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Chair

Mr. Neil Ellis

Standing Committee on Veterans Affairs

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● (1540)

[*English*]

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

Good afternoon, everybody. This is the Standing Committee on Veterans Affairs, meeting number 39. Pursuant to Standing Order 108(2), we are conducting a study of mental health and suicide prevention among veterans.

There are just a couple of quick housekeeping items today.

We have a new clerk assigned to the committee. Grant McLaughlin has moved on. We'd like to welcome Patrick Williams to the committee today.

We have a new member, David Graham. We'd like to welcome David to the committee today. Also, we have a new parliamentary secretary to the minister, Ms. Romanado, who is familiar to the committee. Welcome back, Sherry.

With that, we'll start with witnesses. Each group can use up to 10 minutes.

We'll start with Ms. Le Scelleur, who is here as an individual.

[*Translation*]

Ms. Hélène Le Scelleur (As an Individual): Thank you, Mr. Chair.

My thanks also go to all the committee members for inviting me to appear as part of this important study.

My name is Hélène Le Scelleur; I am a retired captain. I joined the Canadian Armed Forces at the age of 17. Belonging to something bigger than myself was what motivated that decision. Basically, I saw myself meeting the challenges shown in the recruiting advertisements.

I started out as a member of the first cohort of women in the infantry reserve, then I joined the regular forces. I committed myself heart and soul. I took my place, and achieved success, in a predominantly male environment. As a soldier, I was always one of the elite and I was rewarded in many ways. During my career, which extended over 26 years, I served in a number of units: twice in the former Yugoslavia and then, in 2007, in Afghanistan. I was also an aide-de-camp to the Right Honourable Michaëlle Jean, the Governor General of Canada.

My career was full of rich and rewarding moments, both in the ranks and as a commissioned officer.

However, in April 2016, I was discharged from the forces on medical grounds, after a diagnosis of post-traumatic stress.

From the time I was put into a permanent medical category until my discharge from the forces, two years and three months went by. The transition period was difficult and marked by times of intense suffering. I had suicidal thoughts. Like a number of my comrades, I went through episodes of suicidal thoughts and, had it not been for my husband and my children, I would not be here to testify before you.

I would like to make it clear to you that the problem is not related to my vocational transition because I have been able to pursue doctoral studies in social work. Nor is the problem because of a lack of health care, which would have made my symptoms worse. I was actually looked after very well by health professionals: the psychiatrists, the psychologists, my psychotherapist and my family doctor.

In my case, as in the cases of all the other veterans I know, and there are hundreds of them, it is the social aspect of the transition that has been completely eliminated from the process.

The 2014 Senate report entitled “The Transition to Civilian Life of Veterans” significantly echoes that discourse. The current trend is to maintain a focus on the vocational aspect of the transition but without considering another aspect inherent to it, namely, the adjustments to one’s identity and interpersonal relationships.

In addition, throughout the work of the Standing Committee on National Defence, despite the many research projects on mental injuries being conducted in the public sector and in universities, the statement is that it remains key to be critical of the medical profession, which is desperately trying to find a biological reason to explain mental conditions. With that in mind, approaches other than medical ones must be considered in the treatment of operational stress injuries, specifically the question of identity in the process.

In the Senate report I mentioned previously, the Standing Committee on National Defence also pointed out that, despite significant efforts at awareness and the range of mental health services in the Canadian Armed Forces, the feeling of lost identity is likely to make itself felt upon leaving the forces, which increases the psychological distress that is already present.

The Canadian Armed Forces have adopted clear policies for the reintegration of soldiers with their families, and with their organizations when they return to their bases after an operational mission. However, their reintegration in other aspects, such as their personal and social identity, after fighting a war, seems to be missing from the current process of transition.

In addition, little research has been done into the subjective experiences of current and former members of the military, into evaluating their process of transition towards their discharge from the Canadian Armed Forces in terms of how their well-being increases or decreases, and into expressing their needs outside the constraints of the prevailing discourse.

Currently, there is no Canadian literature on interpersonal rehabilitation with veterans and their families as they make the transition to civilian life. In his 2012 report, Pierre Daigle, the Ombudsman for the Department of National Defence and the Canadian Forces, points out that the simple use of the expression "return to civilian life" could in fact be a factor in the suffering.

● (1545)

> Finally, the term "return to civilian life" is sometimes employed by CF leaders and administrators. It completely misrepresents the reality facing most members afflicted with OSIs and no longer fit to serve. Though demographics are shifting, a preponderance of CF members still joined the military in early adulthood and know only what it is to be a sailor, soldier or airman/woman. Not only has their military career been the only one they have ever had, but it is a major part of their identity. As a result, the notion of "returning to civilian life" is invariably more complex and cathartic than the term suggests. More often than not it is an arrival to adult civilian life rather than a return, with all the uncertainty and trepidation that such entails.

I fully support that statement. The shaping of a soldier, from the oath of allegiance ceremony, through basic training — which is designed to get the civilian out and put the military unit in — and becoming a trained military member, forms the foundation on which a military identity is built. That identity remains ingrained for the rest of our careers.

We put a lot of effort into training our military, but we forget that we have to detrain them when they leave. The detraining cannot take the form of current transition programs, because they are not designed to consider that aspect. We should invest in training to return to civilian life that would focus on helping us to rediscover ourselves as individuals. It should establish our own values and our own needs, something members of the military have never done, because we think and act as a team in which individualism has no place. We have to learn how to build our own individuality once more.

However, that is not easy when you are going through the transition in isolation, as is the case for all those who are discharged for medical reasons. As soon as the diagnosis is given, a label follows, and a kind of rejection is experienced immediately. We are slowly moved aside, or even transferred to the Joint Personnel Support Team. From that point, the entire process is individual. In a way, we are isolated from and forgotten by the system that shaped us. We feel the burden of our suffering in addition to the burden of this rejection.

We go through the discharge process ourselves, with no social support, no comrades or peers to help. We wear our equipment, an important symbol of identity, and our identity cards, with no thanks, no honours, and no acknowledgement of what we have given. We have to beg to leave with dignity; there are no parades to recognize our service and our sacrifice.

So ask yourselves, when you add all that up, whether it may be normal for a person to have suicidal thoughts.

I would have liked to leave with honour. The current process leaves us with a bitter taste that implies that, because we are wounded, we are no longer worthy enough to be mentioned or respected for what we gave to the fight. Believe you me, that is enough to lead a person who is suffering to suicide.

Once again, Mr. Chair and members of the committee, I am extremely grateful for this opportunity to testify today. I sincerely believe that changes can be made to support our veterans in an honourable and respectful transition that could, I am convinced, avoid a descent into hell and a fatal act.

I will be pleased to answer your questions about my situation, and I gladly welcome your comments.

Thank you.

[*English*]

The Chair: Great. Thank you.

From the Mounted Police Professional Association of Canada, we have Sebastien Anderson, an employment, human rights, and labour lawyer; Rae Banwarie, president; and David Reichert. They also have a document to hand out, but unfortunately it is not translated. I would need consensus to hand this out, or we could get it translated and get it back to members at the next meeting.

Is there consensus to hand out the report in English only?

● (1550)

Ms. Irene Mathyssen (London—Fanshawe, NDP): I would prefer to make sure it's translated in respect to those who have French as—

The Chair: So you don't want to hand it out today?

Ms. Irene Mathyssen: No. I would prefer the translation.

The Chair: Okay. Thank you.

With that, we will turn the floor over to you for your 10 minutes. Thank you.

Mr. Rae Banwarie (President, Mounted Police Professional Association of Canada): Thank you, Chair and committee members, for allowing us to be here to present with regard to a very important topic.

