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Chair

Mr. Gary Schellenberger

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● (1530)

[*English*]

The Chair (Mr. Gary Schellenberger (Perth—Wellington, CPC)): Now that Peter's here, we'll start the meeting.

Welcome, everyone, to meeting number 38 of the Standing Committee on Veterans Affairs.

Pursuant to Standing Order 108(2), we are studying combat stress and its consequences on the mental health of veterans and their families. This afternoon our witness is from the Canadian Association for Suicide Prevention, Tim Wall, executive director.

Welcome, Mr. Wall. I understand you have a presentation. Could you please enlighten us, sir?

Mr. Tim Wall (Executive Director, Canadian Association for Suicide Prevention): Great, thank you.

I've already begged the indulgence of the chair that my presentation is 13 or 14 minutes.

On behalf of the Canadian Association for Suicide Prevention, I would like to thank this committee for the invitation, providing us an opportunity to speak with you today. I've had the opportunity of speaking with some of the members already at other standing committees, so some of what I'm going to say may sound a little familiar to you.

The Canadian Forces has publicly acknowledged suicide as a public health problem, unlike the Government of Canada, which has yet to do so formally. The Canadian Forces has made significant investments in suicide prevention and is developing a strategy to address this issue within the armed forces.

CASP, our board of directors, and our members across Canada commend and are proud of the Canadian Forces for its leadership and commitment to suicide prevention. It is our hope that someday soon the Government of Canada will follow its example, acknowledge suicide as a public health priority, and demonstrate the same type of leadership.

Over the past two decades close to 100,000 Canadians have died by suicide. Last year almost 4,000 Canadians died by suicide, more than the total number of fatalities from all injury-related deaths and homicides in Canada combined.

Canada's suicide rate ranks in the top third of countries with the highest suicide rates. We wonder how many of these deaths may have been veterans. At a recent U.S. suicide prevention conference, Veterans Affairs Secretary Eric Shinseki reported that 20% of that country's 30,000 suicides each year were acts of veterans.

Over three million Canadians—no doubt some of us in this room—have known the pain and anguish that comes when someone we love dies by suicide. Sadly, when someone dies by suicide the pain is not gone. It is merely transferred to family, friends, and communities. Their injuries are largely invisible and mostly suffered in silence.

Suicide is not the result of a single cause. It is complex, and suicide prevention requires a multi-faceted approach. Suicide is the result of an interaction of complex bio-psychosocial and spiritual factors that can include social isolation, trauma, stress, family violence, substance abuse, poverty, poor mental health, and physical and mental illness, to name but a few. Suicide prevention therefore requires a coordinated, multi-faceted approach involving multiple sectors and domains. Unfortunately, in Canada suicide prevention is fragmented and lacks a national vision. There is currently nothing that unifies suicide prevention in our country.

In 2010 the Canadian Forces issued a comprehensive report on suicide prevention in the military. This document will no doubt make important contributions to suicide prevention within that community. The report's conclusion stated that many suicide prevention programs have mass education as their centre of gravity. The expert panel proposes instead that the centre of gravity for the Canadian Forces' program should be the delivery of effective mental health care to those who need it. This is because effective mental health care is what fixes suicidal behaviour.

While we must underscore the significant effects of mental health conditions such as depression and post-traumatic stress disorder and treat them accordingly, it is also important to acknowledge that treatment for suicidality is not necessarily synonymous with treatment of these conditions, nor is it sufficient in itself to reduce the risk of suicide. Our position is that suicide prevention cannot be based on a single centre of gravity, but instead should include many centres and be guided and informed by an overarching national strategy.

The Canadian Forces' efforts should be coupled with the development of a national strategy that targets not only other communities under the jurisdiction of the federal government, such as veterans and federal prisons, but looks to reduce the suicide risk for the general population as well.

While the Canadian Forces' report is an important and progressive document, this work has been undertaken in isolation and is disconnected from what is being done in other communities, regions, sectors, and jurisdictions.

● (1535)

The efforts of the Canadian Forces is just one of many examples of how fragmented suicide prevention is in Canada. The good work being done by the Canadian Forces is not being guided by a larger national vision designed to connect and build upon all the good work that is being done in Canada and worldwide with respect to suicide prevention, intervention, and “post-vention”. Canadian research indicates that, in general, suicide rates are slightly lower among active military personnel and put forward some sound hypotheses to explain this fact. Perhaps one of the strongest protective factors for CF members is that there is likely more connection to peers and to a stronger social network than is the case of the general population.

This protective factor in all likelihood decreases after leaving the service. Up to now, however, Canadian research has excluded veteran populations and discharged military personnel, and only included suicides among actively serving soldiers. It is generally understood that many soldiers will experience traumatic events while in service and may not display any signs of post-traumatic stress while in service. Many service members will also have experienced a trauma even before starting their military careers.

Trauma, however, can lie dormant, slowly ferment over time, and find expression later in life, long after the trauma was experienced. Canadian Forces policy does not address the risk in veterans. Without question, veterans are a high-risk group and require significant attention. Recent research out of the U.K. reported that the risk of suicide among male soldiers who had left the service and were less than 24 years of age was two or three times higher than among the general population and those who are currently serving. Other research, also out of the U.K., indicates that only one in five veterans in that country who died by suicide sought help prior to their death.

