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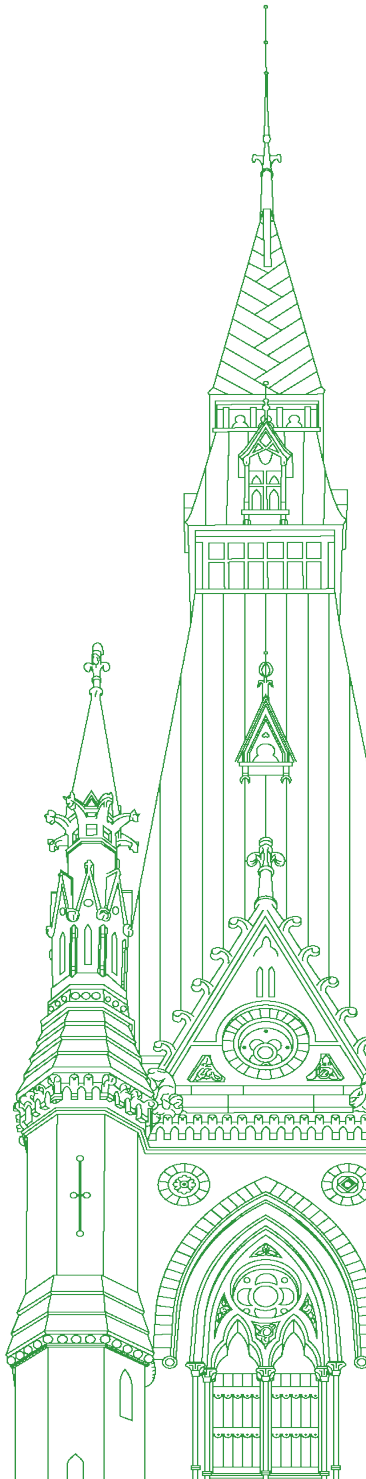

Chair: Mr. Bryan May

# Standing Committee on Veterans Affairs

**Monday, March 22, 2021**

● (1535)

[*English*]

**The Chair (Mr. Bryan May (Cambridge, Lib.)):** I call this meeting to order.

Welcome to meeting number 16 of the House of Commons Standing Committee on Veterans Affairs. Pursuant to Standing Order 108(2), and the motion adopted by the committee on October 27, 2020, the committee is resuming its study on supports and services to veterans' caregivers and families.

Welcome to all of the witnesses who have taken the time to join us today.

From Whelan Psychological Services Inc., we have Dr. John Whelan, lead psychologist. Appearing as individuals, we have Sean Bruyea, captain (retired); Tracy Lee Evanshen; Dr. Heather MacKinnon; and Gerry White, lieutenant-commander (retired).

Each of you will have five minutes for opening remarks, and after we'll proceed with rounds of questions.

Dr. Whelan, the next five minutes are all yours.

**Dr. John Whelan (Lead Psychologist, Whelan Psychological Services Inc.):** Thank you, Chair, and thank you for the invitation.

My comments reflect our clinical work with serving and retired military members, along with some of my research at Mount Saint Vincent University.

I served in the navy for about nine years, then as a psychologist at the military base in Halifax for another 10, and then headed off to lead a clinic of five psychologists for 18 years. During that time we assessed and treated several thousand members and veterans for OSI— primarily operational PTSD and substance abuse. About 40% could be classed as highly invested in treatment and recovery, did their best to stay connected with their families; the remaining 60% were more ambivalent about the need for treatment, and about one-third of those were primarily men who were intensely angry with the military and Veterans Affairs, and were not invested in treatment.

When it comes to veteran caregivers, they're primarily women spouses and partners, in our experience. I think understanding their needs requires a re-examination of our veteran-centric approaches that focus on symptoms and trauma triggers that position family members as passive participants. Their primary role is to attend to the mental and emotional needs of injured veterans. Caregiver spouses are expected to reduce stress and manage potential triggers, primarily dealing with Veterans Affairs Canada, or keeping children quiet in the home, which is a continuation, on some level, of the strength behind the uniform promoted in the military, and as a belief, held among many male veterans, that is premised on taking for granted women's role to manage the home front.

Most of these caregivers are stoic women. Canadian military family researchers have catalogued the extraordinary efforts they expend in seeking out formal and informal supports. They seek out treatment options for their partners while often working outside the home, cleaning, managing bills, cooking and caring for children. Among those we saw, sleep disturbances, anxiety and physical and emotional exhaustion were quite common. They often placed their own needs second.

In our clinic, we routinely asked to interview veteran caregivers during assessment and treatment planning, and sometimes met them privately. Despite fears of creating issues for veteran claims, we heard often about veterans withholding information about their volatility, or spending their days drinking or being disengaged from family life and responsibilities. These caregivers were often quite frustrated with treatment approaches that excluded them and their families. We also received many phone calls from distressed partners whose partners were not clients of Veterans Affairs, so they were left out, despite their obvious needs.

Military veterans are under continual scrutiny, yet we lack a parallel framework to assess the consequences of military OSIs on family members, including vicarious and secondary trauma. In my view, the standing model of “veteran as casualty” excludes the entire family system, which can be a casualty of military service. Veterans' partners receive little direct, practical help in managing their day-to-day lives with former military men with mental health problems. A persistent fear among many of these partners centres around veteran self-harm should they decide to leave the relationship, or even leave the home for errands or to attend work. At other times, veterans would simply leave the home for days following conflicts or disagreements to be alone, to visit buddies, and then show up again unannounced, often throwing families into disarray. This lack of predictability is a formula for all kinds of mental health issues.

In considering the supports needed for veteran caregivers, it is important to acknowledge that spouses, mothers and adult daughters are often given de facto responsibility to manage veterans in between scheduled mental health appointments. In our experience, this vigilance and monitoring role is also handed to adolescents and older children as well, yet none of these people have a say in treatment decisions. They are the ones who call authorities or military buddies to help manage crises. They talk down veterans from nightmares, they contend with drunken tirades and they're expected to be on guard for suicidal indicators. Many partners describe having an additional child at home in terms of reminding their partners to eat, to bathe, to take medications or to organize their days.

Despite our public statements to the contrary, veteran families are often invisible linchpins to veteran recovery status. As noted by military family researcher Deborah Norris, veteran and family well-being is a dynamic, bi-directional process. Family members have a central role in veteran well-being, and vice versa, that far exceeds the effects of medication and individually focused therapies. In sum, no matter the specific individual veteran-centric treatment, it is the social and family context that matters most to veteran welfare and progress.

● (1540)

In Canada we have not explored this intersection of family mental health and family involvement investment in treatment as requisites of veteran health.

It is my view that entire families are often casualties in military service, especially in the case of service-related mental health problems. In keeping with the recent veterans ombudsman's report, families, not just veterans, require assessment of needs and ongoing case management supports.

Thank you, Chair.

**The Chair:** Thank you, Mr. Whelan.

Now we go over to Captain Sean Bruyea for five minutes.

Go ahead, sir.

**Mr. Sean Bruyea (Captain (Retired), Columnist and Advocate, As an Individual):** Thank you, Chair, ladies and gentlemen.

I feel sincere gratitude to be here. Your study, the accompanying report and the hope for changes will not reverse the tragedies and neglect of the past, but your work can change the future. We as a nation can make up for years of neglect of the most vital, the most critical pillar to veterans' well-being, their families.

I would like to first put on the record that I have gathered evidence regarding the retaliation against our son's carer following articles I authored critiquing Pension for Life. This evidence provides a much-needed insight into the culture of senior managers and their hindering of frontline workers' ability to be compassionate. The evidence is not political but cultural. Unacceptable behaviour by senior bureaucrats has endured through various governments.

Senior officials will likely petition you not to invite me back. That very reason should justify why I humbly request that you would. I recommend that Alan Hunter, my advocate, as well as Tina Fitzpatrick join me to speak to these cultural issues.

Veterans and families are treated as both separate and unequal entities for policy purposes in spite of clear, guiding statements to the contrary. Families are relegated not to the backseat but often to running behind the last car of a meandering train of dizzyingly complex policies for veterans, with an opaque bureaucracy as conductor.

Our families and veterans cannot be separated or diminished in this manner. The veteran is embedded, integral and vital to the family, just as each and every other family member is critical to the family and its well-being. A bridge cannot function if even one support is damaged. The family will only function when everyone is healthy.

Research has told us this for decades. Quite simply, chronic illness not only causes emotional distress in the entire family but impairs the family's ability to support the patient. Families with one member suffering mental health issues suffer the greatest. The negative impacts on the psychological health of the family members are sometimes greater than the direct psychological impacts on the patient.

Canada has more than 35,000 veterans and RCMP members suffering a psychiatric disability resulting from their service, 25,000 with a PTSD diagnosis. Each household member should be given access to VAC-funded mental health care in their own right and of their own accord. How many tragedies could be avoided? It is cruel for families, and veterans for that matter, to be put on a waiting list for a case manager— suffering while a rehabilitation plan is developed in the hope that they might receive mental health care.

Families also need a unique VAC identification to access services of their own accord. The most disabled veterans already have their earning potential paralyzed at a lower rate than when they served. The inability of spouses to pursue their career to the fullest while they care for veterans and children further impacts their earning potential.

Why then are only 1,200 spouses receiving the caregiver recognition benefit when there are approximately 9,000 spouses caring for veterans who are permanently incapacitated and 14,000 spouses caring for veterans with mental illness? Parsimonious programs that discriminate against families have been perennial. Why are non-family members entitled to compensation for escorting a veteran to medical appointments, but families are not?

The lack of support for families of veterans with psychological injuries could explain why only 56% of veterans with a mental disability are married or living common law, as opposed to 71% of Canadians. Veterans Affairs Canada restricts access to programs for the most vulnerable members of the family, our children. Sixteen months after spontaneously cancelling dependent care for our six-year-old son, VAC fabricated new criteria to justify cancelling that care. The program will only pay for basic needs, refusing to recognize the special needs of children. In a glaring omission, the purpose clause of the Veterans Well-being Act has no stated obligation to children or dependants while the veteran is alive.

The wording of the dependant care policy for veterans on medical rehabilitation is generous and compassionate. Decisions need to be broad, flexible and holistic, addressing the unique needs and circumstances of the veteran. One would assume that having a dependant with special needs would be a unique circumstance. However, when veterans' illnesses create the inevitable emotional and psychological burdens upon children, VAC has circled the wagons against these children. VAC will not support any care between the hours of 8:30 a.m. and 3:30 p.m. on school days even when the public system cannot—as if a child's suffering somehow follows a schedule.