My name is Rae Banwarie. I'm the national president of the Mounted Police Professional Association. We are the group trying to organize and unionize the RCMP. We have with us Mr. Sebastien Anderson, a lawyer who represents a lot of our members in a lot of the cases involving mental health and the fallout. Also with me is Dave Reichert, a retired member who is helping a lot of our members in the transition from currently serving to being retired. As the committee knows, all of our members are veterans who are done with the force.

I've given the clerk copies of my presentation, which has our brief as well as a couple of attachments. One is on an investigation that was done by the Privacy Commissioner of Canada regarding a mental health issue and case. It was very significant. There is also the letter from Blue Cross that was sent to all of our members specifically on health care and the parameters under which our people can get help from it.

Our presentation focuses primarily on four main points: lack of consultation by the RCMP with employees and employee organizations when drafting the mental health strategy that's currently in place; access to Veterans Affairs' occupational stress injuries clinics, which is also regulated by the RCMP health services officer; health services given to our members, which are contingent on the release of members' medical information; and the employer-employee relationship between the RCMP and its psychologists and doctors, which is very problematic.

I'll begin with the mental health strategy—MHS, as it's called—and highlight just a few of the issues.

This process was initiated in 2014 and is a step in the right direction, as it recognizes the importance of mental health for RCMP officers. What is stated in this strategy appears to ensure that the members have the appropriate mental health care necessary to meet the significant demands of police work. However, when you dig deeper into the strategy, you realize that this program was created primarily with the input of sub-group professionals within the organization under contract to the RCMP, unlike the case for other police agencies, such as the city police in Ottawa or Victoria, whose associations' independent bodies are part of these processes.

The RCMP used its own doctors and psychologists from its approved lists, along with the return-to-work coordinators. In all of these situations, right now, in every division across the country, the client of these doctors, physicians, and psychologists is the RCMP. It's not the member; it never has been the member. These groups take their direction from their employer and answer to the RCMP, not to the members whom they're supposed to be assisting.

How much substantial input was sought from the national membership regarding the design and development of this program? Shouldn't our members and their families, the people who would utilize the process and resources, be at the front, as they are the focus of the program? In reality, very little of this was done.

What about our association, which has been advocating for and representing members since 1994? We've had very little, if any, input into this process. We have had little or no input into these processes although we have been the members on the front lines helping and providing physical and emotional support for hundreds of members suffering from the myriad issues occurring in the RCMP, including harassment, bullying, intimidation, PTSD, depression, anxiety, and addictions.

Along with many of the other national officers, I have been providing emotional and physical support for these members and their families on a national scale. The primary thing for a lot of our members—even those going into retirement, at which point Veterans Affairs takes over from our employer-controlled program for currently serving members—is that our people trust us. Right now, as far as a lot of our members are concerned, there's no trust in the employer, especially on the medical side. Sadly, we've lost many good people to suicide. My brief references a study on occupational health and safety that says we have had more than 31 suicides of current and retired RCMP members since 2006. That's a significant number, and that's once they started counting. How many were there before? We don't know.

● (1555)

If our organization were truly committed to the mental health of our people, they would embrace any and all support from any mechanism, including us, to help. I was the one who reached out to our CO, or commanding officer, in the biggest division, E division, and offered assistance in an unofficial capacity to help with outstanding grievance and harassment complaints, usually the precursors that can snowball into worse and worse situations—PTSD, anxiety, OSI, all kinds of issues.

To his credit, he did accept the offer, but this is off the corner of our desk and never in a full-time capacity. Since we have been engaged in this work, we're batting at least a 90% success rate. A lot of it comes down to the fact that we're independent and the members trust us. We need to be able to move on this full time to reduce the harm and reduce all of the issues that are happening in our organization.

I have shared with this committee just a brief overview of one of the points contained in the brief. When the brief is translated and you have it, please take the time to go over it in more detail. We're prepared, and I'm prepared, to present more information to the committee at any time.

I will turn the presentation over now to Dave Reichert, from the Retired Members Alliance. As a retired member, he can talk to the issues from that side of the house.

Thank you.

Mr. David Reichert (Officer, Retired Members Alliance, Mounted Police Professional Association of Canada): Thank you.

My name is Dave Reichert. I spent 35 years in the RCMP and I've been retired now for the last two years.

The RCMP is a large organization, which has grown and evolved to the point where the needs of management have minimized the needs and health of its members. An RCMP officer who declares they have health problems, PTSD, or other ailments is stigmatized and soon develops into a person who is ostracized by others within the organization. He or she begins to seek support to overcome these issues and related stigma.

The RCMP becomes the client, and the member participates helplessly under its direction. It is the RCMP health service that decides which medical doctors, psychologists, and other specialists are approved. These doctors participate with the affected member, while agreeing to follow the rules and direction of RCMP management. They accept this knowing that they will receive other referrals and become the doctor of choice.

This control by the RCMP has escalated to the point where doctors are told what to do, what the desired outcomes are, what they can say about the treatments, and how the treatments are done. In some cases, the member never knows what is happening.

The RCMP uses bullying tactics, including having officers attend physicians' offices and tell the doctors what to do. They have letters of conduct forwarded to the college of specialists to complain about the actions of the doctors, and they outright refuse doctors and access by members to those doctors. RCMP health services has had its own doctors tell the doctors paid by the force to return people to work without doing any consultation whatsoever with the members.

Trust of the RCMP management is quickly waning. Personal health information is often shared by others. The RCMP has removed doctors from RCMP patients and has failed to follow up to ensure their safety and their health. It has done this without their knowledge and while knowing that some of the people they removed the doctors from were suicidal. Again, there was no follow-up, no phone call, no referral to any doctor. They just left them alone.

The privacy breach that occurred across Canada, mainly in British Columbia, involved the RCMP taking the files of members under the care of a particular psychologist and forwarding them to the college of physicians and sharing them with the membership. The privacy breach was that the information was shared when all the names and everything else remained in the files.

Grievances pertaining to this breach were not replied to by the RCMP. We sent in numerous letters and gave them numerous opportunities to deal with this. I was involved with this particular case, and I gave them every opportunity for change. All I wanted was change. I was forced to go through the court process. I paid for the lawyer myself out of my own money, while the force, or members who were involved or implicated in this, went and used the public purse for their defence and for the actual action. Basically, it's very expensive and it's very cumbersome to deal with.

The RCMP preaches about its core values of honesty, integrity, compassion, accountability, and professionalism on a regular basis, but once a member sees these values violated and sees the outright disregard for the health of the members, the member becomes and feels very isolated.

Accountablility for that breach of trust and privacy was perhaps best demonstrated in a recent court decision that awarded $100 million to the abused female members of the RCMP. This was a great decision, but on one side it wasn't. In that decision, nobody was held accountable. Not one change was required to be made by the force, and no one was held accountable. Again, the $100 million didn't come out of the RCMP budget; it came out of the public purse. That made it very, very difficult for members to swallow that.

Several members are now removing themselves from the process of helping members, citing that it is becoming too political or too much work. The delayed-payment structure in the force is also causing problems.

● (1600)

The Chair: Thank you.

Next we have Veterans Emergency Transition Services and Debbie Lowther, the co-founder.

Mr. David Reichert: If I may just interrupt, Sebastien Anderson was to speak.

The Chair: Okay.

I guess we do have a few minutes. Sebastien, I didn't get your address. Do you have just a couple of minutes?

Mr. Sebastien Anderson (Employment, Human Rights and Labour Lawyer, Mounted Police Professional Association of Canada): I do.

The Chair: Do I have permission? We're okay with that? Seeing that, go ahead, and then we'll come back. Thank you.

Mr. Sebastien Anderson: Thank you very much.

Mr. Chairman and members of the committee, thank you for the opportunity to appear before the committee today. It's my privilege to appear today to give voice to those RCMP members suffering from mental disabilities who are reluctant to speak for themselves publicly as a result of the risk of the stigma associated with mental illness and for fear of repercussions.