Over 15 years ago the United Nations and the World Health Organization recognized suicide as a major public health issue but did not confine the responsibility to a single domain. In 1992 the United Nations asked Canada to take a lead role in developing international guidelines for suicide prevention, which were later adopted by the UN in 1996. The UN guidelines and the subsequent World Health Organization guidelines asked that every country have both a national suicide prevention strategy as well as a national coordinating suicide prevention body.

Shortly afterwards, countries around the world began developing their strategies. To date, all industrialized countries have national strategies, all with the exception of Canada. In fact, not only has Canada failed to act on and recognize both the UN and the WHO guidelines, but it has yet to even acknowledge suicide as a national public health issue and priority. The Government of Canada contributes to the stigma and problem of suicide by its silence, rather than publicly and vigorously declaring its support for suicide prevention in all communities and jurisdictions.

As the UN recognized in 1993, suicide is not the responsibility of a single sector. It belongs to public health, mental health, social wellness, injury prevention, National Defence, Veterans Affairs, and Corrections Canada. We should and must work together. However, at this time the government has not provided us with the mechanisms to do so. There is no national strategy to guide us and no structure or body to promote collaboration and coordination. No one can say it is not my problem or responsibility, and yet to many of us it seems that this has largely been the message that we have heard from the government. To date, the federal government's response—and not just this government, but in all previous governments—to our pleas has been that this is a provincial-territorial responsibility and not a responsibility of the federal government.

Suicide is in fact everyone's responsibility, and everyone has a role to play. The Canadian Forces have recognized their responsibility and the role they play in suicide prevention, as I believe does Veterans Affairs. When will the rest of the government recognize their responsibility and the important role that they can play as well?

● (1540)

Our national government has in the past demonstrated leadership and worked collaboratively with the provinces and territories on numerous public health issues and pandemics, such as H1N1, SARS, and AIDS. It is now time for our national government to get involved in a meaningful way to systemically address Canada's suicide pandemic. While our federal government has made important investments in suicide prevention in first nations communities, it has failed to take action beyond this very limited and selective response and has made no direct investments in suicide prevention outside of those communities.

The good news is that suicide is preventable. We know what to do, and we can do it. None of us, including the Canadian Forces or Veteran Affairs, can or should do it or go it alone. We are all in this together.

For the past seven years CASP has been offering the Government of Canada the gift of a national strategy for suicide prevention. This strategy was first published in 2004, and a second edition in 2009. Unfortunately, our gift to the government keeps being returned. This strategy has received international as well as provincial and territorial recognition. If the government does not want or like this particular gift, then at least let it say so, acknowledge that something is needed, and take a leadership role in calling all stakeholders together to build something better.

Both Scotland and England launched national suicide prevention strategies in 2002, and both countries later reported a fall in the overall rate of suicide in the general population. In fact England recorded its lowest suicide rate ever and saw a reduction of 20% in deaths by suicide. England determined that if there was a 20% reduction in suicides, their national strategy would be cost-saving in terms of deaths avoided and quality of life adjustments. Scotland calculated their entire strategy would be paid for if only five additional lives were saved.

In 2001 the Surgeon General of the United States issued the national strategy for suicide prevention. Inherent in the strategy was an acknowledgement that suicide was a serious public health problem and was preventable. The U.S. strategy, like Scotland's and England's, established a common reference point that allowed disparate elements of the suicide prevention movement to see their own priorities, while influencing each of them to work within the overall framework. It also served as a guide for identifying shared goals that provided a credible rationale for gaining public support. The strategy also served as a wide-ranging catalyst for social change, with the power to transform attitudes, policies, and services. One of the most active and key partners in the U.S. strategy is the Department of Defense.

There are many good things happening across this country in the field of suicide prevention. However, one region, department, or sector does not know what the others are doing. There is no system in place to share and exchange information, promote and build best practices, coordinate research, cross-pollinate ideas, coordinate our efforts, and collaborate. Simply put, we are not communicating with one another and working and learning together. There is also no national public awareness and education on suicide prevention, nor support for evaluating existing initiatives against a standard.

In a recent conversation that I had with one of your colleagues in December, a fellow MP, we had an opportunity to discuss this issue. In the course of that conversation it was again expressed to me that this was a provincial issue and responsibility. The analogy was used that you don't bring in an electrician—the federal government—to do the job of a plumber: the provinces and territories. If we follow that analogy, while an electrician shouldn't tell a plumber how to do their job or fulfill their responsibilities, we would suggest that you still need both to build a house and that you need a good contractor to facilitate communication and planning.

It is our belief that it is the role and responsibility of the government to ensure that suicide prevention has a contractor—in other words, a funded national coordinating body. The first litmus test for any country when it comes to judging its efforts to promote suicide prevention is whether there is a national coordinating body. Canada has not passed this test.

● (1545)

Our national government has in the past demonstrated leadership and worked collaboratively with the provinces and territories on numerous public health issues and pandemics, such as H1N1, SARS, and AIDS. We have pointed out to previous governments, and the current one, the economic advantages of a national suicide prevention strategy, but we know that our concern cannot be just about saving money. It's about doing the right thing, saving lives and keeping families from being torn apart and traumatized by suicide.