Internal emails show a callous insensitivity: “...how realistic would it be for Rehab to swoop in with care when a child when a child is unexpectedly sick? Not Likely—it would need to be predictable....” “Part of the intent here is to avoid fostering dependency on a short-term program.” Perhaps it escaped the observations of policy-makers isolated in Charlottetown away from the daily struggles of veterans and their families. Dependants are dependent.

● (1545)

No attempt to save the Crown money can force a three-year-old to grow up, the missing parts of a brain injury to grow back or PTSD to spontaneously heal, but there is a bigger perceptual barrier deeply infecting VAC. They interpret programs in a manner that sees disabled veterans—and especially their families—as being liabilities, annoyingly dependent on VAC.

Children are haphazardly added to incidental expenses along with mileage and parking. Perhaps this explains why no veterans were granted dependant care for the families in the first four years of the program, or why, of almost 20,000 veterans on medical rehabilitation, only 106 were able to receive dependant care from 2014 to 2019, for a total cost of less than one year's salary of a cabinet or deputy minister.

I have provided you with a list of recommendations in consideration of your report.

I sincerely thank you for all your time, energy and caring for families.

**The Chair:** Thank you, sir.

Now we will go over to Ms. Evanshen for five minutes.

**Ms. Tracy Lee Evanshen (As an Individual):** Good afternoon. My name is Tracy Lee Evanshen. I'd like to thank you for the opportunity to speak today and to give you a small glimpse into my life as the common-law partner of a veteran.

I thought the easiest way to explain who I am and what we go through is to give you a sample day in our household.

It's Friday and my boys are visiting for the weekend. We leave Belleville and take the 401 or sometimes highway 2 to the 35/115 and head north. Kevin won't take the 401 if he can help it. It is riddled with triggers and causes stress. He then insists on taking the 407 toll highway. I cringe at the expense, as we must take it to Brampton. Kevin proudly served as a medic, but he was also a paramedic for many years, with the 401 being one of his routes. The triggers are everywhere.

We pick up the boys and head home. A two-and-a-quarter-hour one-way trip can take anywhere from two and three-quarters of an hour to four hours. We get home. Kevin is both mentally and physically exhausted and he goes to bed.

It's Saturday morning. Kevin gets up and follows the same routine every day. He's up, so in his mind everyone else should be, too.

The kids wake up, eat breakfast and head back downstairs to play Call of Duty. One turns it up for the full experience. The other jumps up and turns it down. “Not too loud. Think about Kevin. It will trigger him.”

They give up and move to a movie. One turns it up and the other turns it down. “Think of Kevin. It will trigger him.”

While this is happening, Kevin goes back to bed. He's still exhausted from the drive the day before, so the house must be quiet. Our neighbours let the dogs out and [*Technical Difficulty—Editor*] talk to them and it doesn't really go anywhere. We call the police. They visit. The dogs stop for about 30 minutes and then they start again. Kevin loses it, gets angry, stomps around and threatens to go up there. I am the buffer. I try to calm him. I try to quiet his mind. I am the go-between. I talk to the neighbours. I talk to the police. Now, I'm mentally exhausted.

I ask my son to mow the lawn. He starts the lawnmower, it backfires and the smell of gas fills the air. Kevin jumps up. He panics at the sounds and the smells. You see, Kevin was on the first plane that arrived into Haiti after the earthquake. The smells he experienced will never leave him. The simple activity of someone else cutting the grass can send him into a tizzy for days.

My daughter puts a pizza in the oven. Cheese drops onto the element and starts to smoke. The smoke detectors go off. She panics, opens the windows and turns on the fans. Kevin freezes, panics and scrambles. The smell of burning sends his PTSD into overdrive.

All of a sudden, a multitude of weapons are being discharged. It's the same neighbour. Kevin tailspins. He panics. It truly sounds like a war movie. I call the neighbour and ask them to please stop.

They say that they have a farm and it's their right.

My clipped answer is that Kevin is a veteran with PTSD. This is a neighbourhood. There are homes with children and animals around them. They have acreage, not an active farm. I understand they want to have fun, but that's what firing ranges are for. It happened daily for months.

Kevin is absolutely done. My boys are confused. I am exhausted. My daughter heads to her friend's to get away from all the noise and the distractions so she can do her homework and attend her Queen's University classes in peace.

The same neighbour is now driving a super-loud dirt bike up and down the driveway. I make supper. We sit down as a family. That goes well until the dogs start barking again. Kevin does the dishes and heads to bed.

I go downstairs and play video games with my boys. The TV is on mute. We pop in a movie and watch it on low. The boys go to bed. I go upstairs and ask myself what I've gotten myself into. Honestly, the thought lasts less than a heartbeat. This man has given me and my children everything he possibly can.

I crawl into bed, but I don't fall asleep. This is when the night terrors begin. I don't want to sleep to ensure he's safe. The dreams start. He kicks, flails, cries out, screams, grabs and punches. You get where this is going. I don't sleep properly. He offers to sleep in another room. No, I need to make sure he's safe. It's time someone was there to protect him.

When he turned 65, his take-home monies went from $2,032 to $932. Let me repeat that. He now gets a whopping $932. At 65, 20% is supposed to be deducted from their pre-65 pay. I guess life ends for a veteran at 65. When they need help the most, they get thrown out with the bathwater. He was unceremoniously released from the military because he was considered old. Sixty is not old.

We are on the phone daily with VAC, the ombudsman's office and human rights to try and get straightforward answers. Those answers are rarely given. We receive responses that go in circles and by the end we are so confused and frustrated that we cave.

● (1550)

We are not uneducated people, but we feel that way each and every time we get responses and not answers, responses that seem to change like the weatherman’s predictions. When we need to make things easier, things are made harder—so much harder.

We have figured out that maybe, as a common-law partner, I am entitled to his VAC benefits but not his military benefits. How does that make sense? We found out that if a veteran is not married by the age of 60, any partnership after 60 will not be recognized. Once married, we have a year to submit this paperwork in order for me to be able to get his military benefits—i.e., pension—but we have to pay into it from what little money we now have coming in.

Veterans Affairs returns upwards of $150 million a year to the government. This money could be used to support veterans and their families no matter what the family unit looks like. They reduced the IRB by 20%, yet give back millions to the government.

I have reached out to groups for support, but I am not married or an active servicewoman. I am common law. I don’t count.

Please know that I am new to this life, and I wouldn't change it. It would be helpful if there was someone who reached out and said, “Hi. Can I help you with anything? Can I explain anything for you? If I can’t, I will find someone who can.”

Veterans have to chase people for help—but it isn't help. It’s more trouble. They give up. They are tired of being marginalized, cast aside and forgotten. As a common-law partner, for the most part I don’t even exist.

Thank you.

● (1555)

**The Chair:** Thank you very much for sharing with us today.

We'll move on quickly to Dr. Heather MacKinnon.

The next five minutes are yours.

**Dr. Heather MacKinnon (Physician, As an Individual):** Thank you.

Mr. Chair and members of the committee, thank you for allowing me this opportunity to speak on behalf of veterans, veterans' caregivers and families.

I would like to start by telling you about myself. I am former military medical officer who served in both the regular and reserve forces. I have participated in numerous military operations both at home and overseas. I have a unique general practice in Halifax that is composed of former military and RCMP members and their families.

I would like to thank Veterans Affairs Canada for the wonderful help and services that are presently provided to our veterans. There are many positive aspects to the programs available to our veterans, notably for mental health treatment. It is my understanding that veterans' mental health supports are only available to current spouses and their children as long as the veteran gives permission. There are no mental health services for ex-spouses, parents of veterans and children older than 25 years.

Many veterans have been exposed to multiple stressors during their careers. Their spouses and children follow them from base to base, often giving up careers and friends. If a veteran has an occupational stress injury, the family dynamics can be further stressed.

I am a family physician, so I believe the best way I can communicate the issues that I see in my practice is to give examples of how lack of access to mental health care affects spouses, caregivers, children and ex-spouses. These are not just single cases but represent multiple examples from the veteran patient population.

Veterans' families can be subjected to extreme stressors, not only if a veteran suffers from mental health stressors, but physical and financial stressors. When a marriage breaks down, everyone is a loser. The veteran may be getting mental health services via Veterans Affairs, but the ex-spouse receives no assistance. In this case, it is up to the family physician to help the wife. There are no free mental health counselling services available. Often, former spouses face financial losses, have nowhere to live and can only afford legal aid, which is totally unreliable.

Unfortunately, medication dependency such as benzodiazepines and suicidal ideations become a major problem. In one case, we asked Veterans Emergency Transition Services Canada, which is VETS Canada, for housing assistance. In another case, the ex-spouse moved from house to house until she became a senior so that she could get assisted housing. When children are involved, the matter becomes even more complex.

Veterans Affairs Canada only provides mental health treatment to family members when the veteran's treatment or rehabilitation plan has established that doing so will achieve a positive outcome for the veteran. The amount of treatment a family member gets varies from case to case. Children over the age of 25 are not eligible for mental health treatment from Veterans Affairs. I have adult children in my practice who have serious mental health issues and are not able to receive treatment. These mental health issues can be traced back to deployments that the fathers made over 25 years ago.

One patient is both physically and mentally ill. The father has PTSD that arose from these deployments. One child started becoming both physically and mentally ill when the father returned. His mother and he were receiving mental health counselling, which was pulled when the son of a veteran who murdered a police officer was found to be receiving counselling in prison. This caused a review and tightening of the policy. The family has never been able to get further treatment via VAC.

Veterans who have an occupational stress injury and other mental health injuries are often very difficult to live with. They become verbally and physically abusive, drink, hide in the basement and ruminate. The whole family walks on eggshells when the veteran is upset. Veterans who are ill will try to avoid any contact with the outside world. One veteran has multiple cameras outside his house. He is on constant surveillance. One spouse, who was not a patient, came to see me to try to get her husband to stop verbally abusing her in public. This is difficult to deal with. How do you treat the situation, the wife and the husband and not trigger further consequences? I wish this spouse could have received mental health services via VAC. One of these situations got very much out of hand with weapons and a two-day standoff with the police. The situation was diffused with speaking [*Technical difficulty—Editor*].

One of the spouses reminded me that, when a military member serves, the whole family serves. The veteran says, “These aren't my medals; these are my family's medals.”

● (1600)

Veterans Affairs has made advances in mental health treatment for veterans and for families of those with OSI injuries. These moves are very important. The only problem here is, how do you get to these services? You need a case manager. How do you get a veteran into an OSI clinic? You need a case manager.

I used to be able to call a case manager to help any veteran, but not anymore. They are a rare breed. If veterans with recognized OSI injuries can get help, what about all of the other veterans' families who don't have a case manager? What is there to offer their spouses, caregivers and children, who need help?