There is no meaningful mental health strategy within the RCMP. As a result of the amendments to the RCMP Act sought by the RCMP commissioner, the implementation by the Conservative government of the enhancement to the RCMP Act accountability, and section 6 of the commissioner's standing orders, RCMP members with a physical or mental disability, such as post-traumatic stress disorder, are being medically discharged with no meaningful attempt to accommodate their respective disabilities. In reality, the RCMP's mental health strategy is nothing more than meaningless platitudes.

Rather than fulfilling their legal duty to accommodate disabled RCMP members by attempting to relocate or retrain them, the RCMP's health services officers have engaged in a widespread campaign throughout the force to declare them totally disabled from performing any RCMP work, resulting in medical discharge.

Consequently, too many disabled RCMP members to count are finding themselves summarily discharged to the scrap heap of humanity by the force. The RCMP's conduct with respect to disabled RCMP members is unconscionable. The RCMP's harsh conduct not only aggravates any underlying mental health issues for disabled RCMP members but can also lead to suicide.

I point out in my speaking notes that the vocational rehab services that are typically available to members of the Armed Forces are not available to RCMP members, and there's no explanation for that other than the RCMP opting not to engage those services for their members.

I've cited in my speaking notes and in the appendices two case studies. I won't go into them now, but they will illustrate two of our current cases that we have undertaken on behalf of individual RCMP members, and they're illustrative of cases that we've handled on behalf of RCMP members across Canada. We're a virtual law office operating out of Coquitlam. We represent RCMP members in every province of Canada except Quebec, and it's against that background that I make these statements.

Unlike the Canadian Armed Forces or the provincial workers' compensation regimes, the RCMP does not have a vocational rehabilitation program. However, a vocational rehabilitation program is absolutely necessary to accommodate sworn RCMP members suffering from a properly diagnosed mental or physical disability such as PTSD, either to another meaningful law enforcement role or to alternative employment as a civilian employee, so that they can continue to contribute as valuable members of society at work, at home, and in the community. A vocational rehabilitation program should include benefits such as career transition services, relocation, and retraining, including priority hiring within the federal public service.

Vocational rehabilitation benefits and programs ought to be available to current and former RCMP members prior to the RCMP initiating a medical discharge, similar to the vocational rehabilitation benefits and programs available through the various workers' compensation regimes available to municipal and provincial police officers and most other employees in the federal, provincial, and private sectors.

Those are my comments.

● (1605)

The Chair: Thank you.

Now we will hear from the Veterans Emergency Transition Service and Debbie Lowther.

Ms. Debbie Lowther (Co-founder, Veterans Emergency Transition Services): Good afternoon, Mr. Chairman and committee members.

It's my pleasure to be here before you today. My name is Debbie Lowther, and I am the chair and co-founder of Veterans Emergency Transition Services, VETS Canada, but I'm also the spouse of a veteran of the Canadian Armed Forces, a man who served this country proudly for 15 years until his career was cut short due to injuries, both physical and psychological. He was diagnosed with post-traumatic stress disorder in 2002 and was released in 2005. We founded VETS Canada together in 2010.

VETS Canada is an organization dedicated to assisting veterans who are homeless, at risk of becoming homeless, or are in crisis. To date we've assisted over 1,400 veterans across the country; the vast majority of those veterans have struggled with mental health issues, some diagnosed and some not yet diagnosed. While some of our volunteers have health care backgrounds, we as a whole are not a health care organization, and we are not researchers. We are simply a group of over 500 volunteers who work closely with these veterans who, for one reason or another, have found themselves in crisis.

To that end, I'd like to share some of our observations with you as they relate to mental health and suicide prevention. I would also like to point out that the majority of our volunteer base is made up of still-serving members and veterans of the Canadian Armed Forces and RCMP, as well as their family members. Many of these volunteers have also dealt with or are still dealing with mental health issues. These common bonds of military service and mental health struggles lend themselves to wonderful peer support, which we have learned is a key component in the successful transition from both military life to civilian life and from a life of crisis to a stable life.

As I said earlier, the majority of the veterans we serve are struggling with poor mental health. Many end up on the street due to lack of medical attention for their mental illness. This lack of medical attention seems to occur either because the member or the veteran did not seek help or because the help they received was insufficient: there are long wait times to see mental health care practitioners, and there is difficulty finding mental health care providers who have experience and knowledge in dealing with PTSD.

The veterans community has been asking for quite some time for a veteran-specific treatment facility. Veterans can go to Homewood and they can go to Bellwood, and we've had veterans go through those programs successfully, so I'm not criticizing them. These facilities depend heavily on group therapy, which is great if the group has some common ground, aside from the fact that they all have mental illnesses.

To give you an example, I'd like to relay what a veteran who had been to Homewood explained to me. This veteran had deployed twice, once to Bosnia and once to Afghanistan, and had witnessed horrific things. While at Homewood he was participating in group therapy, and what he said to me was this: “How am I going to talk about finding mass graves in bloody combat when the girl next to me is talking about her mummy-and-daddy issues?” He certainly was not intending to diminish the importance of her issues; rather, he was more concerned about putting the thoughts and visions that he had in his own mind into someone else's.

I know this to be a common concern for veterans suffering from PTSD. My own husband was very reluctant to open up in the beginning of his treatment for PTSD for fear of transferring his torment into the mind of the psychologist that he was seeing at the time. A treatment centre specifically for veterans would most definitely be more effective, as we know that veterans will be more open to treatment if they are surrounded by their peers, people who understand them.

We're seeing that men and women who wear the uniform are often forced to take it off before they're ready, both mentally and financially. We've been hearing for a long time about closing the seam, but it still isn't closed. These situations are what could be referred to as a domino effect. In the cases of medical releases, the member is dealing with an injury, either physical or mental, so there is stress number one. They're losing their career, their sense of purpose, and their support system, so there's stress number two. They're waiting unacceptable amounts of time for their pensions and benefits to kick in, their savings are being depleted, and their credit cards are being maxed out; there's stress number three. We all know that financial issues often lead to marital breakdown, or at least marital discord; there's stress number four.

Imagine dealing with all of this while struggling with mental health issues such as PTSD, depression, or anxiety. All these stresses tend to intensify one another, and they affect coping abilities. Mental health is impacted by each of those factors of job loss, financial hardship, and marital or familial breakdown. I think even a person who doesn't have mental health issues would have a hard time dealing with this domino effect of one stressful situation after another.

● (1610)

I would also like to point out that the member isn't just losing a job or a career: serving in the military is a way of life, a culture all its own, and it is the member's identity. If you were to ask my husband which branch of the military he was in, he wouldn't tell you that he was in the army. He would say, “I was army.”

Our men and women who join the military go through basic training to learn this new culture or way of life. They're stripped down and turned into soldiers. Perhaps at the end of their career there should be an exit boot camp to teach that soldier, sailor, airman, or airwoman how to be a civilian.

Another thing that would be helpful would be to have the releasing member assigned a peer, someone who has already gone through the process, to provide them with support. As I mentioned earlier, we know that peer support is a crucial piece in a successful transition.

I'd like to go back to the medical release process for a minute, as it relates back to that seam that remains unclosed.

When a member is released from the military due to an injury—a physical or mental injury sustained as a result of service—that has been diagnosed by a Canadian Armed Forces medical officer, the member has to deal with a new department, Veterans Affairs Canada. You would think that they would accept the diagnosis of the Canadian Armed Forces medical officer, but no, that is not the case. They then have to be evaluated by a Veterans Affairs-approved physician. That physician may not agree with the diagnosis of the Canadian Armed Forces medical officer, so then what? Based on this new physician's opinion, the member does not receive a disability award—more financial stress. They can appeal the decision—more mental stress.

I know that this is not news to any of you. You've heard it all before. In fact, I brought it up myself the last time I was here. This process is a bureaucratic waste of time and money, but most importantly, it causes undue stress to the injured member.