We are talking about our brothers and sisters, mothers and fathers, aunts, uncles, cousins, friends, co-workers, and the people we pass on the street every day. We are talking about people who served our country and made enormous personal sacrifices that most of us cannot fully comprehend. We need to ensure that we keep our veterans safe, just as they kept us safe.

In conclusion, what can the Government of Canada do?

We are asking that the Government of Canada, with your support, formally recognize suicide as a serious public and community health and injury prevention issue and policy priority; appoint and adequately fund a national suicide prevention coordinating body that will serve as a knowledge broker, promote knowledge exchange, best practices, research and communication; and commit to working cooperatively with that national coordinating body, the provinces, and the territories on establishing a national suicide prevention strategy.

We believe that positive changes are accomplished through informed collaboration. CASP would welcome any opportunity to work with this committee, Veterans Affairs, the Department of National Defence, and the Department of Health to move suicide prevention, intervention, and postvention forward across Canada.

Too many people's lives are being cut short. Too many people are being deprived of a future that could be hopeful and fulfilling. Too many people and families are being deprived of loved ones who would have continued to enrich their lives and our communities. There are hundreds of thousands of people in this nation whose lives have been forever altered by a tragic and needless suicide death. Some of them are your constituents. Some of them may be your neighbours, your friends, or your family.

Suicides are preventable. There is hope, and with your support we can and will save lives and heal those who grieve.

The Chair: Thank you.

First question, Ms. Sgro, please.

Hon. Judy Sgro (York West, Lib.): Thank you very much, Mr. Wall, for making such an important statement to us as we move along on this particular study.

How long has the Canadian Association for Suicide Prevention been an organization, and how long have you been the executive director?

Mr. Tim Wall: CASP has been around for about 25 years. I should point out that the work of CASP is done all by volunteers. I am a volunteer. My position as executive director is not a funded position.

We are made up of researchers, academics, survivors, mental health professionals, caregivers, and just concerned citizens from all over the country. We operate under the governance of a board of directors.

● (1550)

Hon. Judy Sgro: In the analysis that you've done, you have indicated there were 4,000 Canadians, but that Canada was in the top one-third around the world. Is it because we haven't developed a strategy to deal with this head-on that our numbers continue to be so very high compared to other countries?

Mr. Tim Wall: I don't think that the lack of a national strategy is a contributing factor to the suicides, but I think a national strategy and, just as important, a funded coordinating body are part of the solution.

Hon. Judy Sgro: Which comes first, the strategy or the body?

Mr. Tim Wall: I would suggest the body. It is a bit of a which came first, the chicken or the egg scenario. I think we can learn from what the government did, which we applaud the government for doing, in trying to address the issue of mental health, which was to create the Mental Health Commission of Canada, which is a coordinating body. They were charged with the task of establishing a national strategy, which they are still working on. We should follow that example. That's something that has already proven to be working well.

I would, though, like to stress in making reference to the Mental Health Commission of Canada that in their strategy and in their report, "Toward Recovery & Well-Being", in the entire document there is only one reference to suicide prevention. Sometimes there's confusion that the mental health strategy is a suicide prevention strategy, but it's not; they are two different things. It's not a substitute for a suicide prevention strategy, but certainly the Mental Health Commission is an important stakeholder in this issue. We would like to see it prioritized somewhere. Currently it is not a priority for the Mental Health Commission.

Hon. Judy Sgro: If you were going to make a couple of recommendations to us when it comes to dealing with the trauma, the PTSD, the issue of veterans in particular, what would those recommendations be?

Mr. Tim Wall: I would strongly suggest that it is important that services being provided through Veterans Affairs and the Canadian Forces and others be trauma-informed. There is an international movement, in which Canada is somewhat lagging, that is promoting trauma-informed care and practices. That includes looking at every aspect of how service is delivered to ensure those services are sensitive and supportive of the needs of people who have been affected by trauma.

The agency I work with is Klinic Community Health Centre, in Winnipeg, and we produced a trauma tool kit. It's about how you deliver and promote trauma-informed care and practices. We're sending this document all over the world. The U.S. and other countries have seen it and they are asking to use it.

There are wonderful resources available to help organizations and services to be more trauma-informed, and I would say that should be something Veterans Affairs should really be looking at. I'm assuming they already are, but there are lots of tools out there that can assist in that process.

Hon. Judy Sgro: Did your organization put that trauma tool kit together?

Mr. Tim Wall: Yes, Klinic did.

Hon. Judy Sgro: And the funding came from where?

Mr. Tim Wall: The funding for the tool kit came from the Public Health Agency of Canada.

Hon. Judy Sgro: Good. So they're recognizing the good work your organization is doing.

Mr. Tim Wall: I hope so.

Hon. Judy Sgro: The whole issue of suicide prevention is something I think all of us care very much about, whether we're talking about the veterans or we're dealing with it in the general population. But in particular with the veterans, the trauma is a very important part of it, that whole issue of what's required to identify it early. I would think that would require some very special training for counsellors and those working with our veterans, to be able to identify the particular points that tend to lead....