Supports and services, including mental health services for veterans, caregivers and families, can be done. The system just needs to be tweaked a bit.

Mr. Chair, and members of the Standing Committee on Veterans Affairs, thank you for having taken the time to listen to me today.

If you have any questions, I will do my very best to answer them.

**The Chair:** Thank you very much, Dr. MacKinnon.

We are now going to our final witness.

Lieutenant-Commander Gerry White, the next five minutes are all yours.

**Mr. Gerry White (Lieutenant-Commander (Retired), As an Individual):** Thank you very much, Mr. Chairman.

[*Technical difficulty—Editor*] participate at this standing committee. I don't usually work from notes and I speak a lot locally. When I started my service, I was sworn into the Royal Canadian Mounted Police on my 19th birthday—on May 29, 1974—and served a total of 31 years. I served initially with the Royal Canadian Mounted Police and then accepted a commission into the navy, which was the start of some excellent service and some serious trauma. They both go with the job.

I retired in 2004 after 31 years of service. There are a few people on my computer who are being vastly underscored, mostly by themselves. My treatment was started by Dr. MacKinnon. Dr. MacKinnon and former NDP member Peter Stoffer are probably considered the two patron saints of veterans and their families, and I am not exaggerating.

It seems that a great deal of the care that comes to veterans and their families comes after an incident, and we are hip deep in incidents here in Nova Scotia. What happened in Portapique impacted many mounted policemen, some of whom I trained many years ago. Heidi Stevenson (Burkholder)—that will tell you how far back we go—was a very good friend of mine. The names on the wall keep going, and they shouldn't.

When I retired, I was medically released—mind you, after 31 years—as a result of injuries sustained when I was picking children out of a minefield halfway through a UN deployment to the killing fields of Cambodia in 1992. Even though that happened on August 14, 1992, it never came to light until 2002, and that was only because Dr. MacKinnon saw a few things that she didn't like. She started me down a rabbit hole that is perhaps the reason I'm still alive today.

There are all sorts of facilities in Halifax, and I don't know if it's because I retired as a senior officer or why it would be, but I seem to have better success accessing these facilities and benefits than any other members. If you go to a Facebook page called “UN and NATO veterans group”, you'll see that I am a member. We get together every Saturday morning—about 80 of us—for breakfast, and there are only two officers in the entire group. I am one of them and the other is Commander Fred Maggio, who, like Dr. MacKinnon, was a very instrumental medical officer in the military in Halifax.

I offered to join this group because I wanted to try to address the problem of the difficulties veterans and their families have in being addressed only after there is an incident. I am not very far from Lionel Desmond's home. I'm one hour away from that terrible tragedy. I did not walk in his moccasins so I have no idea what the situation was, but all of a sudden I hear the same rhetoric over and over again: Where did we go wrong? What did we miss? What could we have done?

I will gladly point [*Technical difficulty—Editor*]. My boss at the time, R. A. Dallaire, said that we should probably talk to somebody about this. But in 1992, for those of you with a poor memory, there was such a great stigma attached to mental health issues that nobody ever went forward. They put a piece of rope up around a beam in the basement instead. There are still people doing that, and I deal with it every day.

My life support system is my beautiful wife. Even though she's the one who many mornings gets me out of bed and gets me to take on the world, there are no benefits whatsoever for her. She is one-fifth of my life support system. My daughter and three grandchildren are the others. They are what keep me going. When things start crossing my mind that I wish wouldn't cross my mind, it is my beautiful wife Jane and my grandchildren who pull me back from the precipice.

● (1605)

We have a veterans memorial park in Bass River, Nova Scotia. Please google it. Once again, another doctor, Dr. Karen Ewing, created a world-class veterans memorial park that is a magnet, a gravitational point for veterans here in Halifax. We muster there for United Nations celebrations. We muster for Remembrance Day. We muster for Holocaust memorial. It's all those little non-VAC support systems that get us through the day.

With my dual background, I started out with the Royal Canadian Mounted Police and then retired from the military. There are so many Mounties here in Halifax, so many Royal Canadian Mounted Police members who still, in many circles, are not even considered veterans. They come to me and ask, how do you address this problem, how do you get access to this, how do you get this benefit, or how do you get a disability tax credit from CRA?

I hope I'm wrong, but it seems that the default setting in response to any query or inquiry directed at VAC is “no”. If 50% of the people who apply for a stairclimber, a TENS machine or whatever, are met with a no, 50% of them say, “Well, I applied for it and they denied it, so I guess we're done.” Then you go to the Veterans Review and Appeal Board and you put in an appeal. Maybe that works, or maybe they will come back again and say, “No, that's not related to your pension condition.”

If you have PTSD and when you get an attack you are shut down muscularly and Dr. Leckey loans you a TENS machine and says, “Here, try this”, and you put it on your neck and start zapping yourself and all of a sudden you can move and can get back to attacking the problem that put you there in the first place, she says, “Wow, it seems to work.” She sends the letter saying, “Listen, I did one of these on a trial basis and did it ever work” They come back and say, “Yes, but it's not related to his pension condition.” Then you want to jump into your car or onto your motorcycle ride up to Ottawa and find this individual who keeps saying no to medical professionals who say this might help. They don't say this will help; they say this might help.

The response or the approach is quite often, and I hate this, I have it written down here, that you have to find an angel, a “VAC angel”, we call them. One of them is on my computer here. She knows who she is. They know what buttons to push. You're not supposed to have to know which buttons to push.

I was in charge of the most unpopular organization in the military, the career manager shop. I would sit my staff down every morning and say, “Listen, let's try to help out more people today than we piss off. You're not going to get them all right, but let's just try to help out more than we hurt. That's the best we can hope for.”

● (1610)

**The Chair:** On that sentiment, sir, I'm terribly sorry, but we're well past the time, into the seven- or eight-minute mark now. You'll get to know throughout the next hour and a half or so that I am a professional interrupter, so I do apologize in advance. I've let everybody go a little long in their opening remarks.

Quite frankly, the clerk has whispered in my ear, saying it's time, and I'm saying, “I dare you to cut them off.”

**Mr. Gerry White:** I will leave you with one thought, then: Answer the friggin' phone. That's all I want; just answer the phone.

**The Chair:** Thank you, Mr. White.

To start us off, we have MP Brassard for six minutes.

**Mr. John Brassard (Barrie—Innisfil, CPC):** Thank you, Mr. Chair.

Far be it from me to preclude the analysts' report, but I think recommendation number one might be to just answer the phone.

Gerry, thank you for that.

I have a lot to get to here, but I want to start with Mr. Bruyea.

Sean, thanks for being here. In the time I've known you, over all these years, there's no one who can come to the committee and nobody outside the military who is more prepared than you are with respect to the information that you provide.

In remarks, the ombudsman, like you, used the expression that families should receive care “in their own right”, but you added the phrase “and of their own accord.” What do you mean by that, and what are the obstacles to some of the families receiving mental health care now?

**Mr. Sean Bruyea:** Thank you very much, Mr. Brassard. I'm very humbled by your comments.

The ombudsman was absolutely correct in using the expression "in their own right". That is the availability part of the program. We all know that there are a lot of programs... [*Technical difficulty—Editor*] said something about accessibility. That would be of their own accord, because accessibility too often is determined by Veterans Affairs and not by the needs of the family member or the needs of the veterans themselves.

I wanted to use the words "of their own accord", which means that if there is a wish and there is a medical need identified by a practitioner outside of Veterans Affairs, then that care should be given—no questions asked and no delays given.

The obstacles to families searching for mental health care.... All of us have identified the need for it here today, so I won't belabour that point, but many technicalities exist today.

First of all, as Dr. MacKinnon pointed out, in order to get the mental health care for the family, the veteran first has to be case-managed.

Once the veteran has put in a waiting period—and for some of those waiting periods, we're talking about months and sometimes more than a year in some districts for a veteran to receive a case manager—then the veteran is admitted to the medical rehabilitation plan, or perhaps it might be a vocational rehabilitation plan. Once they're admitted to a plan, then they have to go on to develop a case management plan with the case manager. Then the case manager has to identify whether that family needs those plans.

The important thing here is that it's not whether the family has a need; as Veterans Affairs says, it's whether the veteran has a need for the family to get the care. When obstacles are presented, such as those that numerous people pointed out—when the veteran doesn't want the family to get care or doesn't even want a case manager—the veteran's family is left in the lurch.

Veterans Affairs has wonderful rhetoric about how families of veterans should be receiving care. Garnier resulted in both good and bad policy interpretations. One of the good ones that doesn't seem to be acted upon is:

> Achieving a positive outcome can be compromised if the client is treated in isolation without addressing the effects that the mental health condition has on the family or the effects that the family dynamic have on the patient’s mental health condition.

● (1615)

**Mr. John Brassard:** Thank you for that.

I want to go over to Gerry, because one of the issues that Sean just brought up was that there are no VAC support systems.

You mentioned that in your opening remarks, Gerry, and the fact that the family is paying a price as well. You mentioned specifically the help that your wife has given you.

What types of supports or what improvements can be made in the overall caregiver benefit to help you in your situation, Gerry, with your wife?

The challenge is that you have to be extremely disabled in order to even apply for the caregiver benefit. Speaking specifically to your case, what can we do to help?

**Mr. Gerry White:** Thank you, Mr. Chairman.

It's not that it's not available. I understand that a percentage or portion of my Veterans Affairs benefits, of which I am in receipt, is allocated to my wife. I understand that.

Firstly, if I may take your question in two parts, the system acknowledges a missing arm or blind eyes or a missing leg a lot more readily than it acknowledges mental health issues. Perhaps that is because they are more difficult to quantify or qualify, but we have some really smart people here at the OTSSC in Halifax. [*Technical difficulty—Editor*] to investigate what that caregiver does.

I don't like calling my wife a caregiver. She's my wife; I didn't marry a caregiver. I would not be participating in this panel today if it weren't for her—just to be able to put it in and acknowledge it.

**Mr. John Brassard:** Thank you.

I hate the fact that we're limited in time, but Ms. Evanshen, you told your story. What help do you need from this study?

**Ms. Tracy Lee Evanshen:** I need acknowledgement that as a common-law partner, I am just as valuable as a wife, a spouse. At the moment, I get rather shuffled to the back. I'm new to this life with him, but in doing this, we've come so far in three years, and yet I get next to nothing. It's as though I don't count and my kids don't count.

**Mr. John Brassard:** Thank you.

Mr. Bruyea, I'm going to come back to you in a later round.

Thank you.