In closing, I will mention suicide prevention. I don't think there's a concrete method of prevention, but I do think that we can put things in place to reduce the number of suicides. The first would be to keep the member in until things are lined up for them to transition seamlessly from DND to VAC. Maybe there needs to be a transition case manager who ensures that all paperwork is completed properly and who also ensures that the paperwork is not lost, as this seems to be a common problem. This process should include applications for benefits through VAC and SISIP before the member is released. A strong peer support network would also be very beneficial in suicide prevention. This would also include the veteran's specific treatment program.

Thank you again for the opportunity to speak with you today.

The Chair: Thank you.

We'll start our first round of questioning with Ms. Wagantall.

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

Thanks to all of you for coming today and for what we again get to hear.

Debbie, you are correct: we have heard many of these things many, many times. In all honesty, if I look back to previous committees, they have been heard many, many times. There's trouble pulling the trigger, it would appear.

The things you suggest are simple in many ways, and so clear and specific, and I'm pleased to say that a lot of them are in our report. However, the challenge, of course, is to see them actually happen and close that seam, which I truly believe everybody in this room really wants to see. The more that I have the opportunity to be here.... I mean, having been in business, I'd like to fire everybody and start over sometimes, quite honestly, but that's enough of my ranting.

Voices: Oh, oh!

Mrs. Cathay Wagantall: Hélène, I'd like it if you could talk a bit more about the process of deconstruction, because this is something I brought up right near the beginning.

We know what goes into creating our soldiers. I just spoke with the parents of Patrick Rushowick from my riding. He committed suicide. You're right: they didn't have a clue as to what his life was about. I know that information isn't shared with their families, with people who possibly.... When you talk about a deconstruction program, can you envision a bit more of what that would look like? That's also for anyone else who would like to share.

● (1615)

[*Translation*]

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

De-training means taking the time, whether in cooperation with the Canadian Armed Forces or with Veterans Affairs Canada, to go through a training phase where you learn to calmly let go of the military identity.

As I said previously, this involves reconnecting with our own values and letting go of the ones instilled in us throughout our careers. We need to take time to sit down with professionals, psychotherapists, social workers. We need to reconnect with who we are as individuals. We also need to establish our own needs. Personally, just last September, I couldn't have said what my own needs really were because I had always thought in terms of who was to my left and to my right. It's what we do as soldiers; we keep an eye on each other and work as a team.

The de-training of soldiers should include the psychosocial aspect. It would allow them to dig in order to find their own identities. Nothing is available for that currently. I think it would be important, as Ms. Lowther was saying, that there be a kind of exit boot camp or something like that where people could take time together to move onto something different.

[*English*]

Mrs. Cathay Wagantall: Would anyone else like to add to that?

Ms. Debbie Lowther: I would like to say that I agree 100%. When our men and women join the military, they are basically just out of childhood. They join at 17, 18, and 19, and they have no idea who they are. Then they're turned into a soldier, a sailor, an airman, and at the end of that, they're not that anymore and they don't know who they are, so I think it is important.

I don't know what that boot camp would look like, but I think it would involve some psychological counselling, some educational counselling, and even some life coaches.

Mr. David Reichert: I think from the RCMP perspective, we don't really have anybody to go to. We have no association other than MPPAC, which is not our approved section yet. We can't go to the force and we can't go to the doctor, so we're kind of left on our own. They send us in the direction of filing grievances. Well, we file grievances, and the earliest, in some cases, that you're going to get first resolution is five years after the fact. You can have grievances when you retire, but again, you have no one to go to. Some of the grievances have been going on for over 12 years, and they're still not resolved. There is no one to go to to deal with those unless you get a lawyer.

I am aware of three members. One in particular has been sitting at home waiting for a decision on a grievance, at full pay, for 16 years. I know another member in Langley who has been sitting at home waiting for a decision on a grievance, with no medical problems or anything like that, while receiving full pay for 10 years. The last one is a staff sergeant out of headquarters in E division, which is British Columbia, and he's been sitting at home with no decision or anything else for five years.

These people are all willing to go back to work and they have no mental problems, but now they're starting to get them. I think it's very important that we have some sort of process through which we can de-escalate and have answers to some of our questions before we retire. Right now, when you retire from the RCMP, you basically sign the paper and you're gone.

I'm well aware that in the NHL they actually have a de-escalation type of debriefing and they teach the people in the NHL how to come back to normal life. That's part of the process in order to save lives and to get these people back into society. There's nothing in the RCMP. We have no oversight committee and no one to take that next step for us. It's very important for someone to help us. We have no one to go to, and that's why guys look to suicide. It's because they feel very lonely. Even as retired members, we have no one to go to.

● (1620)

Mrs. Cathay Wagantall: I appreciate what you're saying, so can I ask a question? Just very briefly, it sounds to me as though the suicide issue grows over time because of the circumstances of discharging—not due to serving, but to discharging. Do you see that as a key element of the issues with suicide?

[*Translation*]

Ms. Hélène Le Scelleur: I think that the entire process only aggravates the situation. When we are isolated, alone, and no one is there to guide us, to help us, the feeling of rejection grows.

I was talking before about de-train. Being able to experience a form of grief, but in a group, might help avoid these kinds of situation that can lead to suicide. If we are isolated, lose this form of identity and brotherhood, and have to rebuild who we are, we no longer have benchmarks. We have nothing anymore. So it's easy to move toward suicidal thoughts.

The men I speak to often say that the woman is at home and will take care of the children. The man, in many cases, gives up. The mother tends to stay. That's one thing to consider.

Thank you.

[*English*]

The Chair: Thank you.

Ms. Lockhart is next.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you.

Thank you to all of you for appearing today.

Ms. Lowther, thank you for coming back to see us again. I understand that you participated with the Mental Health Commission of Canada when they were customizing their mental health first aid program for veterans. That's something we haven't heard about before, so I'm wondering if you could tell us a bit about that and about the actions associated with it.

Ms. Debbie Lowther: Veterans Affairs contracted the Mental Health Commission of Canada to adapt their mental health first aid program for the veterans community. It's geared toward people like our volunteers, who deal with veterans who may be struggling with mental health issues. A group of about 10 of us met a couple of times to go through the basic mental health first aid handbook and make recommendations on how to adapt certain aspects of that program as they pertained to veterans.

The most specific piece, obviously, was the section regarding PTSD. We did a lot of elaboration on that. We also talked about the instructors for that course. We basically decided that instructors for that course preferably should be veterans themselves. It all comes back to the peer support, to the social support thing. We felt that because the military was such a unique culture, the instructors needed to have that background.

I know that the program is up and running now. It's been offered in a couple of cities across the country, and so far we're hearing good things about it.

Mrs. Alaina Lockhart: Where it is being offered? Who is administering it? Who is offering it?

Ms. Debbie Lowther: The Mental Health Commission of Canada is offering it. In most places across the country, it's being offered at the MFRCs, or basically wherever there's a location available. That was another thing we talked about in the adaptation process—where to hold this mental health first aid program. We know that a lot of veterans don't like to go back on base. Some suggested having it somewhere on base, that kind of thing, but we know that a lot of veterans, once they leave, don't want to go back on base. That was another recommendation we had: be very careful in choosing the locations for the courses offered.

● (1625)

Mrs. Alaina Lockhart: Thank you. That's very helpful, especially as we know that the government has recently announced a specific investment in mental health across Canada. Perhaps that's an area that can be expanded upon in communities across Canada.

I also wanted to ask you about rural areas. What have you found in terms of delivering services through the VETS program in rural areas? What are the challenges?

Ms. Debbie Lowther: The challenge in rural areas for us is that, first of all, we don't have a large volunteer base there. There's also a lack of resources. There's the challenge that veterans who live in rural areas also have to travel a fair distance to access the services they may require.