When we talk about suicide prevention, they'd have to be trained fairly well, would they not?

● (1555)

Mr. Tim Wall: In terms of suicide risk assessment?

Hon. Judy Sgro: Suicide prevention.

Mr. Tim Wall: Training is an important component to an overall strategy, and I think you need to look at other pieces as well.

There is excellent training that's already been developed. I'm thinking of ASIST, for example, which is being used throughout the world. Something like ASIST is very accessible to the average person. It does not require a background in mental health or health care.

There are very simple things we can do to train people to become gatekeepers and to help to assess somebody who may be at risk, and then help them get the support they need. It's not about training people to become therapists, clinicians; those people are available. We need to know how to identify people and then link them to resources.

Hon. Judy Sgro: You said it was ASIST? Could you...?

Mr. Tim Wall: ASIST is a suicide prevention training program. It's a two-day training that was developed by LivingWorks, and it's used throughout Canada, the U.S., and Europe. Then there's a half-day training called safeTALK.

The Chair: Thank you.

Mr. André, please.

[*Translation*]

Mr. Guy André (Berthier—Maskinongé, BQ): Good afternoon, Mr. Wall.

I'm worried, on the one hand, because I would like more details. In Quebec, we have an entire strategy for addressing the problem of suicide. Our suicide prevention services can be found in every region of Quebec. There are hotlines and intervention services. There is really a lot being done on this issue. I understand that something similar is in place throughout Canada. But my concern is not comprehensive and does not target the entire population. It is more specific to veterans and soldiers who, of course, become veterans.

What is your experience in terms of intervention with veterans? Do you have specific experience? Have you conducted pilot projects with veterans?

[*English*]

Mr. Tim Wall: CASP has not. CASP would be very much interested in supporting that kind of initiative, because, as I think I indicated in my presentation, there's been very little research done specifically in terms of veterans. There's been a lot done in terms of those who are actively and currently serving in the military, but very little in terms of veterans, not just in Canada but also in the U.S. and in other countries. CASP simply does not have the resources to engage in that kind of research.

[*Translation*]

Mr. Guy André: I'm surprised by that because you were invited as a witness of the Standing Committee on Veterans Affairs to talk about the problem of suicide. Perhaps it isn't your responsibility. Maybe it's our place to wonder about who we invite as a witness, not yours.

I am only going to ask you questions about certain things you mentioned. You said that, in the United States, the general statistics tell us that 20% of soldiers and veterans commit suicide. You said that, in the United Kingdom, there is some data indicating that soldiers and veterans are two or three times more likely to commit suicide, compared with the rest of the population. You also said that close to 20% of veterans commit suicide. But you didn't give statistics for Quebec and Canada. Why? Is it more difficult to get data?

We read the statistics on the United Kingdom and the United States, but here, when we talk about suicide in relation to soldiers and veterans, we're told that it's very difficult to get that data. In committee meetings, various people have told us that the numbers are high, whereas others tell us that the numbers are comparable with the rest of the population. We have heard all kinds of things, but no one can give us exact data. Can you tell me why?

● (1600)

[*English*]

Mr. Tim Wall: Because they don't exist. It's not there.

Your point is a good one. I think that we need to be looking specifically at the issue of suicide among veterans. When we did our own research to look at what was currently available, in preparing for a meeting with you today, we couldn't find anything. We consulted with some of the people in Canada—for example, Dr. Paul Links, who is one of the leading researchers in suicide in Canada and who actually sat on the expert panel that the Canadian Forces have put together. He said it's not there. There's a huge gap in the research. You're quite right.

[*Translation*]

Mr. Guy André: Okay.

But I imagine that the worlds of the departments of defence, both in Great Britain and in the United States, are secret and hidden. It's very difficult to know what goes on in those environments. It is very difficult to get obtain statistics. Does that mean that the other countries are more open than here when it comes to gathering statistics on suicide rates? Do you understand what I'm saying?

If we can get data on suicide in Great Britain and the United States and we can't get it here, I imagine that the departments of defence in those countries are more open than Canada's is.

[*English*]

Mr. Tim Wall: It's my understanding that even the research that comes out of the U.K. and the U.S. is limited. It's certainly not as extensive as it is in terms of the kind of research that's been done with those who are serving in the military. But it would appear that they are a little more in front of this than we are in terms of looking at the issue of veterans.

I'm not exactly sure why that is. My speculation would be that some of it may have to do with the fact that both of those national governments have identified suicide as a public health priority, and with that comes resources.

[*Translation*]

Mr. Guy André: There are resources and a greater openness.

[*English*]

The Chair: Thank you.

Mr. Stoffer, five minutes, please.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you, Mr. Chairman.

Mr. Wall, thank you very much for coming in today, sir.

That figure of 4,000—where does that figure come from? You said that last year 4,000—

Mr. Tim Wall: Yes. It was about 3,750. I believe that comes from Statistics Canada, but I'd have to double-check that.