**The Chair:** Thank you, John.

Up next we have MP Fillmore, please, for six minutes.

**Mr. Andy Fillmore (Halifax, Lib.):** Thanks, Chair, and tremendous thanks to all of the witnesses today for giving your time and experience.

A particular thanks goes to Ms. Evanshen for painting a very vivid picture of the challenges facing family members, including kids, in a different kind of family permutation. You made the case very well there. Thank you for that.

My fellow committee members have heard me speak in the past about the tremendous concentration of active service people in all three branches, plus the RCMP as well as retirees and veterans of those branches, in Halifax. Every challenge that we can imagine and every uplifting moment that we can imagine that comes with veterans exists here in Halifax. That's why I'm so glad that retired Lieutenant-Commanders Dr. Heather MacKinnon and Gerry White are able to be here.

I want to direct my question first to Heather and will try to split the time in half.

Heather, if I start to get fidgety, it means that I'm hoping to save some time for Gerry.

You have an incredible, unique perspective and practice and you have so much to share. I really want to give you broad leeway on [*Technical difficulty—Editor*] about the importance of supporting families and caregivers, based on your experience.

● (1620)

**Dr. Heather MacKinnon:** It's very frustrating. I can't seem to get help. I try all sorts of tricks, because I've been at it a long time. I can call and I rather beg people to take patients.

I have a situation with a fellow who is 33; he can't get help. His mother and I were on the phone. The father's a veteran; he's a patient, and the son is a patient. I'm going to beg a psychiatrist to see him, but I've also made my plan with the mom, and we decided that what I would do is start him on medication. It would just be nice to get a psychiatrist to confirm the things that are wrong with him, but I'll go ahead with it on my own anyway.

That's the way it is. Sometimes I can get the psychiatrists who are working for VAC to see somebody. I have a situation right now with somebody who was a medic in the military. [*Technical difficulty—Editor*] severe illness, had four strokes, and we're having a terrible time getting him registered with VAC.

It's just not happening. It's been four or five months, and he's fallen off the wagon, and everything's deteriorating. There is a psychiatrist involved, but we just don't seem to be getting help. Again I'm dealing with his family. I'm dealing with his sister; I'm dealing with other people in his family, because he lives alone. It's a horrible situation. His ex-wife is helping me. Everybody is contributing, but we're not moving forward.

This happened in June. Why isn't he into VAC now? Why hasn't he been registered? We started this in September when he was released from hospital. I don't understand it.

These are the frustrating bits. I will go anywhere for help, and Gerry knows that. I will go to other systems to get help. I'll go through the public system; I'll go through other VAC; I even get veterans to help other veterans. I call on them to help with a situation, if we think somebody needs to be babysat or we're a little bit worried about suicidal ideations.

We work on it. That's what I'll say.

**Mr. Andy Fillmore:** Thank you very much for that, Heather. I'm very grateful for your time today.

Gerry, you started your remarks today, before we started the meeting, by saying that you put to rest a veteran this morning. I know that you also will go to anybody's home in the middle of the night to help and do everything in between those two things. You have an incredibly active life of helping people in Nova Scotia.

You ran out of time when you were talking about the importance of support for family and caregivers. I wonder if you could complete what you wanted to say, with the focus on what benefit is derived to the veteran by providing those supports to family members.

**Mr. Gerry White:** Thank you, honourable member, I appreciate it.

My caregiver is taking care of me even while I'm talking to you. There you go.

For the care and support given by the primary caregiver, which is my wife, if you added all of your salaries together and started paying her that much, it might be half of what she earns.

Just putting up with us, you're a mental health administrator. My wife has retired from 30 years of taking care of troubled children, so God picked the perfect caregiver for me.

Our UN and NATO veterans group here is supposed to help out where VAC cannot deliver the goods. We end up being the primary support organization for our veterans here. There are 800 of us here in Nova Scotia. There are 400 in metro and we are the midnight phone calls and the interventions.

Fortunately I managed to get through life without pills or alcohol or whatever. We are the intervention team—an assembly of veterans from all backgrounds and all histories. If we can, we get VAC to help out.

I'd love to have a caseworker. I've been trying for years. My last one was 10 years ago—a fine gentleman who retired.

Our group here is taking care of our veterans. Then if we can bang down enough doors—if we can get the MacKinnons, the Ottomans and the Dr. Daniel Rasics to push the right buttons—then we will get what we need from Veterans Affairs.

I'm not here to slag. I have been very well taken care of by VAC. I really have. I have no complaints whatsoever with the care I get, but it has taken a lot of door pounding. Sean will tell you that retired military officers don't do really well at negotiating. We like to negotiate at the end of a carbine.

That's it. Thank you for your time.

● (1625)

**The Chair:** Thank you, Mr. White.

I really hope not to make a habit of cutting you off. I apologize.

**Mr. Gerry White:** Cut me off all you want.

**The Chair:** We will go over to MP Desilets, for six minutes, please

[*Translation*]

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

I want to thank all our witnesses. Their evidence is important. It helps us to clarify and understand what our veterans are going through. I also want to thank them for their service to our country.

We heard some really touching presentations. Ms. Evanshen, I must say that I'm very sympathetic to your cause and sensitive to your situation.

Two weeks ago, we heard from a veteran. He gave us several concrete examples of what veterans face. He told us about his specific case and how he had trouble receiving services in French. He also spoke about all the effects that this can have.

I'll start by asking you a quick question. It may sound silly, but it isn't. Do you know whether this situation has occurred, or may occur, when it comes to services in English?

[*English*]

**Ms. Tracy Lee Evanshen:** As far as I am aware, in our instance, it has not been a problem. I'm from Quebec. I speak French, so I understand the hurdles outside of French-speaking areas. Particularly in this regard, I could see how it would be almost like Mount Everest, to be honest, to try to get over it.

It's hard enough to get someone to help. To throw another language in there would be next to impossible, to be honest.

[*Translation*]

**Mr. Luc Desilets:** Thank you, Ms. Evanshen.

I'm happy to know that you're from Quebec.

Can you tell us about other major barriers that veterans face? You referred to barriers earlier when you said that sometimes you get a nonsensical answer or two different answers to a question.

[*English*]

**Ms. Tracy Lee Evanshen:** Pick up the phone.

We call and leave messages. We send emails. They don't get back to us. We're still waiting. Kevin has sent emails and six, seven and eight weeks go by and we still don't get an answer.

You don't want someone to pick up the phone and call every time they have a problem, but when there is a steady need, you need to help people. Just answer us. Give us a simple answer. We won't necessarily go away, but at least we can understand better. We don't get that.

If someone would just pick up the phone, it would be helpful.

[*Translation*]

**Mr. Luc Desilets:** I see that Mr. White agrees with you, Ms. Evanshen.

Mr. White or Ms. Evanshen, you were talking about calls that you've had to make in the past few months and telephone wait times. How long have you had to wait?

**Mr. Gerry White:** I took a picture of the wait times with my cell phone. The wait times were one hour and 14 minutes, one hour and 40 minutes, or one hour and 15 minutes. It's a constant struggle. First, you need a response. They then transfer you from one department to another. In the end, they give you a name. Otherwise, and this is the most frustrating situation that can occur, they put you on hold and then disappear. You must then start the whole process over again.

● (1630)

[*English*]

And you start the whole process all over again. It is so frustrating. You just give up, which is almost.... I hate to say it, because I know your staff come to work in the morning wanting to do good for people, but that is not the way it comes across, Mr. Chair. It is not the way it comes across. It seems that they just want you to go away, as Tracy so succinctly put it.

The good news is that we keep dying, so we will go away. You just have to wait us out. We keep dying, but in the meantime, it would be nice to have a little, tiny bit of dignity accorded to us by VAC. I'm sorry, but if I get emotional, it's because it is an emotional procedure.

My dear friend Andy Fillmore knows part of the therapy. He tasks us. He calls veterans and says, “I need you to do an income tax run”, or “I need you to do a food bank run” or “I need you to go and visit this guy”. He knows what the answer is going to be when he calls us. The answer is going to be, “I'm on it, Mr. Member”, and we just go. That's our therapy, but we had to do it all within ourselves. I'm sorry, but we had to do it all within ourselves with the faint hope clause that we will get through or that we will find....

Heather MacKinnon should have retired three or four years ago. We need new guardian angels just to know what buttons to push to get through to Veterans Affairs.

I'm sorry; I apologize.

Thank you, Mr. Chair.

**The Chair:** I'm afraid that's time, Monsieur Desilets.

[*Translation*]

**Mr. Luc Desilets:** Thank you.

[*English*]

**The Chair:** Up next is MP Blaney for six minutes, please.

**Ms. Rachel Blaney (North Island—Powell River, NDP):** Thank you, Chair.

I want to thank everybody for their service. In one way or another, you have given a great service to our country.

Perhaps I will start with you first, Tracy. First of all, I want to acknowledge the real story that you told us. I thought it was very powerful to clarify that experience, how much work it is, and much work you have to do just in the forethought, knowing that every step of the way there are going to be more and more challenges.

One of the things you talked about was the fact that you've only been in this for three years and that you're common law and often feel that you don't count. We've heard from VAC that common-law partners are the same as every other partner, but I'm hearing from you that this is not the case. It would really be helpful to this committee if you could explain what you see as the clear differences.

**Ms. Tracy Lee Evanshen:** To be honest, it wasn't easy to give you a day in the life. Sometimes not all of these things happen, but by and large, they happen.

Unfortunately, given that I've been with Kevin for three years, it is a fight for recognition that I, much like Gerry said, am a caregiver. He's not a child; he's not a baby. I'm not tending to his diapers and giving him a bottle, although sometimes it feels that way. I hope he's not listening.

You can't go into meetings with them. They won't speak in front of you. I'm not entitled to groups. I'm not entitled to certain benefits. We have to buy into them with what very little we have. As much as he feels marginalized as a veteran, as do most, I don't even come onto the scale. I just feel that I should be under a rock somewhere, and that's where I'm viewed by the powers that be, if that makes any sense at all.

I hope it answered your question.

**Ms. Rachel Blaney:** It does make sense, and I really appreciate that. I appreciate also the bravery from you to be able to answer these questions so honestly, and share so intimately your experience.

I have just one last question. You talked about the neighbour and all those stresses. When you were telling that story, I was thinking that so many people would say, yes, that would irritate me too. What I really would appreciate, if you can, is to explain what the difference is. What a person who does not have PTSD would experience is one thing, but you're somebody who's living with those realities, and then there's the work that you have to do as the caregiver.

I really want to make sure that we have it on the record, the clear difference you experience because of that history.