It's challenging, but when we need somebody in those areas, if we don't have somebody, we can kind of reach out and do a lot of networking and make sure that we do have somebody close by who can help out. We also work very closely with Veterans Affairs case managers to almost remotely guide that veteran through whatever their crisis may be at that time.

Mrs. Alaina Lockhart: When I had the opportunity to go out with the Boots on the Ground crew in Fredericton, we talked about how they were travelling too. That group has travelled into some of the outside areas when called upon to do so.

Ms. Debbie Lowther: Yes, and they do. Our volunteers are very good. They will travel up to a certain distance. One of the questions we ask them when they go through the screening process is whether or not they're willing to travel to assist a veteran.

Mrs. Alaina Lockhart: Thank you.

Ms. Le Scelleur, I know that when you were working on your Ph. D., obviously you were doing research, but I have a question about the amount of research that's already out there. Did you find that there was a substantial amount of research specific to mental health with the military, or is that an area where we need to be focused as well?

[*Translation*]

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

As I mentioned previously, in the literature I've reviewed, there is a great deal of medical research on post-traumatic stress disorder and on vocational transition. However, interpersonal relationships and the psychosocial aspect are still rarely addressed in the Canadian literature. There is a little more information on this in the literature from our allied countries, but once again, the same question remains on psychosocial, identity and interpersonal issues.

[*English*]

Mrs. Alaina Lockhart: Thank you.

I think it's interesting that you both brought that up in your testimony. We have actually heard that in our other study as well, that the transition and the identity piece are so important, so I thank you for bringing that to us again in this context of mental health and the triggers that happen through that transition process.

Thank you.

The Chair: Ms. Mathyssen, go ahead.

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

Thank you for being here. You put a lens on some of the things we've heard and you've helped us to understand better, and I am very grateful for that.

I have a number of questions. I'll start with Madame Lowther and Madame Le Scelleur.

You talked about the exit boot camp. It's very clear from your description that a very young person, sometimes an adolescent, goes in, and they become an adult in the military. They never became an adult in civilian life. You've both obviously identified something significant here. Have you given thought to what that exit boot camp would look like? What kind of services should be provided so that this human being can refine that adult identity?

[*Translation*]

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

I enlisted when I was 17. When I left military life last year, at age 43, I had no idea how I could be an adult in civilian life. As mentioned earlier, support groups could be created. I would say that this goes even beyond support groups. I would include learning how to make a budget, to find a doctor and to take the time to discuss returning uniforms.

We receive our service pin at the end of our career. Why wouldn't we have a ceremony in front of family and friends, like a graduation? Why not have one last parade to mark our service? We could receive our pin then, in front of family and friends.

All service members who retire or are injured could take small steps like this, together, the same as when they started their career.

Thank you.

● (1630)

[*English*]

Ms. Debbie Lowther: I agree with that. We see a lot of veterans who, as you said, become adults in the military, and when they get out, they really have no idea how to function in society, how to do things like paying bills or things like, as my colleague here mentioned, going to the doctor, finding a doctor. We had one veteran tell us that when he was still serving, he was always told when he had a medical appointment or a dentist's appointment. Once he got out, he didn't have a person reminding him all the time. A member who deploys often counts on the spouse at home to look after everything, so once that's over, they need some coaching in basic day-to-day living.

Ms. Irene Mathyssen: You mean life skills.

Ms. Debbie Lowther: It's life skills, yes.

Ms. Irene Mathyssen: Thank you very much.

To the representatives from the RCMP, I heard two things. The first was that someone who is injured and diagnosed is treated by RCMP doctors who are told by the RCMP establishment what treatment should happen, etc., without consultation with the individual who is receiving the treatment. I was quite astonished by that. How can that that happen? How can that very basic, very personal thing be taken away from the individual? It seems to me that this would make getting better extremely difficult. Your whole sense of self or self-determination has been removed.

Then there's the opposite: being told by others that you have to go back to work when you may not be ready, when you haven't had any input into that, and the opportunity for rehabilitation is taken away entirely. It seems that those two things are happening at the same time.

In addition to that, I wonder what kinds of opportunities there are if vocational rehabilitation is provided in a meaningful way. What opportunities would exist for the individual?

Mr. Sebastien Anderson: Thank you very much for your question.

In practice, if an RCMP member is required to see a psychologist outside of the Blue Cross program that's offered, their only choice is to select one of the psychologists that the RCMP has on its list as an approved service provider. They have to go to that approved service provider. Service providers are allotted 10 counselling hours at a time, and in order to get another slate of 10 hours, they have to submit detailed briefing notes that include the diagnosis and what was talked about in counselling. All of that is disclosed to the health services office by the service provider. If that information isn't provided, and if the member refuses to allow the psychologist to disclose that information, then the service is cut off. They're cut off treatment. That happened in the two cases that I cited in the case study.

The first one was a member dealing with PTSD. He was on a graduated return-to-work program that was approved by the RCMP. His health care provider, a psychologist, was approved by the RCMP and the member. The RCMP dropped the ball at every step of the graduated return-to-work program, starting with the security clearance that took several months to complete. They put him through the long form that a new employee has to complete, rather than the short form. Next they provided him with a laptop, but to this day, the laptop doesn't have a functional battery; it has to be plugged in. It took three months for the security key to be provided to him. When all of those things were in place, they failed to provide him with any meaningful RCMP work to perform during the graduated return-to-work program.

A line manager then directed him to report to work, in violation of the graduated return-to-work program, and he would have faced discipline if he failed to do that. Ultimately, three years ago, the RCMP cancelled its funding for the treatment being provided by the psychologist. The member remains on sick leave.

● (1635)

The Chair: Thank you.

Mr. Eyolfson is next.

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

Thank you all for coming.

Ms. Le Scelleur, you said that once the diagnosis of PTSD is made, basically the member is steadily set aside. Would you say, in your opinion, that the requirement for universality of service contributes to this?

[*Translation*]

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

That is absolutely the case.

The criteria are different and depend on whether the person is physically or psychologically injured. As for weapon handling and deployments, the same criteria do not apply to members of the Canadian Armed Forces who are physically injured. If I may say so, there is greater tolerance for physically injured people than for people who have been injured psychologically. However, when they leave the forces, they often pick up weapons and become shooting instructors, among other things. But, according to the system, weapons cannot be used once someone has been diagnosed with a psychological injury.

Basically, this legislation identifies many obstacles, and it should be adapted.

Thank you.

[*English*]

Mr. Doug Eyolfson: All right. Thank you.

Now, with regard to the RCMP, I find this very close to my heart. My dad was a 25-year veteran of the RCMP, so some of the issues that you talk about sound very familiar to me.

When someone is on medical leave or a diagnosis has been made, does the RCMP have the equivalent of universality of service that the military has?

Mr. Sebastien Anderson: No.

Mr. Doug Eyolfson: Okay.

Can someone have restricted duties but still be a member of the RCMP? Let's say they have a physical injury that prevents walking for long distances and they would be better at a desk and that sort of thing.

Mr. David Reichert: I find it very strange what the RCMP does. If you get into a car accident, they send out an investigator, they send out an analyst, and they take measurements and photos. They take statements from everybody involved and they find out what the cause of that accident was.

If you're involved in a shooting or you're involved in any use of force, they create an investigation. They do it. They do everything possible to come to a resolution and see if the person needs more training or what they can do to deal with the situation.

When it comes to workplace injuries involving PTSD and everything else, there's no investigation. All that happens is you come into the office and they tell you you're going to see a psychologist by policy, and that's the end of it. A number of times what they do is send you to your doctor, and he sends you back to work in the same environment that you were having issues with.

There's a very common factor here that when you speak to lawyers, doctors, psychologists, and treating physicians, the same names of people involved in these issues keep coming up, and unless you know what the problem is, how do you treat? You can't send the same person back to the same environment unless there's change, and the responsibility lies not only with the employer but also with the employee. They have to work together to resolve the issue, but right now it's all on the employee, and it's very difficult for that employee to return to that environment.