Mr. Peter Stoffer: Okay. That's fair. Because the reality is that.... I know that when I spoke to our health minister in Nova Scotia a while ago on this, they indicated that it's very difficult to ascertain how many committed suicide. If a coroner's report says “drug overdose”, that person may have overdosed on drugs willingly, but it doesn't say “suicide”. A person who has a car accident in front of a semi-trailer, for example, or off a bridge, may have committed suicide, but it shows as “accident”.

So the figures can actually be much higher. Am I correct?

Mr. Tim Wall: Yes.

It's our belief that the numbers of suicides that actually take place are under-reported. In fact, one of the things that appears in the strategy for a suicide prevention strategy that we developed...it does address the issue of improving and expanding surveillance systems so that we can actually get more accurate statistics.

But you're right: there are many deaths that were likely a result of a suicide that were not reported as such.

● (1605)

Mr. Peter Stoffer: Right.

Well, as you know, Mr. Richardson and his wife, of Ottawa, suffered a severely unfortunate loss. I was very proud to see the House leader of the Conservative Party, as well as members from all parties, gather yesterday in solidarity, not just in the House, but at a press conference that was held in the lobby of the foyer of the House of Commons. Six of our colleagues were wearing hockey jerseys. It was quite a show of support for the family in that regard.

The government also should be congratulated for what they did a couple of years ago when they instituted what was called the national cancer strategy, where they coordinated the efforts of the provinces and various organizations to develop best standards practices and everything else. I hear this a lot too—and we all hear it—that health care is a provincial responsibility, but the government has shown once and in several other cases, such as SARS, AIDS, etc., that it is willing to participate in a national system—in this case, cancer.

I think it would only follow that all of us—not just government, but all parliamentarians—must ensure that this very serious public health issue, which unfortunately is growing, and for a variety of reasons, is seriously attended to. It is something that I think we should all look at in that regard. I can't speak for the government; they're very capable of speaking for themselves.

On the veterans' side of the issues, do you have any veterans or military personnel on your volunteer board?

Mr. Tim Wall: Let me just go through our roster. We are just in the process of electing a new board of directors. There was at least one board member, who's no longer aboard, who was a veteran. Certainly in putting together our new board we're looking for diverse representation. That would be something we would be looking for.

Mr. Peter Stoffer: If you were the President of the Treasury Board and you were cutting a cheque in the way that you would like to see it done across the country, what would the initial cost to the government be in terms of setting up a national system? Obviously the long-term investment would be a return. As you had indicated for Scotland, if you can reduce *x* number of deaths, then you can actually have it paid for through cost efficiencies in that regard. What would be the initial ask to the government for that initial national strategy?

Mr. Tim Wall: I'll try to answer that question in a couple of ways.

We can refer to what the costs were, what the investments were that both England and Scotland made in terms of their national strategies—and I do have those figures. Our organization doesn't have the resources to cost out a national strategy, so I can't speak to what it would be.

I'll just use Scotland as an example. Their strategy was divided into two phases. In the first phase, which was from 2003 to 2006, they invested the equivalent of just over $14 million. Another amount just under $5 million was set aside for national activities that would support the strategy. An additional amount just over $13 million was set aside for the second phase, which was from 2006 to 2008.

In terms of the cost for a coordinating body, we have projected some figures for that. We're looking at about $700,000 for a coordinating body.

The Chair: Thank you.

Mr. Mayes.

Mr. Colin Mayes (Okanagan—Shuswap, CPC): Thank you, Chair.

Welcome, Mr. Wall, to the committee.

Unfortunately, the past misguided mental health policies of former provincial and federal governments really triggered the Senate report out of the shadows. From that, basically, there is a mental health commission and a strategy.

Unfortunately, I started to read the report but didn't get right through it. Did they touch on suicide prevention and those issues around mental health in the study?

● (1610)

Mr. Tim Wall: I have read the report in its entirety, and there's one sentence about suicide prevention, and it's a passing one.

Mr. Colin Mayes: That's interesting, because I really think that should be incorporated as part of that strategy.

I don't want to get caught up in data, because we're talking about people here, we're not talking about data. The important thing is the people. Mr. André said something that triggered....

In your statement you said that in the study of the forces in the U. K. they found the number of suicides were two to three times higher. But you set an age group, did you not?

Mr. Tim Wall: Yes.

Mr. Colin Mayes: So it was not all Canadian Forces; it was an age group. I'd just like to make sure that data is straight, because data can say a lot of things. We've got to be careful.

Mr. Tim Wall: Yes. And that was the only study we could find.

Mr. Colin Mayes: Right.

There was one thing I wondered about that. An unfortunate experience when I was in the mining industry was that three miners committed suicide within a month. It was almost like an association. They were all friends. I wondered if that is a common thing that happens. It's what I would call a cluster or association suicide. A lot of the suicides in this particular group, as far as the forces are concerned, could be the association with young men and women who maybe have gone through the same circumstances and seen one of their colleagues do it. Would it make that threshold easier?

Mr. Tim Wall: For somebody who is vulnerable, if they know of someone who has died by suicide, it can increase the risk for them. There's a certain sense of, okay, I have permission. Somebody else did it, so they may view that as a very viable option for themselves.

The contagion effect I think has been better documented among young people, who can react more impulsively.