● (1635)

**Ms. Tracy Lee Evanshen:** There are the dogs, for instance. I have a dog. I have a big dog. He likes to bark. They have two dogs that bark incessantly, so for Kevin it's like nails on a chalkboard. It's a continual nuisance. Then with the police, I call up, I try to buffer. I've gone up there. I've been threatened. They say, "It's dangerous up here, little lady." I'm like, "I hope you're not talking to me like that because that's not going to bode very well for you."

It's always at Kevin's expense. The guns will start going off—same family—with no warning. All of a sudden, Kevin is sitting there, everything's grand, and then all of a sudden a barrage of weapons is being discharged 150 feet from our door. I've seen him hit the ground. I've seen him get angry, go to the bedroom, close the door, go under the blankets and not want to come out. I then go back up there again, and my kids are screaming, "Mom, they've got guns." I'm like, "I don't care, because Kevin means more to me than a bunch of kids playing with guns." If they want to try, then good luck to them again. Then there's the dirt bike, which is loud, it goes up and down.

You call the police, they come, and in all honesty we were told once by a police officer, "I'm not going up there, they have guns." I said, "Okay, I'm pretty sure you have one too, so go on up and take care of this."

It's continual and it can be something as simple as driving down the road and someone inadvertently cuts you off. It sends him into a tailspin. A backfire, the start of a lawnmower, it's all these things that we take for granted that send him somewhere else, and somewhere to a place where we can't get him back from very easily.

**Ms. Rachel Blaney:** Thank you. I think that outlined so clearly what the distinct difference is.

Dr. Whelan, if I could come to you, one of the things you said in your testimony is that the family and caregivers are not trained professionals, yet they're asked to address the issues that the member is experiencing with PTSD and other issues. I'm just wondering if you could speak to the impact on caregivers, but also what we need to put in place to support caregivers.

**The Chair:** Just a brief answer, please.

**Dr. John Whelan:** It's by default that the spouses or partners are given this responsibility because there's nothing else available. Clinicians are not going to meet with them in a crisis. We'll meet with them two or three weeks, and sometimes a month, down the road, so by default it's partners and whoever else who can help them to manage the in-between times, and that gets lost.

The short answer to your question is that the entire family, as I said, needs to be case-managed right from the get-go to rule out consequences for them and the level of responsibilities they have.

**The Chair:** Thank you.

Now we go over to MP Wagantall, please, for five minutes.

**Mrs. Cathay Wagantall (Yorkton—Melville, CPC):** Thank you, Chair, and thank you all for being here today.

I can't help but notice that those who are here in the role of giving assistance are veterans themselves. This just speaks so strongly to the whole case of veterans understanding and helping veterans at every level.

Dr. Whelan, first of all, I appreciate the professional perspective that you bring to this because so often I hear from those who are struggling and it's like they hit a wall when they try to express their concerns. Coming from you, it adds that other level of credibility.

Caregivers' Brigade were here and gave testimony, and today we heard from Ms. Evanshen. These are people who are in the circumstances of experiencing what you call being "invisible linchpins". Their role is essential. I can't help thinking of COVID and how we've all come to realize the importance of essential services. Could you just expound on that essential service that plays such a huge role in the health of our nation, let alone the health of these particular individuals?

● (1640)

**Dr. John Whelan:** Not to get too far off track, but I think it really becomes part of, and an extension of, an ideology that those responsible for managing family life, home life and the emotional culture of that home were, by default, women.

Inadvertently or due to not thinking it through, I think our policies take that for granted in terms of how the departments think about the roles of women in families. It's a no-brainer because nobody wants to acknowledge how much we actually take for granted.

**Mrs. Cathay Wagantall:** That's great.

That's the truth. There's a lot of responsibility in that home that people take for granted in the best of circumstances, let alone in these circumstances, so that's very significant.

Dr. MacKinnon, thank you so much for your service, and also for your service now in the role that you're playing.

I keep hearing that we do not have a [*Technical difficulty—Editor*]. How do we get more doctors who have that understanding and that passion to serve our veterans, both within the armed forces and the RCMP?

It sounds like you are on your own. We hear over and over again that the availability of doctors like yourself is something we should be making a priority, even in how we set up supports for our veterans.

**Dr. Heather MacKinnon:** Well, part of it is because I was in the military for so long, and I was on a lot of missions, and a lot of my patients come from the missions that I was on.

The other part is that I think that you could recruit [*Technical difficulty—Editor*]. It takes a lot of time, and there's a lot of paperwork involved, and if you're on "fee for service", you wouldn't get paid very well. I think that's part of it.

There are a few people who do it. There's another doctor who wasn't in the service, but she did work for the service, and she's very good with veterans, so that's two of us.

**Mrs. Cathay Wagantall:** You just mentioned that you're paid through "fee for service", the way it's typically done. Perhaps we need to look at another model in regard to doctors serving veterans with the expertise that you have, just a quick.... I mean we need to do something different.

**Dr. Heather MacKinnon:** Yes, you certainly do.

If you do a medical, you can charge VA for that, but you don't get paid by Veterans Affairs for anything really.

This is an issue too because the civilian side of it doesn't recognize you for what you're doing, and they make it quite hard on you. At one point, they all thought that I should have been billing Veterans Affairs for everything I did.

When I see a patient, the responsibility belongs to the Nova Scotia Health Authority, it doesn't belong to Veterans Affairs, so this is a problem some of the doctors run into.

**Mrs. Cathay Wagantall:** Okay, thank you so much.

Retired Lieutenant Gerry White, you mentioned something that intrigues me because I'm aware of this in other cases. A patient needs a certain treatment, and they're just not getting that access from VAC, so the doctor goes ahead and tries things, does things, and finds results that work, and then it isn't recognized; they're not listened to.

I can say this specifically in regard to mefloquine and brainstem injuries. There are methods of dealing with this in amazing ways, and yet VAC is not responsive.

**The Chair:** I'm afraid that's time, but I'll let Gerry give a quick answer.

**Mr. Gerry White:** Fortunately, I took doxycycline instead of mefloquine, but you just keep banging on the door until they answer.

I would like to address one of Tracy's comments. I am also a justice of the peace in and for the province of Nova Scotia, and I currently have several military and a couple of mounted police on the docket so that I can marry them before they turn 60, so that their spouses can get benefits. I don't know how you spell "pathetic", but that's got to be right up there with it.

That should answer a plethora of questions.

**Mrs. Cathay Wagantall:** Thank you.

**The Chair:** Now, it's over to MP Samson for five minutes, please.

**Mr. Darrell Samson (Sackville—Preston—Chezzetcook, Lib.):** Thank you, Chair.

I can't thank all five of you enough for your presentations today. With the presentations and the feedback we're receiving, it will be extremely helpful for our committee to put a report in place that will help veterans. I just can't say enough. To each and every one of you, thank you very much for that information.

As you know, the population of Nova Scotia has the highest ratio of active and retired military in the country. Sometimes people forget that, but we have very high numbers. In my riding of Sackville—Preston—Chezzetcook, it's the highest yet. We have here today what I call team Canada, or team Nova Scotia, I should say. We have Dr. MacKinnon, Mr. White and Dr. Whelan, all three very important individuals, to support the veterans in our communities. How they help each other is just amazing. I know the connections between Heather in her work as a doctor supporting.... I can't say enough about you, Heather. Every time I listen to you, I'm just amazed by the things that you're doing. Mr. White and the support that you're giving, 24/7.... I think of the support that individuals but also VETS Canada provide. Dr. Whelan, the research is so important, and there's a link between all of you for that research, and that's why I think we're able to find some solutions as we move forward.

Dr. Whelan, very quickly, you talked about 40% of the veterans being invested in their treatments while 60% are not. Why is the number who are not invested so high and what can we do to change that?

● (1645)

**Dr. John Whelan:** Among the 60%, it would come down to the circumstances of their release from the military. If they're disgruntled about their release, if they want to stay in uniform and they still have a military code, they really don't want to move into civilian life and accept that they have problems and have to change some of their behaviours at home. They'll start and stop their therapy sessions, they may disappear for a while if they hear something they don't particularly like. We may invite their partners in and sometimes they don't want their partners involved. They're ambivalent. “I think I need it, I think I want it”—but then they disappear and they may show up again.

**Mr. Darrell Samson:** What can we do to change that?

**Dr. John Whelan:** I think, stepping back, that we need to debrief people before they leave the military culture, so they're not leaving angry, ashamed and feeling like a failure. That just continues and continues, and we're left trying to undo those effects.

**Mr. Darrell Samson:** That's a very good point.

Mr. White, you spoke about Peter Stoffer. I can't say enough about Peter Stoffer and his work as an advocate. He and I have been friends for a long time, and even today, we are working together to support veterans and their families. It's so important and I appreciate that comment.

I have two quick questions for you, and of course for Dr. MacKinnon, about the new programs that are out, the caregiver recognition benefit and the veteran and family well-being fund. How are they being received on the ground and what can we do to improve them?

We'll start with you, Mr. White, and then go to Dr. MacKinnon. Please be very quick because we're short on time.

**Mr. Gerry White:** Most people probably do not realize that those programs exist. I learned about them much after the fact. Simply getting the news that those programs are out there, getting your staff and your constituency staff to publish it in the quarterlies you put out to constituents, that is what is needed. Most veterans have no idea of the assistance available to them until they see that somebody else got it. The question is always, “How do I get that?” We say, “Well, go see Dr. MacKinnon, she'll be able to help you out.”

**Mr. Darrell Samson:** Thank you.

Dr. MacKinnon, quickly.

**Dr. Heather MacKinnon:** That's about it. Usually I don't know exactly who qualifies or why, I mean, it's not—

**Mr. Darrell Samson:** What can we do to improve it, Dr. MacKinnon?

**Dr. Heather MacKinnon:** You need to publicize it more. Send it out to veterans. Send it out to all people. Make it big and public, because they don't know. I'm using it for dying patients at the moment, but get it out. That's the big thing.

**Mr. Darrell Samson:** Thank you.

[*Translation*]

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

Mr. White responded sharply to my last question about wait times.

Ms. Evanshen, you were about to speak and respond to my comments, but we ran out of time. Would you like to speak now?

Our discussion concerned telephone wait times, which are very long, over an hour.

● (1650)

[*English*]

**Ms. Tracy Lee Evanshen:** Thank you.

No doubt, thank goodness for phones with speakers, because we will just put it on the table and go about our business. We have been on the phone, and I'm not lying, for half a day. When we finally get through to somebody an hour and a half later and then they say, oh, let me just put you on hold, then another person picks up the phone and we have to start all over again. Then we're put on hold again, and then we're disconnected somehow. That just sends Kevin right over the edge. It's not even, let's just call back and do it all over again. We have to wait days before he can come back down and we can even attempt that. We get nowhere fast—hurry up and wait.