● (1640)

Mr. Doug Eyolfson: All right.

Have there been any initiatives in the RCMP to address the kinds of situations or procedures that bring about PTSD? Has anyone said that when occurrence *x* happens, they have a higher incidence of PTSD? Can we review how this is dealt with when officers have to face situation *x*? Has anything like that been done in the RCMP?

Mr. David Reichert: Not that I'm aware of, and I deal with a lot of members. Even though I'm retired, I have them phoning me up at night when they're having problems, and there's that gap. The idea is if you have a mental problem or you're having a problem, go see a doctor. We now kind of wash it away. We're not dealing with you. It just becomes no resolve, and it doesn't help the patient. It doesn't help anybody.

I'm not aware of any direction like that.

Mr. Rae Banwarie: Part of that issue, and it's a big piece, stems from trust, as I mentioned in my presentation. You're seen as one member, and—probably parallel to the military—if something happens, you become the weak link. You're seen now as the weak person, and that in itself has all kinds of repercussions, especially for front-line police work, where you're supposed to be the guy or gal to go out in public and be in control, take charge, and have the ability to make decisions and have a back-up plan. If you can't, because of whatever issues you're facing, you're the weak link now. You're no good, so we'll put you somewhere else where you're not in the limelight, which undermines and exacerbates the situation. It makes it even worse.

You don't trust the employer and the health care process because, if you report it, it gets worse. You're not seen, or there's no process in place to help you get past that effectively. You're just in a cycle until you either leave or you get to the point where you can't work and they medically discharge you, and then there's the whole other side of that, because now your situation is even worse. You're more isolated.

Then there's the spinoff of that with your wife, family, relationships, and all of that.

Mr. Doug Eyolfson: Thank you.

The Chair: Mr. Fraser is next.

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

Thank you all very much for being here today, for sharing your stories, and also for your service to Canada.

Ms. Lowther, I will start with you. I believe that your organization was started in 2010 and since that time has assisted a thousand homeless veterans in getting off the street. Your organization is very much to be commended for that good work and for your continued efforts.

With regard to that progress, as an organization, have you seen the incidence of homelessness on the decline? Are there more supports in place? Have improvements been made, and if so, can you tell us about them?

Ms. Debbie Lowther: We certainly haven't seen the numbers decline. If anything, we're seeing more, but I think that might be due to the fact that we have more and more volunteers out in the streets looking.

I think improvements have been made. I know the department has assigned a case manager in each district specifically to be the homeless point of contact who will oversee issues of veteran homelessness. I think that's a positive step.

The fact that the department awarded us a contract in itself I think speaks to the fact that they've recognized there is an issue. When we started in 2010, we went to Veterans Affairs in Halifax, and the case manager we talked to said there were no homeless veterans because they had brochures printed up and took them to the shelters and nobody called them. Therefore, there were no homeless veterans. We had already found three in Halifax at that point.

That was 2010. Fast-forward to 2014, and we are awarded a contract in the field of veterans homelessness outreach. I think that speaks to some progress being made. Then there's the fact that the department is willing to work more and more with community organizations like ours. Like the shelters, they're getting more involved and more interested, and I think they're taking the issue more seriously. I think improvements have been made.

● (1645)

Mr. Colin Fraser: Thank you.

One of the things that I think you've indicated in previous discussions is that training for caregivers is important to ensure that they have the resources and tools they need to help their spouse or partner or family member. Have you seen improvements in that regard with training for caregivers, and if so, can you tell us what they are? If not, does your organization help in that department as well?

Ms. Debbie Lowther: I'm not aware of any kind of training, so to speak. I know discussions are under way, so again, I think that issue is being recognized, and it definitely is important.

I can speak from my own experience. When my husband was struggling with PTSD, I never knew if what I was doing was helpful or harmful. I'm not an educated caregiver, and most spouses aren't. I think it would be very important to have that training.

We aren't really in a position to offer that kind of training or that kind of counselling to spouses who are in a caregiving role, other than, again, peer support. As I mentioned, the majority of our volunteers are still serving members or veterans, or they're family members, so if we have a situation in which the caregiver seems to be the person who's struggling, then we will try to have one of our military spouses team up and offer some peer support.

Mr. Colin Fraser: You mentioned in your opening comments that perhaps upon being released, a member should be assigned peer support. Is that for every releasing member, do you think, or for those who perhaps have already identified mental issues?

Ms. Debbie Lowther: I think it would probably be beneficial for everyone, and then it would be determined if it needed to continue. I look at that as almost like an Alcoholics Anonymous sponsor, if I could use that comparison. That's what I'm thinking of when I talk about having a peer assigned. It's somebody to guide that member through the process, somebody just to talk to or go and have coffee with.

Mr. Colin Fraser: Thank you very much.

Mr. Anderson, if I could turn to you, Ms. Lowther touched on the importance of having training for caregivers. I wonder what your experience is with regard to family members being assisted or having access to counselling or support within the RCMP community. Could you touch on that, please?

Mr. Sebastien Anderson: Frankly, it's non-existent.

I often end up speaking with the spouses. They are often the first ones to contact the office when things aren't going well at home and the member, due to pride or personal embarrassment, hasn't shared the full story of what's happening at work with their spouse. Tensions increase at home. The spouse doesn't understand why. They contact our office, and we try and walk them through the process, but just as there is no support for the member, there is no support for the spouse either. It's a really bleak situation.

One of our clients, a female RCMP member, needed a transfer because she was no longer physically able to do the tasks of a constable on the beat. Her detachment commander told her there was no possible way she could get a transfer to headquarters or to another assignment because, and I quote, “I own you.” That's an indication of the mentality that exists within the RCMP. There is no meaningful accommodation in those circumstances. If the members aren't getting the support and go home with those kinds of stories, the spouses just don't understand and are left in just as much of a quandary. Then the whole family suffers.

The Chair: Thank you.

Go ahead, Mr. Kitchen.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair, and thank you all for being here today. It's nice and very helpful to have the RCMP providing a perspective within this conversation.

One of the things that I've said for quite a while, and I think we're hearing it here from all three organizations, is that we construct our soldiers and our RCMP officers, but we don't deconstruct them once they're done. How can we do it to make it successful such that we don't see issues build up as we have heard?

I appreciate your comments and I know my colleagues do as well, so I thank you.

Captain, your conversation touched on that quite a bit, and I appreciate that. As you see, I called you “Captain”. That comes from growing up in a military life. It's just out of respect.

With regard to having soldiers there to discuss the issues around mental health, training them in that aspect, and putting them into that role, how do you see that assisting soldiers as they make that transition?

● (1650)

[*Translation*]

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

I think it would be a good idea for service members who have left the Canadian Armed Forces to act as mentors or peer helpers to help people going through this transition.

When we talk about exit training, I also think it would be worthwhile to include families and children. It would be good to inform them about the situation, the mental health issues and how they can help. I think bringing families and soldiers together can help make this transition easier.

Have I answered your question?

[*English*]

Mr. Robert Kitchen: Yes, thank you very much. I appreciate that, very much so.

Gentlemen, I don't know to whom this should be addressed, so maybe I'll address it to whoever feels comfortable on this. I've had the privilege in my practice of having many friends and patients who were RCMP officers. I've watched them transition, and I've seen one or two that have had to deal with mental health issues as things went on.

You made a comment about OSI and the issues. It really was a very brief one. I'm wondering if you could expand on that experience and how your officers are dealing with that.

Perhaps Mr. Banwarie might be able to answer.

Mr. Rae Banwarie: Right now, you do have the ability through Veterans Affairs to go to an OSI clinic, depending on a diagnosis for whatever it may be, whether it's PTSD or anxiety and depression and that type of thing. From what I understand, the process has changed. Before now, you could get referred by just your GP. Now it has to be a referral from your doctor and health services through the RCMP. That is a huge issue for a lot of people.