In Canada there are three high-risk groups: first nations peoples, youth, and older adults. Some of the research we've looked at suggests that actually the rate of suicide among older adults is higher than with youth, but they tend not to get the same attention as when there's a death of a young person. When we look at certain segments of the veterans population, there are so many risk factors there that, as I said in my presentation, it makes them particularly vulnerable.

Mr. Colin Mayes: Unfortunately, through what we see, we have a society that has, I think, diminished the value of life, the sanctity of life. Youth have grown up in that type of environment. I'm just wondering, I know we can tie the issue to, for instance, combat duty or some of the challenges of living in the Canadian Forces, such as all living together in one spot. That's a challenge. Have you done any studies or gleaned any information with regard to the Canadian Forces and some of those things in the Canadian Forces that could be improved to minimize some of those outcomes?

Mr. Tim Wall: I think the Canadian Forces have done that. They did this very extensive report that included, I think, something like 59 recommendations for improving the forces' response to suicide prevention. I think the forces are probably doing a pretty good job of that. I don't know that there's anything I could add to this report that isn't already there. Again, I think what has been pointed out many times, what we haven't looked at, is the issue of veterans specifically.

● (1615)

Mr. Colin Mayes: Do you think maybe that is something this committee should be looking at and maybe recommending, that transition from active duty to veteran and trying to get that information transfer so they can identify potential risks?

Mr. Tim Wall: Yes.

Mr. Colin Mayes: Okay.

One of the things you mentioned was suicide as a public health problem and having a national strategy. Who do you see championing that? I was thinking about the Mental Health Commission, but would it be through Health Canada or through the Mental Health Commission? How do you see that happening? That could be tied in with Veterans Affairs too as a partner in some sort of strategy.

Mr. Tim Wall: It could lie with the Mental Health Commission. That was the approach that Scotland took. They developed a mental health strategy and under that umbrella they developed a suicide prevention strategy.

I think the Public Health Agency of Canada could potentially play a role there, although again, to the best of my knowledge, when I go to their website they don't include or address the issue of suicide prevention.

I think it is important to remember that, as I said, we have to be careful about assigning this to only one segment. There's a tendency to want to look at it as only a mental health issue, or a health issue.... It affects all these sectors. That's why I think a coordinating body is so critical, because we need a body that can bring them all together, and it's just not happening.

Mr. Colin Mayes: Thank you for all that your organization does for mental health and suicide prevention.

Mr. Tim Wall: Thank you.

The Chair: Thank you.

Ms. Duncan, please.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Mr. Chair.

Thank you, Mr. Wall, for your presentation and for your tremendous work in this field.

You talked about having a national strategy, and I'm wondering about the key planks of that strategy or the framework.

Mr. Tim Wall: Did you want me to...?

Ms. Kirsty Duncan: Just give us an idea of what the key pieces are, please.

Mr. Tim Wall: I think we can divide it into three and then three main goals and their objectives under each.

First is awareness and understanding. So public education and awareness is one of those pillars.

Prevention, intervention, and postvention is the second.

Knowledge development, transfer, and exchange would be the third.

Ms. Kirsty Duncan: Okay, that helps. Thank you.

Mr. Tim Wall: I have left a copy of our strategy with the committee, for anyone who may want that.

Ms. Kirsty Duncan: Do you think this is a useful way...? In terms of this committee, the prevention, intervention, postvention I think is a useful framework. Could you talk about best practices for each of those areas and make specific recommendations to this committee? Could you speak to that?

Mr. Tim Wall: I would be challenged to do that simply. I think the best practices that fall under each of those areas are outlined in detail in the strategy we put together.

Ms. Kirsty Duncan: Okay, that's fair.

Mr. Tim Wall: I couldn't do that very easily.

Ms. Kirsty Duncan: On postvention, what would you make as a recommendation to this committee? Veterans' families are affected. What action should then be taken to build resiliency?

● (1620)

Mr. Tim Wall: While suicides are preventable, we know that sometimes people will die. So we need to make sure that people have access to the supports they need, and there are lots of them out there. There have been a lot of really good resources developed for people who have been affected by suicide. So I think we need to look at a way of pulling that all together so that we can do a better job of making sure that people, when a suicide does happen, have access to that information and to those supports.

Ms. Kirsty Duncan: What research do we have regarding postvention? Should there be interviews with families, with veterans, to try to understand what happened?

Mr. Tim Wall: What we need to be doing, in my opinion, is outreach. So when we are aware of a family that has lost someone, at least make an initial contact, introduce ourselves and say if they need support or want to talk to someone—and we would really encourage them to do that—here is where we are, please call us, and maybe follow up sometime later.

Ms. Kirsty Duncan: Are there specific recommendations to build resiliency? These are families that are going to need tremendous support.

Mr. Tim Wall: There aren't the same kinds of standards for best practices that have been established in terms of support around suicide bereavement as there have been in terms of prevention. We're just working on that right now at my home agency clinic in partnership with CASP in developing those kinds of standards or best practices around supporting people following a suicide.

Ms. Kirsty Duncan: What can you tell us of what you know now on how to build resiliency? Or does it not exist and this is somewhere we really have to...?