[*Translation*]

**Mr. Luc Desilets:** I have another question for you, Ms. Evanshen.

If I were to say that we needed to stop injecting money sporadically and ultimately find more beneficial solutions that help us provide the resources needed to keep veterans and their spouses from distancing themselves from their families, what would be your solutions?

The problem is very real, and your presentation is excellent evidence of this reality.

How can we take action? Should we provide money or move human resources? What do you think?

How can we ensure that our veterans' family caregivers, such as you, can properly support their spouses?

[*English*]

**The Chair:** That's time, but I'll allow for a brief answer, please.

**Ms. Tracy Lee Evanshen:** Thank you.

I think a case manager would be helpful. Kevin had a case manager. Then they said that we didn't need them anymore and we were dropped. We have nobody taking care of us, and then we're just bounced around.

More money, yes. More case managers, yes. More help. More empathy—not sympathy, empathy.

**The Chair:** Thank you.

We have MP Blaney for two and a half minutes, please.

**Ms. Rachel Blaney:** Thank you, Mr. Chair.

Mr. Bruyea, perhaps I will come to you.

You said in your testimony that veterans and their family caregivers are treated separately, like they're two different things and not related at all. You talked about things like not supporting children or dependants appropriately.

Could you speak a little bit about what those gaps are and what would be the next step? I know we've had witness testimony about the systems being put together a long time ago and that they don't apply anymore in the world that we live in.

What fundamentally do you think needs to be available for those dependants and caregivers?

**Mr. Sean Bruyea:** Thank you, Ms. Blaney. That's an excellent question.

If we take bits and pieces of what everyone has said here today, I think we really need to include a multidisciplinary approach. Mental health research has shown that veterans, especially with severe chronic illnesses, do not get better or progress in their lives unless they have a multidisciplinary approach.

The same would apply for those family members. The members have to be involved in that case management plan. We need to strip all the work and paperwork that case managers have to do so they're freed up to find those practitioners.

For instance, in the United States context, veterans can go to a hospital that offers all the multidisciplinary facilities that can address the veteran. What I would like to suggest is in Canada we don't have that one-stop facility. A case manager has to prove each individual practitioner for that team. Then, the burden is upon us, the other veterans, or the family members, to try to get that team to talk to one another. We can be much more creative about this. We can start working in a team management context.

Veterans Affairs in the United States has 24-hour-a-day mental health care. We can do the same in Canada if we start training and educating practitioners, bringing them into the Veterans Affairs' fold, and offering these services to the families, to the children, and to the veteran, of course.

**Ms. Rachel Blaney:** You also talked about the fact that, and I think you said 56% of veterans with mental disabilities are married or in a common-law relationship. This means there's a large portion of veterans who are not in a relationship.

One thing we've heard is that sometimes it's very hard for female and male veterans who are single to get supports from who they designate as a caregiver.

Do you have anything to reflect on in that area?

● (1655)

**The Chair:** That's time, sir, but I'll allow for a brief answer, please.

**Mr. Sean Bruyea:** It's a very tragic situation that needs to be addressed and I would think a multidisciplinary team can help fill that gap that families would normally fill.

**The Chair:** Thank you.

We'll go over to MP Davidson, for five minutes, please.

**Mr. John Brassard:** Mr. Chair, it's going to be me, MP Brassard.

**The Chair:** Oh, that's my mistake.

MP Brassard, please.

**Mr. John Brassard:** Thank you.

Mr. Bruyea, I mentioned that I'd come back to you. I have a simple question.

Would you say that you have successfully challenged successive governments in some of the claims they've made with respect to certain benefit provisions that are applied to veterans? Would that be a fair assessment to make?

**Mr. Sean Bruyea:** In the public opinion field, yes, I think I have. Has government done anything to change it? No.

**Mr. John Brassard:** You were involved in a highly publicized situation that involved your son. It goes back several years, to his education. I want to focus a little on dependants. Ms. Blaney started us down this path.

You challenged then veterans affairs minister O'Regan in a column for a pension for life article that you had written. Minister O'Regan wrote back, there was a defamation suit filed by you, and then the day after that article appeared, the benefits to your son were cut off. I know that the veterans ombudsman wrote a report with respect to that, that basically deemed it as retaliatory.

I wonder if you could share with the committee your experiences there. I will be cutting you off at the four-minute mark because I have another question to ask you, but could you share with us what you've experienced through that?

**Mr. Sean Bruyea:** Thank you.

As you know, Mr. Brassard, I usually come here and advocate for policy change and on behalf of other veterans. It is very difficult for me as a veteran to speak personally about what I go through. I can't tell you all, members of the committee, how difficult it is to see the effects of my [*Technical difficulty—Editor*] PTSD has on my family.

I'll try to keep it together here, but I can tell you that when they cut off that care, it was devastating. The timing of it, of course, was the immediate link, but as we progressed I discovered that my case manager didn't keep any case management notes as to why she cut off that care. I found that assistant deputy ministers were intruding and preventing all opportunities, including appointments of inquiries resolution officers, to try to find an answer as to how to get that care back.

For me personally and my family, they've watched me spiral out of what was really.... I had advanced so far in my rehabilitation plan up until that day, and then they saw me attend hospital appointments, go to emergency wards once a month at least, and I can tell you, every single appointment, whether it was for mental health care, massage or physiotherapy, was preoccupied with addressing the negative effects of VAC going after my family.

Veterans have very little self-esteem when they come out with PTSD. They have such a low sense of having accomplished anything. Their families are the one solid backbone for them, as we've heard from all testimony today. When that family is attacked, and we're not talking about just not supported, but when the care of a six-year-old boy, our son, was attacked at that time, it was something I'm still recovering from.

**Mr. John Brassard:** I can tell.

You've mentioned at the beginning of the answer you gave about policy changes and in your opening remarks that you'd like to come back to the committee to talk about and maybe expand on some of your experiences about a culture change within VAC as well.

If we were to invite you back, and I know you mentioned a couple of other names as well, your advocate Allan Hunter, and Tina Fitzpatrick, what is it that you would hope to share with the committee in a longer fashion?

**Mr. Sean Bruyea:** I would really like to show the trail of how decisions are made, how senior bureaucrats interfere with frontline workers, the burden that's placed on frontline workers, what little time they have to help with their veterans when they're being case-managed. I'd be able to show overall how that culture works.

I would also be able to show a cultural insensitivity to the needs of veterans and their families. For instance, more than 30 different communications went to that department, to Deputy Minister Walter Natynczyk, to Assistant Deputy Minister Bernard Butler and Michel Doiron, and they documented the harm that was being done to myself, my son and my wife. Never once after those 30 emails was there an email or a letter that came back and said, “I'm sorry to hear you guys are hurting.” There was never an acknowledgement of that suffering.

I think that culture pervades the entire department from the senior bureaucracy that has really lost touch with what it means to care for veterans and families. Then, unfortunately, they allow personal bias against someone such as me who criticized them, to take retaliation against the veteran or the family.

● (1700)

**Mr. John Brassard:** Thank you, Mr. Bruyea.

**The Chair:** Now we'll go to MP Casey, please, for five minutes.

**Mr. Sean Casey (Charlottetown, Lib.):** Thank you very much, Mr. Chair.

Mr. White, I had the honour to serve with Peter Stoffer, an absolutely fine gentleman, but I can honestly tell you that I have never ever heard anyone use the words “Peter Stoffer” and “saint” in the same sentence.

I have a brief story, if I may. Peter was one of these guys who would go through Parliament and call every single person by name. It didn't matter whether it was another MP, a security guard or somebody in the cafeteria. He called everyone by name. The reason he was able to do that is that he thought everyone's name was “Buddy”.

Mr. White, I'm going to begin with the other patron saint you referenced: Dr. MacKinnon.

Dr. MacKinnon, in your remarks, you talked about the challenges associated with caseworkers or with the availability of caseworkers. This has been a vexing problem over the years. It's certainly one that we inherited and have put a lot of money into, for more caseworkers with smaller caseloads. I would like to hear from you if you could elaborate a bit more on this caseworker challenge. We do hear a lot from the union about it. I would like your advice on how we solve that.

**Dr. Heather MacKinnon:** Well, you've just solved it by saying, “more caseworkers with smaller caseloads”. That would be fantastic.

The other thing is that when people do get a caseworker, they're very good and they work hard for them, but the problem is that they don't have them very long. They are often told, “Well, you don't need one anymore.” That's not the case. People deteriorate. They change. Situations develop, and they don't have anybody. I think this is where it doesn't work.

I really think that veterans need a caseworker, a manager or somebody who is theirs to contact. Like Tracy—she should have somebody that's always hers to call for them. I think if we could just have more of that, a lot more problems would be sorted out and solved.

**Mr. Sean Casey:** Thank you.

Dr. Whelan, I would like to turn to you for a moment. There's a program called “VAC assistance service”. It's a 24-7 toll-free telephone service. Is this a program with which you are familiar? Is this a program that refers cases to you or your clinic?

**Dr. John Whelan:** No, Mr. Casey, it's not a program that I'm familiar with. Most of the people we saw.... I should say that at the end of 2019, before COVID, that clinic was closed, just because there was so much frustration and burnout among our staff that, really, it's back to individuals. To answer your question, it's not a service that I'm aware of.

**Mr. Sean Casey:** When you say you closed the clinic, do you mean the clinic that serves veterans or that you closed your practice altogether?

**Dr. John Whelan:** No. I closed the clinic itself just because I had staff retiring and just because of the years of frustrations and just not being able to do other types of work that have shown a benefit. It was just time on that....

**Mr. Sean Casey:** Allow me to ask you about another program that's offered: the occupational stress injury social support group. This is something that I know is active here in Charlottetown and provides an excellent network for veterans and their families. Have you had experience with that through your practice or otherwise and can you offer a comment on it?

● (1705)

**Dr. John Whelan:** Yes. I'm very familiar with OSISS and the workers here in Nova Scotia.

It has changed quite a bit over time. There were a lot of conditions put on it. Veterans would go and then didn't feel safe, in that they couldn't really talk about things that were of concern to them. There were strict rules around what could and could not be discussed. Initially, we used to advise people “yes”, and then we became much more judicious about that, in that it would cause them more harm to attend than not, actually.

**The Chair:** That's almost your time. You have about 10 seconds, Sean.

**Mr. Sean Casey:** Thank you, Mr. Chair.

**The Chair:** Now we will go to MP Wagantall, please, for five minutes.

**Mrs. Cathay Wagantall:** Thank you, Chair.

Thank you so much again, all of you, for your help today. It's been very revealing.

