been made aware. There is a lack of respect and understanding. As a caregiver, I can tell you that, when we seek care, we are often asked why we brought the person. We are told that they are doing very well and that they can go back home. Those people then return to their fortress, all alone, and have no one to complain to about their difficulties. That's the result.

There's not enough awareness among doctors. We live in a society where people are heavily and dangerously prescribed medication precisely because we do not understand what is happening to them. We are putting people to sleep and killing them from the inside, then we get offended when they switch to medicinal cannabis and suddenly start having meaningful emotions or undergo a course of therapy that works because they are no longer zombies.

● (1305)

[*English*]

Mr. Dave Bona: I'd like to bring up one point: Lionel Desmond actually was on mefloquine on his deployment. We've ascertained—we've proven—that on the day of his incident when he killed his family he was having a mefloquine-related incident, as described by his sister, who was the last person to see him alive.

I would like that on the record. Thanks.

[*Translation*]

Ms. Jenny Migneault: Thank you.

[*English*]

The Chair: That ends our testimony today.

On behalf of the committee, I want to thank all of you for coming today and for all that you have done and continue to do for the men and women who serve.

The meeting is adjourned.