Mr. Tim Wall: In terms of resiliency.... I may be misunderstanding the question a little bit. There are all sorts of programs for building mental health resiliency, increasing capacity for people to be more flourishing in terms of their mental health. There are lots of programs that have been developed that are separate from the issue of suicide bereavement.

When there has been a loss related to suicide, we need to help people walk through their grief. And sometimes that's just not there, giving people an opportunity to understand how they've been impacted by what's happened to them, and to give them room to tell their stories and to recover from that trauma.

Ms. Kirsty Duncan: I guess that's what I'm asking.

The Chair: We have come to our time.

Mr. Lobb, please.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you, Mr. Chairman.

The Chair: I just want to remind people that we'll be going until about 4:35.

Mr. Ben Lobb: Mr. Wall, thank you.

In your statement you talked about a national strategy on suicide prevention with DND and Veterans Affairs Canada underneath that strategy, or involved in that strategy. Is that correct?

Mr. Tim Wall: They are involved, yes.

Mr. Ben Lobb: You are partnering with that strategy.

The veterans ombudsman testified at our last meeting, and we've heard this before, that Veterans Affairs and DND are, on the world stage, really leading the way on PTSD and operational stress injuries. From your objective eye, do you believe that statement to be true? Do you believe that we are on the right track and are leading?

Mr. Tim Wall: I don't know if we're leading compared to other countries, because I don't know what's happening in other countries in terms of their military or their departments of veterans affairs.

I think there is certainly growing attention being paid to the issue of trauma within the military. I think the military is looking at some really progressive ways of addressing the issue of trauma. From what I've seen so far, I've been generally impressed with the direction they're taking. I don't know that they're there yet, but I think they're on the right path.

● (1625)

Mr. Ben Lobb: Another question I've asked a couple of witnesses is whether they feel that there's adequate training for the mental health professionals who are providing support to members of the Canadian Forces and our veterans. Their answer, both times I've asked the question, was that they felt that the psychologists or psychiatrists, or whoever is treating those individuals, do receive the proper training because of the experience they get when they're doing their practical training, whether it's at Parkwood in London or at Ste. Anne's in Montreal or wherever they are learning their craft. Is that something you subscribe to?

Mr. Tim Wall: I'm aware of some programs that deal with the issue of operational stress that are very progressive and very much on top of the issue of trauma. I'm making some assumptions based on my experience with mental health programming outside of the military. I'm making an assumption that there are probably not huge differences between those two groups. There is still a bit of work to be done in becoming more trauma-informed. The whole area of trauma and trauma recovery has grown in leaps and bounds. Even in the last year we've had new information. I think that some of the training being offered hasn't kept up.

Mr. Ben Lobb: Senator Kirby and his Mental Health Commission I think have received some high grades for the work they have done. Are there pieces within that commission, within the work he has done, this committee should look at and further investigate? It may not be on trauma or PTSD, but there may be some pieces on the mental health side of it that we should look at and should try to add to this report.

What are your thoughts on that?

Mr. Tim Wall: I think in terms of mental health overall and mental health promotion, what the Mental Health Commission has come up with is fairly comprehensive. There isn't too much I could see that would be missing, with the exception of suicide prevention and trauma. I think there are seven pillars to the strategy they came up with. I would love to have seen nine, one of which looked at the issue of trauma, which is something that connects most of the other pillars. Trauma is often the undercurrent of all those other issues. And of course there is suicide prevention. I think those are the two things that are....

The Chair: Thank you.

We'll go to Mr. Vincent, please, for five minutes.

[*Translation*]

Mr. Robert Vincent (Shefford, BQ): Good afternoon, Mr. Wall.

You said earlier that the armed forces have a coordinated approach for its suicide prevention strategy and you congratulated them on their efforts. Have you been in the field, to any military base, to evaluate the Canadian Forces' current prevention efforts and the services offered to veterans?

I understand that veterans fall under one of your national areas of authority. Did you really go into the field to evaluate the Canadian Forces' strategy?

[*English*]

Mr. Tim Wall: In terms of going to bases, no, I haven't. I wish I had the resources to do that.

[*Translation*]

Mr. Robert Vincent: I'm sorry for you because you spoke previously about $700,000. Right now there is a freeze on budget envelopes. So to go further with your $700,000, I think you're going to have to come back in a few years.

You said that you have a report containing 50 points, and you talked about its benefits. But you know that there's a big difference between what is really happening in the field and what is being written. I'm having difficulty following your strategy. You say that, yes, it's good, it's perfect and you're moving in the right direction, except that no one will check what's going on in the field. There isn't any monitoring. What do you think about that?

● (1630)

[*English*]

Mr. Tim Wall: I can't tell you things are going fine. I can just tell you that it's my belief that the Canadian Forces are working on a plan, on a strategy, to do that.

I think your point is well taken that whatever we do needs to be evaluated in some way to see if it is having the desired effect, if it's making a difference. I think the evaluation piece is often missing. So I agree with you.