Sean, I'd just like to go to you to ask a question in regard to one of your recommendations that you've spoken of. It's the values of upfront and long-term benefits to a veterans' families advisory group. I know this government has a lot of advisory groups in place. You indicate that it should be created and composed of veterans with families, veterans' family members, rehabilitation and mental health specialists as well as medical specialists with a strong background in family dynamics and needs. Yet you also say that they would not be required to sign disclosure agreements and would not include government officials.

Could you just expound a bit on that? It's so crucial that, if we're going to do these things, they hear what needs to be heard to get it implemented.

**Mr. Sean Bruyea:** Thank you, Ms. Wagantall.

I think today is a perfect example of how you are all hearing from individuals who are unhindered in their ability to speak openly. That's what we really need. I think the public and Parliament needs to hear this unfiltered information, the unfiltered data that comes to you.

As for the current structure of the advisory groups, yes, they have some of these experts on board for the families, but the problem is that they're co-chaired by bureaucrats. There are always bureaucrats running around the room presenting material, deciding on the agenda and then editing the final reports.

I've heard from various members of various advisory groups that this is in no way conducive to providing independent, authentic and meaningful recommendations. I think it would be to the benefit of all people, Canadians and Parliament, to have these independent advisory groups that are chosen, hopefully by an independent body such as.... Currently it could be the ombudsman, but hopefully an independent federal appointments commissioner.

**Mrs. Cathay Wagantall:** Great, thank you.

Dr. MacKinnon, you mentioned the need for more case managers, and I hear so often from veterans, “I had such a good case manager” at some point in time. I couldn't agree more with you. That's absolutely crucial.

I also have heard from case managers that their role right now as it stands is in the middle. They're between a hierarchy above them who give them directives, and then they have the veterans and their families who have the needs. They get caught in this dynamic. If they had more authority, more education, more understanding and more incentive to stay on long term because they didn't have such a huge caseload and weren't facing dynamics where they really don't have the opportunities to provide the care they want to give to veterans, would that make a difference? How do you see that could be improved?

**Dr. Heather MacKinnon:** Certainly if they had more of that, that obviously would help. I think more of them is also another issue that's really important. With these OSI clinics, you can't get into them without a case manager. They work wonderfully, but in my practice of all veterans, I only have two people in an OSI clinic, because they had to have a case manager put them there.

That's one of the things that we really miss, but I would say the case manager, yes, is instrumental because they know what things are available for veterans. Maybe veterans wouldn't have to ask for things if the case manager could bring it to their attention, and say, "Yes, I can give you this or do that. Have you thought about it?" Most of them say, "No, I didn't know about this," or the caregiver didn't know what was available. I think that would be wonderful.

As I said, it just needs to be tweaked. There are things out there; you just have to get to them.

● (1710)

**Mrs. Cathay Wagantall:** Right now, you know about the backlog obviously—

**Dr. Heather MacKinnon:** Yes.

**Mrs. Cathay Wagantall:** —and what's going on there. Who doesn't? Every Canadian knows that now.

The truth of the matter is that our case managers are burnt out, and they're being replaced or more are added in on a temporary basis. We've heard over and over again that is the wrong direction to go. What is your perspective on that?

**Dr. Heather MacKinnon:** You're right on that. They just disappear. I guess they have to look at that level in Veterans Affairs to see what can be done to support them.

**Mrs. Cathay Wagantall:** Thank you so much.

[*Technical difficulty—Editor*] talk to me.

**The Chair:** You have about 30 seconds for an answer, please.

**Mr. Gerry White:** Our problems aren't temporary, so the people who address them can't be temporary. I'd like to make a quick comment on what Sean said about one-stop shopping. I travel a lot in the U.S.A. I can go into a veterans affairs hospital in the United States and get my problems taken care of if I have a problem.

The one-stop shop that Sean was talking about existed. It was called the OTSSC. It was in Halifax. It had a mental health clinic on the fifth floor. It was a physical hospital. It had physiotherapy and, in case you knocked somebody's teeth out, it had a dental clinic. The one-stop shop that we needed for veterans existed. It was called the OTSSC, and then somebody said, "We need to reinvent the wheel." I'm sorry, once again, but we're banging drums that have been banged so much they've got holes in them. Sorry.

**The Chair:** Thank you, Mr. White.

Up next we have MP Lalonde, please, for five minutes.

[*Translation*]

**Mrs. Marie-France Lalonde (Orléans, Lib.):** Thank you, Mr. Chair.

I want to start by thanking all the witnesses for their presentations. They shared their perspectives in a transparent and unique manner.

[*English*]

I come from a social work background. I graduated a few years ago and I certainly appreciate all of you sharing the multidisciplinary approach to things as a possible recommendation for this committee.

Dr. Whelan, I want to go back to some of your years of experience. This is not to neglect Ms. Evanshen's role as a caregiver as a spouse, but perhaps you can give a little bit more of your perspective on the children and teens within that family unit and on how they themselves are possibly the caregivers of that veteran. Perhaps you would like to share a little bit more on that front and maybe some recommendations that we can make as a committee.

**Dr. John Whelan:** When it comes to military families, we know that children and adolescents in military families take on responsibilities. Everybody chips in with the idea of "team". So when those families leave service, those children already know those roles. When there's distress in the families, what we've [*Technical difficulty—Editor*] boys who were really trying to protect the family, or trying to protect the mom, trying to keep the dad kind of on an even keel. They're beyond us trying to offer individual services. There is very little available for them.

We didn't treat younger children. I have a colleague who tells me often about the level of devastation among these children because of the lack of predictability and control.

Again, I come back to the idea of case management. Case management means not managing files; it means going into families, doing a comprehensive needs assessment, and ruling out the effects of military service—not ruling it in, but making sure [*Technical difficulty—Editor*] attributable to military service there.

**Mrs. Marie-France Lalonde:** Thank you very much for your in-depth recommendation, I hope, for my colleagues here.

Ms. Evanshen, I think some of my colleagues made reference to your current status. You did share that you are a common-law partner. You're saying there's a difference, if I understood you correctly, between being a spouse married under the law, if I may, versus a common-law partner. I know you made reference to Quebec. Is that particular to Quebec, or is that something systemically problematic with the policies currently in place?

● (1715)

**Ms. Tracy Lee Evanshen:** From what we've seen at this point, it's not the same over everything. If you talk to the military, it's one answer. If you talk to VAC, it's another answer. There's no consistency. For me, being common law, there is no consistency on my status, if you will. Especially since I met Kevin after he was age 60, it's almost as though, as Gerry mentioned, I don't even exist. They kind of laugh: "See you." There was some gold-digger clause that I believe was created in 1901. That makes a lot of sense in today's day and age.

I hope that answered your question.

**Mrs. Marie-France Lalonde:** Well, I'm going to go back and ask what you would recommend we change in terms of ensuring that the way we are making you feel, and the sentiments you're expressing, are not there any more for others, and hopefully you, in terms of benefiting from our recommendations.

**Ms. Tracy Lee Evanshen:** Thank you.

I think there has to be a deep dive into post policies that are so antiquated it's ridiculous. Yes, I'm sure 100-odd years ago with the gold-digger clause people were trying to coat-tail on the benefits of veterans and dying veterans. That's not the case any more. That's not to mention the fact that veterans are living longer than they were before. They're lost in the shuffle. I'm 50, and God willing Kevin will be with me for some time, but he has a lot of medical issues. Right now we scramble because we're not married. We couldn't get married because of COVID. We were planning on it.

We don't know. We're so left up in the air. That's just another layer on top of having to deal with PTSD and crazy neighbours and medical things that.... For Kevin, he feels he can't take care of us if something happens to him.

**Mrs. Marie-France Lalonde:** Thank you for sharing.

**The Chair:** Up next for two and a half minutes is MP Desilets, please.

[*Translation*]

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

My last question is for Mr. White and Ms. Evanshen.

I want you to explain something to me. You're both experienced people and your comments make sense. You know about helping veterans and you're on top of things.

Good grief! Can you explain why the government isn't listening to you?

My question is simple: why?

You each have one minute to answer my question.

[*English*]

**Ms. Tracy Lee Evanshen:** I don't even know what to say. I believe if someone hasn't walked in your shoes, they honestly have no idea of the journey. Most people are too self-absorbed—not everybody—so they don't see the picture, they don't care, and everybody is falling by the wayside. People just don't care.

**Mr. Gerry White:** I have a plan, Tracy.

**Ms. Tracy Lee Evanshen:** Thank you, Gerry.

**Mr. Gerry White:** I can come up to Ontario if I forge your partner's birth certificate. I can perform the wedding ceremony, and that should put everything just about right.

This is what we have to resort to, folks. That's the kind of way we have to think.

I'm very sorry, but I'm just trying to help out a fellow casualty here.

**Mrs. Cathay Wagantall:** I want to come to the wedding.

**A voice:** You're all invited.

**The Chair:** For the sake of Monsieur Desilets, I have to step in.

You have one minute left, sir.

[*Translation*]

**Mr. Luc Desilets:** Mr. White, you didn't answer my question.

Why isn't the government listening to you? You have all the knowledge, expertise and experience needed.

You're an emotional man, so don't hold back.

[*English*]

**The Chair:** Give a brief answer, please.

[*Translation*]

**Mr. Gerry White:** It's very frustrating.

[*English*]

We just give up. We try and we try and we try and we give up. Hopefully we have an Andy Fillmore or a Heather MacKinnon or a John Whelan out there somewhere, but then, when we go over the top, if you read some writings of Franz Kafka, who says rightly that he just couldn't take it anymore, then the system kicks into high gear and says, “Where did we go wrong?”

Tracy and Sean Bruyea can tell you where it's going wrong now before there's another regrettable casualty.

● (1720)

[*Translation*]

**Mr. Luc Desilets:** Thank you.

[*English*]

**The Chair:** MP Blaney, you have two and a half minutes, please.

**Ms. Rachel Blaney:** Thank you, Chair.

Dr. MacKinnon, I'll come to you. Of course we've heard caseworker testimony from back when they talked about having too many people on their lists, a lot of burnout, not being able to make decisions and having to go up the chain and how frustrating and time-consuming that is. We have definitely heard from them what those challenges are.

I am wondering about two things from you, since this is a study specifically on caregivers. What are the impacts on caregivers when we have veterans who are constantly having to retell their story to new case managers when staff are changing all the time? Then there is the fact that caregivers cannot have their own case manager and what the challenges are.

Could you just talk about that and the impact of the caseworkers on the caregivers?