Again I have to come back to the point on the trust issue. This is part of the whole problem: being seen as the weak link. The stigma is still there, and especially in our organization, for mental health. There are a lot of platitudes, a lot of paper, and a lot of documents, but when you start digging deeper to see how well it works, it's not working very well at all.

I've also been diagnosed with an OSI, and I know how hard it is and how that affects you in so many different ways. There are a lot of issues or problems, and I'm looking for the solutions as well, because I'm a very solution-driven individual. I look to see what else is happening. What's happening in the policing world with other agencies? A big part of it is that an independent body like the police association works collaboratively with the employer to address a lot of the falling-downs and shortcomings.

In terms of this change to needing to have the approval of the health services officer, a lot of the time it's just a commissioned officer who's working in conjunction with the doctors and psychologists who are paid by the force and who report to the force.

Let's give a practical example. You go in. You've been exposed to so much stuff. You're diagnosed with an occupational stress injury, whether it's PTSD or anxiety or depression or whatever it may be. The current process we have through Blue Cross gives you six hours to go and see any psychologist. After that, you have to apply to get the okay from health services to be able to continue getting treatment.

In my brief, you'll see an actual letter that was sent to every single member from Blue Cross, and I must share this with you, because it's pretty significant. It says that when you use the program, the "legislative and regulatory authorities to collect, use, and disclose your personal information is contained in" the new act that my colleague Mr. Anderson spoke about. It states, "By using this card, you are authorizing the RCMP, Medavie Blue Cross, its agents and service providers to collect, use, and disclose information about you for the purpose of RCMP Supplemental and Occupational Health Care benefits...." The only way you can get this is if you agree to share your information.

I also have in the brief the letter that I wrote to the privacy officer at Blue Cross asking who these agents are. Who are these other people? In any situation, the privacy.... It would be no different from you going to see your doctor and then finding out after you've seen your doctor that your employer knows everything about you and everything about your situation. Right away, the red flags go up. That's just the way it is for the members who call us and who reach out to us. That's just the simplest piece, the starting point.

● (1655)

The Chair: Thank you.

I want to ask a clarifying question. On the Blue Cross, do you have a turndown rate for separate applications? You say they're only allowed so many chances.

Mr. Rae Banwarie: I don't have that statistic to tell you how many have been disallowed in terms of getting more care.

The Chair: Okay. If you could get that data and get it back to us, please, it would also help us.

Mr. Rae Banwarie: Okay.

The Chair: Mr. Fraser, you're splitting your time, I guess?

Mr. Colin Fraser: Yes.

I have a question for you, David, if it's okay.

I found it disturbing when you mentioned how the set-up goes for getting a doctor, in that it's basically the RCMP who is the client and the member is left out of the loop, so to speak, in making that connection. That's if I correctly understood what you said.

Mr. David Reichert: That's correct. Once the force gets involved, they become the client. They direct and they pay the fees, so the doctor is obligated to pay back to them. They take your information and forward it back, and it goes back to your medical file. The issue with that—

Mr. Colin Fraser: Just so I understand, is this a physician you're talking about, or a mental health provider, or any kind of...?

Mr. David Reichert: I'm talking about any physician.

Mr. Colin Fraser: Okay. You referred to the college. Do you mean the College of Physicians and Surgeons? Have there been incidents of a complaint being made that this was not in keeping with the professional responsibilities of the physician?

Mr. David Reichert: What they tried to do was control a doctor. The doctor had come to them and said that the issue of problems with PTSD and the anxiety disorders and everything else was not really with the members; they were okay. The issue was the workplace. The workplace was sick and needed some help.

The force was not happy with that reply, so they went after this doctor, Dr. Michael Webster. They gathered all the members' information, started doing all kinds of different things on collecting that information, and ended up taking the members' personal files and forwarding them to the college and sharing them amongst the members. It was unknown to the members themselves what was being shared until later on, when we found our full files were disclosed, including names.

Mr. Colin Fraser: Have there been members who have made complaints to the college about the professional responsibility of physicians under this scheme?

Mr. David Reichert: Yes.

Mr. Colin Fraser: What's been the result from the college?

Mr. David Reichert: The result is that the RCMP is too big, and no one wants to take them on.

Mr. Colin Fraser: Have there actually been reported decisions by the college on these sorts of things?

Mr. David Reichert: They've looked at them and said it's fine, and that was it. They won't deal with the issues.

It's very difficult to do anything, whether you do a privacy information...to lay a charge, or anything to deal with that, particularly in British Columbia. I've had experience in all of that. You just can't do it.

Mr. Colin Fraser: Do you have any documentation back from the College of Physicians and Surgeons saying that they're too big to deal with?

Mr. David Reichert: We have the entire file, and it's now before the courts in British Columbia under breach of privacy. We've also involved the federal Privacy Commissioner, who gave us a decision. I believe Mr. Banwarie is providing that information to you.

Mr. Rae Banwarie: Yes.

Mr. Colin Fraser: All right.

Mr. Rae Banwarie: It's included in the brief.

● (1700)

Mr. Colin Fraser: Okay, fine.

Mr. Rae Banwarie: It's the full, entire investigation. There were approximately 30 members or more affected in that case in which all the medical information was gone through. It was well founded, a serious privacy breach, because of the type of information—

Mr. Colin Fraser: But it's before the courts now, so that hasn't been determined by the court yet.

Mr. Rae Banwarie: Well, the members have no choice. It has to go to the courts.

Mr. Sebastien Anderson: Well, no; it has been decided. It went to the federal Privacy Commissioner. The federal Privacy Commissioner upheld the complaint and found that there was a fundamental breach of privacy. The breach was that the members' psychological health information was not only shared with the college but was also shared with the administrative chain of command up to the commissioner, who ultimately approved filing the complaint against Dr. Webster.

Mr. Colin Fraser: Thanks very much. I look forward to reading that in the brief.

My friend will finish the time.

The Chair: Go ahead, Ms. Lockhart.

Mrs. Alaina Lockhart: Thank you.

While we were going through the testimony here, I looked back and saw that in October of last year we had retired Captain Andrew Garsh here. He talked about reconstructing identity and had found a program called Shaping Purpose, which they were going to pilot in Fredericton. I'm just wondering if any of you are aware of that. It's a training program. We'll go back to that at some point, because I think it hit a lot of the things that you were talking about, but it was in a pilot stage.

I wanted to congratulate to you, Ms. Le Scelleur, for being selected to represent Canada in the Invictus Games.

Ms. Hélène Le Scelleur: Thank you.

Mrs. Alaina Lockhart: The reason I bring it up is that I wanted to talk to you a little bit about how activities like sports can impact those who are transitioning out of the military. Maybe you can tell us a little bit about your personal experience.

[*Translation*]

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

Actually, I just returned yesterday from Switzerland, where I was skiing with two Canadian veterans and some British veterans, for the Supporting Wounded Veterans charity. The idea of this organization is mainly to use sport to provide a mentoring program, which is offered by the business community. The goal is to help the individual to find a job, to return to work or to take training to find a new occupation.

The positive response to my participation in the Invictus Games came in November, as was the opportunity to go skiing with veterans. I can assure you that the change in my life occurred then. Indeed, I had an objective in front of me that allowed me to consider participating, with my friends, in something much bigger than me.

Thank you.

[*English*]

Mrs. Alaina Lockhart: Thank you.

Here is a question to all of our witnesses.

We've mentioned sports. Are there other alternative therapies that you have seen that have had positive results that we should be looking at closely?

The Chair: I'll just have to apologize. We'll have to make it very quick because we are short on time.