[*Translation*]

Mr. Robert Vincent: It's clear that the strategy's principle is to save lives, but what happens if we can't do that? Especially since Canada has not signed a national suicide prevention strategy agreement. How can we have a suitable strategy for the Canadian Forces when we don't even have a national one? This leaves a really big gap for all these people and there is no strategy. We don't where we're going, we don't know what we're doing, the left hand doesn't know what the right hand is doing. We hope, we think that it's being done well, but there is no one outside the Canadian Forces who can go into the field to evaluate what is currently being done and make recommendations. Do you believe that this would be one of your recommendations, that people outside the Canadian Forces be able to go and evaluate the training that is given to these young people who go into theatres of operations? I don't know too much about what training that would require because we have no idea what the training strategy or the plan is. It's easier for my conservative friends to understand the word "strategy" than the word "plan". There is no plan. We don't know what their plan is to ensure that our young people be able to return in an intellectual state similar to the one they had when they left for a theatre of operations. I would like to know your opinion on that.

[*English*]

Mr. Tim Wall: I agree with you that because suicide prevention is so fragmented, as you said, the right hand doesn't always know what the left hand is doing. I think the work that's being done by the Canadian Forces, as with other groups that are involved in suicide prevention, would be better served if it fell under a larger umbrella, that of a national strategy, and was informed by that so that there was some continuity and some consistency in our approaches and what was being done.

I think that any kind of evaluation and looking at what the outcomes are of a strategy or any kind of program needs to be done objectively and needs to involve input and some oversight by a group that is diverse in its representation. So that includes outside experts, and it's not an evaluation process that's insulated and only involves those who are directly involved. I think you always benefit from bringing other people in.

[*Translation*]

Mr. Robert Vincent: I have one last question.

You agree with me that if there was a national strategy and we had the money required, we could possibly save the lives of our veterans who have left the Canadian Forces. These individuals are often left on their own and end up in the streets, in groups like AA or groups like that. If there was a national strategy, do you think that we would be able to save these lives?

[*English*]

Mr. Tim Wall: Yes, I do.

The Chair: Mr. Kerr, please.

Mr. Greg Kerr (West Nova, CPC): Thank you.

I'll be very brief. I'm not going to ask you a question because I think it's been well covered today and we're a little short of time. But I really want to say thank you. I know the work that you're doing. The fact that you've left the study, which has the recommendations in it, certainly helps our effort as a committee, because it's very difficult to get a consistent pattern of where the issues are coming from, and what are the recommendations. And I think you underscore the fact that this is an extremely difficult issue we're dealing with and it may never be totally resolved, but there's an opportunity for better coordination. So I just want to say thank you for the work you do and for having the study. We're certainly going to review it very carefully, because I think there's some good work in it.

● (1635)

The Chair: As chair, I have one small question I'd like to ask. This bothers me quite a bit. If a person has a mental health problem, suicidal tendencies, and does not accept help or treatment, can that person be forced into treatment or care? Whether a veteran, a Canadian Forces person, or a civilian, can that person be forced into care?

Mr. Tim Wall: If there is imminent risk, yes.

The Chair: Imminent risk of suicide.

Mr. Tim Wall: Yes.

The Chair: Not mental health, necessarily.

Mr. Tim Wall: This may vary in terms of other jurisdictions; I'm familiar with Manitoba. You have to demonstrate that there is a fairly pressing risk that the person may harm himself or herself or harm another person. The person may not be functioning well in terms of mental health but may not be an immediate risk; then there's not a lot you can do.

The Chair: Again, thank you for your testimony today, Mr. Wall. I'm very pleased. Have a safe trip home, sir.

Just as Mr. Wall is leaving, we have on the list two witnesses we still haven't approved yet. It's my understanding that those two witnesses should appear.

Hon. Judy Sgro: Good idea.

The Chair: Is that a good idea?

Mr. Vincent.

[*Translation*]

Mr. Robert Vincent: I'm going to give you a little relief, Mr. Chair.

I had on my list Colonel Drapeau, a lawyer who represents the members of the Canadian Forces or other members who are veterans. It's his job to represent them with the Canadian army. I am going to set him aside. Mr. Drapeau will come back another time for another matter that we will discuss at some point here at the Standing Committee on Veterans Affairs.

[*English*]

The Chair: Mr. Stoffer.

Mr. Peter Stoffer: I just throw this out in addition to it. We hear a lot about Senator Michael Kirby's report. I just look to the committee for support on this. Would it be advisable to invite him or members of that committee who helped on the report to come to advise us on our way forward?

The Chair: My analyst has just advised me that he has read the report and that there isn't much in it on suicide, and nothing at all on veterans.

Mr. Peter Stoffer: I stop right there, then.

The Chair: It's suggested, then, that.... Do we want to take Mr. Drapeau off?

Mr. Peter Stoffer: *Oui.*

The Chair: Okay, then that's all.

Andrew Cohn will be coming. All in favour of that?

Mr. Jean-Rodrigue Paré (Committee Researcher): In terms of Mr. Cohn, the program he developed is specifically on resilience building. It's specific to that. He got an award and he got a Royal Society.... It's on resilience building in the military, before deployment, and it seems to be working quite well.

The Chair: He's the Australian—correct?

The Clerk of the Committee (Mrs. Julie-Anne Macdonald): He's the Australian, yes.

The Chair: So we'll be doing that via teleconference.

With that, I'm going to adjourn the meeting.

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