**Dr. Heather MacKinnon:** Really, there's not much help for caregivers now. As we said, there is only one criterion where caregivers get help, which would be for spouse and children under 25. That is, if the veteran gives permission, is recognized [*Technical difficulty—Editor*] and has a case manager, they can get help, but if you take any other situation where that veteran doesn't fit into that criteria, there is nothing, and there is so little for families.

There is just so little for the abused wife who just sits at home and gets abused, or the wife who is dealing with a husband who is living in a basement with cameras around the house and neighbours complaining because they think he's going to come out and shoot people or something like that. There's nothing for these people, and we just have to get to them and help them, and it may not always happen through a case manager, but we have to look at the families very closely.

**Ms. Rachel Blaney:** Thank you.

Mr. White, if I can close with you, you talked earlier about how much work it is for a veteran and their caregiver to search continuously for supports and programs instead of having that one-stop place where they can go.

Just tell us about the impact—I think about your wife—without having that accessible service.

**Mr. Gerry White:** My caregiver? I'll call her a caregiver. Since I sat down here, my caregiver has given me this glass of water, and she has brought me this box of Kleenex. Clearly, I have a better caregiver than Bruyea. Also, when this conversation is over, she's going to spend the next two hours talking me down from how wound up I am as a result of participating in this.

You can google “roast Peter Stoffer” or “Peter Stoffer roasted”. I was the MC of that roast. I put body armour on him and gave him a name tag that read “Stoffer PD”, and I picked a trade for him—“SD1”. That stood for “shit disturber 1st class”. Pardon the vulgarity, but that's what we need. We need people to go into the corners after the puck. We need people to say that not only is the veteran spiralling out of control, but he's dragging down with him somebody who he stood up with in front of 150 people and who he said he would love until he was dead. He's dragging her or him down with him. That's the problem.

Now, I realize that we're standing at the bottom of a mountain looking at the top, and it's going to be a very tough job to get there. We had the one-stop shopping that Sean was talking about. It was called the Stadacona Hospital, and everything a veteran needed was all in one building. They gradually....

Sorry, Mr. Chair.

Just get in corner after the puck and, above all else, pick up the phone and take the time. It's empathy, as Tracy said. Just empathize. I don't want your sympathy. I want your empathy.

**The Chair:** Thank you, Mr. White.

Now we'll move to MP Brassard for five minutes.

**Mr. John Brassard:** Thank you, Mr. Chair.

Gerry, I have to tell you that when I'm in Nova Scotia you and I are going to get together for a beer, because I'd love to spend more time with you, other than having the chair just cut you off, although that's his job and he has already acknowledged that.

Dr. Whalen and Dr. MacKinnon, I don't want to take up too much time here, but we've heard the stories. We've heard Ms. Evanshen's stories and we've heard Gerry's story about his wife. You've done studies. You've been in the trenches.

Is this symptomatic of and consistent with what you've heard over the years? How do we fix it?

● (1725)

**Dr. Heather MacKinnon:** How do you fix it?

**Mr. John Brassard:** Yes. First of all, these are consistent stories. [*Technical difficulty—Editor*] give us some recommendations on how we move forward here, because this is going to be an important part.

**Dr. Heather MacKinnon:** You need more people. That's the bottom line.

You need more people in Veterans Affairs. You need more people at that level, not higher up. At that level, focus on putting the policies together, getting these people and getting them out seeing the people. That's the level we need to get this done.

**Mr. John Brassard:** Dr. Whalen.

**Dr. John Whelan:** Yes, I would agree. We need more case managers, and case managers who are not so inundated with files that they can't assess the families. Also, we need to move past this ideology we have that it is the veteran only. It is not the veteran only. It is everybody that is close by.

Also, yes, these stories today are all too familiar for me as well.

**Mr. John Brassard:** Thank you.

That's all I have, Chair, unless Ms. Wagantall wants to take up the rest of my time, but I do have a notice of motion that I would like to put on the floor.

Mr. Chair, you're aware of that, so I think we can do that after we're done. Do you want me to do it now?

**The Chair:** Either way—it's up to you, sir.

**Mr. John Brassard:** Okay. Well, I do have time.

Based on some of the discussion today with Mr. Bruyea, I believe that he has some pretty relevant information [*Technical difficulty—Editor*] I'm going to put the following notice of motion to the committee, and that is:

> That the committee invite Sean Bruyea, Allan Hunter, Tina Fitzpatrick and the Veterans Ombudsperson, Col (Ret.) Nishika Jardine to brief the committee on the VAC mental health care programs, for one meeting no later than April 14th, 2021.

The clerk has that in both official languages, Mr. Chair.

Thank you.

**The Chair:** Mr. Brassard, do you wish to move this motion today or are you just putting it on notice?

**Mr. John Brassard:** I'm just putting it on notice, Mr. Chair. We're going to deal with it at a later time. I just wanted the committee to be aware.

**The Chair:** I will have the clerk distribute the motion, and that is perfect timing.

Thank you.

**Ms. Rachel Blaney:** Mr. Chair, our witness Tracy just put her hand up.

**The Chair:** I see that.

Go ahead, Tracy, and then we'll go to the final questioner.

**Ms. Tracy Lee Evanshen:** Thank you.

I just wanted to mention that it's great to have more case managers, but the case managers need to have an understanding of the military and how it works, because they don't. They don't understand the scope. They don't take it seriously, and then our veterans are kicked to the curb by case managers because they just can't understand the problems.

**The Chair:** Thank you.

We do have a few minutes left here before the end of our time. Up next we have MP Amos.

You're going to have a shortened time slot, sir, so probably two or three minutes maximum.

**Mr. William Amos (Pontiac, Lib.):** Thank you, Mr. Chair.

Thanks to all of our witnesses. I'll keep my question brief.

Do you feel that the challenges and problems you've highlighted today are having a material impact on the ability of the Canadian Forces to recruit, and if so how would you characterize that? Maybe we'll start with Ms. Evanshen since she's from the province of Quebec and then we'll go over to Mr. Bruyea and Mr. White and Mr. Whalen and Ms. MacKinnon.

**Ms. Tracy Lee Evanshen:** I will give you just a brief synopsis. I'm 50, and I applied to go into the military last year. I went through this big rigmarole. There were letters written all over the place. It's almost the end of March, and I haven't heard from the recruiting office in Kingston in nine weeks. No one will return calls. No one answers emails. I don't even think they're in the office, let's be honest. They're dropping the ball all over the place especially with women. I'm sorry.

● (1730)

**Mr. William Amos:** Mr. White.

**Mr. Gerry White:** It's really easy for us to sit here and just destroy or eviscerate VAC; that is not what any of us wants to do. When somebody says they want to join the military, I say “what a beautiful career”. I've been all over the world several times in both directions, and now the pay is good, but that is not a motivator. You need to know that someone has your back. We have a patch in veterans and it says “ IGY6—I Got Your 6”. Now, I know that I can phone somebody at four o'clock in the morning, because they're going to have my back; they're going to have my 6. That's what you need. Yes, it is not prestige or status—and it's also affecting the RCMP very dramatically. They need to know somebody cares if they make it to the end of their watch, and then the end of their shift, and then the end of their career, and then in retirement. Applicants right from the get-go need to know that somebody has their back, has their 6, other than just fellow veterans.

**The Chair:** Thank you.

I'm afraid it's appropriate that I cut off Mr. White at the end of this. I owe a special apology to him for continuously doing that. It's just a matter of timing.

We are unfortunately at the end of our time, and I do want to personally thank each and every one of you for contributing to this difficult study. I would have Mr. White on Zoom calls at each and every meeting if we could, just for his reaction to what other people say; it's heartwarming. I appreciate—

**Mr. John Brassard:** Mr. Chair, can we give Mr. White the participation ribbon for being cut off the most?

**The Chair:** I think so, absolutely.

[*Translation*]

**Mr. Gerry White:** I'm always at your service.

[*English*]

**Mr. John Brassard:** You get the medal, Mr. White.

**The Chair:** I want to thank everybody.

Before I dismiss my colleagues, however, we do have a deadline to determine the suggested witness list for the next study, which of course is the study on a strategy for commemorations. I will be so bold as to suggest Friday, March 26 by 4 p.m. If there are no objections to that, I would suggest that we—

**Mr. John Brassard:** Mr. Chair.

**The Chair:** Yes, sir.

**Mr. John Brassard:** I have no objection to that. There's just one thing I would ask for. We haven't really got into a habit, but I remember my first go-round on Veterans Affairs we used to get the master witness list. Each party used to get the proposed witness list from each party and we haven't seen that. I would like that list. Other than just simply submitting, I'd like to see who some of the other witnesses are as well, Mr. Chair.

**The Chair:** John, let's you and I talk about this maybe off-line. It's not something that I've ever done as a chair either in this committee or in HUMA. I'm not sure if that was the practice before. It will be up to the committee if they want me to start doing that. There are some challenges with that, which I will chat with you about.

**Mrs. Cathay Wagantall:** I'd like to speak to that, Chair.

**The Chair:** Okay. We can get going on that, but there are a few challenges with it. Like I said, it's just not been a practice. What we do is we share the witnesses who have been confirmed and that allows the clerk to do their job.

Cathay, go ahead.

**Mrs. Cathay Wagantall:** Thank you, Chair.

I just want to make a comment. Looking around the room, I think I'm the old lady matron of the group since this government came into effect in 2015. I've never sat on this committee and not had full access to that list. So I would encourage us to consider doing that. It's very important that we be prepared and be aware of who is coming before us and give them their due. I really appreciate everyone who is here today.

Thank you.

**The Chair:** Just to be clear, everybody is given a list of witnesses who are appearing, but again there may be some unintended consequences of sharing the entire list. Again, I'm open to that discussion and maybe we can talk about this in a committee business meeting and weigh the pros and cons.

MP Blaney also has her hand up.

● (1735)

**Ms. Rachel Blaney:** I just wanted to agree with that. I was there with Cathay for part of last term. We did receive that, and I have received that in other committees. It's just helpful, and I recognize that things happen, so not everybody's going to show up. We also recognize that [*Technical difficulty—Editor*]on your list. Those things we've seen before. It's just so that we know who might be coming and we might be able to do some preparation.

I look forward to that discussion. Thank you, Chair.

**The Chair:** I'm happy to have it.

If there's nothing else, as always I want to thank the clerk and the analysts.

Please, just pick up the phone, as Mr. White just said.

I want to double-check. The clerk is just asking me if we have an agreement for a March 26 four o'clock deadline for witnesses for the next study. There are no objections. Fantastic.

Thank you very much, everybody.

Thank you to all the techs and the translators in Ottawa for helping us out here.

The meeting is adjourned.