Ms. Debbie Lowther: I could talk about a program that we launched about two years ago called Guitars for Vets. The idea behind that came from when my husband was struggling with PTSD. He decided to pick up his guitar, which had been sitting in the corner for a long time, and it was very helpful for him. Back in late 2013 and early 2014 we saw a string of veteran suicides, and at that point in time he decided that something should be done, so we launched Guitars for Vets. Basically, we use donated guitars, and the veteran or RCMP member is provided with 10 free lessons with a volunteer guitar instructor. I have to say that we get more response from that program, with people saying, "You saved my life", than we do with people whom we've taken off the streets. It's amazing.

Mrs. Alaina Lockhart: Thank you very much.

Mr. Rae Banwarie: That is a fabulous strategy, getting that sort of response and basically saving lives. For us, what we did was support peer groups, just for members to get together and talk, and you'd be amazed at how much healing came from that. For us who are part of this work, this is healing when we can help others and save lives, because that's what it is.

The Chair: Thank you.

Mr. Brassard is next.

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

I want to start with you. We're hearing two different stories here. We had management and HR from the RCMP come in talking about the stigma associated with mental health and how it's actually seemingly okay now, but I'm hearing a different story from you, so I want to touch on that. I want you to touch on that briefly if you can. Why are we hearing two different stories on this?

● (1705)

Mr. Rae Banwarie: There are many things you have to consider. I'm a proud member of the organization, still a serving current member, and I am leading the charge to bring about a lot of changes. At the end of the day, when you cut everything aside, put everything off the table, it's control and putting out what people want to hear and what people want to see versus what is actually happening.

The case that was cited, the privacy breach, is a clear indicator of that in terms of the stigma. We have been actively helping our members. They're turning to us. The trust component is there for us. We are not being given the ability to do this work full time to save, to reach out, to make differences in people's lives.

You will always get management telling you about all these great programs, all these great processes. I've had the same discussion with several senior officers. I've said that you can put however many programs and however many processes in place, but none of it is going to matter if you don't have the trust. That is a key piece that is missing.

Dr. Webster is one of the psychologists. There's another one, Dr. Passey, a well-known psychologist in B.C. who has spoken out against the same issues, who's also in the same situation. Just by looking at this idea or problem as a different concept, I became aware in different provinces—Ontario, Manitoba, and I think Alberta—of presumptive legislation for PTSD. The biggest division in the country, British Columbia, does not have that for all first responders. It's not only police; it's military, it's firefighters, it's ambulances. Those basic things must be in place.

An NDP member in British Columbia, Shane Simpson, was the one who entered a private member's bill—I don't have the number in front of me—to try to get that recognized in the province of B.C. It didn't go anywhere.

Mr. John Brassard: Right. You'll be glad to know that there's a private member's bill coming nationally that we're going to be debating soon that's going to speak to a national framework on PTSD recognition.

I have another question.

I had the opportunity to visit the Sunnybrook Health Sciences Centre, and I know that one of the things they're proposing is a centre for post-traumatic stress disorder. I would like briefly to hear from all of you whether you think it would be a good idea to have a centre for post-traumatic stress disorder to deal with not only veterans but also RCMP, or the potential of both.

Debbie, would you start quickly?

Ms. Debbie Lowther: Absolutely, I think that would be wonderful. As I mentioned earlier, the veterans community has been asking for a veteran-specific treatment program for quite some time. If that were to happen, it would make a lot of people very happy.

Mr. John Brassard: Rae, would you comment?

Mr. Rae Banwarie: I would concur with that. Anything we can put into play that will help our people will be money well spent.

Ms. Hélène Le Scelleur: I would say the same thing.

[*Translation*]

I would like to add that the services should be bilingual.

[*English*]

Mr. John Brassard: You'd like them to be bilingual. Okay. Thank you.

How much time do I have?

The Chair: You have just over a minute.

Mr. John Brassard: Okay.

On the issue of suicide, I know you mentioned 31 suicides. How does the RCMP track suicides? Among current members it's obvious, but more specifically for the retired members, how is that done, Rae?

Mr. Rae Banwarie: I am unaware of any process until recently, when it became an issue and they started tracking and looking at this. That number starts from 2006. Prior to that, I have no idea if they even counted.

My colleague Mr. Reichert could talk to you about some of the situations prior to that, specifically in Burnaby.

Mr. David Reichert: In the detachment I had in Burnaby, in one year five people committed suicide. In my career, 19 guys I've worked with have committed suicide. I'm not aware of any investigations that took place. I know I spoke to them hours before or sometimes just the day before some of these people took their lives, and no one ever asked me any questions. I know what was going through their heads. I know what occurred in their lives to lead to their decision. No one ever talked about it. I'm not aware of any investigation. I think basically they kept it quiet so that no one had to take the responsibility.

I advise the members to pull their health records, because when you pull your health records, you want to have a look at your sign-out card to see who had access to your particular files—if, in fact, they've filled it out. In one case in particular, a member who was going through PTSD had on their health record, "This person is a nut", written by a member of the force. Who knows who looked at that health record? That's part of the whole issue.

However, I'm not aware of any record or cause and effect or any study that's ever been done.

● (1710)

The Chair: Thank you.

Mr. Rae Banwarie: If I might, I would mention one thing quickly. You asked about suicides. I am aware that a special coroner has been appointed to do an investigation on suicides in B.C. John Knox, out of the B.C. coroner's office, will start with the suicide of Pierre Lemaitre and look at the suicides of several other RCMP members. That report is at least two years overdue, and I believe it is being stifled for political reasons. The families that have reached out to us have not had any response or any follow-up.

The Chair: Thank you.

Go ahead, Ms. Mathyssen.

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

I want to come back to the situation within the RCMP.

I want to say thank you to you, Mr. Banwarie, for your efforts regarding unionization. I see that as an important key in a lot of this discussion. It also seems to me that you keep coming back to the point that nobody takes responsibility, whether it's for those women who were sexually harassed and who lost their careers or whether it was with regard to a confidentiality breach. I have never heard of it being okay for there to be a breach of patient/provider confidentiality or for files to be shared with the College of Physicians and Surgeons. Over and over again nobody's taking responsibility.

You said nobody's been held accountable. Is that the problem? If, indeed, we are going to make recommendations about how we can assist those who are facing despair and thinking about suicide, does it come down to the responsibility of the employer, the RCMP, or the responsibility of the Department of National Defence, to accept their role in ending this travesty of despair and suicide?

Mr. Rae Banwarie: Absolutely, yes, but we're here and we recognize in an organization as big as ours we're always going to have these issues, but not to the extent that they should be happening.

If you're being offered help and resolutions and solutions to reduce the harm, why would you not accept it? The only reason you would not accept the help is control. With that, you've touched on a very key part about the lack of accountability. That is a very big issue.

If you want to take other agencies—for example, big agencies, police agencies—and if you want to be specific just for our organization, how are they managing? What are they doing differently? How come you don't see all these issues happening in metro Toronto or the OPP?

A very simple piece of this is that it is because they have an independent body there that is holding management accountable. There's also a collective bargaining agreement that lays out the framework for the responsibilities of the management as well as the members, and if there are issues, this is how they're addressed and they're addressed in a timely fashion.

That's all part of the process. That's all part of what keeps the members and those agencies healthy and helps toward their overall wellness, because they know if issues occur and things happen, they're going to be addressed and they're going to be addressed impartially. That is what is missing out of all of this. You fix that and you will change the culture. You change the culture and you're going to change the RCMP. That's the solution, and that's why this work is so important.

The files and the investigations and all that stuff—that's important, but your people are more important than all of that.

● (1715)

The Chair: Thank you.

That ends our committee meeting today. I'd like to thank all of you on behalf of all the members for your testimony today and for your continued support to our men and women who serve our country.

If there's anything you want to add to your testimony or any questions you want to elaborate on, if you could get it to the clerk, the clerk will distribute it to the committee.

Thank you. The meeting is adjourned.